09WC28907

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dunsy Haynes

Petitioner,

vs.

No. 09 WC 28907

Gunite Corporation

15IWCC0410

Respondent,

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Petitioner's Petition for Review, which was timely filed on January 13, 2012.

FACTS AND PROCEEDURAL HISTORY

Applications for Adjustment of Claim were filed on July 13, 2009 for the case at bar, 09WC28907, as well as cases 09WC28908, 09WC28909, and 09WC28910. Petitioner's counsel in this matter also represents the other petitioners in the three referenced cases. All four of the applications filed name Gunite Corporation as Respondent.

On July 15, 2011, Arbitrator Akemann dismissed all four cases. No record was made.

On or about November 10, 2011, Petitioner's counsel filed Petitions to Reinstate all four cases. In his petitions, Petitioner's counsel alleged that at the time of the dismissals, the cases were not above the Commission's mandatory trial line and that he had not received notice of the dismissals. Petitioner's counsel explained that he found out about the dismissals when he checked on the status of the cases on the Commission website.

Petitioner's Petition to Reinstate this claim and the three companion matters was heard on December 16, 2011. At that time, Arbitrator Akemann denied Petitioner's Petitions for Reinstatement. Again, no record of those proceedings was made.

On or about January 13, 2012, Petitioner's counsel filed a Petition for Review on this and the three companion matters. While the Commission file for case 09WC28907 did not contain the Petition for Review for that case, the Commission files for cases 09WC28908, 09WC28909, and 09WC28910 do and these petitions indicate that Petitioner's counsel requested that a transcript of any hearing held on December 16, 2011 be prepared, as part of the Review process.

Subsequent to the filings of the Petitions for Review, as aforesaid, the Commission discovered that certain documents necessary to consider the allegations raised by Petitioner's counsel and others could not be found in the Commission files for all four cases. Specifically, the July 15, 2011 orders from Arbitrator Akemann dismissing each case were not found.

Thereafter, the Commission contacted the attorneys and requested that copies of certain documents, including the July 15, 2011 dismissals, be presented to the Commission so that a completed record could be had and due consideration could be given to the issues at hand.

Respondent's counsel objected to the supplementation of the Commission records by Petitioner's counsel. Respondent refused to tender copies of any documents in its possession, regarding any of the four referenced matters.

On or about June 4, 2012, Petitioner's counsel filed Statements of Exceptions relative to all four cases. In the Statements of Exceptions, Petitioner's counsel alleged that on July 15, 2011, all four cases were before Arbitrator Akemann on Respondent's request for a hearing. It appears Motions to Dismiss were filed by Respondent's counsel due to a lack of progress in discovery in each case.

Petitioner's counsel further alleged that an informal discussion between both attorneys occurred outside the presence of the Arbitrator regarding some confusion regarding discovery. Petitioner's counsel alleged that he then spoke to the Arbitrator and it was his understanding that the cases were to be returned to the call and continued generally. Petitioner's counsel alleged that the cases were not set for hearing in his presence. After Petitioner's counsel left, Arbitrator Akemann dismissed all four cases. Petitioner's counsel alleged that he did not receive notice of the dismissals until almost three months after the dismissals had occurred.

On or about June 6, 2012, Respondent filed a Motion to Dismiss this Review, and the Review Petitions filed in the three additional matters, for Lack of Subject Matter Jurisdiction on all four cases. In its motions, Respondent alleged that Petitioner had failed to abide by the requirements under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") and that neither a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings on July 15, 2011 had been filed in accord with the statute. Respondent again filed Motions to Dismiss this Review, and the Review Petitions for the three additional matters on August 22, 2012 and August 27, 2012.

On or about October 4, 2012, Petitioner's counsel filed Responses to Respondent's Motions to Dismiss the said Review Petitions for Lack of Subject Matter Jurisdiction and Motions to Declare Arbitrator Akemann's Dismissals Void as Violative of Section 19(b). In his responses and motions, Petitioner's counsel reiterated his earlier arguments that the cases were not above the Commission's trial line and had not been set for trial or hearing, to his knowledge, when the said cases were dismissed.

On or about October 23, 2012, Respondent's counsel filed a Reply to Petitioner's Response Brief in this and the companion matters. In the Reply, Respondent's counsel reiterated Respondent's earlier argument that Petitioner's counsel failed to abide by the requirements under

Section 19(b) of the Act by failing to file a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings.

On January 11, 2013, a hearing was held before Commissioner Kevin Lamborn in Rockford, Illinois relative to Respondent's Motions to Dismiss each of the Petitioner's Petitions for Review. Said hearing was held on a consolidated basis, as one record was made for all of the matters collectively.

Respondent's counsel started by explaining that his argument applied to all four cases as they involve the same factual and legal issues. Respondent's counsel then reiterated Respondent's argument that Petitioner's counsel failed to perfect the review of Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate by failing to provide a transcript of evidence or an agreed statement of facts as required under Section 19(b) of the Act. Therefore, Respondent's counsel argued, Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate have become final and the Commission no longer has jurisdiction over any of the said cases.

Respondent's counsel also argued that Petitioner did not request that the Commission issue a written order regarding the dismissal of the claim(s). By Respondent's theory, Petitioner's Motion, which is contained in Petitioner's brief, requesting that the Commission strike the Arbitrator's original dismissal, is "void" because Petitioner failed to request a written order as required by the Rules Governing Practice before the Illinois Workers' Compensation Commission. The Commission has searched the Rules, as aforesaid, and finds no such requirement.

Petitioner reiterated his argument that Arbitrator Akemann's original Dismissal(s) is flawed and violative of Section 19(b) of the Act since Petitioner was not promptly notified of the dismissals, receiving notice of same almost three months after the entry of the order(s). Petitioner's counsel also argued that if the Commission were to accept Respondent's argument that Petitioner's counsel failed to perfect the Review(s) by failing to provide a transcript or an agreed statement of facts, the Commission would be putting form over substance.

Arbitrator Akemann's appointment was not renewed and he was terminated from employment with the Commission on September 24, 2012.

FINDINGS OF THE COMMISSION

It is readily apparent to the Commission that Arbitrator Akemann failed to make a record of the proceedings in this case, and the listed companions, either at the time of the dismissals or at the time when he denied Petitioner's Petition to Reinstate.

It is readily apparent to the Commission that Arbitrator Akemann failed to tender the documents appurtenant in this matter to the Commission, thus depriving the Commission and the parties a sufficient basis by which a record could be prepared.

Also it is readily apparent to the Commission that Respondent's efforts at obfuscation in this case have been made in an effort to prevent the Commission from reaching the singular most

important issue in this matter, which is; "Was the dismissal of these claims by Arbitrator Akemann appropriate under the Act and the Rules?"

To that end, the Commission notes that Section 19(b) of the Act states, in pertinent part,

> The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed....Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. (820 ILCS 305/19(b) (2011))

Furthermore, Section 7040.10(b) of the Rules, Order of Arbitration Transcript, reads in pertinent part:

> 1) Stenographic reports of proceedings before the Industrial Commission shall be furnished the parties only upon written order filed by the Commission.
>
> 2) For purposes of perfecting a review, an arbitration transcript must be ordered within the time fixed by statute. (50 Ill.Adm.Code §7040.10(b) (2012))

The Commission notes that Petitioner made a good faith effort to obtain a transcript of proceedings as evidenced by the Petition for Review that was filed in this and the companion matters. Arbitrator Akemann's failure in his obligation to make an appropriate record such that the Commission could understand his basis for the dismissal of this claim and the companion claims does not negate counsel's meeting of his obligation by attempting to obtain a transcript of any proceedings held on July 15, 2011, when the dismissals occurred, pursuant to the Rules and Act.

It is apparent by its actions that Respondent is neither interested nor willing to provide documents such that the Commission would have a more clear understanding of the intent of Arbitrator Akemann and his reasons for dismissal and reasons for his refusal to reinstate said claims.

Therefore, based upon the record before us and the dearth of information and pleadings, the Commission is compelled to reverse the actions of Arbitrator Akemann and Reinstate said claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss the Review is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Reinstate is granted.

Dated: JUN 2 - 2015
MJB:ell
52

Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

09WC28908

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Ketton

Petitioner,

vs.

No. 09 WC 28908

Gunite Corporation

Respondent.

15IWCC0411

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Petitioner's Petition for Review, which was timely filed on January 13, 2012.

FACTS AND PROCEEDURAL HISTORY

Applications for Adjustment of Claim were filed on July 13, 2009 for the case at bar, 09WC28908, as well as cases 09WC28907, 09WC28909, and 09WC28910. Petitioner's counsel in this matter also represents the other petitioners in the three referenced cases. All four of the applications filed name Gunite Corporation as Respondent.

On July 15, 2011, Arbitrator Akemann dismissed all four cases. No record was made.

On or about November 10, 2011, Petitioner's counsel filed Petitions to Reinstate all four cases. In his petitions, Petitioner's counsel alleged that at the time of the dismissals, the cases were not above the Commission's mandatory trial line and that he had not received notice of the dismissals. Petitioner's counsel explained that he found out about the dismissals when he checked on the status of the cases on the Commission website.

Petitioner's Petition to Reinstate this claim and the three companion matters was heard on December 16, 2011. At that time, Arbitrator Akemann denied Petitioner's Petitions for Reinstatement. Again, no record of those proceedings was made.

On or about January 13, 2012, Petitioner's counsel filed a Petition for Review on this and the three companion matters. The petitions indicate that Petitioner's counsel requested that a transcript of any hearing held on December 16, 2011 be prepared, as part of the Review process.

Subsequent to the filings of the Petitions for Review, as aforesaid, the Commission discovered that certain documents necessary to consider the allegations raised by Petitioner's

counsel and others could not be found in the Commission files for all four cases. Specifically, the July 15, 2011 orders from Arbitrator Akemann dismissing each case were not found.

Thereafter, the Commission contacted the attorneys and requested that copies of certain documents, including the July 15, 2011 dismissals, be presented to the Commission so that a completed record could be had and due consideration could be given to the issues at hand.

Respondent's counsel objected to the supplementation of the Commission records by Petitioner's counsel. Respondent refused to tender copies of any documents in its possession, regarding any of the four referenced matters.

On or about June 4, 2012, Petitioner's counsel filed Statements of Exceptions relative to all four cases. In the Statements of Exceptions, Petitioner's counsel alleged that on July 15, 2011, all four cases were before Arbitrator Akemann on Respondent's request for a hearing. It appears Motions to Dismiss were filed by Respondent's counsel due to a lack of progress in discovery in each case.

Petitioner's counsel further alleged that an informal discussion between both attorneys occurred outside the presence of the Arbitrator regarding some confusion regarding discovery. Petitioner's counsel alleged that he then spoke to the Arbitrator and it was his understanding that the cases were to be returned to the call and continued generally. Petitioner's counsel alleged that the cases were not set for hearing in his presence. After Petitioner's counsel left, Arbitrator Akemann dismissed all four cases. Petitioner's counsel alleged that he did not receive notice of the dismissals until almost three months after the dismissals had occurred.

On or about June 6, 2012, Respondent filed a Motion to Dismiss this Review, and the Review Petitions filed in the three additional matters, for Lack of Subject Matter Jurisdiction on all four cases. In its motions, Respondent alleged that Petitioner had failed to abide by the requirements under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") and that neither a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings on July 15, 2011 had been filed in accord with the statute. Respondent again filed Motions to Dismiss this Review, and the Review Petitions for the three additional matters on August 22, 2012 and August 27, 2012.

On or about October 4, 2012, Petitioner's counsel filed Responses to Respondent's Motions to Dismiss the said Review Petitions for Lack of Subject Matter Jurisdiction and Motions to Declare Arbitrator Akemann's Dismissals Void as Violative of Section 19(b). In his responses and motions, Petitioner's counsel reiterated his earlier arguments that the cases were not above the Commission's trial line and had not been set for trial or hearing, to his knowledge, when the said cases were dismissed.

On or about October 23, 2012, Respondent's counsel filed a Reply to Petitioner's Response Brief in this and the companion matters. In the Reply, Respondent's counsel reiterated Respondent's earlier argument that Petitioner's counsel failed to abide by the requirements under Section 19(b) of the Act by failing to file a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings.

On January 11, 2013, a hearing was held before Commissioner Kevin Lamborn in Rockford, Illinois relative to Respondent's Motions to Dismiss each of the Petitioner's Petitions for Review. Said hearing was held on a consolidated basis, as one record was made for all of the matters collectively.

Respondent's counsel started by explaining that his argument applied to all four cases as they involve the same factual and legal issues. Respondent's counsel then reiterated Respondent's argument that Petitioner's counsel failed to perfect the review of Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate by failing to provide a transcript of evidence or an agreed statement of facts as required under Section 19(b) of the Act. Therefore, Respondent's counsel argued, Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate have become final and the Commission no longer has jurisdiction over any of the said cases.

Respondent's counsel also argued that Petitioner did not request that the Commission issue a written order regarding the dismissal of the claim(s). By Respondent's theory, Petitioner's Motion, which is contained in Petitioner's brief, requesting that the Commission strike the Arbitrator's original dismissal, is "void" because Petitioner failed to request a written order as required by the Rules Governing Practice before the Illinois Workers' Compensation Commission. The Commission has searched the Rules, as aforesaid, and finds no such requirement.

Petitioner reiterated his argument that Arbitrator Akemann's original Dismissal(s) is flawed and violative of Section 19(b) of the Act since Petitioner was not promptly notified of the dismissals, receiving notice of same almost three months after the entry of the order(s). Petitioner's counsel also argued that if the Commission were to accept Respondent's argument that Petitioner's counsel failed to perfect the Review(s) by failing to provide a transcript or an agreed statement of facts, the Commission would be putting form over substance.

Arbitrator Akemann's appointment was not renewed and he was terminated from employment with the Commission on September 24, 2012.

FINDINGS OF THE COMMISSION

It is readily apparent to the Commission that Arbitrator Akemann failed to make a record of the proceedings in this case, and the listed companions, either at the time of the dismissals or at the time when he denied Petitioner's Petition to Reinstate.

It is readily apparent to the Commission that Arbitrator Akemann failed to tender the documents appurtenant in this matter to the Commission, thus depriving the Commission and the parties a sufficient basis by which a record could be prepared.

Also it is readily apparent to the Commission that Respondent's efforts at obfuscation in this case have been made in an effort to prevent the Commission from reaching the singular most important issue in this matter, which is; "Was the dismissal of these claims by Arbitrator Akemann appropriate under the Act and the Rules?"

To that end, the Commission notes that Section 19(b) of the Act states, in pertinent part,

> The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed....Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. (820 ILCS 305/19(b) (2011))

Furthermore, Section 7040.10(b) of the Rules, Order of Arbitration Transcript, reads in pertinent part:

> 1) Stenographic reports of proceedings before the Industrial Commission shall be furnished the parties only upon written order filed by the Commission.
>
> 2) For purposes of perfecting a review, an arbitration transcript must be ordered within the time fixed by statute. (50 Ill.Adm.Code §7040.10(b) (2012))

The Commission notes that Petitioner made a good faith effort to obtain a transcript of proceedings as evidenced by the Petition for Review that was filed in this and the companion matters. Arbitrator Akemann's failure in his obligation to make an appropriate record such that the Commission could understand his basis for the dismissal of this claim and the companion claims does not negate counsel's meeting of his obligation by attempting to obtain a transcript of any proceedings held on July 15, 2011, when the dismissals occurred, pursuant to the Rules and Act.

It is apparent by its actions that Respondent is neither interested nor willing to provide documents such that the Commission would have a more clear understanding of the intent of Arbitrator Akemann and his reasons for dismissal and reasons for his refusal to reinstate said claims.

Therefore, based upon the record before us and the dearth of information and pleadings, the Commission is compelled to reverse the actions of Arbitrator Akemann and Reinstate said claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss the Review is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Reinstate is granted.

Dated: JUN 2 - 2015
MJB:ell
52

Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

09WC28909

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leon Brown

Petitioner,

vs.

No. 09 WC 28909

Gunite Corporation

15IWCC0412

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Petitioner's Petition for Review, which was timely filed on January 13, 2012.

FACTS AND PROCEEDURAL HISTORY

Applications for Adjustment of Claim were filed on July 13, 2009 for the case at bar, 09WC28909, as well as cases 09WC28907, 09WC28908, and 09WC28910. Petitioner's counsel in this matter also represents the other petitioners in the three referenced cases. All four of the applications filed name Gunite Corporation as Respondent.

On July 15, 2011, Arbitrator Akemann dismissed all four cases. No record was made.

On or about November 10, 2011, Petitioner's counsel filed Petitions to Reinstate all four cases. In his petitions, Petitioner's counsel alleged that at the time of the dismissals, the cases were not above the Commission's mandatory trial line and that he had not received notice of the dismissals. Petitioner's counsel explained that he found out about the dismissals when he checked on the status of the cases on the Commission website.

Petitioner's Petition to Reinstate this claim and the three companion matters was heard on December 16, 2011. At that time, Arbitrator Akemann denied Petitioner's Petitions for Reinstatement. Again, no record of those proceedings was made.

On or about January 13, 2012, Petitioner's counsel filed a Petition for Review on this and the three companion matters. The petitions indicate that Petitioner's counsel requested that a transcript of any hearing held on December 16, 2011 be prepared, as part of the Review process.

Subsequent to the filings of the Petitions for Review, as aforesaid, the Commission discovered that certain documents necessary to consider the allegations raised by Petitioner's

15IWCC0412

counsel and others could not be found in the Commission files for all four cases. Specifically, the July 15, 2011 orders from Arbitrator Akemann dismissing each case were not found.

Thereafter, the Commission contacted the attorneys and requested that copies of certain documents, including the July 15, 2011 dismissals, be presented to the Commission so that a completed record could be had and due consideration could be given to the issues at hand.

Respondent's counsel objected to the supplementation of the Commission records by Petitioner's counsel. Respondent refused to tender copies of any documents in its possession, regarding any of the four referenced matters.

On or about June 4, 2012, Petitioner's counsel filed Statements of Exceptions relative to all four cases. In the Statements of Exceptions, Petitioner's counsel alleged that on July 15, 2011, all four cases were before Arbitrator Akemann on Respondent's request for a hearing. It appears Motions to Dismiss were filed by Respondent's counsel due to a lack of progress in discovery in each case.

Petitioner's counsel further alleged that an informal discussion between both attorneys occurred outside the presence of the Arbitrator regarding some confusion regarding discovery. Petitioner's counsel alleged that he then spoke to the Arbitrator and it was his understanding that the cases were to be returned to the call and continued generally. Petitioner's counsel alleged that the cases were not set for hearing in his presence. After Petitioner's counsel left, Arbitrator Akemann dismissed all four cases. Petitioner's counsel alleged that he did not receive notice of the dismissals until almost three months after the dismissals had occurred.

On or about June 6, 2012, Respondent filed a Motion to Dismiss this Review, and the Review Petitions filed in the three additional matters, for Lack of Subject Matter Jurisdiction on all four cases. In its motions, Respondent alleged that Petitioner had failed to abide by the requirements under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") and that neither a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings on July 15, 2011 had been filed in accord with the statute. Respondent again filed Motions to Dismiss this Review, and the Review Petitions for the three additional matters on August 22, 2012 and August 27, 2012.

On or about October 4, 2012, Petitioner's counsel filed Responses to Respondent's Motions to Dismiss the said Review Petitions for Lack of Subject Matter Jurisdiction and Motions to Declare Arbitrator Akemann's Dismissals Void as Violative of Section 19(b). In his responses and motions, Petitioner's counsel reiterated his earlier arguments that the cases were not above the Commission's trial line and had not been set for trial or hearing, to his knowledge, when the said cases were dismissed.

On or about October 23, 2012, Respondent's counsel filed a Reply to Petitioner's Response Brief in this and the companion matters. In the Reply, Respondent's counsel reiterated Respondent's earlier argument that Petitioner's counsel failed to abide by the requirements under Section 19(b) of the Act by failing to file a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings.

On January 11, 2013, a hearing was held before Commissioner Kevin Lamborn in Rockford, Illinois relative to Respondent's Motions to Dismiss each of the Petitioner's Petitions for Review. Said hearing was held on a consolidated basis, as one record was made for all of the matters collectively.

Respondent's counsel started by explaining that his argument applied to all four cases as they involve the same factual and legal issues. Respondent's counsel then reiterated Respondent's argument that Petitioner's counsel failed to perfect the review of Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate by failing to provide a transcript of evidence or an agreed statement of facts as required under Section 19(b) of the Act. Therefore, Respondent's counsel argued, Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate have become final and the Commission no longer has jurisdiction over any of the said cases.

Respondent's counsel also argued that Petitioner did not request that the Commission issue a written order regarding the dismissal of the claim(s). By Respondent's theory, Petitioner's Motion, which is contained in Petitioner's brief, requesting that the Commission strike the Arbitrator's original dismissal, is "void" because Petitioner failed to request a written order as required by the Rules Governing Practice before the Illinois Workers' Compensation Commission. The Commission has searched the Rules, as aforesaid, and finds no such requirement.

Petitioner reiterated his argument that Arbitrator Akemann's original Dismissal(s) is flawed and violative of Section 19(b) of the Act since Petitioner was not promptly notified of the dismissals, receiving notice of same almost three months after the entry of the order(s). Petitioner's counsel also argued that if the Commission were to accept Respondent's argument that Petitioner's counsel failed to perfect the Review(s) by failing to provide a transcript or an agreed statement of facts, the Commission would be putting form over substance.

Arbitrator Akemann's appointment was not renewed and he was terminated from employment with the Commission on September 24, 2012.

FINDINGS OF THE COMMISSION

It is readily apparent to the Commission that Arbitrator Akemann failed to make a record of the proceedings in this case, and the listed companions, either at the time of the dismissals or at the time when he denied Petitioner's Petition to Reinstate.

It is readily apparent to the Commission that Arbitrator Akemann failed to tender the documents appurtenant in this matter to the Commission, thus depriving the Commission and the parties a sufficient basis by which a record could be prepared.

Also it is readily apparent to the Commission that Respondent's efforts at obfuscation in this case have been made in an effort to prevent the Commission from reaching the singular most important issue in this matter, which is; "Was the dismissal of these claims by Arbitrator Akemann appropriate under the Act and the Rules?"

To that end, the Commission notes that Section 19(b) of the Act states, in pertinent part,

> The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed....Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. (820 ILCS 305/19(b) (2011))

Furthermore, Section 7040.10(b) of the Rules, Order of Arbitration Transcript, reads in pertinent part:

> 1) Stenographic reports of proceedings before the Industrial Commission shall be furnished the parties only upon written order filed by the Commission.
>
> 2) For purposes of perfecting a review, an arbitration transcript must be ordered within the time fixed by statute. (50 Ill.Adm.Code §7040.10(b) (2012))

The Commission notes that Petitioner made a good faith effort to obtain a transcript of proceedings as evidenced by the Petition for Review that was filed in this and the companion matters. Arbitrator Akemann's failure in his obligation to make an appropriate record such that the Commission could understand his basis for the dismissal of this claim and the companion claims does not negate counsel's meeting of his obligation by attempting to obtain a transcript of any proceedings held on July 15, 2011, when the dismissals occurred, pursuant to the Rules and Act.

It is apparent by its actions that Respondent is neither interested nor willing to provide documents such that the Commission would have a more clear understanding of the intent of Arbitrator Akemann and his reasons for dismissal and reasons for his refusal to reinstate said claims.

Therefore, based upon the record before us and the dearth of information and pleadings, the Commission is compelled to reverse the actions of Arbitrator Akemann and Reinstate said claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss the Review is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Reinstate is granted.

Dated: JUN 2 - 2015
MJB:ell
52

Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

09WC28910

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Keith L. Buford

Petitioner,

vs.

No. 09 WC 28910

Gunite Corporation

15IWCC0413

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission pursuant to Petitioner's Petition for Review, which was timely filed on January 13, 2012.

FACTS AND PROCEEDURAL HISTORY

Applications for Adjustment of Claim were filed on July 13, 2009 for the case at bar, 09WC28910, as well as cases 09WC28907, 09WC28908, and 09WC28909. Petitioner's counsel in this matter also represents the other petitioners in the three referenced cases. All four of the applications filed name Gunite Corporation as Respondent.

On July 15, 2011, Arbitrator Akemann dismissed all four cases. No record was made.

On or about November 10, 2011, Petitioner's counsel filed Petitions to Reinstate all four cases. In his petitions, Petitioner's counsel alleged that at the time of the dismissals, the cases were not above the Commission's mandatory trial line and that he had not received notice of the dismissals. Petitioner's counsel explained that he found out about the dismissals when he checked on the status of the cases on the Commission website.

Petitioner's Petition to Reinstate this claim and the three companion matters was heard on December 16, 2011. At that time, Arbitrator Akemann denied Petitioner's Petitions for Reinstatement. Again, no record of those proceedings was made.

On or about January 13, 2012, Petitioner's counsel filed a Petition for Review on this and the three companion matters. The petitions indicate that Petitioner's counsel requested that a transcript of any hearing held on December 16, 2011 be prepared, as part of the Review process.

Subsequent to the filings of the Petitions for Review, as aforesaid, the Commission discovered that certain documents necessary to consider the allegations raised by Petitioner's

counsel and others could not be found in the Commission files for all four cases. Specifically, the July 15, 2011 orders from Arbitrator Akemann dismissing each case were not found.

Thereafter, the Commission contacted the attorneys and requested that copies of certain documents, including the July 15, 2011 dismissals, be presented to the Commission so that a completed record could be had and due consideration could be given to the issues at hand.

Respondent's counsel objected to the supplementation of the Commission records by Petitioner's counsel. Respondent refused to tender copies of any documents in its possession, regarding any of the four referenced matters.

On or about June 4, 2012, Petitioner's counsel filed Statements of Exceptions relative to all four cases. In the Statements of Exceptions, Petitioner's counsel alleged that on July 15, 2011, all four cases were before Arbitrator Akemann on Respondent's request for a hearing. It appears Motions to Dismiss were filed by Respondent's counsel due to a lack of progress in discovery in each case.

Petitioner's counsel further alleged that an informal discussion between both attorneys occurred outside the presence of the Arbitrator regarding some confusion regarding discovery. Petitioner's counsel alleged that he then spoke to the Arbitrator and it was his understanding that the cases were to be returned to the call and continued generally. Petitioner's counsel alleged that the cases were not set for hearing in his presence. After Petitioner's counsel left, Arbitrator Akemann dismissed all four cases. Petitioner's counsel alleged that he did not receive notice of the dismissals until almost three months after the dismissals had occurred.

On or about June 6, 2012, Respondent filed a Motion to Dismiss this Review, and the Review Petitions filed in the three additional matters, for Lack of Subject Matter Jurisdiction on all four cases. In its motions, Respondent alleged that Petitioner had failed to abide by the requirements under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") and that neither a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings on July 15, 2011 had been filed in accord with the statute. Respondent again filed Motions to Dismiss this Review, and the Review Petitions for the three additional matters on August 22, 2012 and August 27, 2012.

On or about October 4, 2012, Petitioner's counsel filed Responses to Respondent's Motions to Dismiss the said Review Petitions for Lack of Subject Matter Jurisdiction and Motions to Declare Arbitrator Akemann's Dismissals Void as Violative of Section 19(b). In his responses and motions, Petitioner's counsel reiterated his earlier arguments that the cases were not above the Commission's trial line and had not been set for trial or hearing, to his knowledge, when the said cases were dismissed.

On or about October 23, 2012, Respondent's counsel filed a Reply to Petitioner's Response Brief in this and the companion matters. In the Reply, Respondent's counsel reiterated Respondent's earlier argument that Petitioner's counsel failed to abide by the requirements under Section 19(b) of the Act by failing to file a transcript of evidence of the proceedings or an agreed statement of facts of the proceedings.

On January 11, 2013, a hearing was held before Commissioner Kevin Lamborn in Rockford, Illinois relative to Respondent's Motions to Dismiss each of the Petitioner's Petitions for Review. Said hearing was held on a consolidated basis, as one record was made for all of the matters collectively.

Respondent's counsel started by explaining that his argument applied to all four cases as they involve the same factual and legal issues. Respondent's counsel then reiterated Respondent's argument that Petitioner's counsel failed to perfect the review of Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate by failing to provide a transcript of evidence or an agreed statement of facts as required under Section 19(b) of the Act. Therefore, Respondent's counsel argued, Arbitrator Akemann's denial of Petitioner's Petitions to Reinstate have become final and the Commission no longer has jurisdiction over any of the said cases.

Respondent's counsel also argued that Petitioner did not request that the Commission issue a written order regarding the dismissal of the claim(s). By Respondent's theory, Petitioner's Motion, which is contained in Petitioner's brief, requesting that the Commission strike the Arbitrator's original dismissal, is "void" because Petitioner failed to request a written order as required by the Rules Governing Practice before the Illinois Workers' Compensation Commission. The Commission has searched the Rules, as aforesaid, and finds no such requirement.

Petitioner reiterated his argument that Arbitrator Akemann's original Dismissal(s) is flawed and violative of Section 19(b) of the Act since Petitioner was not promptly notified of the dismissals, receiving notice of same almost three months after the entry of the order(s). Petitioner's counsel also argued that if the Commission were to accept Respondent's argument that Petitioner's counsel failed to perfect the Review(s) by failing to provide a transcript or an agreed statement of facts, the Commission would be putting form over substance.

Arbitrator Akemann's appointment was not renewed and he was terminated from employment with the Commission on September 24, 2012.

FINDINGS OF THE COMMISSION

It is readily apparent to the Commission that Arbitrator Akemann failed to make a record of the proceedings in this case, and the listed companions, either at the time of the dismissals or at the time when he denied Petitioner's Petition to Reinstate.

It is readily apparent to the Commission that Arbitrator Akemann failed to tender the documents appurtenant in this matter to the Commission, thus depriving the Commission and the parties a sufficient basis by which a record could be prepared.

Also it is readily apparent to the Commission that Respondent's efforts at obfuscation in this case have been made in an effort to prevent the Commission from reaching the singular most important issue in this matter, which is; "Was the dismissal of these claims by Arbitrator Akemann appropriate under the Act and the Rules?"

To that end, the Commission notes that Section 19(b) of the Act states, in pertinent part,

> The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed....Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. (820 ILCS 305/19(b) (2011))

Furthermore, Section 7040.10(b) of the Rules, Order of Arbitration Transcript, reads in pertinent part:

> 1) Stenographic reports of proceedings before the Industrial Commission shall be furnished the parties only upon written order filed by the Commission.
>
> 2) For purposes of perfecting a review, an arbitration transcript must be ordered within the time fixed by statute. (50 Ill.Adm.Code §7040.10(b) (2012))

The Commission notes that Petitioner made a good faith effort to obtain a transcript of proceedings as evidenced by the Petition for Review that was filed in this and the companion matters. Arbitrator Akemann's failure in his obligation to make an appropriate record such that the Commission could understand his basis for the dismissal of this claim and the companion claims does not negate counsel's meeting of his obligation by attempting to obtain a transcript of any proceedings held on July 15, 2011, when the dismissals occurred, pursuant to the Rules and Act.

It is apparent by its actions that Respondent is neither interested nor willing to provide documents such that the Commission would have a more clear understanding of the intent of Arbitrator Akemann and his reasons for dismissal and reasons for his refusal to reinstate said claims.

Therefore, based upon the record before us and the dearth of information and pleadings, the Commission is compelled to reverse the actions of Arbitrator Akemann and Reinstate said claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss the Review is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Reinstate is granted.

Dated: JUN 2 - 2015
MJB:ell
52

Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Ayers,
Petitioner,

vs.

NO. 14 WC 01749

Younkers, Bon-Ton Stores, Inc.,
Respondent.

15IWCC0414

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, medical expenses, and penalties and fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with additional reasoning, 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 review of the record as a whole, the Commission affirms and adopts the Arbitrator's finding of accident and provides additional reasoning in support of that determination. The Commission further clarifies the award of medical expenses and prospective medical care as outlined below.

Petitioner, a loss prevention and safety manager, fell on ice on the sidewalk outside his employer's building, Younkers Department Store, on December 20, 2013 and sustained injury to his right knee. On appeal before the Commission, the Respondent argues that Petitioner failed to prove that his accident arose out of his employment with Respondent. Arising out of employment refers to the origin or cause of the accident and presupposes a causal connection between the employment and the accidental injury. Petitioner must present evidence which supports a reasonable inference that the fall stemmed from a risk particularly associated with the employment or a neutral risk to which he was exposed to a greater degree than the general public by reason of his employment. The risk of slipping on icy pavement during inclement weather is a neutral risk and Petitioner must show that he was exposed to that hazard to a greater degree than the general public by reason of his employment. First Cash Fin. Servs. v. Indus. Comm'n , 367 Ill. App. 3d 102, 304 Ill. Dec. 722, 853 N.E.2d 799 (2006), Butler Mfg. Co. v. Indus. Com., 85 Ill. 2d 213, 52 Ill. Dec. 623, 422 N.E.2d 625 (1981).

15IWCC0414

Petitioner was not instructed by the store manager, Ms. Robbins, to exit the store in order to check on her or any activity in the parking lot. However, Petitioner's job description included leading safety efforts in the store and ensuring that the outside walkways were in good condition. Petitioner testified that while he was not responsible for the safety of customers in the parking lot, he did get calls regarding suspicious people in the lot, which he would investigate in tandum with alerting mall security and/or the police. He testified that for a situation such as car doing donuts in the lot, he would investigate, call mall dispatch to handle the situation, and follow up with his supervisor regarding the outcome of the situation. Petitioner testified that when he received the call from Ms. Bell on December 20, 2013, regarding the car doing donuts in the parking lot, he immediately called dispatch. The call was answered by Officer Brown at the police department substation in the mall. Officer Brown told Petitioner he would look into it, and Petitioner assured Officer Brown that he investigate the situation as well.

Neither the police nor Ms. Robbins told Petitioner to remain in the store. On the way out to investigate, Petitioner stopped by Ms. Robbins' office to tell her about the situation and was advised she was outside salting the walk. Petitioner was not injured while off the clock or attending to personal business. He was not carrying anything at the time of the fall. There is no evidence Petitioner was doing anything other than checking on the safety of Respondent's employees and the public in the parking lot. The proximate cause of his fall was the ice that had accumulated in front of his employer's premises on the sidewalk used by the general public. Respondent had accepted responsibility for maintaining the area of the sidewalk where Petitioner fell, as evidenced by the fact that Respondent's agents were salting the icy sidewalk at the time of Petitioner's fall. The Commission finds it was reasonably foreseeable and incidental to Petitioner's work duties to step outside to check on the perimeter of the building, the wellbeing of Respondent's employees, and the safety situation in the parking lot. The Commission affirms the Arbitrator's finding that Petitioner sustained injury on December 20, 2013 that arose out of and in the course of his employment with Respondent.

Regarding the award of medical expenses, the Arbitrator awarded "all of Petitioner's medical bills in amounts as stipulated by the parties...Petitioner is entitled to prospective medical care casually connected to the injury." No further order regarding medical expenses was given. The Commission orders Respondent pay to Petitioner the reasonable and necessary medical expenses contained in Petitioner's Exhibits 8-15, as provided in Sections 8(a) and 8.2 of the Act. Regarding prospective treatment, Petitioner testified that Dr. Boardman has recommended additional treatment for the right leg, but there are no supporting medical records in evidence. Petitioner only submitted the off work notes of Dr. Boardman in evidence as Petitioner's Exhibit 2, the actual records are not in evidence. The FMLA requests filled out by Dr. Boardman do not list any additional treatment recommendations. There is no documentation in the record or stipulation by the parties that any medical provider has recommended further treatment for Petitioner related to the December 20, 2013 accident. Therefore, the Commission strikes the sentence "Petitioner is entitled to prospective medical care casually connected to the injury" and vacates the award of prospective medical care.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 29, 2014 is hereby affirmed in part and modified in part with additional reasoning.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses is modified. Respondent is to pay Petitioner the reasonable and necessary medical expenses contained in Petitioner's Exhibits 8-15 pursuant to Section 8(a) and 8.2 of the Act.

15IWCC0414

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $344.35/week for 13-6/7 weeks, commencing December 21, 2013 through March 27, 2014, as provided in Section 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.

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 $4,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/01/15
jdl/adc
68

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

AYERS, MICHAEL
Employee/Petitioner

Case# **14WC001749**

YONKERS; BON-TON STORES INC
Employer/Respondent

15IWCC0414

On 4/29/2014, 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 0.45% 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:

1367 HOPKINS & HUEBNER PC
M ANNE McATEE
100 E KIMBERLY RD SUITE 704
DAVENPORT, IA 52806

0560 WIEDNER & McAULIFFE LTD
MICHAEL DOERRIS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael Ayers
Employee/Petitioner

v.

Younkers; Bon-Ton Stores, Inc.
Employer/Respondent

Case # 14 WC 01749

Consolidated cases: N/A

15IWCC0414

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable McCarthy, Arbitrator of the Commission, in the city of **Bloomington** 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 December 20, 2013, the Respondent Younkers was operating under the provisions of the Act.

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

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

- Timely notice of this accident was given to the Respondent.

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

- In the year preceding the injury, the Petitioner earned $22,520.44; the average weekly wage was $516.52.

- At the time of the injury, the Petitioner was 33 years of age, married with 1 child under age 18.

- Necessary first aid, medical, surgical and hospital services have ***not*** been provided by the Respondent.

- No benefits have been paid by the Respondent on account of this injury, including temporary or medical benefits.

ORDER:

- Respondent shall pay all of Petitioner's medical bills in amounts as stipulated by the parties.

- Petitioner is entitled to TTD benefits from 12/21/13 to March 27, 2014, thirteen weeks and six days at a weekly TTD rate of $344.35 totaling $4,771.66, during which period Petitioner was totally incapacitated and for which compensation is payable, and continuing.

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

- Respondent is not due any credit for sick pay benefits which Petitioner earned over the course of his seven plus years of employment at Younkers.

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

April 25, 2014
Date

APR 29 2014

FINDINGS OF FACT:

Petitioner was employed as a Loss Prevention Supervisor and Safety Specialist at Younkers department store at South Park Mall in Moline, Illinois for more than 7 years (testimony of Petitioner). The job description of Loss Prevention Supervisor of Store includes loss prevention and security, as well as leading the safety efforts in a single location. (Petitioner's Ex. 4). Petitioner's job included shrinkage reduction including implementation and management of programs to keep shrink and loss to a minimum by control of shoplifting, internal theft and paperwork errors. (Petitioner's Ex. 4). Shrinkage reduction also required Petitioner to build and maintain a strong channel of communication with store management including Respondent's two witnesses, Val Robbins, Store Manager, and Jodie Bell, Supervisor. (Petitioner's Ex. 4). In addition, as set forth in the Petitioner's Job Description, (Petitioner's Ex. 4), Petitioner was responsible for conducting Store Compliance Audits and ensuring Exception Reports were being utilized. (Petitioner's Ex. 4). The Store Compliance Audit (Petitioner's Ex. 7) required Petitioner to conduct a Monthly Safety Audit and record the results on the document. The document was not required in the months of November, December and January; however, Petitioner was still required to perform the safety activities identified in the audit. (Testimony of Petitioner, Testimony of Val Robbins, Petitioner's Ex. 7). The Safety Audit required Petitioner, among other things, to review the following:

Entrances/exits

1.1 Is the lighting adequate in the parking lot, exterior dock, and landscaping?

1.2 Are the outside walkways in good condition? (Petitioner's Ex. 7)

In addition, Petitioner's Job Description required that he coordinate and assist with internal investigations related to, but not limited to, policy violations, employee and vendor theft, robbery, burglary, etc. (Petitioner's Ex. 4). These activities included requiring Petitioner to walk the outside perimeter of the Younkers building on a regular basis including the area where he fell on December 20, 2013. (Testimony of Petitioner).

The Job Description of the Petitioner, Loss Prevention Supervisor-Stores, also required him to evaluate performance and provide coaching and direction to the loss prevention agents in the store and lead the safety efforts in a single location. (Petitioner's Ex. 4). Petitioner's job not only included Loss Prevention Supervisor, but also leading the safety efforts in a single location (Petitioner's Ex. 4, Testimony of Petitioner).

On December 20, 2013, Petitioner was at work performing his duties as Loss Prevention Supervisor-Stores and Safety Specialist. In the course of his employment, he received notification that there was a vehicle doing donuts in the icy parking lot. He immediately notified mall security. (Testimony of Petitioner; testimony of Val Robbins). He also testified that during the course of his conversation with mall security he advised them he was also going to investigate the incident.

Petitioner and Val Robbins testified that Younkers kept salt in the store for purposes of salting the sidewalks, and such salting activities were being performed by Ms. Robbins prior to the incident. (Testimony of Val Robbins and Petitioner). Val Robbins further testified that the landlord did not keep the walks sufficiently salted. (Testimony of Val Robbins)

Petitioner was aware that Jodie Bell and Val Robbins, the store manager, were outside placing salt on the sidewalk outside the store at the time he received the report of a vehicle doing donuts in the parking lot. After approximately two minutes since Petitioner had notified mall security of the individual doing donuts in the parking lot, and Ms. Bell and Ms. Robbins did not return to the store following their salting activities on the Younkers sidewalk, Petitioner stepped outside to check on their safety and also the situation in the lot. (Testimony of Petitioner; testimony of Val Robbins; testimony of Jodie Bell). As Petitioner exited the building, the store manager, Val Robbins, told him to "be careful, it's icy." (Testimony of Val Robbins). Ms. Robbins did not direct Petitioner to return to the store nor did she indicate that he should not come toward her. As Petitioner walked toward his supervisor and store manager, he slipped and fell on the ice suffering significant injury. (See Pretrial Stipulation, Testimony of Petitioner; Testimony of Val Robbins).

The employer contacted 911 and an ambulance arrived and took Petitioner to Trinity Medical Center in Rock Island via EMS. (Testimony of Val Robbins; testimony of Petitioner). The Respondent's chosen physician at Trinity Medical Center referred the Petitioner to ORA where he has been seen by Steven Boardman, MD, an orthopaedic surgeon, who has taken him off work since the date of injury. (Petitioner's Ex. 1; 2). Also, Petitioner has undergone physical therapy. (Petitioner's Ex. 3). Petitioner continues off work per his doctor and has received no temporary total disability benefits or medical benefits for his injury.

Petitioner made multiple attempts to obtain required approval for medical care including an MRI, but Liberty Mutual failed to return his calls or authorize treatment. (Testimony of Petitioner). On January 3, 2014, Stephanie Volm at Liberty Mutual Group forwarded a letter to Petitioner's attorney via e-mail indicating that she had completed her investigation of the workers' compensation claim and that she found the claim to be non-compensable as the injuries "did not arise out of" Petitioner's employment. She indicated that she would be denying his claim. (Petitioner's Ex. 16). At no time, did Ms. Volm indicate that it was Respondent's position that the injury did not occur in the course of the Petitioner's employment; nor did she ever give any explanation of the basis of her denial of Petitioner's claim or why she concluded it did not "arise out of his employment", or what investigation she had done.

In the Response to the Petition for Immediate Hearing under Section 19(b) of the Act, filed March 18, 2014 by Respondent, Respondent gives several explanations for the denial. First, "Respondent is a tenant in the commercial mall. Petitioner slipped and fell on ice in the common area of the mall owned, maintained and controlled by the landlord that has a sole responsibility for the maintenance of the property, and in particular, the area of Petitioner's fall." However, Respondent's Ex. 8 is the lease with the landlord which clearly states that the tenant (Younkers) is responsible for payment of its pro rata share of CAM charge. (common area of maintenance) (Respondent's Ex. 8, pg. 2). It is found that at the time of the incident, Younkers' store manager, Val Robbins was in the process of placing salt on the area where Petitioner

slipped. This is contrary to Respondent's assertion that the mall was solely responsible for the maintenance of the property and in particular the area of the Petitioner's fall. (Testimony of Val Robbins; testimony of Jodie Bell; testimony of Petitioner).

CONCLUSIONS OF LAW

The Respondent contends that the Petitioner's accident did not arise out of or was in the course of his employment. In the Respondent's Response to Petition for Immediate Hearing under Section 19(b) of the Act, Respondent states that the "Petitioner's slip and fall on ice was not a risk distinctly associated with his employment. Instead, the area of the fall was open for use by the general public and snow and ice are a natural hazard to which the public is equally exposed." However, in the present matter, the Petitioner's presence on the sidewalk where he fell, was entirely due to his employment. There was no evidence that indicated that Petitioner was doing anything other than checking on the situation of the vehicle doing donuts in the parking lot, as well as checking on his supervisor and manager who were placing salt down on the icy area. Part of Petitioner's duties required him to be aware of the safety for employees and customers of Younkers. Petitioner testified at hearing that if he did not have to work on this day, he would not have come to Younkers and would not likely have left his house due to the inclement weather and icing. In fact, the testimony also included that the Younkers store was slow this day due to the poor weather. (Testimony of Val Robbins; testimony of Michael Ayers). It is found that Petitioner's employment put him in a place of danger beyond that of the general public. Petitioner's presence on the icy walk was entirely due to his employment. Therefore, Petitioner was placed at a greater degree of risk due to his employment, but for the demands of Petitioner's job, he would not have been on the icy sidewalk where the injury occurred.

Considering that Petitioner was expected as part of his work to use this sidewalk for various reasons including premises checks, door checks, theft checks, safety, etc., the sidewalk is considered part of the employer premises and therefore this slip and fall leading to Petitioner's injury did arise out of his employment.

His accident also occurred in the course of his employment. Respondent asserted that at the time of the fall, Petitioner was "not acting at the directive of his employer, nor performing an activity he had common or statutory obligation to perform." There was no evidence submitted at the hearing which supports this explanation pled by the Respondent. In fact, Respondent's store manager, Val Robbins, specifically testified that she did not advise Petitioner to return to the store, but rather advised him to be careful due to the ice on the sidewalks. Petitioner was responsible for the safety and security of the building and was checking on the vehicle doing donuts in the parking lot as well as the store manager, Val Robbins, and Jodie Bell who had been outside for a period of time salting the sidewalks. Also, Ms. Bell testified that herself, Ms. Robbins and the Petitioner had the status of "key holders." This meant that they had the duty to respond to any situation at the store. Accordingly, when the Petitioner immediately headed outside for the purposes stated above, he was acting in the course of his employment.

The parties stipulated that the Respondent was contesting causation, temporary total disability and medical on the basis of liability. In light of the Arbitrator's findings above, Respondent is liable for payments of those benefits.

In light of the finding above that Petitioner's injury did arise out of and in the course of employment by Respondent, Petitioner is entitled to prospective medical care causally connected to the injury.

Petitioner received earned sick pay from December 21, 2013 through February 21, 2014. Since this earned sick pay was a benefit which Petitioner earned as a result of his employment at Younkers, Younkers is not entitled to any credit for these payments.

Finally, Petitioner is not entitled to penalties and attorney fees as requested. The Respondent asserted good faith defenses to liability particularly with respect to whether the accident occurred in the course of the Petitioner's employment.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julian Alexander,

Petitioner,

vs.

NO: 11 WC 14407

Yellow Roadway Corporation,

15IWCC0415

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, permanent disability, Section 8(j) credit, and penalties and attorney's fees, reverses the Decision of the Arbitrator and finds that Petitioner failed to establish that he suffered injuries arising out of and in the course of his employment with Respondent and vacates all awards of compensation.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent.

One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

With the above in mind, the Commission finds that Petitioner's testimony regarding the alleged accident is not credible and is unsupported by the evidence. The Commission notes that despite having suffered multiple work accidents in the past while working for Respondent and reporting them immediately after occurring, this time around Petitioner failed to report the accident until January 28, 2011, nine days after the alleged accident occurred. (T.49) While

Petitioner met the notice requirement under the Illinois Worker's Compensation Act (hereinafter "Act"), Petitioner's failure to immediately report the alleged accident as he had done in the past puts Petitioner's behavior into question. We find Petitioner's behavior questionable in light of his extensive knowledge regarding safety requirements, his involvement in training new hires regarding safety requirements, and his access to safety requirements and reporting procedures. (T.69-73,RX1,RX3,RX5)

The Commission notes that when Petitioner sought treatment following the alleged work accident it was not due to low back pain, but due to unrelated chest pain. (PX9) The medical records show that Petitioner initially reported that chest pain and bilateral leg pain "with no associated history of trauma, fall, back pain, urinary or bowel symptoms." (PX9) A progress note dated January 24, 2011, indicates that Petitioner reported that he "had a fall on the back last week but was okay afterwards." (PX9) The Commission notes that the majority of the medical records from his initial treatment at St. James Hospital deal with Petitioner's chest pain and fail to mention any work related injury. (PX9)

As explained by the Illinois Appellate Court in *Dillon v. Industrial Commission*, 195 Ill. App. 3d 599, 607 (1990):

> It is well settled that [HN2] the Commission is the judge of the credibility of the witnesses. (*Caterpillar Tractor Co. v. Industrial Comm'n (1983), 97 Ill. 2d 35, 454 N.E.2d 252.*) It is the peculiar province of the Commission not only to determine the credibility of witnesses but also to weigh the testimony and to determine the weight to be given to the evidence. (*Berry v. Industrial Comm'n (1984), 99 Ill. 2d 401, 459 N.E.2d 963*; *Dunker v. Industrial Comm'n (1984), 126 Ill. App. 3d 349, 466 N.E.2d 1255.*) Regardless of whether the Commission hears testimony in addition to that heard by the arbitrator, it exercises original jurisdiction and is in no way bound by the arbitrator's findings. (*Berry, 99 Ill. 2d 401, 459 N.E.2d 963*; *Dunker, 126 Ill. App. 3d 349, 466 N.E.2d 1255.*)

Based on Petitioner's behavior following the accident and the lack of a history of the alleged accident in the medical records, the Commission finds that Petitioner lacks credibility and that his testimony regarding the January 19, 2011 accident is not supported by the record. As such, the Commission finds that Petitioner failed to establish that he suffered a work related accident on January 19, 2011 under the Illinois Workers' Compensation Act. Therefore, the Commission reverses the Arbitrator's Decision and vacates all awards of compensation.

15IWCC0415

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 8, 2014, is hereby reversed as stated above and all awards of compensation vacated.

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.

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

DATED: JUN 2 - 2015
MJB/ell
o-04/06/15
52

Michael J. Brennan

Kevin W. Lamborn

15IWCC0415

DISSENT

I am in agreement with the Arbitrator that the Petitioner sustained his burden of proof with regard to the issue of accident. First, the Arbitrator specifically indicated that he observed the Petitioner's testimony and found him to be credible.

The Petitioner testified that he did not have any low back pain prior to January 19, 2011. He slipped and fell that day while working, and testified that he had back pain into his buttocks. After working one additional day despite having pain, he awoke on January 21, 2011 with soreness in his back and legs, and he did not go to work. He testified that he began to experience chest pain on January 22, 2011, so he called his cardiologist, who asked him to go to the emergency room, which Petitioner did at St. James Hospital.

Petitioner testified he reported back pain along with chest pain. The report from St. James indicates a clear concern for the Petitioner having chest pain. It is understandable to me that, until he learned that his problem was not due to his heart, the Petitioner's focus on that aspect of his condition, and the possible relationship of his back and leg pain to it, was reasonable. On January 24, 2011 the Petitioner reported to St. James that he fell on his back the prior week but was okay afterwards. I see nothing unusual about Petitioner's initial belief that he had no major sequelae from the fall, and that he then reported the accident once he realized that this was not the case.

Further, as noted by the Arbitrator, I believe the Petitioner's testimony was consistent with the sequence of events, and corroborated by the medical records. I dissent.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALEXANDER, JULIAN
Employee/Petitioner

Case# **11WC014407**

15IWCC0415

YELLOW ROADWAY CORPORATION
Employer/Respondent

On 10/8/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0863 ANCEL GLINK
BRITT ISALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
JIM ROACH
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

Julian Alexander
Employee/Petitioner
v.
Yellow Roadway Corporation
Employer/Respondent

Case # **11 WC 14407**
15IWCC0415

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 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 **January 19, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**26,936.33**; the average weekly wage was $**1,122.35**.

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

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

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

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

Respondent is entitled to a credit of $**51,629.22** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $**51,629.22** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay $**207,062.92** for medical services, as provided in Section 8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

Respondent shall pay Petitioner temporary total disability benefits of $**748.24**/week for **105 5/7^{ths}** weeks, commencing **January 21, 2011** through **January 29, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 19, 2011** through **October 8, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of $**669.64**/week for **250** weeks, because the injuries sustained caused the **50%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

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

Signature of Arbitrator

October 8, 2014
Date

OCT 8 - 2014

FACTS

Petitioner testified that on January 19, 2011, he was employed as a truck driver for Respondent. Petitioner testified that on that date he slipped and fell on ice and snow in the Respondent's truck yard while conducting a pre-trip inspection of his truck and trailer. Petitioner testified that he then felt pain in his back and his butt. (T. 17, 27-28) Petitioner testified that he then drove his trailer to the Respondent's shop for repairs. (T. 29) Petitioner testified that after getting back his repaired trailer, he performed his work duties. Petitioner testified regarding his performance log. (PX2) (T. 30-32) Petitioner testified that at the end of his day on January 19, 2011 he had a little pain and was sore. (T. 32) Petitioner testified that he worked the following day, January 20, 2011. (T. 33) Petitioner testified that on January 21, 2011, he did not go to work because when he woke up he was not feeling his best and had soreness in both legs and pain in his back. (T. 33-34)

Petitioner testified that prior to January 19, 2011, he had never had pain in his low back, that he had never seen a physician for any low back problems, and that he had never seen any physician for pain in his thigh prior to January 19, 2011. (T. 32)

Petitioner testified that on January 22, 2011 he went to the St. James Hospital emergency room. Petitioner testified that he had chest pains becoming progressively worse and that after talking with his cardiologist he was told to go straight to the emergency room. Petitioner testified that he told the doctors he had fallen. (T. 40-41) The St. James Hospital January 25, 2011consultation record includes a history that Petitioner

had complaints of bilateral lower extremity pain with symptoms beginning approximately 6 days earlier when he fell backwards. (PX9, p.148)

Petitioner testified that he had not sought medical care sooner because he thought he could walk it off as he had done with other falls. Petitioner testified that underwent diagnostic testing, was discharged from St. James Hospital on January 26, 2011, and saw Dr. Srdjan Mirkovic at Northwestern Orthopedic Institute on January 27, 2011. (T. 43-44)

On January 31, 2011, Dr. Mirkovic performed an L3-L4 laminectomy, an L5 hemilaminectomy and an L4-L5 left partial diskectomy at Northwestern Memorial Hospital. (PX10, p. 124-125) Petitioner testified that Dr. Mirkovic sent him for a functional capacity evaluation, performed on December 3, 2012 and included in the Petitioner's Exhibits as PX 12. Petitioner testified that Dr. Mirkovic told him to limit his activities. (T. 51-53) Petitioner testified that he continued his medical treatment with Dr. Mirkovic through January 29, 2013. (T. 46) On January 3, 2013, Dr. Mirkovic charted that Petitioner could return to work at the light physical demand level (RX18, p.2).

Petitioner testified that he has been unable to work for Respondent since January 21, 2011. However, he has served during this period as a Trustee for the Village of Richton Park. (T. 66-67) Petitioner testified that he continues to be employed for the Respondent, that his employment has never been terminated, and that he has never quit the job. Petitioner has requested accommodations for his work restrictions but this request was denied by Respondent. (T. 59-61)

Petitioner testified that he has ongoing back symptoms that have restricted his activities. Petitioner testifies that the surgery alleviated some, but not all, pain (T. 56) Petitioner testified that he takes prescribed pain medications. (T. 58)

Petitioner met with Lisa Helma, a vocational counselor at Vocamotive (T. 61) She testified at an evidence deposition. She opined that Petitioner is not a candidate for vocational rehabilitation at this time. (PX 13, p. 25)

ACCIDENT

This is the core issue.

Respondent contends Petitioner, an experienced truck driver, knew the rules regarding accident reporting, yet he waited several days to do so. Respondent points out that Petitioner first went to the emergency room for chest pain. Respondent contends that Petitioner's claim of accident should not be believed.

The Arbitrator closely observed Petitioner's testimony. The Arbitrator finds that Petitioner unsuccessfully attempted to work through the injury. The Arbitrator finds Petitioner to be credible. Petitioner's testimony is consistent with the sequence of events. Petitioner's testimony is corroborated by the medical records.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of employment.

CAUSATION

Respondent's dispute on this issue is based on the premise of no accident, which has been resolved in Petitioner's favor.

Therefore, the Arbitrator finds that Petitioner's current condition of ill being is causally related to the accident.

MEDICAL

Respondent's dispute on this issue is premised on the defense that no accident has occurred, which has been resolved in Petitioner's favor.

Therefore, the claimed medical expenses are awarded.

TEMPORARY TOTAL DISABILITY

Since the Petitioner suffered a compensable injury on January 19, 2011, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits from January 21, 2011, which was the first day he

missed work, through January 29, 2013, which was last date he received medical treatment from his surgeon, Dr. Mirkovic.

The Arbitrator finds that January 29, 2013 is the date that Petitioner's medical condition plateaued.

NATURE AND EXTENT

Petitioner's proposed decision requests a disability for the loss of the person as a whole.

The Arbitrator finds that the evidence in this case establishes that Petitioner has lost his profession as a truck driver.

Therefore, the Arbitrator finds that Petitioner has sustained a 50% loss of the person as a whole.

.

PENALTIES AND ATTORNEYS FEES

The Arbitrator does not agree with Respondent's dispute regarding accident, but finds that Respondent has not been unreasonable and its position.

Therefore, Petitioner's claim for penalties and attorneys fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID J. FISCHER,

Petitioner,

15IWCC0416

vs.

NO: 11 WC 5381

VILLAGE OF MCCOOK POLICE DEPARTMENT,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner proved a work related accident on February 7, 2011 and provided proper notice. She awarded him 181&2/7 weeks of temporary total disability benefits through the date of arbitration, $4,634.49 in medical expenses, and ordered Respondent to authorize and pay for prospective medical treatment prescribed by Dr. Chudik as well as associated rehabilitative care. The Arbitrator also denied Petitioner's request for penalties and fees. The Commission concurs with the Decision of the Arbitrator regarding accident, notice, temporary total disability benefits, and the award of medical expenses both current and prospective and affirms those aspects of the decision.

The record demonstrates that on February 7, 2011, Petitioner was injured while he was getting out of his police vehicle after slipping on a wet floor where he was getting the vehicle serviced at a facility run by Respondent village. After treatment at an emergency department, he sought treatment from an orthopedic surgeon, Dr. Smith, who had performed surgery on his left knee 16 years earlier. Dr. Smith recommended arthroscopic meniscal repair surgery to his left knee. Dr. Smith performed a meniscectomy on March 1, 2011.

Petitioner continued to experience pain in his knee. On August 12, 2011, Dr. Smith ordered a repeat MRI which showed chronic degenerative trizonal intrameniscal 3 cm tear in the body of the posterior horn of the medical meniscus and evidence of an associated tiny parameniscal cyst in the subcapular region, focal grade 4 posterior MFC chondromalacia and grade 2-3 chondromalacia in the medial aspect of the patellofemoral compartment, and prominent patellar hypertrophic tendinopathy with no tear. Petitioner and Dr. Smith decided that a repeat arthroscopy be performed.

On September 19, 2011, Respondent sent Petitioner to Dr. Tonino for a medical examination pursuant to Section 12 of the Act. He concurred with the surgery recommended by Dr. Smith. On October 20, 2011, Dr. Smith performed left knee medial meniscectomy and chrondroplasty shaving, of the medial, lateral, and patellofemoral. On January 16, 2012, Dr. Smith noted that while Petitioner was in physical therapy he reported "a setback to his left knee about a week" ago. Dr. Smith continued physical therapy, kept Petitioner off work, and wanted workers' compensation authorization for a Supartz and Viscosupplementation.

On February 13, 2012, at Respondent's direction Dr. Tonino performed a second Section 12 examination of Petitioner. He noted that since his previous examination, Petitioner "underwent a partial medial meniscectomy with radiofrequency treatment of his meniscus tear chondromalacia of the medial femoral condyle, although no specific grade was mentioned in the operative report; and, chondromalacia of the patella grade 2 to 3." He noted that the operative photographs showed significant chondromalacia of the left knee. Petitioner was doing well until January of 2012 when he had a setback with no associated trauma and developed persistent pain and swelling. Dr. Tonino diagnosed possible internal derangement of the left knee, with possible meniscus tear, or loose body. He did not believe viscosupplementation was indicated because of the lack of degenerative changes. He wanted an MRI before opining about additional treatment.

Petitioner testified that he was accompanied by a representative of Respondent's workers' compensation insurer during Dr. Tonino's second examination. The representative told Petitioner that she could ensure approval of the recommended MRI if he agreed to choose to be treated by Dr. Tonino instead of Dr. Smith. Petitioner agreed. Petitioner's testimony was unrebutted. His condition did not significantly improve despite Dr. Tonino's conservative treatment. Dr. Tonino concluded that there was no recourse other than surgery and on April 17, 2012 he performed arthroscopic partial medial meniscectomy, and debridement of arthrofibrosis of the patellofemoral compartment for left meniscus tear and arthrofibrosis.

Dr. Tonino ordered a Functional Capacity Evaluation, which was performed on October 22, 2012. Petitioner was found to provide maximum effort and the evaluation was considered valid. The therapist noted that Petitioner frequently verbally expressed pain complaints but they were not inappropriate pain responses. He generally reported 2-6/10 pain. Petitioner was rated at light-medium/medium physical demand level. The occupation of police officer was rated as medium. However, Petitioner had difficulty with certain essential elements of his job activities such as kneeling and crawling, so full duty return to work was not recommended.

On October 29, 2012, Petitioner returned to Dr. Tonino and reported but it was too early to tell if the pain was better. Dr, Tonino administered a Synvisc injection with little effect. Dr. Tonino declared Petitioner at maximum medical improvement, released him to work with the restrictions identified in the valid Functional Capacity Evaluation, and released him from care prn. Petitioner testified that at that time he complained to Dr. Tonino that he was still in pain and Dr. Tonino told him there was nothing more he could do for him and he would have to live with it.

In his deposition, Dr. Tonino testified when he last saw Petitioner he still had some pain and popping. Therefore, he administered a Synvisc injection in case there was still some chondromalacia in the knee. Synvisc is an artificial lubricant to dissipate pain and obviate or at least delay the need for a knee replacement. He considered Petitioner at maximum medical improvement at that time and released him with the restrictions identified in the Functional Capacity Evaluation. Petitioner's continuing symptoms could be caused by the scarring, but it was more likely that he still had some chondromalacia. He did not recommend additional treatment because he did not think it would help him. He did not think a knee replacement was indicated at that time. While the fact that Petitioner had five previous arthroscopies was significant, Dr. Tonino would not say that it heightened the risk of complications for an additional surgery. However, he may be more reluctant to perform additional surgery because he had not gotten better with the previous surgeries.

Less than a month after being released from treatment by Dr. Tonino, Petitioner sought treatment at Hinsdale Orthopedics. After it was determined that he was not currently a candidate for knee replacement, he came under the care of Dr. Chudik. He ordered a repeat MRI which was taken on July 15, 2012. The MRI showed a 5mm full thickness chondral defect of the medial femoral condyle articular surface without underlying osseous reaction, intrameniscal degeneration of the medial meniscus with evidence of prior partial meniscectomy but no recurrent displaced tears, mild chondral softening of the lateral patellar facet articular surface without chondral defect of osseous reaction, and moderate joint effusion. On July 19, 2013, Dr. Chudik recommended a left knee abrasion plasty of the femoral condyle. He kept Petitioner off work. On October 16, 2013, Petitioner returned to Dr. Chudik. Dr. Chudik's recommendation for arthroscopic surgery remained the same and noted that delay could be detrimental and lead to permanency. He noted that Respondent's pension board sent him to three orthopedic surgeons, two of whom recommended surgery.

At arbitration, Petitioner testified he applied for a disability pension before Respondent's pension board. The board found that his disability was not sustained in the line of his duty as a policeman. He did not appeal that decision. Respondent submitted into evidence the entire proceedings before the pension board and argued the board's decision was dispositive of the issue that Petitioner's accident did not occur in course of or arising out of his employment citing *McCulla v. Industrial Commission*, 232 Ill. App. 3d 517 (1st Dist. Ind. Com. 1992). The Arbitrator rejected Respondent's argument and Respondent preserved the issue on review.

In *McCulla*, the Appellate Court held that a decision of a pension board finding that a knee condition was not causally related to the claimant's activities as a firefighter precluded the claimant's litigating that issue before the Commission. In *McCulla* there was no acute accident or apparent acute injury. However, in *Demski v. Mundelein Police Pension Board*, 358 Ill. App. 3d 499 (2rd Dist. 2005) the Appellate Court held that the Decision of the Workers' Compensation Commission that an accident occurred in the course and arose out of his employment as a policeman did not preclude litigation of the issue of whether the accident arose in the line of his duty as a policeman by the pension board. It found that the issues of whether an injury occurred in the line of duty as a policeman and whether an injury occurred in the course of and arising out of his employment as a policeman, were "substantially different." 358 Ill. App. 3d 499, 504. Therefore, the *Demski* court found that collateral estoppel did not apply. Accordingly, we concur with the Decision of the Arbitrator that the doctrine of collateral estoppel on the issue of whether there was a compensable accident does not apply in this claim.

Respondent refused to pay all medical expenses incurred after Dr. Tonino found Petitioner at maximum medical improvement and released him from care. The Commission finds that Respondent's refusal to authorize treatment after Dr. Tonino's release to be unreasonable. It was clear that Petitioner still had significant pathology after that release as evidenced by the MRI in 2013. Even Dr. Tonino acknowledged in his testimony that Petitioner had residual symptoms when he released him and that he administered a Synvisc injection because of his suspicion that Petitioner suffered from continuing chondromalacia. The Commission is also somewhat troubled with the actions of Respondent's insurer in its arguable coercion in convincing Petitioner to treat with their recommended doctor over his obvious choice by suggesting that treatment would be approved more quickly if Petitioner treated with Dr. Tonino.

The records of the Commission show that Petitioner filed a Petition for Penalties and Fees on July 30, 2013. We consider that the date on which Petitioner made a written demand for payment of medical expenses thereby evoking Section 19(l). The time period for assessing penalties under Section 19(l) begins 14 days after the written demand or in this case August 13, 2013. Respondent had not paid the medical expenses at the time of arbitration on July 29, 2014. The Commission calculates that period between August 13, 2013 and July 29, 2014 spans a total of 351 days. At a penalty rate of $30.00 a day, the total penalty would amount o $10,530.00, which is over the statutory maximum penalty of $10,000.00. Therefore, the Commission assesses penalties in the amount of $10,000.00 pursuant to Section 19(l) of the Act.

15IWCC0416

Finally, the Commission notes that as cited above the Arbitrator awarded temporary total disability benefits through the date of arbitration, at which time he was still kept off work by Dr. Chudik. However, in section "L" of the Decision of the Arbitrator, the Arbitrator wrote that Respondent had not presented evidence of what temporary total disability payments it had made. "Therefore, this issue is held in abeyance until a further hearing date." The Commission is not certain what that statement is supposed to mean. The decision was issued pursuant to Section 19(b). Once liability has been finally established after review by the Commission or judicial appeal the case is necessarily remanded for a determination of any additional temporary total disability and possible permanent partial disability. In this case, the Arbitrator awarded temporary total disability benefits through the date of arbitration. Therefore, the Arbitrator in no way held the issue in abeyance. In the interests of clarity and eliminating superfluous verbiage the Commission strikes the sentence quoted above from the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $925.89 per week for a period of 181&2/7 weeks, that being the period of temporary total incapacity for work as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $4,634.49 for medical expenses under §8(a) of the Act subject to the applicable medical fee schedule provided in §8.2.

IT IS FURTHER ORDERED BY THE COMMMISSION that Respondent shall authorize and pay for any reasonable and necessary prospective treatment prescribed by Dr. Chudik and any reasonable and necessary rehabilitative care as needed, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $10,000.00 in penalties as provided in §19(l) of the Act.

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

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

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

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

DATED: JUN 3 - 2015

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
O-5/19/15
46

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

15IWCC0416

FISCHER, DAVID J
Employee/Petitioner

Case# **11WC005381**

VILLAGE OF McCOOK POLICE DEPT
Employer/Respondent

On 9/18/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0140 CORTI ALEKSY & CASTANEDA
RICHARD E ALEKSY
180 N LASALLE ST SUITE 2910
CHICAGO, IL 60601

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

15IWCC0416

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)

David J. Fischer
Employee/Petitioner

v.

Village of McCook Police Dept.
Employer/Respondent

Case # 11 WC 05381

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **July 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Does the doctrine of collateral estoppel apply in this case?

FINDINGS

On the date of accident, **2/7/2011**, 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**72,172.36**; the average weekly wage was $**1,387.93**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit for any payments made to Petitioner for TTD, $**0** for TPD, $**0** for maintenance, and for other benefits paid to Petitioner, 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 $925.89/week for 181 2/7 weeks, commencing February 7, 2011 through July 29, 2014, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability and any other benefits previously paid to Petitioner.

Respondent shall pay Petitioner temporary total disability benefits of $925.89/ week beginning July 30, 2014, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner for reasonable and necessary medical services of $4,634.49, as provided in Section 8(a) of the Act.

Penalties and attorney's fees are not awarded as provided in Sections 16, 19(k); and 19(l) of the Act.

Respondent shall authorize and provide payment for reasonable and necessary prospective medical care as prescribed by Dr. Steven Chudik and any reasonable and necessary rehabilitative care needed, as provided in Section 8(a) of the Act.

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

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

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

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability payments; 6) penalties; 7) attorney's fees; 8) prospective medical treatment and 9) whether the doctrine of collateral estoppel should be applied in this matter. *See*, AX1.

Petitioner testified that he underwent the initial surgery to his left knee in May 1991, after being struck by a car. He testified that Dr. Smith performed that surgery and that he filed a workers' compensation case for that date of accident. Petitioner further testified that he experienced another injury to his left knee on October 5, 1994, and he underwent a second left knee surgery on November 29, 1994. Petitioner testified that that surgery was also performed by Dr. Smith and that his knee had been fine until the subject accident. Tr. pgs. 59-60.

Officer David J. Fischer ("Petitioner") testified he was hired as a police officer for the Village of McCook ("Respondent") on September 11, 2000. Petitioner testified he was injured on February 7, 2011, while working for the Village of McCook Police Department. Petitioner performed a physical agility test and physical examination prior to being hired by the respondent. He testified that in the course of his activities as a sworn police officer, he investigated calls and accidents; and conducted search and seizure, traffic stops. Petitioner testified that the respondent provided him with a squad car, in order to carry out his duties. He testified that if the car needed maintenance, he would be assigned a different car. He testified further that he did not ride with a partner, but other officers would be assigned to the same car. Petitioner testified that every day he took the car to the Department of Public Works for the village, to have it serviced and washed. Petitioner testified that his shift in February 2011 began at 6:50 a.m. and normally ended at 3:00 p.m. and that he was responsible for the entire village, as his designated patrol territory. Tr. pgs. 11-15.

Petitioner testified that on February 7, 2011, the roll call was held at the beginning of his shift, after which he obtained his vehicle. Petitioner testified that the vehicles are one-manned cars, that he inspected his vehicle and started his shift. At approximately 10:30 a.m., he took his vehicle to the Village of McCook Department of Public Works, placed it in park, opened the door, stepped out, slipped and fell. Petitioner testified that Armor All, along with soap and water, was on the floor. Petitioner testified that he gave notice of this accident to Sergeant Mark Elsalger. The Arbitrator notes that his testimony was credible and unrebutted. Tr. pgs. 16-19.

Petitioner testified that he was immediately taken to LaGrange Memorial Hospital, by ambulance and that he believed that Sgt. Elsalger completed an incident report. Records from LaGrange Memorial Hospital note that the petitioner was an emergency patient, the accident was "employment related" and the time of admittance was 11:05. Under "History of present Illness", it is noted that "the patient presents with Left knee pain after (sic) fell on slick surface at work today." It is also noted that "the onset was just prior to arrival and 9 hours ago. The location where the incident occurred was at

home". The doctor noted "very minor right elbow pain", as well. Petitioner testified that he did not provide a history that the incident happened at home. Petitioner was diagnosed as having a right elbow contusion and left knee sprain. Tr. pgs. 20 & 63; PX1, pgs.3-4.

Petitioner testified that doctors at LaGrange Memorial Hospital advised him to stay off work and that he was not advised to follow-up with a specific doctor. The Arbitrator notes that the medical records indicate that he was to return for a follow-up on February 8, 2011, with Dr. Edward Marcoski. Petitioner further testified that on February 9, 2011, he sought treatment with Dr. David Smith and that following that visit, Dr. Smith recommended an MRI. Following the MRI, Dr. Smith recommended surgery. Petitioner underwent that surgery on March 1, 2011, performed by Dr. Smith, at Ingalls Memorial Hospital. Tr. pgs. 21, 22. PX1, pg. 10.

Petitioner testified that he continued to see Dr. Smith, who recommended physical therapy and continued his "off work" status as of March 2, 2011. Petitioner testified that Dr. Smith continued to recommend post-surgical physical therapy at Ridge Orthopedic and Rehabilitation Specialists and that he continued to see Dr. Smith for follow-up care. Dr. Smith provided him with medication and continued his "off work" status. Tr. pgs. 23, 24.

Petitioner testified that on May 5, 2011, Dr. Smith recommended a cortisone injection to his knee, as there had been no improvement. He underwent that injection and continued with physical therapy through July 2011.

Petitioner testified that he saw Dr. Pietro Tonino on September 19, 2011, pursuant to Section 12 of the Act. Following his initial examination with Dr. Tonino, he testified that he continued to treat at Ridge Orthopedic and Rehabilitation Specialists. Petitioner testified that Dr. Smith recommended additional surgery, which he underwent on October 28, 2011, at Ingalls Memorial Hospital. He continued to follow-up with Dr. Smith after surgery and participated in for physical therapy. Tr. pgs. 24-32.

Petitioner returned to see Dr. Tonino on February 13, 2012, pursuant to Section 12 of the Act and testified that Dr. Tonino made recommendations for an MRI and additional treatment. Petitioner further testified that he had a conversation with nurse Patti Schultz about obtaining an authorization for surgery. Petitioner testified that nurse Schultz initiated the conversation and she indicated that surgery would be approved, without delay, if Petitioner switched from Dr. Smith to Dr. Tonino. Petitioner further testified that he did not know if his surgery would be approved if he did not select Dr. Tonino. Petitioner testified that he did not "willy-nilly" abandon Smith and go with Tonino; that he did not want to wait for treatment and the nurse said she could get it approved immediately, if he utilized Dr. Tonino's services. Tr. pgs. 29-34.

Petitioner testified he had an MRI on February 21, 2012 and that nurse case manager Patti Schultz was present during all of his appointments with Dr. Tonino except one. Petitioner testified that on the date that he initially saw Dr. Tonino for treatment, Dr. Tonino provided Petitioner an injection into his knee.

Dr. Tonino performed surgery on April 17, 2012. Petitioner testified that following surgical intervention, Dr. Tonino recommended physical therapy at ATI, which Petitioner underwent. Petitioner testified that he continued under the care of Dr. Tonino and that his knee condition progressively worsened. Tr. pgs. 35-42.

Petitioner testified that on August 27, 2012, he discussed a future knee replacement. Petitioner underwent a functional capacity evaluation ("FCE") at Industrial Rehab Allies on October 22, 2012. Petitioner testified that he did not recall if Dr. Tonino recommended any additional course of treatment but that he informed Dr. Tonino of the pain and difficulties he was experiencing on October 29, 2012. Petitioner testified that Dr. Tonino advised him that he could not "do any more or something to that effect".

Deposition of Dr. Pietro M. Tonino dated April 28, 2014

Dr. Tonino testified that he performed a partial medial meniscetomy on Petitioner's left knee on April 17, 2012. He testified that at that time, Petitioner also exhibited arthrofibrosis and some scar tissue, from the prior surgery, which he removed. Dr. Tonino testified that following his surgical procedure, he recommended postoperative physical therapy and that he evaluated Petitioner in July, August and September of 2012. Dr. Tonino testified that Petitioner completed a valid FCE on October 22, 2012 that placed Petitioner in the light-medium to medium duty category. RX3, pgs. 12-18.

Dr. Tonino further testified that he evaluated Petitioner for a final appointment on October 29, 2012. Petitioner had full extension of his knee with some popping. He testified that he performed an injection of Synvisc on that date, due to chondromalacia in his knee joint that he believed Petitioner to be at MMI. According to Dr. Tonino, further care would not improve the petitioner's condition.

Dr. Tonino further testified that he released Petitioner from care with the restrictions noted in the FCE. Dr. Tonino did not recommend additional surgery for Petitioner because he did not believe that additional surgery would help. Dr. Tonino did not believe a knee replacement was appropriate treatment for Petitioner at the time he released him from care on October 29, 2012. RX3, pgs. 18-21; Tr. pg. 44; PX6.

Petitioner testified that the respondent did not accommodate his restrictions consistent with his FCE, and that he has not returned to work anywhere and that the respondent has not offered vocational rehabilitation. Petitioner testified that no physician referred him to Hinsdale Orthopedics ("Hinsdale"); that he contacted his attorney who directed him to Hinsdale. Petitioner testified that he

first presented to Dr. Justin LaReau on November 27, 2012, at the suggestion of his attorney. Tr. pgs. 42-48, 77-78, 94.

Petitioner testified that he presented to Dr. Justin LaReau at Hinsdale on November 27, 2012, January 31, 2013, and June 2013. His initial appointment, on November 27, 2012, states a history of "present illness as Petitioner having had several surgeries on his left knee with the most recent taking place in April of this year". Petitioner's history also notes, "since surgery, he has developed a lot of clicking, grinding and popping in the knee." Petitioner further testified that after a couple of visits with Dr. LaReau, Dr. LaReau determined that he needed intervention by Dr. Chudik, as opposed to a total knee replacement. PX9.

The Deposition of Dr. Steven Chudik dated June 16, 2014

Dr. Chudik testified that he believed Petitioner was referred to him from Dr. LaReau because Dr. LaReau did not believe that Petitioner was a candidate for a knee replacement; and that he might benefit from an arthroscopic procedure. Dr. Chudik testified that he also did not believe that Petitioner was a candidate for a knee replacement due to his age and that his knee looked "pretty good" other than the meniscus and a hole in the cartilage on the femur. Dr. Chudik testified that he recommended a left knee arthroscopy with an abrasionplasty of the medial femoral condyle. He testified that the proposed surgery would address a chondral defect of the medial femoral condyle.

Dr. Chudik further testified that he did not review the operative photographs of Dr. Tonino's April 17, 2012, surgical procedure. Dr. Chudik was aware that Petitioner had undergone five previous surgeries to his left knee and he testified that while he did not believe that Petitioner's symptoms were due to scar tissue, additional surgery would cause scar tissue; and that there is some permanence related to the development of scar tissue. PX11, pgs .13-43.

Petitioner testified that Dr. Chudik has authorized him to take off work and that he last saw Dr. Chudik on October 16, 2013; when Dr. Chudik continued to recommend surgery. Tr. Pgs. 45, 46.

Petitioner testified that he moves his leg up and down to alleviate the stiffness from his knee caused by sleeping; and then goes about his daily chores. He testified that walking on stairs and unlevel surfaces is painful; and his knee swells. He no longer rides a bike because of the pain and that he cannot kneel on his left knee. It locks up and gives out. Petitioner hears clicking, popping and grinding when he takes steps and that he wants the surgery so that he can return to gainful employment.

Petitioner testified that the respondent required him to see doctors other than Tonino and that they discussed treatment recommendations with him. He testified that those treatment recommendations have not been acted upon. Petitioner testified that he has not injured his left knee since February 7, 2011 and that Dr. Smith's surgeries did not fix his knee. Tr. pgs. 51-53; 73.

Upon cross-examination, Petitioner testified that he filed a claim for a line of duty disability pension with the Village of McCook, on or about March 7, 2013. He testified that the claim related to the subject accident date of February 7, 2011. He testified at the hearing before the Board of Trustees of the Pension Fund of the Village of McCook on February 18, 2014 and was represented by counsel. He further testified that his attorney presented evidence in support of his application. Petitioner further testified that he received an unfavorable decision on the issue of duty disability and an order was entered, granting a non-active duty disability pension. In an offer of proof, Petitioner testified that he did not appeal the non-duty disability finding. Tr. pgs. 78-83.

Finally, Petitioner testified that he believes that he received TTD benefits from February 7, 2011 until July 4, 2013; and that he was paid TTD from September 16, 2013 to June 16, 2014, to the best of his knowledge. Tr. pg. 84.

CONCLUSIONS OF LAW

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

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

It is axiomatic that the injured worker must prove by a preponderance of the weight of the evidence that her accident arose out of and in the course of her employment. The "arising out of" component speaks to risk and the needed association of an employment risk to the resultant injury. "For an injury to 'arise out of' the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury [citations omitted]." *Caterpillar Tractor Company v. Industrial Commission*, 129 Ill. 2d 52, 58; 549 N.E.2d 665 (1989). This is true whether an injured worker is claiming injury due to a single

identifiable trauma or due to a more insidious repetitive trauma. *Peoria County Bellwood Nursing Home v. The Industrial Commission*, 115 Ill. 2d 524; 505 N.E.2d 1026 (1987). In short, the petitioner's employment must be a causative factor.

First, Petitioner claims to be a traveling employee because he uses the work vehicle issued to him by the Respondent, to travel the territory of the village on patrol. The Arbitrator finds that his job does not fit the definition of a traveling employee as defined in the Act; and concludes that he is not a traveling employee.

Petitioner testified that at approximately 10:30 a.m. he took his vehicle to the Village of McCook Department of Public Works, placed it in park, opened the door, stepped out and slipped and fell. Petitioner testified that Armor All, along with soap and water, was on the floor. This testimony was credible and not rebutted. The Arbitrator concludes that the Petitioner has proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of his employment with Respondent.

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

Petitioner testified that he gave notice of this accident to Sergeant Mark Elsalger. Petitioner testified that he was immediately taken to LaGrange Memorial Hospital, by ambulance and that he believed that Sgt. Elsalger completed an incident report. This testimony was credible and unrebutted. The Arbitrator concludes that the Respondent received timely notice of the accident.

F. Is Petitioner's current condition of ill-being causally 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).

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).

Given the Arbitrator's findings on the issue of accident, the Arbitrator finds that Petitioner's condition of ill-being is causally related to an accident that arose out of and in the course of his employment.

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

Petitioner offered into evidence medical expenses totaling $4,634.49; these expenses were incurred for services rendered by Hinsdale Orthopaedics, MRI of Oak Lawn, and Advantage Home Medical Equipment. The Arbitrator finds that the uncontradicted testimony of Petitioner as well as the certified medical records, establish that these expenses were incurred when Mr. Fischer sought alternative treatment after Dr. Tonino told him he could to nothing further for him.

Petitioner testified that he was told by Patty Schultz, Respondent's nurse case manager, that his treatment would proceed more smoothly and approvals and authorizations would be much simpler to procure, if he would give up treating with his chosen physician, Dr. Smith, and treat with Respondent's doctor. The Arbitrator notes that this testimony was unrebutted as Respondent did not call Ms. Schultz to the stand to dispute Petitioner's claim or explain her conduct.

Petitioner acquiesced and transferred his care to Dr. Tonino, who performed an additional surgery. The testimony and medical records show that despite the fact that Petitioner had ongoing symptoms, which were consistent with his objective examination findings, Dr. Tonino felt there was no further treatment he could offer Petitioner. He advised that Petitioner had reached maximum medical improvement ("MMI").

Petitioner testified that he was dissatisfied with Dr. Tonino's treatment of his case, and therefore sought a second opinion at Hinsdale Orthopaedics. Petitioner was evaluated by Dr. LaReau, who determined that there were certain, viable treatment alternatives, available to Petitioner. This conclusion was echoed by Dr. Chudik, upon review of Petitioner's most recent MRI. Dr. Chudik concluded that the petitioner would benefit from a left knee abrasionplasty of the femoral condyle. These conclusions are documented in the medical records and the depositions, which were offered into evidence.

The Arbitrator finds that the treatment rendered by Drs. LaReau and Chudik, was necessary and

reasonable as defined by Section 8(a). Therefore, the Arbitrator finds Petitioner is entitled to an award of $4,634.49 for said medical expenses.

Section 8(a) of the Illinois Workers' Compensation Act mandates that the employer is liable to pay for (1) all first aid and emergency treatment; plus (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee...; plus (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee...

Petitioner's testimony and the medical records verify that after Petitioner received emergency care at LaGrange Memorial Hospital, he treated with Dr. David Smith, who performed two left knee surgeries. Dr. Smith was Petitioner's first treating physician. After multiple surgical procedures did not improve Petitioner's left knee condition, Petitioner was encouraged by Respondent, to seek treatment with Dr. Pietro Tonino. Dr. Tonino also performed surgery on Petitioner's left knee and told him that his condition was at MMI. It is Respondent's position that Dr. Tonino was Petitioner's second choice of treating physician. However, the Arbitrator finds that the petitioner was influenced to accept Dr. Tonino as a treater, so that his medical treatment would be approved in a timely manner and therefore Dr. Tonino was not really an affirmative choice on the part of the petitioner.

Petitioner testified that nurse Schultz told him that surgery would be approved without delay, if he switched physicians, and sought treatment with Dr. Tonino. In addition, he testified that nurse Schultz spoke to Dr. Tonino, on his first visit and after his functional capacity evaluation however, he could not hear what they were saying. After Dr. Tonino released him from care, with a less than positive result, Petitioner testified that his attorney suggested that he go to Hinsdale Orthopaedics. The Arbitrator concludes that Respondent has not paid all appropriate charges for a reasonable and necessary medical treatment.

K. Is Petitioner entitled to any prospective medical care?

Dr. Tonino performed the most recent surgery to Petitioner's left knee and subsequently determined that there was nothing further that he could offer Petitioner; and that additional surgery would not alleviate Petitioner's symptoms.

Petitioner was evaluated by Dr. LaReau, who determined that there were certain, viable, treatment alternatives, available to him and Dr. Chudik supported this opinion, upon review of Petitioner's most recent MRI. Dr. Chudik concluded that the petitioner would benefit from a left knee abrasionplasty of the femoral condyle.

The Arbitrator finds the opinions of Drs. LaReau and Chudik to be more persuasive than those of Dr. Tonino. Dr. Chudik is recommending additional arthroscopic surgery, and while he has not reviewed

Dr. Tonino's operative photographs, he has suggested a viable additional procedure that could assist in the relief of Petitioner's condition. The Arbitrator concludes that the petitioner is entitled to prospective medical care. The Arbitrator finds Dr. Chudik's treatment plan to be reasonable and appropriate and orders Respondent to authorize said treatment, as well as pay the reasonable and necessary rehabilitative costs, as provided under Section 8(a).

L. What temporary benefits are in dispute?

Petitioner testified that he believes that he received TTD benefits from February 7, 2011 through July 4, 2013 and from September 16, 2013 through June 16, 2014. The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from February 7, 2011 up to and including July 29, 2014, a period of 181 2/7 weeks minus whatever weeks of TTD has been paid by Respondent. Petitioner has disputed the amount that Respondent claims it is entitled to as a credit for TTD benefits, i.e. $183,562.45. Respondent has not presented any evidence to prove what amount was paid to Petitioner for TTD benefits. Therefore, this issue is held in abeyance until a further hearing date. However, as the petitioner is still being held off work by his treating doctor, Respondent shall pay to Petitioner TTD benefits beginning July 30, 2014 until the petitioner reaches MMI, pursuant to Section 8(b) of the Act.

M. Should penalties or fees be imposed upon Respondent?

Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay,

intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

Respondent alleges that in good faith, it paid TTD benefits from February 8, 2011, through October 29, 2012, when Dr. Tonino released Petitioner from care; and continuing paying benefits until July 4, 2013. Following a pretrial in this matter, Respondent states that it again paid benefits from September 16, 2013, until doctors' evidence depositions could be completed on June 16, 2014. Petitioner has begun receiving non-duty disability benefits based on an order of April 7, 2014. Respondent paid reasonable, necessary and causally related medical bills until Dr. Tonino released Petitioner from care on October 29, 2012; and there are issues of fact and law in dispute in this matter. The Arbitrator concludes that the Respondent's behavior has not been unreasonable and there has not been vexatious delay in the payments of benefits. Petitioner is not awarded penalties or attorney's fees pursuant to Section 19(l); 19(K) or Section 16 of the Illinois Workers' Compensation Act.

O. Should the doctrine of collateral estoppel apply in this case?

Petitioner testified that he filed a claim for a line of duty disability pension with the Village of McCook on or about March 7, 2013. He testified that it was for the same February 7, 2011 date of accident. Petitioner testified at Arbitration that he testified at the full hearing before the Board of Trustees of the Pension Fund of the Village of McCook on February 18, 2014 and was represented by counsel. He further testified at Arbitration that his attorney presented evidence in support of his application. He received an unfavorable decision on the issue of duty disability. Petitioner testified that on April 7, 2014, an order was entered granting a non-active duty disability pension. In an offer of proof, Petitioner testified that he did not appeal the non-duty disability finding. It is Respondent's position that the collateral estoppel branch of the doctrine of *res judicata* applies in this matter.

The principle of "collateral estoppel prohibits the relitigation of an issue essential to and actually decided in an earlier judicial proceeding by the same parties or their privies. *Blair v. Bartelmay* 151 Ill. App. 3d 17, 502 N.E.2d 859 (1986). Collateral estoppel may be asserted so long as the party against whom its application is sought is identical in both actions, and the party had a full and fair opportunity to contest an issue which was necessarily determined in the prior proceedings. *Herriford v. Boyles,* 190 Ill. App. 3d 947, 550 N.E.2d 6544 (1990). Generally, administrative agency decisions have *res judicata* and collateral estoppel effect where the agency's determination is made in proceedings which are adjudicatory, judicial or quasi-judicial in nature. *Godare v. Sterling Steel Casting Co.*, 103 Ill. App. 3d 46, 430 N.E.2d 620 (1981)." *David G. McCulla v. Industrial Comm'n*, 232 Ill. App. 3d 517, 597 N.E. 2d 875 (1992).

In *McCulla,* the claimant filed an application for adjustment of claim under the Act, of which benefits were awarded on some disputed issues. On review, the appellate court ruled *inter alia,* that "the claimant's claims are barred under the doctrine of *res judicata* and/or collateral estoppel because the Retirement Board of the Firemen's Annuity Benefit Fund of Chicago (the Board) denied the claimant's claims for duty disability benefits arising out of the same accident and injuries at issues in this case". "To establish *res judicata*, a party must show (1) that the former adjudication resulted in a final judgment on the merits; (2) that the former and current adjudication were between the same parties; (3) that the former adjudication involved the same cause of action and same subject matter of the later case; and (4) that a court of administrative agency of competent jurisdiction rendered the first judgment. *Hannigan v. Hoffmeister*, 240 Ill. App 3d 1065, 1075-75, 608 N.E. 2d 396, 181 Ill. Dec. 323 (1992).

However, the Arbitrator finds that in the instant matter, the evidentiary standard of review, as to the issue of accident, is different before the Commission than the determination of a "line of duty" disability before the Board of Trustees of the Police Pension Fund of the Village of McCook. The Arbitrator therefore concludes that the doctrine of collateral estoppel does not apply, in this matter.

15IWCC0416

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11 WC 05381
SIGNATURE PAGE

Signature of Arbitrator

September 18, 2014
Date of Decision

SEP 18 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

Manuel Beltran,
Petitioner,
vs.
City of Chicago,
Respondent,

NO: 07WC 28914

15IWCC0417

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 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: JUN 5 - 2015
MJB/bm
o-04/07/15

052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELTRAN, MANUEL
Employee/Petitioner

Case# **07WC028914**

15IWCC0417

CITY OF CHICAGO
Employer/Respondent

On 7/28/2014, 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:

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CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOSEPH A ZWICK
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

Manuel Beltran
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 07 WC 28914

Consolidated cases: _____

15IWCC0417

An *Application for Adjustment 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 **7/16/2014**. 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. ☐ 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 _____

15IWCC0417

FINDINGS

On **6/8/2006**, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned **$62,711.22**; the average weekly wage was **$1,205.95**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **6** 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 **$24,808.22** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$24,808.22**.

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 $803.97/week for 30 3/7 weeks, commencing 6/9/2006 through 1/7/2007, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $591.77/week for 50 weeks, because the injuries sustained caused the 25% loss of the leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

07-25-14
Date

JUL 28 2014

ILLINOIS WORKERS COMPENSATION COMMISSION

Manuel Beltran,	)	
	)	
Petitioner,	)	
v.	)	**07 WC 28914**
	)	**Arb. Carlson**
City of Chicago,	)	
	)	
Respondent.	)	

15IWCC0417

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT:

As this matter is the subject of a prior decision, only those facts necessary to an understanding of this nature and extent award will be reviewed.

The accident

Petitioner, Manuel Beltran, testified that on June 8, 2006 he was employed by the City of Chicago, Water Department as a laborer. (Tr. p. 6-8). Beltran testified that he assembled and repaired fire hydrants for the City of Chicago and provided other assistance to plumbers employed by the City. (Tr. p. 7). Petitioner was required to lift and carry up to 100 lbs. continuously, climb ladders frequently, walk frequently and stand and bend continuously. (Pet. Ex. 4).

On June 8, 2006, Beltran was working with fire hydrant parts in a City of Chicago Water Department yard. (Tr. p. 8). He had worked for the City of Chicago for 9-10 years prior to June 8, 2006 and had always worked in a full-duty capacity. (Tr. p. 7, 28). On that particular day, he was moving material when he stepped in a hole and twisted his right knee. (Tr. p. 8-9). His knee struck the ground and his whole body fell to the ground. (Tr. p. 9). Petitioner immediately

reported the accident to his supervisor, filled out an accident report and was directed to the City of Chicago's occupational clinic at MercyWorks. (Tr. p. 9-10).

Petitioner's Medical Treatment

Petitioner was seen at MercyWorks on the day of his accident by Dr. Hector Marino. (Tr. p. 10-11). The City's doctor took Beltran off work. On June 26, 2006, Beltran underwent an MRI of the right knee, which demonstrated a complex tear of the anterior horn of the lateral meniscus extending into the body and posterior horn, a horizontal nonarticular surface tear of the posterior horn of the medial meniscus with fraying of the medial meniscus and tricompartmental chondromalacia. (Pet. Ex. 1, p. 17).

Based on the MRI results, Petitioner was referred by MercyWorks to Dr. Maday at Midland Orthopedic Associates. Petitioner presented as instructed to Dr. Maday on July 12, 2006. Dr. Maday testified that all of Beltran's subjective complaints were consistent with his objective findings. (Pet. Ex. 6, Dep. of Maday, p. 8).

On August 10, 2006, Dr. Maday performed a right knee arthroscopy with partial medial and lateral meniscectomy. (Pet. Ex. 2, p. 6). On August 16, 2006, Dr. Maday continued Beltran off work and prescribed a course of physical therapy. (Pet. Ex. 2, p. 8). Beltran underwent physical therapy at MercyWorks as instructed in August, September and October of 2006. (Pet. Ex. 1, p. 6-8). On September 27, 2006, Beltran returned to see Dr. Maday. Beltran reported that he felt he was doing better initially in therapy but had slowed recently. (Pet. Ex. 2, p. 12). On October 18, 2006, Petitioner continued to complain to Dr. Maday of pain as well as difficulty with squatting and kneeling. (Pet. Ex. 2, p. 14).

Petitioner continued physical therapy, and then underwent a work hardening program at MercyWorks during October, November and December of 2006. (Pet. Ex. 1, p. 8-12). On

November 6, 2006, Petitioner presented to Dr. Diadula at MercyWorks. (Pet. Ex. 1, p. 9). The City's doctor noted that Beltran complained of "increase right knee pain since he started on the Work Hardening program." (Pet. Ex. 1, p. 9). Petitioner continued to complain of right knee pain at MercyWorks on November 8, 2006 and November 22, 2006. (Pet. Ex. 1, p. 9, 11). Beltran also reported difficulty with work hardening to Dr. Maday on November 8, 2006. (Pet. Ex. 2, p. 16).

On November 22, 2006, Petitioner reported to Dr. Maday for a follow-up examination. Dr. Maday noted that Beltran was up to 50 pounds lifting in work hardening, which is less than the 100 pounds lifting his job requires. (Pet. Ex. 2, p. 18). Dr. Maday noted that if Petitioner "did plateau, he may require additional restrictions." (Pet. Ex. 2, p. 18).

On December 20, 2006, Petitioner was seen by Dr. Maday and had still not met the lifting requirements to safely perform his job. (Pet. Ex. 2, p. 20). Beltran's physical therapy/work hardening program was discontinued and he was given home exercises to perform. (Pet. Ex. 2, p. 20). Beltran testified that, at his December 20th appointment, he and Dr. Maday discussed that Beltran would be traveling to Mexico for Christmas. (Tr. p. 14). Dr. Maday set an appointment for Petitioner to be evaluated upon his return. (Tr. p. 14-15).

Following his appointment with Dr. Maday, Beltran was also seen at MercyWorks. The City's doctor noted that Beltran had knee pain of 5/10 and continued to have some swelling, tenderness and limited flexion. (Pet. Ex. 1, p. 12). The City's Doctor indicated that Beltran was "off duty due to work related condition" and set a follow-up appointment. (Pet. Ex. 1, p. 22).

Beltran was next seen for medical treatment in 2008. On June 4, 2008, Petitioner reported as instructed to Dr. Maday. Dr. Maday noted that Beltran complained of pain in the medial aspect of his knee. (Pet. Ex. 2, p. 21). Dr. Maday also noted medial and lateral joint line

tenderness. (Pet. Ex. 2, p. 21). Dr. Maday's assessment was knee pain with no new history of trauma. (Pet. Ex. 2, p. 21). Dr. Maday recommended an MRI be performed. Dr. Maday's handwritten note reads, "last [office visit] 12/20/06, [follow-up] knee *same condition*." (Pet. Ex. 2, p. 22, emphasis added).

A September 9, 2008 MRI demonstrated chronic tearing of the anterior horn of the lateral meniscus with additional complex subtle tear of the outer periphery of the middle third of the meniscus, a subtle complex microtear of the outer periphery of the posterior horn of the medial meniscus; as well as mild improvement in lateral chondromalacia patella since his last MRI in June of 2006. (Pet. Ex. 2, p. 28).

Beltran returned to see Dr. Maday as instructed on September 24, 2008. Dr. Maday reviewed Beltran's MRI results and performed a physical exam. (Pet. Ex. 2, p. 23). Dr. Maday's assessment was posterior knee pain and he recommended a course of physical therapy to improve his pain. (Pet. Ex. 2, p. 23). Dr. Maday did note that Beltran had a valgus stance of his knee of unknown cause, but this was not causing any instability. (Pet. Ex. 2, p. 23). Dr. Maday took Beltran off work and scheduled a return appointment. (Pet. Ex. 2, p. 25).

Following his appointment with Dr. Maday, Beltran was seen at MercyWorks. The doctor noted a pain score of 7/10 and that Dr. Maday had recommended physical therapy. (Pet. Ex. 1, p. 13). The Respondent's doctor indicated that Beltran was "off duty due to work related condition." (Pet. Ex. 1, p. 20). Petitioner was prescribed physical therapy three times a week for four weeks at MercyWorks. (Pet. Ex. 1, p. 20).

Two days later, MercyWorks indicated it was instructed to close Beltran's case by the Respondent's Committee on Finance because Beltran *would be seen* for an "IME." (Pet. Ex. 1, p. 2, emphasis added).

Petitioner subsequently underwent a section 12 exam with Dr. Charles Bush-Joseph. Dr. Bush-Joseph agreed that Beltran's right knee pain never went away and that Beltran has residual symptoms from his accident. (Resp. Ex. 1, p. 20-21).

Petitioner's condition at the time of the 2010 hearing

At the 2010 arbitration hearing, Beltran testified that his knee still causes him difficulty. (Tr. p. 26). Specifically, he has problems walking up and down steps. (Tr. p. 26-27). He also notices swelling and pain when he walks a couple of blocks or when he carries something heavy. (Tr. p. 27). Beltran has also noticed decreased flexibility. (Tr. p. 27). Beltran continues to do home exercises for his knee. (Tr. p. 27).

Petitioner's testimony at the time of the 2014 Arbitration Hearing

At the 2014 arbitration hearing, Petitioner testified he still continues to have problems with his knee. Petitioner is unable to carry heavy objects and has discontinued "many activities," including sporting activities like basketball and running. He feels a burning and pinching sensation in his knee.

Petitioner testified that he continues to seek medical treatment at Cook County Hospital and that he has received injections and taken ibuprofen for his knee.

Petitioner has not consistently worked since his injury.

Prior Decisions

A decision was previously entered in this matter on April 7, 2010 pursuant to Section 19(b) and 8(a) of the Act. This Arbitrator found that Petitioner's current condition was not related to his June 8, 2006 accident and that the Petitioner was not entitled to additional physical therapy or vocational rehabilitation. The Commission affirmed the arbitration decision, but modified the T.T.D. award to reflect that Petitioner was temporarily and totally disabled until

January 7, 2007. (No. 11 IWCC 0208). Judicial review was subsequently sought in the Circuit Court of Cook County, which confirmed the Commission decision. On appeal, the Appellate Court of Illinois, Workers' Compensation Commission Division, affirmed, finding that the Commission's decision was not against the manifest weight of the evidence. Beltran v. Workers' Compensation Comm'n, 2013 IL App (1st) 10965WC-U (unpublished order pursuant to Supreme Court Rule 23). The Court, noting Dr. Bush-Joseph's testimony, found that although Petitioner had reached maximum medical improvement on January 7, 2007, he was not "fully healed." Id. at ¶32.

The Arbitrator has reviewed the previous hearing transcript, the previous Commission decision and Appellate Court Order prior to making this award.

CONCLUSIONS OF LAW:

(F) Is the Petitioner's Present Condition of ill-being causally related to the injury?

Consistent with the prior decisions in this matter, the Arbitrator finds that Petitioner continues to experience difficulty with his right knee. The Arbitrator finds the testimony of the Petitioner to be credible, and finds that his complaints at arbitration are causally related to his June 8, 2006 accident.

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

The Arbitrator notes that Petitioner suffered from two different tears in his knee as a result of this accident, one of which was a complex tear. Given Petitioner's ongoing complaints, his surgery, and his lack of consistent work, the Arbitrator finds the nature and extent of the injury is 25% loss of use of the leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Myers,

Petitioner,

15IWCC0418

vs.

NO: 11 WC 08983

State of Illinois,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 6, 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: JUN 5 - 2015

David L. Gore

Stephen J. Mathis

Mario Basurto

DLG/gaf
O: 5/27/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MYERS, LAURA
Employee/Petitioner

Case# **11WC008983**

15IWCC0418

STATE OF ILLINOIS
Employer/Respondent

On 11/6/2014, 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 0.06% 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:

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
PO BOX 1355
CARBONDALE, IL 62903

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

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

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

NOV - 6 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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0418

Laura Myers
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # 11 WC 8983

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 **9/4/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0418

On **10/14/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$69,215.51**; the average weekly wage was **$1,331.06**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **3** dependent children.

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

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

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 for **any medical benefits paid through its group medical plan for which credit is allowed** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**664.72**/week for **61.15** weeks because the injuries sustained caused the 7.5 % loss of use of the right hand, 7.5% loss of use of the left hand, 20% loss of use of the right thumb and 20% loss of use of the left thumb, as provided in Section 8(e) of the Act.

Respondent shall pay the reasonable and necessary medical expenses set forth in PX 5 except for bills for services on March 5, 2010, March 26, 2010 and July 17, 2012 pursuant to the Medical Fee Schedule, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay compensation that has accrued between October 14, 2009 and September 4, 2014 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

October 31, 2014
Date

NOV 6 - 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to her hands as a result of her job as a court reporter for the State of Illinois. She alleges an accident date of October 14, 2009. The issues in dispute are: accident, notice, causal connection, liability for medical costs, and the nature and extent of the injury. Petitioner was the sole witness at the hearing.

The Arbitrator finds:

Petitioner underwent bilateral thumb x-rays on October 14, 2009 per the order of Dr. Vasu. The right thumb x-ray showed moderate osteoarthritis of the carpometacarpal joint. Petitioner's left thumb x-ray showed severe osteoarthritis of the carpometacarpal joint at the base of the left thumb. (PX 1) Six weeks of physical therapy (three times per week) was ordered, per Dr. Jon Humphrey. (PX 2)

Petitioner underwent physical therapy for her thumbs between October 20, 2009 and November 19, 2009. According to the therapists' notes Petitioner had trouble opening bottles, turning door knobs, and "pain with work." Petitioner completed a Medical History Progress Note on October 20, 2009 which included a pain drawing in which Petitioner indicated bilateral thumb complaints. While asked about it, Petitioner did not indicate any hand or wrist complaints such as numbness, "pins and needles" and burning. (PX 2) According to the Occupational Therapy Evaluation, Petitioner gave an onset/exacerbation date of October 14, 2009. The diagnosis was severe osteoarthritis of the bilateral carpometacarpal bones of the thumb joints. Petitioner indicated she had been experiencing symptoms of thumb pain and achiness diagnosed 1 ½ years earlier and had been diagnosed with De Quervain's Tenosynovitis and undergone an injection with minimal relief. (PX 2)

On November 3, 2009 Petitioner slipped and fell at the Carbondale WalMart. She was seen at Memorial Hospital where lumbar and cervical x-rays were taken and reported as negative. (PX 2)

Petitioner was again seen by her therapist on December 1, 2009. The therapist recommended a referral to an orthopedic surgeon for evaluation of left thumb and possible CMC reconstruction. There were no complaints of numbness and tingling noted. (PX 2)

On December 4, 2009 Petitioner presented to Dr. Schonewolf's office in "follow up" for bilateral osteoarthritis of her thumbs. Petitioner had been attending occupational therapy for four to five weeks and taking Naprosyn as previously prescribed and as needed. Petitioner was noted to be a court reporter and she reported that her pain had been somewhat less as she had not been as busy. She denied any numbness, just pain with motion. Petitioner was given a left thumb injection and told to return in two weeks for a possible right thumb injection. Petitioner did not return. (PX 1)

Petitioner underwent a right knee x-ray on March 5, 2010, per Dr. Schonewolf. It revealed no significant bony abnormalities of the knee. (PX 2)

Petitioner was next seen by Dr. Vasu on March 12, 2010. At this visit she was complaining of right knee pain especially when kneeling. Petitioner denied any trauma but had noticed a worsening in her knee pain since February. It was again noted that she worked as a court reporter. Petitioner told the doctor she had been to Dr. Schonewolf and had x-rays taken which were negative. She denied any other complaints. The doctor ordered an MRI. (PX 1) Petitioner underwent the MRI and returned to see Dr. Vasu on March 31, 2010 who informed Petitioner that her pain was probably due to chondromalacia and hoffa's fat pad synovitis. He recommended a referral to a surgeon and a steroid injection along with no kneeling and use of ice as needed. (PX 1)

Petitioner next presented to Dr. Schonewolf on January 21, 2011 for "follow-up" of degenerative arthritis involving the joints of her hands. Petitioner's symptoms included pain, swelling, warmth, and stiffness. They discussed the slow progression of degenerative arthritis and the importance of rest, assistive devices when necessary, local heat, a conditioning program, and control of obesity. Dr. Schonewolf described Petitioner's condition as "chronic" and due to no resolution/improvement with conservative therapy he referred Petitioner to Dr. Young for probable surgery. (PX 1)

Dr. Young examined Petitioner on February 18, 2011 at Dr. Schonewolf's request for evaluation of Petitioner's thumbs. Petitioner also reported some numbness and tingling of her bilateral upper extremities. They discussed surgery for Petitioner's severe CMC arthrosis and Dr. Young recommended nerve conduction studies for her upper extremities. "Her type of work, she..., certainly does seem to attribute to those findings." (PX 3) Petitioner's questionnaire of the same date indicated her pain was always present. When asked to describe the associated symptoms, she put "pain." Her pain drawing only identified her thumbs. In another Questionnaire she listed pain, numbness and tingling. Weather and temperature made her symptoms worse as did "anything involving thumb motion." When asked if her symptoms increased while at work she wrote, "Yes. After a long day in court." (PX 2)

Nerve conduction studies revealed severe right carpal tunnel syndrome and mild left carpal tunnel syndrome. (PX 2)

On March 1, 2011 Petitioner completed a Workers' Compensation Employee's Notice of Injury (RX 2). Petitioner did not provide a date or time for the injury/illness. She did, however, indicate that she reported the osteoarthritis on October 15, 2009 and the carpal tunnel syndrome injury on February 24, 2011. Petitioner attributed her injuries to her repetitive job duties as a court reporter which required her to report court proceedings using a shorthand machine on a daily basis since the date of hire. She also referenced computer usage in transcribing the proceedings in her office. Petitioner claimed she notified her supervisor of both conditions on the dates indicated. In an additional section Petitioner indicated she had been diagnosed with bilateral arthritis of her thumbs by x-ray and she then notified her supervisor. She tried conservative treatment and then went back to her doctor who referred her to Dr. Young who ordered x-rays and nerve conduction studies, the latter of which revealed carpal tunnel syndrome. Petitioner was scheduled to see Dr. Young again on March 8, 2011. (RX 2)

Petitioner's supervisor completed a report on March 2, 2011. (RX 3) That same day a Demands of the Job form was also completed by Petitioner's supervisor. According to it, Petitioner engaged in use of her hands for gross and fine manipulation 6 – 8 hours per day (grasping, twisting, handling, typing, and good finger dexterity). (RX 4)

Petitioner signed her Application for Adjustment of Claim on March 3, 2011. (AX 2)

Petitioner returned to see Dr. Young on March 8, 2011.

On May 5, 2011 a "Nurse's Note was entered at the office of Dr. Young. According to it, Petitioner's appointment on February 18, 2011 was scheduled incorrectly as Petitioner stated she thought the visit might be work-related. After seeing Dr. Young Petitioner filed a workers' compensation claim and paperwork was returned to the doctor's office. Petitioner had hired an attorney. Thereafter, the claim was under review by Respondent. A disc with Petitioner's x-rays was going to be burned and sent to Respondent for review. (PX 3)

Dr. Young's office received word on July 12, 2011 that Petitioner's bilateral carpal tunnel releases and CMC arthrodesis had been authorized. (PX 3)

Dr. Young met with Petitioner on July 25, 2011 to review the previous office consultation from February and to discuss surgery. Petitioner wished to undergo the right side first. Dr. Young's diagnosis remained unchanged. The plan was to proceed with the right hand/thumb first. (PX 3)

On July 29, 2011 Petitioner underwent ligament reconstruction/tendon interposition arthroplasty of the right thumb carpal metacarpal joint, a right flexor carpi radialis to the first metacarpal transfer, and a right carpal tunnel release. (PX 3) Petitioner was taken off work at the time of surgery. (PX 3) Dr. Young anticipated a full release to work on September 9, 2011. (PX 3)

At her August 12, 2011 visit with Dr. Young she was placed in the thumb spica cast on the right and given a prescription for Celebrex to help with some mild swelling and a script for occupational therapy. Petitioner was given work restrictions of no use of the right hand. (PX 3)

On September 9, 2011 Dr. Young felt Petitioner was unable to resume full work duties. He ordered occupational therapy and a spica splint for Petitioner's right hand/thumb. (PX 3)

As of November 3, 2011 Dr. Young noted Petitioner was still experiencing a popping sensation with extension and abduction of her thumb with resistance which was somewhat painful. The doctor was able to reproduce it himself. X-rays were taken. Petitioner was still unable to resume full duty as she needed lifting restrictions of 5 – 10 lbs. On going care was prescribed including Mobic, Flector patches, and a Medrol Dosepak. Occupation therapy was put on hold. (PX 3)

Petitioner was released to full duty with regard to her right hand on December 1, 2011. Petitioner reported good grip strength and believed she was progressing well. The focus of attention was turned to the left hand/thumb. (PX 3)

Petitioner underwent the same surgical procedure on the left hand/thumb on December 21, 2011. (PX 3)

Petitioner fell on ice and snow on December 27, 2011 and was seen at Memorial Hospital Emergency Room in Carbondale complaining of right hand pain. Petitioner underwent x-rays and a CT scan of her right wrist. No evidence of any acute osseous abnormality or fracture was noted. The CT scan revealed some small ossific fragments within the surgical bed and post-operative changes with no evidence of any acute abnormality. (PX 3)

Petitioner was examined by Dr. Young on February 9, 2012 and he kept her off work. She was fitted for a thumb spica splint. (PX 3)

As of March 26, 2012 Petitioner was reporting fairly good range of motion although she noted that, as a court reporter, when she tries to type she was unable to do so for more than twenty minutes the first time. Thus, she felt unable to yet return to work. Ongoing occupational therapy was ordered. PA-C Erthall explained to Petitioner that it could take up to a year to recover after surgery. She was instructed to remain off work and not engage in court reporting. Medication was dispensed. (PX 3)

Dr. Young re-examined Petitioner on April 10, 2012. He didn't feel she was ready to return to work except with restrictions of no lifting over ten pounds and no typing. He ordered work hardening and then anticipated a full release to work. Petitioner's examination that day indicated a little crepitus with ranging the right thumb no pain. (PX 3)

Petitioner's work hardening session dated April 16, 2012 reviewed Petitioner's physical job requirements and how she was progressing. Of note, Petitioner was not as fluent and struggling with dexterity. She was able to do 8000 strokes on the 16th and 9000 on the 17th, noting she required breaks about every 45 minutes to stretch. (PX 3)

Both Dr. Young and PA-C Erthall examined Petitioner on April 26, 2012. Petitioner was going to work hardening but still having some pain and swelling. She was also getting numbness in her right small finger and some clicking in the wrist and elbow on the right side. She had full range of motion of her thumb and could make a complete fist. She had no signs of swelling or redness. No clicking or popping could be heard on either side. Petitioner was noted to have a positive Tinel's and ulnar nerve compression test on the right. She was kept off work and therapy was discontinued. Celebrex Was prescribed along with a cubital tunnel splint to be worn at night. Petitioner was to return to work in eleven days. (PX 3)

On October 11, 2012 Petitioner fell while walking from the Circuit Clerk's office to the elevator when she slipped and fell on a wet floor that had just been mopped. Petitioner presented to Dr. Young's office on October 17, 2012 for complaints of neck and back pain and bilateral wrist pain, especially the right wrist. Petitioner was treating with a chiropractor for her neck and back issues. PA-C Erthall noted that Petitioner's prior pain from before the October 11th accident had become much better and she was released; however, now her right wrist felt just like it did before and she occasionally notices some numbness in her hand and ulnar-sided and radial-sided right wrist pain. She displayed fairly good range of motion but had some tenderness over the distal ulnar as well as the lunotriquetral interval and in the radial snuffbox of the right wrist in the scapholunate interval. Petitioner was nontender with scaphoid shift testing and ulnar stressing. X-rays of both wrists were taken. Petitioner was noted to have "DC type wrist of the right wrist." She was placed in a wrist-forearm splint and given a prescription. (PX 3)

Dr. Young examined Petitioner on October 23, 2012. Her exam was much improved but she remained symptomatic. He felt a CT scan would be reasonable so as to rule out a scaphoid injury or an occult break. (PX 3)

Petitioner met with Dr. Young and his PA-C on November 8, 2012. Petitioner's CT scan was reviewed with the doctor noting it was negative. Due to some mild tenderness at the scapholunate interval and in the ulnar snuffbox Dr. Young injected her wrist. She was to return to occupational therapy and see the doctor again in one month. (PX 3)

Dr. Young re-evaluated Petitioner on December 6, 2012 at which time he deemed her at maximum medical improvement. The steroid injection given in November had provided relief. Dr. Young noted that the therapy they had talked about was never approved. Petitioner displayed full flexion, extension, pronation, supination, radial and ulnar deviation of the right hand with very minimal pain with palpation of the ulnar snuffbox. There was no pain over the ECU. She had a negative scaphoid shift test and no pain over the scapholunate interval. Petitioner also had negative thumb compression grind, full range of motion of her digits. She was neurovascularly intact. Petitioner was released to return as necessary. (PX 3)

Doctors' Deposition Testimony

Dr. Young's evidence deposition was taken on October 22nd, 2013. Dr. Young testified that Petitioner might have brought in her equipment for his therapist but that he didn't recall seeing her specifically manipulate the machine. When asked if her symptoms could have been caused or aggravated by her court reporting activities; Dr. Young's response was that it could have. Furthermore, when asked on direct examination if he was aware of any amount of activity that would satisfy him with regard to the relation between the work and condition; his answer was he was not aware of any specific numbers. (PX 4)

On cross-examination Dr. Young admitted that the Petitioner's arthritis would have developed gradually over a period of time and that her work would not be the sole causative factor and that age would have been a factor. Additionally, he testified thumb arthritis is more common in females. When questioned about Petitioner's court reporting activity Dr. Young admitted he did not know the amount of force involved in operation. He also did not know the amount of time the Petitioner spent using her court reporting machine per day. He also admitted the Petitioner's smoking has an influence on carpal tunnel syndrome by diminishing the blood flow to the median nerve because it constricts the blood vessels that supply blood to the nerve. Dr. Young testified he was not aware of any specific articles indicating that data entry or typing could lead to, cause, or aggravate carpal tunnel syndrome. (PX 4)

Dr. Stewart's evidence deposition was taken June 10th, 2014. Dr. Steward testified that approximately 30-40% of his practice is devoted to surgery. Dr. Stewart testified the medical records for Ms. Myer showed a rather normal sequence of events for this type of arthritis. He further stated the Petitioner brought her stenographic machine to the physical exam. Dr. Stewart felt it was noteworthy her thumbs only hit the keys when typing a vowel. It was his understanding she would type six to eight hours a day in some form of stenography. He further testified she had co-morbidity for carpal tunnel due to her age and gender as well as her cigarette smoking. He opined in his deposition her arthritis is found in more than 80% of the population in later life. He explained that this is caused by ligament instability. Under cross-examination he explained that when Petitioner demonstrated her stenography he did not observe her engaged her long tendon or cause any force to be transmitted down the length of the thumb joint or CMC joint. His opinion was the keys were relatively easy to move. He also cited a study from the Mayo Clinic which found that data entry and typing did not cause repetitive trauma. (RX 6)

Petitioner's Testimony at Arbitration

Petitioner testified that she worked as a court reporter at the Pulaski County Courthouse but is employed by the office of the Illinois Comptroller. She was employed in this capacity for twenty-two [22] years at the time of the trial. She testified that her job duties include being a steno writer and typing in court throughout the day. There is one judge and one court reporter so they deal with lots of things during a day. Petitioner explained that she sits with her hands extended for long periods of time. She also answers the phone for the judge and types transcripts; however, most of her work is in the courtroom on her steno writer.

During direct examination Petitioner testified her problems with her thumbs began in 2009. Initially they "bothered" her due to pain. She explained that she operates the vowels on her steno writer with her thumbs so she is using them ("stroking them") at all times. Petitioner testified that she went to "Sportsology" and had x-rays taken. Thereafter, "he" looked and then and told her she had some degenerative osteoarthritis and that it was probably due to the kind of work she did. He prescribed some occupational therapy. The therapist later told her she probably needed to go to Dr. Young or a specialist.

Petitioner testified that she was continuing to work throughout this time and things were getting worse. When she got to Dr. Young he also asked her if she was having any numbness and when she said "yes" he ordered a nerve conduction study.

Petitioner eventually underwent surgery on her thumbs and hands/wrists. She testified she was doing fine now but recovery was rough. Petitioner testified she is "doing good" and has no numbness. She testified that "everything seems to be fixed." Her thumbs are good. As she testified, the problem seems to have been rectified.

On cross-examination Petitioner admitted the court docket changed from day to day in Pulaski County. However, while the docket may change she is still sitting in the courtroom typing all day. One day may be traffic court and the next day may be criminal court. She also admitted the amount of time she spent typing was dependent on the docket of the day. However, if she wasn't in the court room reporting she would be typing up transcripts or typing orders for the judge and answering the phone. She also admitted that technology has made her job easier. When she first began court reporting the machines were manual with paper and she had to read from the notes and type from it. Now there are SD cards that lessen what she has to do in terms of transcription. The steno writing in the courtroom has not changed. While she was off work for her surgeries Petitioner received temporary total disability benefits.

Petitioner denied having ever been told she had osteoarthritis in her thumbs and hands or carpal tunnel syndrome before she underwent the initial testing nor had she ever received any treatment for anything related to her thumbs or hands/wrists before the accident herein. However, with regard to the matter of carpal tunnel syndrome Petitioner added that the State always holds seminars for court reporters and tells them that carpal tunnel syndrome is an "occupational hazard."

Petitioner was asked on further cross-examination about her slip and fall at Walmart on October 30, 2009. She explained that she slipped and fell going into the store due to rain. She injured her back as she fell on her buttocks. Petitioner also had another slip and fall at the courthouse. She could recall no other slips and falls until Respondent's attorney asked her about a fall when she tripped on ice and snow. Petitioner then recalled that occurred on December 27th just after her surgery. She fell on her right wrist but nothing was broken. It just hurt.

Petitioner acknowledged she has smoked a pack or less of cigarettes per day.

Petitioner was shown a copy of RX 4 a job description for a court reporter supervisor. It lists four items/tasks that she performed 6 – 8 hours per day: (1) working on or with moving machine with or without intermittent rest; (2) sitting; (3) using hands for gross manipulation, grasping, twisting and handling; and (4) using hands for fine manipulation, typing, and good finger dexterity. (see also RX 4).

The Arbitrator concludes:

15IWCC0418

1. Issues (C) Accident and (F) Causal Connection.

Petitioner sustained an accident on October 14, 2009 that arose out of and in the course of her employment with Respondent. This conclusion is based upon Petitioner's credible testimony and the causation opinions of Dr. Young and Petitioner's other treating physician(s). In this instance the Arbitrator finds the opinions of Dr. Young more persuasive than those of Dr. Stewart.

At the outset the Arbitrator notes that she had to piece together Petitioner's treatment in the fall of 2009 and, as such, believes that not all of Petitioner's treatment records may be a part of the record. Dr. Humphrey, Dr. Vasu, and Dr. Schonewolf appear to be part of one medical group and they saw Petitioner interchangeably and/or together. When Petitioner saw Dr. Schonewolf on December 4, 2009, the visit was described as a "follow-up" visit. There is, however, no prior visit in the Southern Illinois Medical Family Practice records. Nevertheless, Petitioner had undergone bilateral thumb x-rays on October 14, 2009, followed by a period of physical therapy. Petitioner told the therapist she had been having pain and achiness in her thumbs for 1 1/2 years and had been diagnosed with DeQuervain's Tenosynovitis and undergone an injection with minimal relief. No corroboration for this treatment is in the record. However, Respondent's examining physician, Dr. Stewart, was given Petitioner's medical records to review and in the first sentence of paragraph two of his written report, he wrote, " The records from 2009 from her primary care physician's office indicated the diagnosis of severe osteoarthritis of her thumbs and Dr. Vasu felt it was related to [Petitioner's] work." (RX 5; RX 6, Res. Ex. 2) Normally, this Arbitrator would be troubled by the missing records; however, in this instance, Respondent obviously had the records (or access to the records) and neither party submitted them into evidence. There is also evidence that Dr. Vasu felt Petitioner had a work-related problem with her thumbs in 2009. Respondent did not depose Dr. Vasu.

Additionally, we have Petitioner's testimony that her thumbs were very achy and hurt a lot so she went to Sportsology (she thought) and underwent x-rays and was told she had degenerative osteoarthritis in her thumbs due to the kind of work she did. She also testified to being told by Respondent (in seminars) that carpal tunnel syndrome was an occupational hazard.

Petitioner's testimony regarding her job duties as a steno writer/court reporter was credible.

Respondent's liability argument appears to be centered on causation and not manifestation. Respondent contends that Dr. Stewart's opinions are more credible because he had all the medical records and actually observed Petitioner use her steno writer. Both doctors agreed on Petitioner's diagnosis. Both doctors agreed that Petitioner's sex may have predisposed her to the condition; however, Dr. Young's opinion on aggravation is found to be more persuasive.

In this instance whether one doctor reviewed the prior records and the other one did not does not really matter. There really doesn't appear to be a dispute that hinges on who reviewed the prior treating records. While it is true Dr. Stewart observed Petitioner use the steno writer he provided no details as to the speed with which she demonstrated her use of the machine, etc. His report is devoid of any history taken from Petitioner as to how fast she may have been required to type on it, etc. As Petitioner indicated to the therapist at one point, she was performing 8000 to 9000 strokes on her machine. (PX 3, 4.16.12 o/v) Dr. Stewart acknowledged that Petitioner's job was repetitive (written report -- RX 5, RX 6, Res. Ex. 2).

He acknowledged that the key issue to him was the amount of force or the amount of pressure Petitioner was having to place as well as the direction of the force. He rendered his opinion based upon what he observed her do in his office which may not have been an accurate and true portrayal of her day to day activities. For example, Petitioner told Dr. Young her symptoms were worse after "a long day with court." While Dr. Young may not have known how many hours per day Petitioner spent engaged in court reporting, Dr. Stewart did not provide any information on that issue either. Additionally, while Dr. Young did not observe Petitioner on her steno machine, it was noted during his deposition that they had a court reporter present taking down the proceedings. Thus, Dr. Young was aware of what a court reporter did -- perhaps more so than Dr. Stewart as he was actually watching a court reporter performing her job in "real time." Additionally, while Dr. Stewart reference a Mayo Clinic study on data entry, the studies was not made a part of the record and dealt with data entry and, not necessarily, court reporting/stenographic activities.

Finally, the Arbitrator notes Petitioner's job description which indicates Petitioner spent six to eight hours per day engaged in a job involving fine and gross manipulations of her fingers and hands. Petitioner credibly denied having ever had treatment to her thumbs or having been diagnosed with osteoarthritis of her thumbs prior to this time period. No evidence to the contrary was presented.

Petitioner proved she sustained a repetitive trauma injury to her thumbs and hands/wrists. She proved that those injuries were work-related.

2.Issue (E) Notice.

Petitioner proved timely notice of her injuries/accident was provided to Respondent. Petitioner testified she told her supervisor in October of 2009 about her thumbs. She reported her bilateral carpal tunnel syndrome after it was diagnosed. In filling out a written report for her hands/wrists, she reiterated that October 15, 2009 she notified her employer about her osteoarthritic thumbs. (RX 2) Respondent provided no evidence to the contrary.

Alternatively, one could conclude Petitioner's accident manifested itself on February 18, 2010 when Dr. Young told Petitioner her problems appeared to be work-related. If it did, Petitioner's written notification of her conditions (RX 2) was timely.

3. Issue (J) Medical Expenses.

Petitioner is awarded those medical bills found in PX 5 except for the following:

1. Bill for services on 3/5/10 -- $360.00
2. Bill for services on 3/26/10 - $2,304.00

It appears that the above bills were for services unrelated to Petitioner's thumb and/or hands. Petitioner received treatment for her right knee at the time those bills were incurred.

Petitioner is also not awarded the bill for services rendered on July 17, 2012 ($1291.00). There is no corresponding medical record in evidence nor did Petitioner provide any testimony concerning it.

The remaining bills found in PX 5 are awarded subject to the Medical Fee Schedule with Respondent receiving a credit for any bills that have been paid by it or its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

Petitioner underwent two surgical operations with several procedures being performed during each operation. Petitioner has undergone bilateral carpal tunnel releases, ligament reconstructions with tendon interposition arthroplasties of the thumbs, and flexor carpi radialis transfers to the first metacarpals of the thumbs. When examined by Dr. Young on April 26, 2012 Petitioner had been undergoing work hardening and still complaining of some pain and swelling. She was now experiencing numbness in her right small finger and some clicking in the ulnar aspect of her wrist and in the elbow on the right side. Her wounds had healed nicely. Dr. Young noted no crepitus or tenderness with CMC compression grind. She could make a complete fist and had full range of motion of her thumb. She had no swelling, erythema or ecchymosis. Neither wrist clicked or popped. Petitioner did have a positive Tinel's and positive ulnar nerve compression on the right side. Petitioner was to be kept off work for another eleven days but therapy was discontinued. She was given a prescription for Celebrex and after eight days she was to return to work with no restriction. She was told to wear a cubital tunnel splint on the right elbow at night. She was to return in eight weeks. It does not appear that she did until October 23, 2012. Subsequent treatment with Dr. Young in October of 2012 is unrelated to this claim as the treatment stems from another injury Petitioner sustained on October 11, 2012 when Petitioner was walking from the Circuit Clerk's office to the elevator and slipped and fell on a wet floor that had just been mopped. Additionally, there is no evidence connecting up Petitioner's ulnar complaints to her work or her accident.

At arbitration Petitioner was asked how she was doing as a result of her surgeries on her hands and thumbs and she replied, "I'm fine now." She went on to add that she is doing "good." She no longer experiences any numbness and everything seems to be fixed. She is back to work as a court reporter and working with no restrictions. She did not indicate she was having any kind of problem performing her job. She does not appear to be taking any medications. She has not had to alter any activities or the manner in which she performs her job or any activities.

Petitioner is permanently partially disabled to the extent of 7.5% loss of use of each hand and 20% loss of use of each thumb.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Summers,

Petitioner,

vs.

The American Coal Company,

Respondent.

15IWCC0419

NO: 10 WC 15875

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 2014 is hereby affirmed and adopted.

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

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

DATED: JUN 5 - 2015

David D. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/27/15

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUMMERS, RONALD
Employee/Petitioner

Case# **10WC015875**

15IWCC0419

THE AMERICAL COAL COMPANY
Employer/Respondent

On 10/20/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
BRUCE R WISSORE
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

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 15IWCC0419

Case # **10**WC **015875**

Consolidated cases: _____

RONALD SUMMERS
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **August 6, 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 **Sections 1(d)-(f) and 19(d) of the Occupational Diseases Act**

FINDINGS

On **February 21, 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.

In the year preceding the injury, Petitioner earned **$74,000.00**; and his average weekly wage was **$1,423.08**.

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

Petitioner claims no medical.

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

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.

Edward Lee
Signature of Arbitrator

10/13/14
Date

OCT 20 2014

STATE OF ILLINOIS)
) SS:
COUNTY OF WILLIAMSON)

15IWCC0419

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ronald Summers,
Employee/Petitioner

v.

Case #10 WC 015875

The American Coal Company,
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner was 67 years old at the time of arbitration. He graduated from West Frankfort High School. He worked for 38 years in underground coal mining. During his coal mining career in addition to coal dust he was exposed to silica, roof bolting fumes, diesel fumes and Trowel-on.

Petitioner's last day of exposure in the coal mine was February 21, 2010, at Respondent's Galatia mine. He was 63 years old on that date and his classification was face boss. Rather than sinking a new shaft, the mine was driving a new entrance so they could use the old air shafts and returns. On the last day of employment, Petitioner was exposed to coal dust. He testified that he quit working on that day because they were going to send him to the other portal to go down. His health was getting bad and he could not breathe and he could not walk that much. He testified that it was a difficult decision for him financially. After he left the coal mine he took on some piddly kind of work such as carpentry work which he does not turn in for taxes. He did not seek any regular employment because he could not keep up with what they wanted done.

After high school Petitioner worked at Norge, a washing machine factory. Next he worked at Gardeners Heating and Air putting in air conditioning, furnaces, and duct work. He also worked at Carl Motors in the body shop. Petitioner's first coal mine job was with Inland Steel in 1969. At Inland Steel, he ran a miner and then went to roof bolting. He was at Inland 1 for approximately 12 years. He then worked at Freeman 6 as a face boss for about two years. His next job was with Inland 2 as a face boos in 1987. His next job was with General Belt spotting supplies and conveyor belts in the coal mine. He did that job for about two years and then went to work for Paula Rone. In that job he seeded sides of the roads and similar work. He did that for a couple of years and then went back to the coal mine working for Respondent starting in 2005. He started at Respondent as an examiner, and then went to face boss. He testified that he made the switch because the grandkids he was responsible for were going to college and he needed more money.

Petitioner first noticed breathing problems at work when he was an examiner. As an examiner he would have to walk approximately six miles per shift. During the whole shift he was in the return where all the gases, rock dust, coal dust and everything goes out of the mine. He noticed that he had trouble walking and keeping up. He would have difficulty getting to the board to record his readings on time. As of arbitration Petitioner could walk half a mile on level ground. He testified that he avoids stairs but he could walk up a flight of about 10 stairs.

Petitioner testified that from the first time he noticed breathing problems as an examiner until the last day that he worked at the mine, his breathing problems worsened. He testified that since he quit the mine up until arbitration his breathing problems had gotten just a little bit but not much worse. Petitioner testified that he takes Spiriva with an inhaler. He testified that his breathing problems slow him down in his activities of daily life. He testified that his breathing affects anything he tries to do such as walking and horseback riding. He testified that he cannot get out in the heat and humidity.

Petitioner saw Dr. Graham, his primary care physician, for his breathing problems. Dr. Graham referred him to Dr. Elsherbini. He testified that Dr. Elsherbini did all kinds of tests. He talked to both Dr. Graham and Dr. Elsherbini about his breathing problems. Petitioner testified that he has not done anything other than manual labor. Petitioner started smoking when he was about 18 and continues to smoke about a pack a day. Petitioner also has heart problems and some contusions where he got hit in the head with a rock.

Petitioner testified that if he were offered a job in the mine today, he wouldn't take it because he could not do it. In his last job, he was responsible for a lot of people and had to get them out of the mine. He would never make it out, let alone get them out. He also had to make quick decisions and his thinking is not what it ought to be. He testified that he was "physically and mentally shot."

A couple of months after he retired, Petitioner moved to Oklahoma to be near his son and grandchild. He lived there for two and a half years before moving back to Illinois because of his health and the home they owned in Thompsonville, Illinois. They have 20 acres with horses and barns. Petitioner and his wife care for and feed the horses. He travels to Oklahoma where his son has a horse training business. There is someone there to saddle and unsaddle the horses that Petitioner uses.

Petitioner had a TIA in November 2012, which was about the time he noticed having more significant memory problems. He was also having memory problems when he was still working and is one of the reasons that he quit. He also developed atrial fibrillation, an irregular heart rate, in December 2013. He is still treating for the irregular heartbeat. He testified that he first took breathing medication after seeing Dr. Graham in March 2013. Petitioner testified that Dr. Repsher and Dr. Graham told him to stop smoking. He testified that he was not going to stop. Petitioner testified that he has trouble with his knees.

When Petitioner retired from the coal mine he had a CDL license. He gave it up when he came back to Illinois. He did not use the CDL after he left the mine.

From time to time while he was working as a coal miner, Petitioner underwent chest x-ray screenings for black lung. He never paid any attention to the reports that he received from time to time after those x-rays were done. He testified that when he saw the various physicians, including Dr. Houser, his attorney sent him to, he was always honest with them in describing his complaints and problems.

Petitioner was seen by Dr. William Houser on January 6, 2011, at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 7). Dr. Houser has been the medical director of the Deaconess Hospital Black Lung Clinic since it started in 1979. (Petitioner's Exhibit No. 1, p. 4). Dr. Houser has conducted 3,000 or 4,000 exams in the Black Lung Clinic. (Petitioner's Exhibit No. 1, p. 5). Dr. Houser is board certified in internal medicine, pulmonary disease and critical care medicine. (Petitioner's Exhibit No. 1, Dep. Exhibit No. 1). Dr. Houser testified that he has seen hundreds of patients at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 33). Petitioner was not a patient of Dr. Houser's and he saw him on only one occasion. (Petitioner's Exhibit No. 1, p. 33). Dr. Houser took the test to be certified as a B-Reader and did not pass the test. He has never been a B-Reader. (Petitioner's Exhibit No. 1, pp. 54-55). Dr. Houser is the medical director for the Southwest Indiana Respiratory Disease Program. One of the missions of that organization is to assist miners in obtaining black lung benefits. (Petitioner's Exhibit No. 1, p. 34).

Petitioner was 64 years old at the time of Dr. Houser's examination. He complained to Dr. Houser of shortness of breath. He had some cough and sputum and occasional wheezing. Petitioner told Dr. Houser that he could walk up to a mile at a slow pace. He had smoked for the past 38 years averaging one pack of cigarettes per day, but over the past few years had increased to one and one-half packs per day. Petitioner did not take any regular medications or treatment at the time of Dr. Houser's examination. (Petitioner's Exhibit No. 1, pp. 17-18). On physical examination, Petitioner's chest was clear to percussion and to auscultation. (Petitioner's Exhibit No. 1, p. 18).

On pulmonary function testing, Dr. Houser noted mild airway obstruction with modest bronchodilator response. Dr. Houser testified that there was a 13% improvement with bronchodilator. It did not reverse to normal. He concluded that indicated some sign of a reversible disease, such as bronchospasm or possibly mucosal edema or possibly mucus. (Petitioner's Exhibit No. 1, p. 19).

Dr. Houser testified that Petitioner had coal workers' pneumoconiosis which was related to his 35 year history of coal mine employment. (Petitioner's Exhibit No. 1, p. 25). Based on his diagnosis of coal workers' pneumoconiosis and COPD, Dr. Houser opined that Petitioner could have no further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, pp. 26-27). Dr. Houser testified that independent of causation, exposure to coal and/or rock dust is likely to aggravate COPD and therefore would be a factor that would cause more rapid progression of the disease process. (Petitioner's Exhibit No. 1, pp. 26-27). Dr. Houser testified that in terms of symptoms, shortness of breath and cough with mucus could be some of the symptoms commonly seen with COPD. (Petitioner's Exhibit No. 1, p. 27). He testified that at the cellular level, there is no difference between COPD caused by

mining versus smoking. (Petitioner's Exhibit No. 1, p. 27). Dr. Houser testified that NIOSH and the Department of Labor's official position is that the relative risk of smoking and coal mining for obstructive lung disease is similar. He testified that the American Thoracic Society's position is that coal mining in a heavily exposed miner can be worse than smoking. (Petitioner's Exhibit No. 1, p. 28). Dr. Houser believed that Petitioner had clinically significant pulmonary impairment caused by exposure to coal and rock dust as well as cigarette smoking. He also testified that Petitioner had radiographically apparent abnormalities that are consistent with pulmonary impairment. (Petitioner's Exhibit No. 1, p. 30). Dr. Houser testified that Petitioner would be able to do heavy manual labor if he could go where the labor was to be done safely. (Petitioner's Exhibit No. 1, pp. 31-32).

Dr. Houser testified that with regard to the history of cough and sputum, he felt it was insufficient to make the diagnosis of chronic bronchitis. He testified that Petitioner would be in danger for developing chronic bronchitis with continued tobacco use. (Petitioner's Exhibit No. 1, p. 34). Dr. Houser testified that there are many causes for exertional dyspnea and deconditioning would be high on the list. (Petitioner's Exhibit No. 1, p. 35).

According to Dr. Houser the damage caused by tobacco use shows up on spirometry as an obstruction. When significant dust exposure results in pneumoconiosis and pulmonary impairment is associated with same, then it is classically a restrictive defect. He testified that there was no evidence of restriction in Petitioner. Dr. Houser testified that in about 95% of the cases for those individuals who develop coal workers' pneumoconiosis and cease their exposure to coal mine dust, the disease process is unlikely to progress. (Petitioner's Exhibit No. 1, pp. 36-37). Dr. Houser testified that once a person has radiographic evidence of coal workers' pneumoconiosis, it is permanent. Normally, it will not regress in terms of profusion or disappear from a lung zone where it was previously. (Petitioner's Exhibit No. 1, p. 38).

As for an individual who has developed an obstruction and continues to smoke, Dr. Houser would anticipate an accelerated decline in his pulmonary function over time. He testified that Petitioner's continued use of tobacco was injurious to his health and he told him to stop. (Petitioner's Exhibit No. 1, pp. 39-40).

Petitioner did not tell Dr. Houser that he left coal mining at the time he did due to respiratory disease or relate an inability to perform the duties of his last job in the coal mine. (Petitioner's Exhibit No. 1, p. 42). The only aggravant for his symptoms that Petitioner related to Dr. Houser was exertion. (Petitioner's Exhibit No. 1, p. 43).

Dr. Houser based his diagnosis of obstruction on Petitioner's FEV1/FVC of 68. He testified that the lower limit of normal for Petitioner would be something between 69.5 and 69.3. He testified that Petitioner was right on the cusp, but he was below the lower limit of normal. (Petitioner's Exhibit No. 1, p. 46). Dr. Houser testified that the meaning of a low FEV1/FVC ratio accompanied by an FEV1 within the normal range was unclear. He testified that whether that pattern represents air flow obstruction would depend on the results of additional testing such as bronchodilator response, diffusion capacity, gas exchange evaluation and exercise testing. (Petitioner's Exhibit No. 1, p. 48). Dr. Houser did bronchodilator testing on Petitioner, but he did not measure his blood gases, lung volumes or diffusion capacity and did not perform exercise

testing. (Petitioner's Exhibit No. 1, p. 49). He testified that the spirometry he performed was flagged for a number of variability and quality cautions. (Petitioner's Exhibit No. 1, p. 51). Dr. Houser testified that the results from the bronchodilator testing that was performed on Petitioner was something that is seen with COPD from any cause, including smoking. (Petitioner's Exhibit No. 1, pp. 56-57).

Dr. Henry K. Smith, board certified radiologist and NIOSH B-Reader, interpreted Petitioner's chest x-ray of February 17, 2005, as positive for pneumoconiosis, category 1/1 with P/S opacities in all lung zones. Dr. Smith interpreted the chest x-ray of March 2, 2010, as positive for pneumoconiosis with P/P opacities in all lung zones, profusion 1/1. Dr. Smith also interpreted chest x-ray of November 9, 2011 as positive for pneumoconiosis, category 1/1 with P/S opacities in the middle and lower lung zones. Dr. Smith also interpreted a CT scan performed on November 9, 2011. He noted that the findings on the CT scan were consistent with simple coal workers' pneumoconiosis with small opacities, primary P, secondary S throughout the mid and lower and to a lesser extent upper lung zones. (Petitioner's Exhibit No. 4.)

Dr. Robert Cohen interpreted chest x-ray of Petitioner dated February 17, 2005, as positive for pneumoconiosis, category 1/0 with P/P opacities in all lung zones. Dr. Cohen made an identical interpretation of the chest x-ray dated November 9, 2011. Dr. Cohen also reviewed the CT scan of November 9, 2011. He noted that there were scattered round opacities which were less than 1.5 mm in diameter at low profusion. He noted that these would correspond with P-shaped and sized opacities on plain radiographs. Dr. Cohen is board certified in internal medicine, pulmonary disease and critical care as well as being a NIOSH B-Reader. (Petitioner's Exhibit No. 5).

Dr. Michael Alexander interpreted the chest x-ray of March 2, 2010, as positive for pneumoconiosis, category 1/1 with P/S opacities in all lung zones. Dr. Alexander is a board certified radiologist and NIOSH B-Reader. (Petitioner's Exhibit No. 6).

Dr. Jerome F. Wiot, who has been board certified in radiology since 1959 and a NIOSH B-reader, since the inception of the B-reading program interpreted chest x-ray of Petitioner dated March 2, 2010. He found no evidence of coal workers' pneumoconiosis. Dr. Wiot also served on the American College of Radiology Task Force on Pneumoconiosis beginning in 1969. (Respondent's Exhibit No. 9).

Dr. James Castle, who is board certified in internal medicine and pulmonary disease and has been a B-reader since 1985, interpreted chest x-ray of Petitioner dated March 2, 2010. He found no evidence of coal workers' pneumoconiosis on said film. (Respondent's Exhibit No. 11).

Records from NIOSH were admitted into evidence. A chest x-ray taken on September 4, 1999, was interpreted by an A and B-reader as completely negative for pneumoconiosis. A chest x-ray taken on February 17, 2005, was interpreted by an A-reader as completely negative for pneumoconiosis and by a B-reader gave said film a 0/1 profusion with S/T opacities in the mid and lower lung zones bilaterally. (Respondent's Exhibit No. 10).

Dr. Eric Graham is a family practice physician in Marion, Illinois. In his practice he treats coal miners and former coal miners. He treats patients who have asthma and COPD. On occasions with some patients who have lung problems, he sends them to a pulmonologist for a consult. (Petitioner's Exhibit No. 2, pp. 4-5). In the course of his practice, he has provided care and treatment to Petitioner. He first saw Petitioner on December 11, 2012, and has seen him three times since then. (Petitioner's Exhibit No. 2, p. 7). Dr. Graham responded to eight questions that Petitioner's counsel asked of him in a letter dated July 18, 2013. Dr. Graham testified that he believed Petitioner to have pulmonary diseases and he sent him out for a pulmonary consult to confirm that. (Petitioner's Exhibit No. 2, pp. 8-9).

Dr. Graham testified that Petitioner has COPD which was caused in part or aggravated and made worse by his exposures during his years as an underground coal miner. (Petitioner's Exhibit No. 2, p. 10). In his opinion Petitioner has asthma which was also caused in part or aggravated and made worse by his exposure as an underground coal miner. In light of Petitioner's asthma and COPD Dr. Graham testified that if Petitioner were to have further exposure to the environment of a coal mine, same would present a risk to his health by way of increasing the potential for progression of his asthma and COPD. (Petitioner's Exhibit No. 2, pp. 10-11). Dr. Graham testified that in light of Petitioner's work related lung disease, he did not retain the pulmonary capacity to do the manual labor required of a coal miner. (Petitioner's Exhibit No. 2, pp. 11-12).

Dr. Graham is not board certified. He is board eligible in family medicine. (Petitioner's Exhibit No. 2, p. 12). Dr. Graham is not aware of what Petitioner's physical condition was prior to December 11, 2012, other than by way of history. When Dr. Graham saw him on that date Petitioner related to him shortness of breath on mild exertion. He told Dr. Graham that he had no chronic cough. The medical history that Petitioner related to Dr. Graham was positive for COPD and black lung. He also reported being a current smoker of a pack per day. (Petitioner's Exhibit No. 2, p. 13). Dr. Graham testified that assuming Petitioner smoked between 30 and 50 years, two to two and a half packs a day, that was a significant history of tobacco use. He testified that tobacco use is the leading cause of COPD and is associated with cough, sputum and shortness of breath. Dr. Graham would expect a decline in Petitioner's pulmonary function over time with continued tobacco use. (Petitioner's Exhibit No. 2, p. 14). Dr. Graham told Petitioner to stop smoking. He testified that if he were to stop smoking, the progression of his lung disease, although it would not stop, would decrease. (Petitioner's Exhibit No. 2, p. 15). When Petitioner first saw Dr. Graham he was taking Lisinopril which is an ace inhibitor for blood pressure. Dr. Graham testified that the medicine can be associated with cough. (Petitioner's Exhibit No. 2, pp. 15-16). His O_2 saturation on room air was 97% which was normal. On physical examination Dr. Graham found Petitioner's lungs clear to auscultation without rales, rhonchi or wheeze. (Petitioner's Exhibit No. 2, p. 16). Dr. Graham's assessment on that date was hypertension and dyspnea. The diagnosis of dyspnea was based upon what Petitioner related to Dr. Graham. He did not diagnose him with COPD or asthma. (Petitioner's Exhibit No. 2, pp. 16-17).

Petitioner underwent a chest x-ray in the emergency room on March 1, 2013, because of altered mental status. The impression was no acute cardiopulmonary disease. (Petitioner's Exhibit No. 2, pp. 17-18). Petitioner returned to Dr. Graham on March 11, 2013. Again he had

no chronic cough. His oxygen saturation on that date was 100%. Dr. Graham did not diagnose him with COPD or asthma. Dr. Graham advised him to come back in six months. (Petitioner's Exhibit No. 2, pp. 20-22). Petitioner returned on March 21, 2013, to specifically talk to Dr. Graham about black lung. At that time he related a different history about his cough. He reported to Dr. Graham that he had an established diagnosis of COPD and black lung. (Petitioner's Exhibit No. 2, p. 22). On that date Petitioner's O_2 saturation was 99% on room air which is normal. Physical examination of the chest revealed no rales, rhonchi or wheezes. Dr. Graham's assessment on that date was decompensated chronic obstructive pulmonary disease based upon his interpretation of Petitioner's description of what was going on with him. On that date Dr. Graham planned a referral to a pulmonologist. He could not recall if Petitioner requested the referral to the pulmonologist. (Petitioner's Exhibit No. 2, pp. 24-25).

Dr. Graham testified that in his opinion Petitioner had asthma based upon one of the pulmonary function tests that was performed by Dr. Elsherbini. Dr. Graham testified that Dr. Elsherbini did not diagnose Petitioner with asthma. (Petitioner's Exhibit No. 2, p. 27). Dr. Elsherbini did not diagnose Petitioner with black lung. Dr. Elsherbini is board certified in pulmonary medicine. (Petitioner's Exhibit No. 2, p. 28). Dr. Elsherbini's interpretation of the pulmonary function tests of May 21, 2013, was moderate airway obstruction with significant change post bronchodilator and their use was recommended. Petitioner's total lung capacity and diffusion capacity were normal. (Petitioner's Exhibit No. 2 p. 38). Dr. Graham testified that he could not make a diagnosis of asthma without having a methacholine challenge performed. He did not see a methacholine challenge in the records. (Petitioner's Exhibit No. 2, p. 39). Dr. Graham prescribed Spiriva to Petitioner on March 21, 2013. He believed that was the first time Petitioner had ever taken a breathing medication. (Petitioner's Exhibit No. 2, pp. 42-43).

Petitioner was seen on December 9, 2013 for shoulder pain. His review of systems was negative for cough shortness of breath or hemoptysis. He was still smoking a pack a day. On examination his lungs were clear to auscultation without rales, rhonchi or wheeze. An ECG performed at that time revealed an atrial fibrillation. (Petitioner's Exhibit No. 2, pp. 43-44). Dr. Graham talked to Petitioner about stopping smoking and offered to help him in that, but Petitioner was not interested. (Petitioner's Exhibit No. 2, p. 46).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer interpreted chest films of Petitioner dated February 17, 2005, March 2, 2010, and November 9, 2011. He also reviewed a chest CT scan dated November 9, 2011. Dr. Meyer found the 2005 film to be quality 2 due to mottle. The 2010 film was quality 1. The 2011 film was quality 3 and was barely of diagnostic quality because it was overexposed. It was actually a digital hard copy examination where the size of the film was reduced. (Respondent's Exhibit No. 1, p. 40). Regarding the 2005 film, Dr. Meyer described the lungs as clear and noted there were calcified subcarinal lymphnodes indicating prior granulomatous disease. He found no evidence of coal workers' pneumoconiosis. He made essentially the same interpretation of the 2010. He saw no findings of coal workers' pneumoconiosis on the 2011 film. He did note one vague nodule inferiorly at the left base, for which he recommended repeat examination. The CT scan of November 9, 2011, demonstrated mild centrilobular emphysema but there was no septal thickening or irregularity to suggest fibrosis. There were no findings of coal workers' pneumoconiosis on the CT scan. (Respondent's Exhibit No. 1, pp. 40-41). Dr. Meyer compared the films from February 17,

2005, and March 2, 2010, side by side on his view box. He did not see any differences in terms of the presence of disease on those two films. (Respondent's Exhibit No. 1, pp. 42-43).

Dr. Meyer reviewed the A and B readings from NIOSH for the February 17, 2005, chest x-ray. His interpretation was concordant with the results for the major profusion category as both of the reports from NIOSH gave a major category of zero, meaning no findings of pneumoconiosis. One of the reports described lower zone S and T opacities of profusion 0/1, which Dr. Meyer did not agree with. (Respondent's Exhibit No. 1, p. 45). Dr. Meyer testified that S and T opacities in the bilateral mid and lower lung zones are not characteristic of coal workers' pneumoconiosis. He testified that S and T opacities are linear while coal workers' pneumoconiosis is characteristically a fine nodular disease which begins in the upper zones. He testified that if the S and T opacities were in fact present on the 2005 film, then they should be readily evident on the chest CT scan performed years later, and there was nothing on the chest CT to support that finding. (Respondent's Exhibit No. 1, p. 46). Dr. Meyer testified that the CT scan of Petitioner's chest was a more sensitive tool for the diagnosis of lung disease than plain films of the chest. He testified that pneumoconiosis over time will not typically disappear from a lung zone once it is established there. It will not typically regress over time in terms of profusion. (Respondent's Exhibit No. 1, pp. 48-49).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit No. 1, p. 7). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit No. 1, p. 19). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot. (Respondent's Exhibit No. 1, pp. 19-20). Dr. Wiot was on the original committee that designed the training program for the B-reader program. Dr. Meyer testified that the B-reading entails a very specific form that has been developed to evaluate the chest x-ray for the presence or absence of occupational lung disease. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer testified that the B-reader looks at the lung to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. The distribution of the opacities is also described because different pneumoconiosis are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. (Respondent's Exhibit No. 1, pp. 22-23).

At the request of Respondent, Dr. Lawrence Repsher conducted a review of medical records and examined Petitioner on November 9, 2011, at St. Francis Hospital in Tulsa, Oklahoma. (Respondent's Exhibit No. 2, p. 6). Petitioner complained to Dr. Repsher of progressive dyspnea on exertion for the past several years, as well as cough productive of scant yellow/green phlegm. Petitioner denied having asthma, COPD, emphysema, atopy or GERD. (Respondent's Exhibit No. 2, pp. 9-10). Dr. Repsher recorded a smoking history of two packs per day since 1966 although his smoking was somewhat less than a pack a day while actually working in the mine. Petitioner estimated he had approximately 90-pack-year cigarette smoking history. Dr. Repsher described such smoking history as significant. (Respondent's Exhibit No. 2, p. 10). Dr. Repsher testified that a significant smoking history is associated with the development of chronic obstructive pulmonary disease. In Dr. Repsher's opinion Petitioner's continued smoking habit was injurious to his health. (Respondent's Exhibit No. 2, p. 11). Dr. Repsher would anticipate a progression of Petitioner's symptoms and the potential for a decline in his pulmonary function over time if he continued to smoke. (Respondent's Exhibit No. 2, p.

12). On physical examination of the chest Petitioner's breath sounds were diminished bilaterally. There were no rales, rhonchi or wheezes, even with forced expiration. (Respondent's Exhibit No. 2, pp. 12-13). Dr. Repsher testified that the diminished breath sounds were consistent with Petitioner's smoking history and more consistent with the emphysema component. (Respondent's Exhibit No. 2, p. 13).

Dr. Repsher reviewed chest x-ray taken of Petitioner on March 2, 2010, as well as the x-ray taken as part of Dr. Respher's examination on November 9, 2011. Dr. Repsher found no evidence of coal workers' pneumoconiosis on these films. Dr. Repsher also reviewed a high resolution CT scan of the chest which showed calcified mediastinal and hilar adenopathy. Dr. Repsher testified that CT scans are generally accepted diagnostic techniques capable of showing the presence or absence of radiographic coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, pp. 13-14).

The pulmonary function tests performed as part of Dr. Repsher's examination were normal although the flow volume loops suggested very mild underlying COPD of no clinical significance. The arterial blood gases were normal. The carboxihemoglobin level was elevated at 3.4% which along with the markedly elevated serum nicotine and cotinine levels suggested a current one to one and a half pack per day cigarette smoking habit. (Respondent's Exhibit No. 2, pp. 14-15).

Dr. Repsher's review of outside medical records revealed nothing relevant to the issue of coal workers' pneumoconiosis with the exception of his long and heavy cigarette smoking habit varying from one and a half to two packs per day and a persistent refusal to consider stopping smoking. (Respondent's Exhibit No. 2, pp. 19-20). Dr. Repsher's final impression regarding Petitioner, was no evidence of coal workers' pneumoconiosis on chest x-ray or pulmonary function testing. From a respiratory point of view, Petitioner was fully fit to perform his usual coal mine work or work of a similarly arduous nature in a different industry. (Respondent's Exhibit No. 2). Dr. Repsher agreed with Dr. Houser that Petitioner was capable of heavy manual labor. (Respondent's Exhibit No. 2 pp. 21-22). Dr. Repsher testified that a person who has category 1 radiographically significant coal workers' pneumoconiosis can have normal pulmonary function testing, normal physical exam of the chest, normal blood gases and no complaints. (Respondent's Exhibit No. 2 p. 39). The individual would probably not know he had coal workers' pneumoconiosis until he had a chest x-ray that showed it. (Respondent's Exhibit No. 2, p. 40).

Dr. Repsher agreed that the best thing for a person with coal workers' pneumoconiosis to do is stop the exposure. (Respondent's Exhibit No. 2, p. 45). He testified that it would be very unlikely for a person to be a coal miner and have his coal workers' pneumoconiosis that is radiographically significant manifest itself in the last year of his coal mining. (Respondent's Exhibit No. 2, p. 46). Dr. Repsher testified that the scarring of coal workers' pneumoconiosis cannot perform the functions of normal healthy lung tissue. At the site of that scarring and at the site of the focal emphysema there would be impairment by definition although it may not be able to be measured. (Respondent's Exhibit No. 2, p. 48).

Medical records of Cape Neurological Surgeons were admitted into evidence. Petitioner was seen by Dr. Kee B. Park on July 25, 2007, with complaints of neck and back pain as well as bilateral hand numbness. He denied shortness of breath. History was taken of Petitioner that he was smoking two packs of cigarettes per day. Examination of the chest revealed the lungs to be clear to auscultation. (Respondent's Exhibit No. 4, pp. 2-3). When Petitioner was seen again on August 22, 2007, he again denied shortness of breath and again admitted to smoking two packs of cigarettes a day. (Respondent's Exhibit No. 4, pp. 4-5).

Medical records of Dr. Donnie Shelton were admitted into evidence. Petitioner was seen on August 17, 2006, to establish care. He related that he had not been seen by a doctor for three to four years. He related a history of smoking two packs a day for 20 years. He denied any shortness of breath and his review of systems respiratory was negative. Physical examination of the chest revealed the lungs to be clear to auscultation and percussion. He was counseled to stop smoking. (Respondent's Exhibit No. 3, pp. 42-44). Petitioner underwent a chest x-ray on August 18, 2006. The lungs were free of acute infiltrates. The upper lung zones were relatively lucent, suggesting emphysematous change. The lungs were mildly hyperinflated. There were focal scattered classifications within the lung fields consistent with old granulomatous inflammation. The radiologist's impression was that the films were suggestive of early chronic obstructive pulmonary disease. (Respondent's Exhibit No. 3, p. 40). Petitioner was seen in follow up on August 30, 2006. He again reported smoking one to two packs per day in a 14 hour period. He reported that he worked underground in a coal mine 12 to 14 hours a day. He denied shortness of breath and review of systems respiratory was negative. Physical examination of the chest revealed that the lungs were clear to auscultation and percussion. He was again counseled regarding smoking cessation. (Respondent's Exhibit No. 3, pp. 38-39). When Petitioner returned on April 30, 2007, he was still smoking two to three packs of cigarettes per day. Review of systems respiratory was negative. (Respondent's Exhibit No. 3, pp. 36-37). Petitioner was seen on July 30, 2008, with complaint of ear pain. Physical examination of the chest revealed the lungs to be clear to auscultation. (Respondent's Exhibit No. 3, pp. 10-11). Physical examination of the chest on June 30, 2009, also revealed the lungs to be clear to auscultation. (Respondent's Exhibit No. 3, pp. 8-9).

Medical records of Warren Clinic were admitted into evidence. Petitioner was seen by Dr. Patrick Lee Murphy on November 10, 2011. He was noted to be a tobacco user, smoking two packs a day for 30 years. Review of systems respiratory was positive for dyspnea. Physical examination of the chest revealed the lungs to be clear to percussion and auscultation. Petitioner was counseled about tobacco cessation. (Respondent's Exhibit No. 5, pp. 40-42). On December 12, 2011, Petitioner's review of systems respiratory was negative for cough, dyspnea and wheezing. Physical examination of the chest revealed the lungs clear to percussion and auscultation. (Respondent's Exhibit No. 5, pp. 26-28). Petitioner was seen on November 19, 2012, for possible TIA. He was having increasing memory problems. In that office note Petitioner's tobacco usage was charted to be two and a half packs a day for 50 years, totaling 125 pack years. Review of systems respiratory was negative for cough, dyspnea and wheezing. Physical examination of the chest revealed the lungs clear to percussion and auscultation. (Respondent's Exhibit No. 5, pp. 18-20). On November 28, 2012, Petitioner underwent chest x-ray at St. Francis Hospital which was interpreted by the radiologist as having no abnormality. (Respondent's Exhibit No. 5, pp. 16-17). Petitioner was seen by Dr. Murphy on November 28,

2012. He was noted to still be smoking. His review of systems respiratory was negative for cough, dyspnea and wheezing. Physical examination of the chest revealed the lungs clear to auscultation and percussion. (Respondent's Exhibit No. 5, pp. 2-5).

Medical records of Marion Pulmonary and Sleep Clinic were admitted into evidence. Petitioner was seen there on April 18, 2013, upon referral of Dr. Eric Graham. The referral was for performance of methacholine challenge test. Petitioner complained of moderate daily dyspnea with activity, but no wheeze, fatigue or coughing up sputum. Review of systems cardiovascular revealed no shortness of breath when walking. Petitioner was noted to have smoked for 20 to 30 years. His medications included Spiriva. Physical examination of the chest revealed no wheezing or rhonchi. The assessment was shortness of breath with activities. (Respondent's Exhibit No. 7, p. 11-14). Petitioner underwent a high resolution CT of the chest on May 2, 2013. The radiologist found mild central bronchiectasis with moderate pulmonary emphysema. He also found mild bibasilar intralobular septal thickening with mild ground-glass opacities. There was no mention of pneumoconiosis in the report. (Respondent's Exhibit No. 7, p. 9). Petitioner underwent pulmonary function testing on May 2, 2013. Interpretation was moderate airway obstruction with significant change post bronchodilator with a normal lung capacity and diffusion capacity. (Respondent's Exhibit No. 7, p. 7). Petitioner returned to see Dr. Elsherbini on May 15, 2013, at which time his chief complaint was shortness of breath. Petitioner had no wheeze and no sputum production. Physical examination of the chest revealed no dyspnea and no wheezing or rhonchi with good air movement and decreased breath sounds. (Respondent's Exhibit No. 7, pp. 2-5).

June Blaine is a vocational rehabilitation counselor. She works with individuals that have some type of work related accident or condition and evaluates their ability to return to work. She has been in vocational rehabilitation for 34 years. (Petitioner's Exhibit No. 3, p. 5). Ms. Blaine met with Petitioner at her office and asked questions about his background, work history and subjective complaints and also completed some vocational testing. He was given the Wide Range Achievement Revision 4. It assesses an individual's academic achievement in word reading, reading comprehension and math computation. Petitioner scored grade 2.6 in word reading; he scored grade 7.1 in sentence comprehension; and he scored grade 4 in math. (Petitioner's Exhibit No. 3, pp. 7-8) Ms. Blaine testified that she thought the tests were a fair assessment of what Petitioner could do. (Petitioner's Exhibit No. 3, pp. 8-9). Petitioner was a high school graduate and had previously had a Class A CDL. (Petitioner's Exhibit No. 3, p. 9).

The areas in Petitioner's job history where Ms. Blaine saw some transferrable skills would be along the lines of warehouse clerk, but said history was rather dated. Ms. Blaine testified that he might get an entry level position which would pay minimum to $9.00 per hour. She testified that he might use his CDL experience in a local truck driving type position which would pay $12.00 to $13.00 per hour to start. (Petitioner's Exhibit No. 3, pp. 10-11).

Petitioner's counsel asked Ms. Blaine to determine how much Petitioner was capable of earning outside of coal mining given his age, experience, training, education and transferrable skills in light of the current job market. Ms. Blaine was asked to assume that Petitioner was medically precluded from working as a coal miner due to his occupational disease and to assume any physical limitations he may have most strongly in favor of the coal company and to assume

that he was able to do heavy manual labor. (Petitioner's Exhibit No. 3, pp. 12-13). Ms. Blaine testified that given those assumptions there was no need for her to review medical records. (Petitioner's Exhibit No. 3, p. 13). Ms. Blaine was not provided any medical records regarding Petitioner. All she knows about his medical condition is his self-report and the information that she was provided that he was not able to go back to work in the mine. (Petitioner's Exhibit No. 3, pp. 18-19). Ms. Blaine testified that when she is asked to be involved as a vocational expert, she customarily asks for medical to get an understanding of what the restrictions are and the course of treatment that has been provided. (Petitioner's Exhibit No. 3, pp. 19-20). She could not recall the last time an attorney other than Petitioner's counsel retained her as an expert and gave her no medical to review. (Petitioner's Exhibit No. 3, p. 20). Ms. Blaine did not know who said Petitioner could not return to the coal mine or when it was said. (Petitioner's Exhibit No. 3, pp. 22-23). If the assumption that she was asked to make by Petitioner's counsel is not correct, the opinions which she expressed may very well be different. Petitioner did not ask her to help him in any job search. (Petitioner's Exhibit No. 3, p. 23).

The Arbitrator gives little weight to Ms. Blaine's opinions since she failed to review any medical records or reports to determine limitations on Petitioner's employability. If an expert's opinion lacks a factual basis, the opinion deserves little weight. Doser v. Savage Manufacturing & Sales, 142 Ill. 2d 176, 195-196 (1990).

CONCLUSIONS OF LAW

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

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

Petitioner has failed to prove by a preponderance of the evidence that he has an occupational disease arising out of and in the course of his employment. The Arbitrator finds the x-ray interpretations by Drs. Meyer, Wiot, Castle and NIOSH to be more credible than the interpretations by Drs. Smith, Alexander and Cohen. Dr. Smith interpreted the chest x-ray of March 2, 2010, as positive for pneumoconiosis with opacities in all lung zones. He interpreted the chest x-ray of November 9, 2011, as positive for pneumoconiosis with opacities in the middle and lower lung zones. Dr. Houser testified that once a person has radiographic evidence of coal workers' pneumoconiosis it is permanent and will not regress in terms of profusion or disappear from the lung zone where it was previously.

Dr. Houser testified that on pulmonary function testing Petitioner had mild airway obstruction with modest bronchodilator response. Dr. Repsher testified that the pulmonary function testing performed as part of Dr. Houser's examination was normal despite poor effort and cooperation with testing procedures. Dr. Repsher testified that the pulmonary function testing performed as part of his examination in November 2011, was normal. On testing by Dr. Elsherbini on May 2, 2013, Petitioner was noted to have moderate airway obstruction. The physicians agreed that Petitioner would likely continue to see a decline in his pulmonary function related to his continued cigarette smoking habit.

Although Petitioner testified that he had breathing problems while working in the mine, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that his breathing complaints are causally related to his coal mine dust exposure. Petitioner has failed to prove that his current condition of ill-being is causally related to his employment with Respondent.

Issue (o): Other Section 19(d) of the Occupational Diseases Act

Petitioner has smoked one to two packs of cigarettes per day for almost 50 years. All of Petitioner's treating and examining physicians counseled him on smoking cessation, yet Petitioner continues to engage in said habit. Dr. Repsher testified that continued smoking would be injurious to Petitioner's health. Furthermore, Drs. Graham, Houser and Respher testified that they would anticipate a continued decline in Petitioner's pulmonary function if he continued smoking. In light of his continued smoking habit, the Arbitrator finds that Petitioner is persisting in an injurious practice which is contributing to any decline in pulmonary health which he would be suffering.

Petitioner's claim for compensation is denied. All other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roger Beran,

Petitioner,

15IWCC0420

vs.

NO: 11 WC 31781

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

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

15IWCC0420

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 5 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/28/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERAN, ROGER
Employee/Petitioner

Case# **11WC031781**

15IWCC0420

DYNEGY MIDWEST GENERATION INC
Employer/Respondent

On 4/7/2014, 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:

0368 WIMMER & STIEHL
WILLIAM L WIMMER
2 PARK PL
SWANSEA, IL 62226

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0420

ROGER BERAN
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

Case # 11 WC 31781

An *Application for Adjustment 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 17, 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 21, 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 **$78,644.80**; the average weekly wage was **$1,512.40**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$10,946.89** for salary continuation, for a total credit of **$10,946.89**.

Respondent is entitled to a credit of **$23,267.95** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 7 (and as discussed in the Memorandum of Decision of Arbitrator), as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given credit of $23,267.95 for medical benefits that have been paid by its group insurance carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services and the subrogation claim of Blue Cross Blue Shield of Illinois for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,008.27/week for 10 6/7 weeks, commencing December 13, 2011 through February 28, 2012, as provided in Section 8(b) of the Act. Respondent shall be given credit of $10,946.89 for a salary continuation that was paid to Petitioner during this period, representing payment in full. (Respondent stipulated that it would not seek credit for any overpayment).

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 61.5 weeks, because the injuries sustained caused the 15% loss of use to each hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

03/20/2014
Date

APR 7 - 2014

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

15IWCC0420

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROGER BERAN
Employee/Petitioner

v. Case # 11 WC 31781

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Roger Beran, began working for Respondent, Dynegy Midwest Generation, in May 1979 as a repairman, and has continued in that capacity to the present date. As a repairman, he was responsible for maintenance on all mechanical equipment at Respondent's power generation plant. Petitioner's job requires the regular and repetitive use of numerous handheld tools, including wrenches, ratchets, breaker bars, drive impact wrenches, jackhammers and handheld grinders (which are electric and pneumatic). These tools created substantial vibration that was transferred to the hands and wrists of Petitioner. Petitioner became a certified welder in 1996 in addition to his repairman duties. This job required the use hand grinders, handheld needle scalars and handheld wire wheel grinders in order to prepare surfaces for welding. Petitioner engaged in duties that required the repetitive use of these tools from May 1979 to the present.

The medical records of Petitioner's primary care physician, Dr. Mary Agne, indicated that in January 2008, he complained of numbness in his left fingers. Electrodiagnostic testing of January 14, 2008 noted mild left carpal tunnel syndrome (CTS). (Respondent's Exhibit (RX) 1). Petitioner testified that the complaints in 2008 would "come and go" over the following two years. In late 2010, Petitioner began experiencing pain, tingling and numbness in both hands that was waking him up at night, and which resulted in a visit to the company nurse, Terry Rehmer, on December 21, 2010. Petitioner explained his problems to Nurse Rehmer at that time. Petitioner testified that it was at this time that the complaints were not going away, and were of a constant nature. It was also at this time that Petitioner engaged in active medical treatment to his bilateral hands and wrists.

Petitioner presented to Dr. Agne on February 24, 2011. On that date, Dr. Agne noted that Petitioner was diagnosed with CTS in 2008, "which was mild at that time." Dr. Agne recommended repeat electrodiagnostic testing, which occurred on February 28, 2011. The findings were consistent with bilateral moderate CTS. (RX 1).

Dr. Agne referred Petitioner to Dr. David Reid. Petitioner presented to Dr. Reid on April 7, 2011. (PX 4, p. 7). Dr. Reid recommended bilateral carpal tunnel surgeries. The first surgery was performed on December 13, 2011 to Petitioner's left wrist, and the second surgery to Petitioner's right wrist was performed on December 30, 2011. (PX 4, p. 9). Dr. Reid was provided with Petitioner's job duties, and testified that said duties were causative factors in Petitioner's CTS. (PX 4, pp. 11-15).

Petitioner continued having problems with finger numbness following the surgeries, and Dr. Reid referred him to Dr. Susan Mackinnon. (PX 4, p. 10). Dr. Mackinnon did not have any further treatment recommendations. (PX 3; PX 4, p. 10).

On October 29, 2013, Petitioner was examined by Dr. William Strecker at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). Petitioner testified that he provided Dr. Strecker with a description of his job duties with Respondent and the notes from Dr. Reid. Petitioner offered the report of Dr. Strecker into evidence as Petitioner's Exhibit 9, but Respondent objected to its admission. The Arbitrator sustained the objection, and Petitioner's Exhibit 9 was rejected.

Petitioner was paid a salary continuation when he was off work for the surgeries and subsequent recuperation time. (See RX 3). There may have been an overpayment, but Respondent stipulated at trial that it was not seeking a credit for any overpayment. Petitioner also testified that his medical expenses were paid through his group insurance (see PX 6 and RX 2), but that there remains an outstanding medical invoice from St. Elizabeth's Hospital totaling $711.50, with an outstanding balance of $74.56. (PX 7).

Petitioner returned to his regular job with Respondent following his release from care. Petitioner still has problems with his grip. At times, he experiences weakness in his hands after performing certain tasks. He experiences some discomfort when bending his wrists. He notices issues with his pinch strength, especially when picking up nuts and bolts. If he welds for extended periods of time with no breaks, his wrists fatigue.

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?

The Arbitrator concludes that the repeated use of vibrating hand tools by Petitioner over a 32 year period resulting in pain, numbness and tingling in both hands, which in turn led to a diagnosis of bilateral CTS for which Petitioner underwent surgeries. Dr. Reid, Petitioner's treating surgeon, testified that Petitioner's job duties were causative factors in the development of Petitioner's CTS. Respondent had an examination performed by Dr. Strecker on October 29, 2013, but has chosen not to present any evidence or opinions as to causal connection that contradicted the opinion of Dr. Reid. The Arbitrator further found that Petitioner was a credible witness at trial, and said credibility was evidenced by Petitioner testifying in an open and forthcoming manner. Based on the foregoing, the Arbitrator finds that Petitioner suffered bilateral CTS that arose out of and in the course of his employment, and that said condition is causally related to his work duties with Respondent.

Issue (D): What is the date of accident?; and

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

Petitioner first sought treatment for his left hand in 2008, after feeling episodes of numbness. At this time, Petitioner's symptoms would "come and go." Petitioner was diagnosed with mild left CTS in January 2008. No further treatment was provided. In late 2010, Petitioner's symptoms were bilateral and became worse. He then reported this to Respondent's nurse on December 21, 2010. He then sought treatment from his primary care doctor, and underwent electrodiagnostic testing in February 2011, which revealed bilateral moderate CTS.

The Arbitrator finds that the manifestation date of Petitioner's injuries was December 21, 2010, when his symptoms became so severe that he decided to seek out Respondent's nurse and inform that representative of his condition. Proper notice to Respondent under the Act was therefore given on this date.

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

The Arbitrator finds that the medical bills, as reflected in Petitioner's Exhibit 6, were paid by Blue Cross Blue Shield of Illinois, Petitioner's group insurance carrier, and that the bills represent the customary normal charges for services rendered in connection with the treatment of Petitioner's medical condition consistent with the opinion of Dr. Reid. There is an unpaid medical bill at issue, as reflected in Petitioner's Exhibit 7, with an outstanding balance of $74.56. Respondent shall pay this outstanding bill, subject to the medical fee schedule, Section 8.2 of the Act.

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

The Arbitrator finds that Petitioner was temporarily totally disabled from December 13, 2011, the date of his first surgery, until February 28, 2012, when he was released to return to work by Dr. Reid. Respondent paid Petitioner a salary continuation during this time, and is not seeking a credit for any overpayment.

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

Petitioner suffered from bilateral CTS as a result of his work duties with Respondent. He underwent bilateral carpal tunnel surgeries. Following his surgeries, he still had complications with numbness in his hands and was referred for more treatment to Dr. Mackinnon. However, Dr. Mackinnon did not believe there was any further treatment necessary.

Petitioner returned to his job with Respondent following his medical release. He still experiences issues with his grip. He also experiences weakness in his hands after performing certain duties. Petitioner experiences discomfort when bending his wrists, and notices issues with his pinch strength, especially when picking up nuts and bolts. If Petitioner welds for extended periods of time with no breaks, his wrists will tire.

Based upon the foregoing, the Arbitrator finds that Petitioner experienced the 15% loss of use of the right hand and the 15% loss of use of the left hand, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jackie Matthews,

Petitioner,

15IWCC0421

vs.

NO: 13 WC 40777

Cahokia Unit School District #187,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 17, 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.

15IWCC0421

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

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

DATED: JUN 5 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/27/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

JACKIE MATTHEWS
Employee/Petitioner

Case# **13WC040777**

15IWCC0421

CAHOKIA UNIT SCHOOL DISTRICT #187
Employer/Respondent

On 12/17/2014, 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 0.11% 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:

1846 BROWN & CROUPPEN PC
KERRY I O'SULLIVAN
211 N BROADWAY SUITE 1600
ST LOUIS, MO 63102

0810 BECKER HOERNER THOMPSON ET AL
RODNEY W THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

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

15IWCC0421

Jackie Matthews
Employee/Petitioner

Case # 13 WC 40777

v.

Consolidated cases: none

Cahokia Unit School District #187
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 Zanotti**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 10, 2014**. The case was thereafter assigned to Arbitrator **Jeffrey Huebsch** for decision. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 _____

15IWCC0421

FINDINGS

On the date of accident, **November 28, 2012** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,536.00**; the average weekly wage was **$818.00**.

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

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

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

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

ORDER

Petitioner's claim for prospective medical care, as recommended by Dr. David Robson, is denied.

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

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

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

Signature of Arbitrator

December 16, 2014
Date

ICArbDec19(b)

DEC 17 2014

INTRODUCTION

This matter was tried before Arbitrator Zanotti on June 10, 2014. The issues in dispute were causal connection and medical expenses, both incurred and prospective. The Parties agreed that all of the medical bills, with the exception of the bill from Dr. Robson, have been or will be paid by Respondent. The case was assigned to Arbitrator Huebsch for decision.

FINDINGS OF FACT

Petitioner has been employed by Respondent as a campus security officer for over 5 years. He was 54 years old on the date of accident.

The Parties stipulated that Petitioner sustained accidental injuries, which arose out of and in the course of his employment by Respondent on November 28, 2012. Petitioner intervened in a fight between two girls and they all fell to the ground. He was kicked in the neck and legs by the girls while he was on the ground and one of the girls punched him when they got up. He struck his head and the back part of his neck on the way down.

The first medical treatment was by Dr. Byler, the company doctor, on December 14, 2012. At that time Petitioner reported bilateral knee complaints, headaches and neck stiffness and soreness into the upper trapezius. Dr. Byler ordered physical therapy. Petitioner completed physical therapy at the Work Center. On January 10, 2013, Petitioner continued to complain of cervical pain, neck crepitus and headaches and bilateral knee pain, so Dr. Byler referred him to Dr. Russell Cantrell.

Petitioner requested that both Dr. Byler and Dr. Cantrell order neck and knee MRI studies. Both physicians declined to order the studies.

Dr. Cantrell saw Petitioner on February 13, 2013 and diagnosed a cervical strain/sprain superimposed on a pre-existing cervical degenerative disc disease condition and bilateral knee contusions. Dr. Cantrell ordered additional physical therapy for his neck and knees. On April 3, 2013 Petitioner continued to complain of bilateral knee pain and cervical pain. Dr. Cantrell ordered no additional treatment for Petitioner's knees and recommended a strength assessment at the Work Center. On April 24, 2013, Dr. Cantrell reviewed the strength assessment which noted reductions in strength in all cardinal planes of movement. Dr. Cantrell recommended more physical therapy with strengthening using a multi-cervical unit. On June 4, 2013, Petitioner followed up with Dr. Cantrell and he noted that, although the Work Center records showed improvement in range of motion and strength, Petitioner still had pain complaints and strength measures below normal range. Dr. Cantrell recommended a strengthening program. On July 15, 2013, Petitioner reported neck spasms and improved strength with numbness to both hands and forearms. Dr. Cantrell ordered an EMG/NCV which did not demonstrate denervation consistent with cervical radiculopathy, but showed bilateral median neuropathies at the wrists. There was no evidence of polyneuropathy. Dr. Cantrell released Petitioner at MMI, to continue with a HEP and continue to work at full duty on July 29, 2013. Petitioner testified that, at that time, his neck, head and knees did not feel better. On August 6, 2013, Dr. Cantrell provided an impairment rating of 3% body as a whole and 0% of each knee.

Petitioner testified that he asked the insurance company for authorization for additional treatment and he was told no. He hired an attorney and was referred to Dr. David Robson.

Dr. Robson saw the Petitioner on February 5, 2014 for an IME at the request of his attorney. Dr. Robson opined that the November 28, 2012 injury aggravated an underlying cervical spondylosis. Dr. Robson noted that prior to the motor vehicle accident (sic), Petitioner did not have ongoing cervical or radicular complaints. Dr. Robson recommended an MRI of the cervical spine. Dr. Robson did not think that Petitioner was at MMI for his injuries.

Respondent then sent Petitioner back to Dr. Russell Cantrell on April 28, 2014. Petitioner testified that he told Dr. Cantrell at the appointment that he was only there because workers' compensation sent him there. Petitioner told Dr. Cantrell that he trusted him to provide him treatment and he did everything Dr. Cantrell told him to do as far as therapy was concerned for many months, but Dr. Cantrell did not have his best interests in mind and he did not help him. Dr. Cantrell's report of April 28, 2014 states that since Petitioner was released by Dr. Cantrell previously, he had been "roughed up" several times and that his symptoms had worsened.

Petitioner testified that in August of 2013 he was transferred from the Cahokia High School to an elementary school. Thus, there was no opportunity for him to have been "roughed up" as stated in Dr. Cantrell's report. Petitioner testified to ongoing neck pain that is aching in nature and radiates into his shoulders with numbness in both hands. He described this pain at the base of his neck. He also has complaints with regard to his bilateral knees, such as problems squatting down, problems running and he feels as though his knees are going to give way. Petitioner testified that he has not gotten better.

Petitioner denied prior treatment for his neck and right knee. He had left knee surgery in 2001. He denied subsequent injuries to his neck and knees.

Petitioner lost no time from work as a result of the accident.

CONCLUSIONS OF LAW

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

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

Based upon Petitioner's testimony and the medical records, Petitioner's condition of ill-being (i.e.: bilateral knee contusions and aggravation of cervical disc disease) is found to be causally related to the work injury of November 28, 2012.

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

Per the agreement of the Parties, Respondent has or will pay all medical bills due at the time of trial, with the exception of the disputed bill from Dr. Robson.

Dr. Robson saw Petitioner at the request of his attorney for an IME. The bill for his services is not a proper § 8(a) expense and is not awarded.

Issue O: Is the Respondent liable for prospective medical care?

Petitioner's request for prospective medical care (the MRI of the c-spine and further review, per Dr. Robson) is denied. The lack of physical exam findings suggesting myelopathy and the lack of radiculopathy findings on the EMG/NCV do not support further diagnostic studies, such as the recommended MRI. Dr. Cantrell's opinion on this issue and that Petitioner is at MMI is found to be credible and persuasive.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Peyton,

Petitioner,

15IWCC0422

vs.

NO: 13 WC 35325

M & M Service Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 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.

15IWCC0422

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 $45,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 5 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/27/15
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

PEYTON, ROBERT
Employee/Petitioner

Case# **13WC035325**

15IWCC0422

M & M SERVICE COMPANY
Employer/Respondent

On 11/17/2014, 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:

5341 BROWN & BROWN
DAVID JEROME
5440 N ILLINOIS STSUITE 101
FAIRVIEW HEIGHT, IL 62208

RUSIN & MACIOROWSKI LTD
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STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

15IWCC0422

Robert Peyton
Employee/Petitioner

Case # 13 WC 35325

v.

Consolidated cases: n/a

M & M Service Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Quincy, on October 2, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 15IWCC0422

On the date of accident, August 15 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 $41,969.04; the average weekly wage was $807.10.

On the date of accident, Petitioner was 55 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. The parties stipulated Petitioner was paid full salary during the period of time he was off work.

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

ORDER

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the left knee surgery recommended by Dr. Brett Wolters.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 12, 2014
Date

NOV 17 2014

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on August 15, 2012. According to the Application, Petitioner fell over oversized rocks in a parking lot and injured his right knee (Arbitrator's Exhibit 2). Petitioner subsequently filed an Amended Application which alleged that Petitioner injured both the right and left knees. Respondent stipulated that Petitioner sustained an accidental injury to his right knee that required meniscal surgery; however, Respondent disputed liability in regard to the left knee on the basis of accident and causal relationship. This case was tried in a 19(b) proceeding and Petitioner sought an order for prospective medical treatment in regard to the left knee.

Petitioner began working for Respondent in 1984 as a fuel salesman. Petitioner's job duties included loading a truck and making deliveries of fuel to farms and commercial locations throughout Macoupin and Madison Counties. On August 15, 2012, Petitioner was making a fuel delivery to one of Respondent's customers. When he exited the truck, he stepped onto a large rock and sustained a twisting injury to his right leg.

Petitioner reported the accident to Respondent but delayed seeking medical treatment for a few months because he did not like going to the doctor unless it was absolutely necessary. Petitioner continued to work for Respondent even though he was experiencing right knee symptoms.

Petitioner initially sought medical treatment from Respondent's company physician, Dr. Gregg Laws. Dr. Laws saw Petitioner on December 17, 2012, and he ordered an x-ray of Petitioner's right knee (Respondent's Exhibit 3). He subsequently referred Petitioner to Dr. Brett Wolters, an orthopedic surgeon.

Dr. Wolters evaluated Petitioner on January 8, 2013. Dr. Wolters' records of that date contained a history of the work-related accident and that Petitioner had right knee pain and swelling since that time. Petitioner denied any knee problems prior to the accident. Dr. Wolters' record of that date did not contain any reference to Petitioner having any left knee complaints. Dr. Wolters opined that Petitioner had a possible meniscus tear and ordered an MRI scan (Petitioner's Exhibit 3; Deposition Exhibit 2).

At trial Petitioner testified that his initial primary problem was the pain and swelling in his right knee, but that he also experienced a slight ache in the left knee but no swelling or other significant symptoms. Petitioner stated that he informed Dr. Wolters of the symptoms in both of his knees at the time of the initial evaluation.

The MRI scan was performed on January 14, 2013, and it revealed a tear of the posterior horn of the medial meniscus as well as some fraying of the lateral meniscus. Dr. Wolters saw Petitioner on January 22, 2013, and recommended Petitioner undergo arthroscopic surgery (Petitioner's Exhibit 3; Deposition Exhibit 2).

On February 25, 2013, Dr. Wolters performed arthroscopic surgery on Petitioner's right knee and the procedure consisted of repair of a complex medial meniscus tear and removal of a loose

body. Dr. Wolters also noted the presence of mild chondromalacia. When Dr. Wolters saw Petitioner on March 5, 2013, he observed minimal swelling of the right knee and a full range of motion. He authorized Petitioner to return to work without restrictions on March 11, 2013 (Petitioner's Exhibit 3; Deposition Exhibit 2).

Petitioner testified that he returned to work to his regular job of delivering fuel to farms and commercial businesses. When Petitioner delivered fuel, he had to back the truck up to the tank, remove the hose from the back of the truck and drag it to the location of the tank. Petitioner stated that he would have to drag the fuel hose from 15 to 100 feet to make a fuel delivery.

When Petitioner returned to work, he testified that he was limping while performing his job duties and was putting more weight on his left leg. Petitioner stated that he began to experience aching and swelling in his left knee, but later on he began to experience more severe symptoms similar to those he had in the right knee following the accident.

Dr. Wolters saw Petitioner on April 2, 2013, and Petitioner informed him that he felt he had "overworked" his left knee. Dr. Wolters noted some joint line tenderness of the left knee (Petitioner's Exhibit 3; Deposition Exhibit 2). Petitioner testified that this was the first time he requested Dr. Wolters provide any treatment for his left knee symptoms.

On April 23, 2013, Dr. Wolters saw Petitioner, and, at that time, Petitioner had developed significant swelling in both knees. Dr. Wolters injected and aspirated fluid from both knees. Dr. Wolters' record of that date noted that Petitioner had been experiencing left knee symptoms since the injury (Petitioner's Exhibit 3; Deposition Exhibit 2).

Dr. Wolters saw Petitioner on May 21, 2013, and Petitioner continued to complain of left knee symptoms. Dr. Wolters' record of that date noted that Petitioner had altered his gait and had left knee pain since the time of the accident (Petitioner's Exhibit 3; Deposition Exhibit 2).

Dr. Wolters ordered an MRI scan of the left knee which was performed on June 5, 2013. The scan revealed a possible old ACL tear, an extensive complex tear of the medial meniscus, joint effusion and a bone contusion of the medial femoral condyle. Dr. Wolters saw Petitioner on June 18, 2013, and recommended Petitioner have arthroscopic surgery performed on the left knee (Petitioner's Exhibit 3; Deposition Exhibit 2).

At the direction of the Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on September 5, 2013. In connection with his examination of Petitioner, Dr. Lehman reviewed medical records provided to him by Respondent. Dr. Lehman opined that Petitioner had bilateral degenerative changes in both knees. In regard to the right knee, Dr. Lehman opined that the meniscal tear was degenerative and that the need for meniscal surgery was not related to the accident. In regard to the left knee, Dr. Lehman opined that Petitioner had long term chronic degenerative changes in both the ACL and meniscus which pre-existed any accident (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Lehman was deposed on May 1, 2014, and his deposition testimony was received into evidence at trial. Dr. Lehman's testimony was consistent with his medical report and he

reaffirmed his opinion that Petitioner's right knee surgery was not related to the accident and that the tear was degenerative in nature. He also testified that the left knee condition was a long term degenerative problem that was not related to the work injury. Dr. Lehman did agree that Petitioner's favoring his right leg following the surgery could have caused the tear in the left knee. He further agreed that further treatment of the left knee was appropriate (Respondent's Exhibit 1: pp 19-20; 23-26).

Dr. Wolters was deposed on September 26, 2014, and his deposition testimony was received into evidence at trial. Dr. Wolters' testimony was consistent with his medical records regarding his treatment of Petitioner. Dr. Wolters testified that Petitioner initially informed him that he was having left knee complaints on April 2, 2013. He specifically noted that Petitioner was bearing more weight on the left knee because of the right knee pain. He opined that favoring the left knee and putting more pressure on it could aggravate and make the left knee more symptomatic. Dr. Wolters opined that it was possible that Petitioner's altered gait favoring the right knee following surgery could have caused the left meniscal tear. Even if the left meniscal tear had been present prior to the accident, Dr. Wolters opined that Petitioner's altered gait could have made the left knee symptomatic (Petitioner's Exhibit 3: pp 13-16; 23-24).

While Dr. Wolters conceded that he could not definitively state when the left meniscus tear occurred, Petitioner had no symptoms which would have necessitated surgery until after he sustained the injury to his right knee and had surgery performed. It was the right knee injury that necessitated the surgery which, in turn, caused Petitioner to place greater stress and pressure on the left knee (Petitioner's Exhibit 3: pp 36-37).

Petitioner testified that at the time of trial he is still working for Respondent and continues to perform his regular work duties. Petitioner continues to experience pain and swelling in the left knee and he relies more on his right leg, in particular, to get in and out of his truck. Petitioner does want to proceed with the left knee surgery as recommended by Dr. Wolters.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on August 15, 2012, and that his current condition of ill-being in regard to both his knees is causally related to same.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on August 15, 2012, which caused an injury to Petitioner's right knee that ultimately required arthroscopic surgery.

The Arbitrator found Petitioner to be a believable and credible witness on his own behalf. Further, Petitioner's testimony regarding the accident of August 15, 2012, and his job duties was unrebutted.

Dr. Wolters authorized Petitioner to return to work without restrictions just 15 days after performing arthroscopic surgery on Petitioner's right knee. Petitioner returned to work to a job that was physically demanding and Petitioner favored his right knee because of his ongoing symptoms, causing symptoms in his left knee.

Petitioner testified that when he first saw Dr. Wolters on January 8, 2013, he informed him that he had a slight ache in his left knee, but that the bulk of his symptoms of pain and swelling were in regard to the right knee. Dr. Wolters' medical records and testimony was that the first time Petitioner informed him of the left knee symptoms was when Dr. Wolters saw Petitioner on April 2, 2013. While the Arbitrator acknowledges that this is an inconsistency, it is of minimal significance.

Whether or not Petitioner had some minor aches in the left knee at the time of the accident does not impact the fact that, following the right knee surgery, Petitioner's gait was altered causing him to put greater pressure and stress on his left knee. Dr. Wolters opined that this could cause the meniscal tear in the left knee or make it symptomatic.

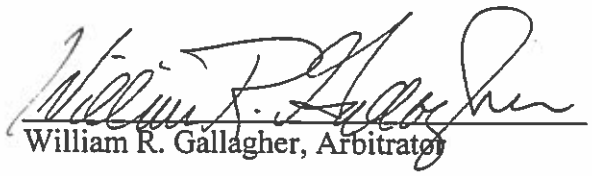
The Arbitrator finds the opinion of Petitioner's treating physician, Dr. Wolters, to be more persuasive than Respondent's Section 12 examiner, Dr. Lehman.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the left knee surgery recommended by Dr. Brett Wolters.

In support of this conclusion the Arbitrator notes the following:

Dr. Wolters has opined that arthroscopic surgery on Petitioner's left knee is appropriate. There is no medical opinion to the contrary.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael D. Scott,

Petitioner,

15IWCC0423

vs.

NO: 09 WC 42028

SMX Corporation/The Seaton Corporation,

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 issue of maintenance and vocational rehabilitation and being advised of the facts and law, expands and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. For the reasons set forth below, we agree with the Arbitrator's finding that Petitioner failed to prove that he is entitled to reinstatement of vocational rehabilitation and maintenance benefits. The Commission remands this case to the Arbitrator 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).

Petitioner sustained an undisputed right knee injury on August 10, 2009 when a pallet jack handle struck his right knee and fractured his tibia. The Arbitrator found that Petitioner's current condition of ill-being in his right knee is causally connected to the August 10, 2009 work accident but that Petitioner failed to prove that his current complaints of low back pain and leg and foot pain are causally connected to the August 10, 2009 accident. The Arbitrator found that Petitioner clearly has ongoing significant problems with his right knee and ordered Respondent to pay for a follow-up examination with Dr. Nunley to determine if there is any further treatment to be provided to Petitioner. The Arbitrator denied Petitioner's request for reinstatement of vocational rehabilitation and payment of maintenance benefits.

Subsequent to the imposition of permanent restrictions by Dr. Nunley on February 27, 2012, Respondent instituted a program of vocational rehabilitation and Petitioner ultimately obtained a transport driver job with Professional Transportation, Inc. ("PTI"), a company that provides transportation for railroad employees going from one location to another. The record shows that during stops or waiting for passengers, he could stretch his leg and walk around the transport van as needed. There is no dispute that the transport driver job fit within Petitioner's permanent restrictions from Dr. Nunley. Petitioner successfully passed the Department of Transportation physical and completed safety education, training, and practice driving for PTI. However, after

Petitioner's first three or four trips as a transport driver, he concluded that he did not feel safe driving due to the aggravation of symptoms in his back, hip and right leg. On March 10, 2014 Petitioner sought treatment at the Veterans Administration hospital. He complained of right knee pain for several days and was excused from work for three days. Petitioner did not perform any further work for PTI and on March 15, 2014 he formally resigned, citing medical reasons. Petitioner requested reinstatement of vocational rehabilitation and maintenance benefits.

After reviewing all of the evidence, we find that the Arbitrator's denial of reinstatement of vocational rehabilitation and maintenance was not contrary to the law or the evidence. Petitioner rejected an acceptable light duty position that he accepted after thorough and successful vocational rehabilitation. There is no dispute that the PTI job was within Petitioner's physical restrictions; the physical requirements of a driver for PTI are within the limitations set by Dr. Nunley, and no doctor has indicated that Petitioner cannot work as a driver. The Act provides incentive for the injured employee to strive toward recovery and the goal of returning to gainful employment by providing that TTD benefits may be suspended or terminated if the employee refuses to submit to medical, surgical, or hospital treatment essential to his recovery, or if the employee fails to cooperate in good faith with rehabilitation efforts. Benefits may also be suspended or terminated if the employee refuses work falling within the physical restrictions prescribed by his doctor. *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 146-147 (Ill. 2010) We agree with the Arbitrator that Petitioner failed to prove that he was unable to continue working at PTI due to a work-related condition stemming from his August 10, 2009 accident and therefore Petitioner was not entitled to reinstatement of maintenance benefits and vocational rehabilitation when he voluntarily terminated his employment at PTI.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 18, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 5 - 2015
RWW/plv
o-4/8/15
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0423

SCOTT, MICHAEL D
Employee/Petitioner

Case# **09WC042028**

SMX CORPORATION/THE SEATON CORPORATION
Employer/Respondent

On 9/18/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5174 EDMONDS LAW OFFICE
J ROBERT EDMONDS
1012 PLUMMER DR SUITE 201
EDWARDVILLE, IL 62025

0445 RODDY LAW LTD
RICHARD ZENZ
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

15IWCC0423

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MICHAEL D. SCOTT
Employee/Petitioner

v.

SMX CORPORATION/THE SEATON CORPORTION
Employer/Respondent

Case # **09** WC **42028**

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 **7/22/14**. 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 **Reinstatement of Vocational Rehabilitation**

FINDINGS

On the date of accident, **8/10/09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,800.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

Respondent *N/A* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$48,244.67** for TTD, **$0** for TPD, **$17,524.61** for maintenance, and $0 for other benefits, for a total credit of **$65,769.28**.

ORDER

Petitioner's current condition of ill-being in his right knee is causally connected to his August 10, 2009 work accident. Petitioner failed to prove that Petitioner's current complaints of low back pain and leg and foot pain are causally connected to his August 10, 2009 accident.

Petitioner's request for prospective medical care is allowed and Respondent is ordered to pay for a follow-up examination with Dr. Nunley to determine if there is any further treatment to be provided to Petitioner regarding his knee.

Petitioner's request for re-instatement of vocational rehabilitation and payment of maintenance is denied.

Petitioner's Petition 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.

Signature of Arbitrator

September 15, 2014
Date

ICArbDec19(b)

SEP 18 2014

Michael D. Scott v. SMX Corporation/The Seaton Corporation,
09-WC-42028 (19(b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This case proceeded to arbitration on July 22, 2014. The issues in dispute were causal connection, maintenance, penalties and attorneys' fees, prospective medical care, and reinstatement of vocational rehabilitation. The parties agreed that in the event there are currently any unpaid medical bills, no objection will be raised later by Respondent that such bills should have been presented at the time of this hearing, if it is necessary to try the case at a later date. Petitioner was the sole witness.

The Arbitrator finds:

Petitioner sustained an undisputed injury to his right leg on August 10, 2009. He was initially seen at Alton Memorial Hospital where x-rays were taken and revealed a comminuted fracture with multiple fragments and displacement of fragments in the proximal tibia; large knee joint effusion; and a foreign body of longstanding duration at the distal thigh. Petitioner was placed in an immobilizer. (PX 1)

Thereafter Petitioner was seen at the Dept. of Veterans Affairs and referred to Dr. Ricci at Washington University's School of Medicine where he was examined on August 18, 2009 and diagnosed with a bicondylar tibial plateau fracture. Surgery in the form of an open reduction and internal fixation of a right bicondylar tibial plateau fracture and a lateral meniscus tear, was performed on August 20, 2009. Petitioner's post-operative progress continued to be monitored by Dr. Ricci and included physical therapy. (PX 3) As of February 16, 2010 Petitioner was ambulating full weightbearing without any assistive devices. He was reporting pain after standing on his leg for any period of time. (PX 3)

During this time Petitioner was attending physical therapy having begun in December of 2009. Petitioner was making very good progress on March 22, 2009. He then missed his appointments on March 24th and March 26th.On March 29, 2010, Petitioner came in stating he had significant pain in his knee and numbness in his lower leg and foot and felt like something was sticking him under his kneecap. Petitioner had experienced trouble walking all weekend. He was scheduled to see his doctor next week. The therapist noted that she felt Petitioner's lower leg pain was radiating pain from his lower back from the way he had walked over the past few months to which Petitioner replied he had issues with his back since he initially hurt his hip a few years earlier. As of April 1, 2010 Petitioner's knee was feeling better but he still reported discomfort in his back and a burning sensation down his right leg. He tolerated therapy well, however, with minimal complaints of pain and difficulty. On April 5, 2010 the therapist noted Petitioner's overall condition was worse when walking as Petitioner was complaining of increased knee pain and numbness in his lower leg and the lateral border of his foot for the last two weeks. Petitioner could recall nothing he had done differently to cause the symptoms. Walking two blocks would cause leg numbness and knee pain. Petitioner's knee felt like it wanted to hyperextend. The therapist noted she explained to Petitioner that it was "possible" the numbness was coming from his low back, noting his history of a low back injury and problems from an initial injury to his hip a few years earlier. (PX 4)

Petitioner returned to see Dr. Ricci on April 6, 2010. Petitioner was doing "fair" with regard to his fracture. Dr. Ricci noted that Petitioner had some numbness in his leg and foot which has been attributed to disc problems in his back. He was also having some instability in his knees and pain. Dr. Ricci imposed permanent restrictions and use of an unloader brace. By July 13, 2010 Dr. Ricci was noting increasing pain in Petitioner's knee even while wearing the unloader brace. Petitioner's exam and x-rays were consistent with post-traumatic arthritis and a bone defect on the lateral side of Petitioner's knee on the tibia. Dr. Ricci recommended evaluation for a possible total knee replacement. (PX 2; PX 3, PX 4)

Dr. Ryan Nunley examined Petitioner on August 16, 2010. According to his notes, Petitioner had developed significant post-traumatic osteoarthritis with failure of his fixation resulting in severe knee pain, cross instability and significant valgus deformity. Dr. Nunley's office note also states, "Of note, [Petitioner] has three herniated discs that have occurred since the injury. He has had cortisone injections as well as used anti-inflammatories. These caused him significant discomfort." (PX 3) Dr. Nunley recommended a total knee replacement when Petitioner reached the point where he could no longer tolerate the pain. In the interim, Petitioner was placed on light duty with no standing for prolonged periods of time, no heavy lifting over twenty pounds, and no bending, kneeling or twisting of the knee. (PX 3; PX 4)

Petitioner underwent a total knee replacement on January 25, 2011 along with removal of previous hardware and a lateral plate. Petitioner was hospitalized for three days and discharged on January 28, 2011. Post-operatively Petitioner was kept off work and given physical therapy.

Petitioner began his therapy on March 1, 2011. As of March 7, 2011 Petitioner was noted to have a big bruise on his leg from kneeling and having been pushed down by someone. On May 5, 2011 Petitioner reported he had mowed yesterday and it wasn't too bad on his knee; however, his back was bothering him. Petitioner's last therapy visit was on May 12, 2011 at which time the therapist recommended three more weeks of therapy to focus on quad strengthening. No back complaints were noted during therapy except for the one comment on May 5, 2011. (PX 5)

By May 16, 2011 Dr. Nunley was issuing light duty work restrictions. (PX 3)

Petitioner began work hardening at SSM on May 27. 2011. He was to undergo work hardening five times a week for six weeks. (PX 3)[1]

As of June 27, 2011 Petitioner reported he had been fired from his job when he went back to try and work. According to the doctor's note, Petitioner had been undergoing work hardening with some improvement but he had backed off of it due to significant exacerbation of his back problems. Dr. Nunley noted Petitioner had two previous herniated discs and some sciatica. Petitioner expressed interest in going back to school. Dr. Nunley recommended continued aggressive work on strengthening. Petitioner was given permanent restrictions of no heavy lifting over 100 lbs. and no squatting or kneeling. Petitioner then returned to Dr. Nunley on June 27, 2011. Petitioner was to return in one year. He was not yet deemed at maximum medical improvement (MMI). (PX 3)

Petitioner began a six month professional dog training program in June of 2011. (RX 3, p. 2)

Petitioner returned to see Dr. Nunley on October 31, 2011. He reported he was working but had developed some shooting pains in his low back radiating down his leg and some tenderness over the pes anserine bursa over his

[1] No other records from SSM regarding work hardening are in the record.

right knee. Regarding his back, Petitioner was noted to have positive straight leg raising and pain shooting down the posterior aspect of his thigh and down the side of his leg into his foot area. Petitioner was instructed in exercises since the symptoms appeared to be periodic. If it didn't improve Dr. Nunley felt a referral to a physiatrist might be appropriate. For his knee Petitioner was advised to do ice massage and avoid heat. Petitioner was told to avoid kneeling and lifting and refrain from repetitive lifting over 25 lbs. (PX 3; PX 5)

Petitioner stopped attending the dog training class in December of 2011. (RX 3, p. 2)

Dr. Nunley re-examined Petitioner on February 27, 2012. Petitioner was "overall" doing "relatively well." Petitioner reported a "little limp" when on his leg all day and some right hip pain.[2] Petitioner reported he had been retrained as a dog trainer. Dr. Nunley scheduled Petitioner for metal ion testing regarding his hip and continued quad strengthening exercises for his knee. Petitioner was also given the following permanent restrictions: no kneeling, squatting, or twisting; no lifting over 20 lbs.; and no walking over two hours continuously. Petitioner was asked to return in one year. There is no mention of any back complaints. (PX 3)

At the request of ISG Medical, Petitioner was next examined by Dr. Bruce Vest on January 17, 2012 for purposes of an independent medical examination. Petitioner reported the periodic use of a cane to help with ambulation. Petitioner was "unable to go back to work." He also reported difficulty with lifting over 25 lbs. and increased pain when trying to bend, twist, and stoop. Petitioner could stand for about one hour, walking about 1 1/2 blocks before needing to sit down and rest and the ability to sit for about 45 to 60 minutes. Petitioner was able to drive. He wasn't using a knee brace but took Flexeril, Aleve and Tylenol as needed.(PX 6)

Petitioner's medical history was noted to include a right total hip replacement in 2007 and chronic lumbar pain having been told he had three herniated discs. Petitioner had undergone lumbar epidural injections but no lumbar spine surgery. On examination Petitioner had minimal tenderness about the scars, active range of motion from 0 to 110 degrees, good stability and mild crepitation. Petitioner's gait was described as "fairly normal." Dr. Vest recommended an FCE. Absent that, Dr. Vest felt Petitioner could do a sedentary job and had reached maximum medical improvement. He felt Petitioner should avoid lifting over 15 lbs on a routine basis, the ability to change positions from sitting and standing, as needed, and no repetitive bending, twisting, and/or stooping. Other than to note a diagnosis of chronic lumbar pain, Dr. Vest had no opinions or recommendations regarding Petitioner's back. (PX 6)

Blaine Rehabilitation issued a vocational assessment on December 10, 2012 (RX 3). Vocational updates were issued periodically between June 6, 2013 and January 17, 2014. (RX 4 - 9) The initial assessment of December 10, 2012 indicates Petitioner reported numerous problems relating to his knee as well as prior injuries including his low back and hip. Petitioner further described having a "knot" in his back and increased pain that interferes with his ability to stoop or complete any ladder climbing. Weather seemed to affect his knee, hip and back. These reports show that Petitioner participated in the vocational rehabilitation program, retraining and attempts to secure reemployment. Petitioner completed a typing tutorial and earned a certificate in a practical PC course to improve his computer skills. He applied for, and received, a PERC Card to make himself more marketable. The reports reveal that Petitioner made contact with potential employers including those suggested by the counselor and those he sought out on his own. (RX 3-10)

On March 15, 2014 Petitioner and Professional Transportation Inc. signed a "Termination/Separation" Form. Petitioner's last day was reported as March 9, 2014. The reason given for the termination was "Medical meds

[2] Petitioner underwent a right total hip replacement a couple of years earlier.

and therapy prevent [Petitioner] from performing driving tasks. Leg falls asleep, knee swells. Neuro related." (PX 9)

Petitioner presented to the Department of Veterans Affairs on March 10, 2014 complaining of right knee pain of several days' duration which he further described as a shooting pain in the middle of his patella and numbness on the lateral side of his lower leg. Petitioner related that the pain was worse when climbing up stairs. Petitioner was working as a truck driver and reported the onset of pain after driving for eight hours. Petitioner also reported lower back pain and pain going down his right buttocks and leg. Petitioner was not taking any pain medication. X-rays were ordered of Petitioner's right knee and he was instructed in various types of back exercises. (PX 7)

Nurse Christine Mayden, of the Department of Veterans Affairs, authored a note dated March 10, 2014 requesting that Petitioner be excused from work due to a medical appointment with the VA and medical issues for which he was being treated there for the next three days. (PX 8)

There are no further medical visits with the Department of Veterans Affairs after March 10, 2014.

Dr. Peter Anderson examined Petitioner on May 29, 2014. At the time of the exam Petitioner reported he was doing reasonably well but continued to have pain and could not sustain a regular job as "even when he does the driving a bus" it bothers him. On examination Petitioner displayed flexion instability. Extension was painless. When Petitioner's knee was put at 90 degrees and rocked back and forth it "hurt him a lot." Dr. Anderson believed Petitioner needed his femur enlarged. At the present time he felt Petitioner would have problems returning to a regular job. His major problem was flexion instability. Dr. Anderson felt Petitioner could drive. Petitioner was not yet at MMI as he needed surgery and he would need ongoing restrictions after surgery and until he reached MMI. He felt that if the knee surgery was revised, it might get better, but his main problem was flexion instability status post total knee in a "very difficult case." His diagnosis was status post tibial plateau fracture with progression of arthritis with total knee arthroplasty and flexion instability. He thought Petitioner could drive again, although he might need further surgery to correct the flexion instability. It was his opinion that Petitioner's inability to work was causally related to the series of surgeries that he has had. It was his further opinion that Petitioner would continue to need restrictions until such time as his knee is revised and stated that the restrictions placed on him earlier were still valid. He was of the opinion that Petitioner was not at maximum medical improvement (MMI) and needs further treatment. (RX 2)

At the time of arbitration Petitioner was 50 years old. Petitioner testified he is a high school graduate and worked at various part-time jobs (fast food, grocery, etc.) while in high school. Thereafter, he joined the United States Marine Corps. He remained there for approximately eight years, serving in the capacity of a combat engineer, serving in several overseas campaigns. He was honorably discharged in 1993 and attended a welding technical school for approximately one year, although he did not graduate. Between 1994 and 2008, he worked at Olin Brass in a variety of capacities in the manufacturing plant.

He suffered a previous work injury in approximately 2006 while working at Olin Brass. This resulted in a right hip replacement after which, a 15 pound lifting restriction was placed upon him. He returned to work at Olin Brass but was terminated in 2007 when he presented his employer with a temporary off work slip. Petitioner testified he was out of work slightly less than 2 years between the time he was terminated from Olin and when he began working for Respondent in 2009. This was the only significant amount of time that he had not worked since he was approximately 16 years old.

Although Petitioner had the aforementioned restrictions due to the right hip injury, he applied for and accepted a position with Respondent in July 2009. Respondent has a warehouse facility where products are repackaged and shipped. Petitioner was working at the facility driving a pallet jack, an electrically operated device on which the operator stands. The machine has a forklift attachment with which the operator can lift, transport and lower palletized products. Petitioner testified that the pallet jack is operated by the use of a control lever (metal handle) that can be raised, lowered and moved from right to left to control the operation of the pallet jack. Petitioner testified that, despite the previous physical limitations placed on him, he passed the physical requirements for the operator position and had no difficulty carrying out his duties during the time he worked for Respondent.

Petitioner testified that on August 10, 2009 he brought the pallet jack to a stop. As he was standing on the machine, the metal control handle suddenly and forcefully struck the side of his right knee. Thereafter he began treating as outlined above.

Petitioner testified that Dr. Ricci ultimately performed surgery on his knee and that he remained non-weight bearing until November of 2009. He then underwent therapy at Alton Physical Therapy between December of 2009 and April of 2010. He testified he worked hard at therapy and that he was given a home exercise program also. Nevertheless, Petitioner testified to ongoing problems with his knee. When asked to explain the nature of his problems, Petitioner testified that when he pushed down on his knee it really started hurting his back and he began limping again. He then went back to Dr. Ricci who told him the bone was dissolving and he needed a total knee replacement for which he was referred to Dr. Nunley.

Petitioner testified that after Dr. Nunley performed the total knee replacement he again underwent physical therapy during which he started lifting weights with his legs and began having back problems. Petitioner testified that the doctors told him his knee was aggravating his back and they recommended therapy end. He later went through work hardening at SSM.

Petitioner testified he requested that Dr. Nunley place restrictions on him that would allow him to attempt to retrain for another job. Petitioner testified he was terminated by Respondent while on light duty.

Petitioner testified that he conducted a search and learned of a state-subsidized program that would allow him to attend a dog training school. Petitioner testified that he attended the classes from June through December of 2011 and was able to pass the core curriculum. However, the school accommodated his physical restrictions in order to allow him to pass the classes. For example, he was allowed to sit for some of the training activities even though the other students were required to stand or walk. Petitioner testified that he was able to learn how to train the dogs. However, his physical limitations (due to his knee injury) prevented him from being able to train a sufficient number of dogs, quickly enough in order to earn a living doing it. He testified that he would need to be able to train 10 to 15 dogs a day to actually work as a trainer. He found he could only train 1 or 2 dogs a day due to his limitations. Ultimately, he could not meet the physical requirements or achieve the pace required to perform the functions of a dog trainer and earn a living doing it.

Petitioner was asked about any problems he was having in January of 2012 and he replied he "believed" his knee was still bothering him a great deal. He then added that he really didn't know what problems he was having but supposed they were the same ones he had always had because they never stopped -- his leg goes numb and hurts sometimes for no reason.

Petitioner testified that he participated in vocational rehabilitation provided by Respondent. Initially, he underwent some testing in December of 2012. His next interaction with the vocational counselor was in May,

2013. He completed a keyboarding course and a Microsoft Windows training course to become more proficient using a computer. He worked with the counselor on job seeking, interviewing and letter writing skills. Petitioner testified that he put in numerous applications, made a number of contacts, and attended a job fair as part of his job search. His first job offer was for a driver position with PTI. The vocational counselor had a personal contact at PTI and helped him get the interview.

Petitioner testified that he eventually went to work for Professional Transportation, Inc. (PTI) a company that provides transportation, including drivers, for railroad employees going from one location to another. Petitioner would drive a minivan with two to six passengers from one town to another, often interstate and six to eight hours in length. Petitioner testified that he feared for the safety of himself and the passengers because his leg would go numb. He didn't have cruise control and was afraid he wouldn't be able to step on the brake fast enough. Petitioner also testified to some swelling in his knee and that it was causing some aggravation to his back.

Petitioner testified that after three or four trips he had a long trip to Indiana and he got nervous while having to quickly step on the brake. He was moving slowly and had trouble getting his foot over to the brake because his leg was asleep. He then pulled the van over and got out for a few minutes. He felt he needed to go see a doctor so he went to the VA and was told to take a few days off, ice and rest it. He thought the VA was trying to get him to a neurologist, too, but he wasn't sure. He was also given an off work slip to take to PTI which he did and the PTI representative told him she hated to see him go but that if he was unable to perform the job that's what he should do.

Petitioner acknowledged that he had a prior right hip injury and that he had some physical restrictions from it. However, he felt he could have performed the PTI job had it not been for his knee injury.

Petitioner testified that he has not received any type of benefits since he stopped working for PTI. He currently lives in the basement of his parents' house. Petitioner testified that after he stands for awhile, he begins to get a limp and it, in turns, irritates his back -- at least that is what the doctors have told him. Petitioner testified that the numbness he experiences in his leg is associated with sitting and standing, especially the latter.

Petitioner testified he wants to go back to his doctor to see about further treatment. He would also like vocational rehabilitation in order to find a job.

Petitioner testified that Respondent requested that he submit to another independent medical examination, which was completed by Dr. Anderson on 5/29/14.

Respondent submitted Dr. Anderson's report in evidence (RX 2). The report indicates that Petitioner continues to have knee pain, is unable to sustain a regular job and has pain when driving. He was noted to have flexion instability in his knee and a lot of knee pain when the joint was put at 90 degrees and rocked back and forth. Dr. Anderson indicated that Petitioner probably needed to get the femur changed and made bigger and if he didn't, he would have problems returning to a regular job. He felt that if the knee surgery was revised, it might get better, but his main problem was flexion instability status post total knee in a "very difficult case." His diagnosis was status post tibial plateau fracture with progression of arthritis with total knee arthroplasty and flexion instability. He thought Petitioner could drive again, although he might need further surgery to correct the flexion instability. It was his opinion that Petitioner's inability to work was causally related to the series of surgeries that he has had. It was his opinion that Petitioner will continue to need restrictions until such time as his knee is revised and stated that the restrictions placed on him earlier were still valid. He is of the opinion that Mr. Scott is not at MMI and needs further treatment. (RX 2)

On cross-examination Petitioner acknowledged that no doctor has restricted him from driving. He also acknowledged back and hip pain before his knee accident. His hip injury was work-related and he settled the case.

On redirect examination Petitioner was asked if his knee injury and subsequent change in style of walking had aggravated his hip and back, and Petitioner replied in the affirmative.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his right knee is causally related to his undisputed accident. Although Petitioner had prior physical limitations due to an earlier right hip injury, he sought out and secured a job with Respondent where he was working at the time of the accident. His previous physical limitations did not prevent him from carrying out his work requirements with Respondent. Based upon all the medical records and evidence, including Petitioner's two orthopedic surgeons and Respondent's independent medical examiners, Petitioner suffered a very complex, comminuted fracture of the knee joint. Thus far, this has required two significant attempts to repair the joint which have largely been unsuccessful. Respondent's most current Section 12 examiner (Dr. Anderson) expressed opinions that Petitioner is not at maximum medical improvement, will probably require additional surgery, and that Petitioner's current inability to work is causally related to the series of surgeries on his injured knee.

Petitioner has not met his burden of proving that any current back complaints, hip complaints, or right leg complaints are causally related to his work accident or knee injury. This conclusion is based upon the following. Petitioner has acknowledged a prior low back condition and, additionally, the medical records indicate a low back problem with two to three herniated discs for which Petitioner has undergone lumbar epidural steroid injections but no surgery. According to Dr. Nunley's records, these herniations occurred since Petitioner's knee injury. Neither party submitted any medical records pertaining to this injury or treatment. Petitioner did not testify concerning it. While Petitioner alluded to occasions (especially during physical therapy) when his back and leg would bother him, no doctor provided a causation opinion relating Petitioner's back and/or leg complaints to his work accident or knee injury. The therapist noted it was only "possible" the leg pain was coming from his back.

Issue (K) Is Petitioner entitled to any prospective medical care?

Petitioner is entitled to prospective medical care in the form of a follow-up visit with Dr. Nunley. Petitioner clearly has ongoing significant problems with his knee. Respondent's Section 12 examiner (Dr. Anderson) is of the opinion that Petitioner is not at maximum medical improvement and requires additional knee surgery. Petitioner testified he desires additional treatment for his knee and would like to go back to see Dr. Nunley on the issue of further treatment.

Issue (L) What temporary benefits are in dispute?

Petitioner requests maintenance benefits from March 15, 2014 through July 22, 2014. Petitioner's request for maintenance benefits is denied. In so concluding, the Arbitrator relies upon her causation determination above and how it ties in with Petitioner's loss of his job with PTI. Petitioner testified that he could not continue driving for PTI due to his right leg going numb. While he mentioned his right knee would swell, he repeatedly went

back to the numbness in his leg as being the reason he feared for his safety and that of his passengers. When he was examined by Dr. Anderson, he did not mention anything about leg numbness, only "pain." Based upon his examination, Dr. Anderson concluded Petitioner could continue driving. Petitioner also testified that when he went to the VA in March, attempts were being made to get him to a neurologist. Petitioner had reported shooting pain in the middle of his patella and numbness on the lateral side of his lower leg -- "worse when climbing up stairs." Petitioner was noted to be a "truck driver" and experiencing lower back pain that would shoot down his right buttock and leg. Petitioner was noted to have decreased range of motion of his lower back and some tightness. Petitioner was told to follow up with his primary care physician for knee x-rays and was given a number of medications and instructions regarding his back pain. It appears from the VA records that the primary focus of Petitioner's complaints and treatment was his back. This would be consistent with his testimony that the VA wanted to arrange for him to see a neurologist. It is also consistent with the "Termination/Separation Form" dated March 15, 2014 -- "Meds and therapy prevent Michael from performing driving tasks. Leg falls asleep. Knee swells. Neuro related." (PX 9) The VA did not prescribe medication or therapy for Petitioner's knee.

In sum, if one looks at the evidence surround Petitioner's cessation of work at PTI in the best light for Petitioner, he may have stopped driving, in part, because of some knee complaints. However, no doctor has indicated Petitioner cannot drive because of his knee. Beyond that, Petitioner has failed to prove that he was unable to continue working at PTI due to a work-related condition stemming from his August 10, 2009 accident. Accordingly, an award of maintenance is not appropriate.

Issue (O) Other -- Reinstatement of Vocational Rehabilitation.

Petitioner is not awarded vocational rehabilitation at this time. Petitioner has failed to prove he cannot continue driving for PTI as a result of a work-related condition. No doctor has taken Petitioner off work at the present time.

Issue (M) Penalties.

Penalties are denied. In so concluding, the Arbitrator relies upon her determinations above.

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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

Roger Stewart,
Petitioner,

vs.

NO: 10 WC 1014

Ambar, Inc.,
Respondent.

15IWCC0424

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Fratianni finding Petitioner sustained an accidental injury arising out of and in the course of his employment on November 9, 2007 and proper notice of the accident was given to Respondent. The Arbitrator further found Petitioner failed to prove a causal relationship exists between the November 9, 2007 work accident and Petitioner's current condition of ill-being. The Issues on Review are whether a causal relationship exists between Petitioner's current condition of ill-being and the November 9, 2007 work accident, and if so, the nature and extent of Petitioner's permanent disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On February 18, 1997, Petitioner saw Dr. Dennis who noted that Petitioner has had episodic back pain throughout his life. Petitioner reported he had an episode a few weeks ago while getting out of his van at church. He collapsed and his legs went completely numb. His February 3, 1997 back x-ray indicated pars defects at the L5 level along with degenerative disc disease at the L2-3 and L3-4 levels. Petitioner reports he has since completely recovered and has no pain today. Dr. Dennis opined that Petitioner has a developmental problem most likely related to a stress fracture in his infancy or adolescence. Petitioner should be on a good maintenance back exercise program and return to see him if he has an episode of his back going out again.

2. Dr. Dennis wrote a letter dated the same day as his examination in which he stated that Petitioner has completely recovered from his recent episode of back pain. His physical examination was unremarkable. His x-rays show a spondylolysis of L5 with a very mild spondylolisthesis. His MRI shows no evidence of any disc pathology. He opined that

   Petitioner's problem is related to his spondylolsis and the best treatment for this would be a good rehabilitation program. Lastly, he noted that if the rehabilitation program is not successful, Petitioner might be a candidate for spinal fusion of this segment.

3. In a July I, 1997 follow up visit, Petitioner was seen by Dr. Dennis. At that time, the doctor noted that he had seen Petitioner in February for back pain related to a spondylolysis at L5. Petitioner was injured on March 25, 1997 when he fell out of a tree with a chain saw. He suffered a laceration to the right lower flank at that time. He is currently concerned that this incident could have aggravated his pre-existing problem. Dr. Dennis stated that he reassured the Petitioner that there is no evidence that his condition had progressed. He reiterated the same diagnosis and treatment regimen that he had given on February 18, 1997 and instructed Petitioner to recheck in six weeks.

4. On September 24, 1998 Petitioner treated with Dr. Carter, his primary care physician, and he reported to him that he had fallen out of a tree, a chain saw hit him in his right lumbar area, and he almost died.

5. Petitioner's testimony at the June 17, 2014 Arbitration hearing supports his medical records. Specifically, Petitioner testified that he had fallen out of a tree, got knocked out of a ladder, hit his kidney with a chain saw and experienced low back pain. At that time, he saw a doctor two to three times. From 1997 through November 9, 2007 he did not seek any additional medical treatment for his low back and he did not lose any time from work due to his low back injury.

6. Petitioner testified on November 9, 2007 he was a working union foreman and ironworker and was picking up iron rebar when he stepped on a four-by-four or something and he rolled his ankle. Immediately after the accident, his low back hurt. He would rate the pain as a 9 out of a 10 on a 10 point scale. The pain was going to his calf and making his leg hurt. Petitioner continued to work after the November 9, 2007 work accident. From November 9, 2007 through November 12, 2007 Petitioner worked 8 and a half hours. On November 13, 2007 he worked ten and a half hours. On November 14, 2007 he worked eleven and a half hours. On November 15, 2007 he worked ten and a half hours and on November 16, 2007 he worked six and a half hours. Petitioner testified after that he quit working for Respondent he took lighter jobs where he would not have to bend over or pick anything up.

7. On November 16, 2007, Petitioner started treating with Chiropractor Olson. As part of his visit, Petitioner completed a personal history form in which he indicated he was there to receive treatment for his low back and hip. He left the form blank as to when the condition began and if the condition had occurred before. He indicated that his condition is job related but he reported that he had not given a report of the same to his employer. He reported in the past he has fallen ten feet and hurt his back. He had also been in a car accident and had broken six ribs, popped his lung and cracked his sternum. When Petitioner was asked if he had had his problem longer than a week or two, he answered in the affirmative and he placed the number three to the right of the preset blocks. In regard to prior accidents, injuries or conditions that could have brought this about or be related to his current condition, Petitioner noted he had experienced a fall, auto injuries, work injuries, repetitive motion on the job, had fallen out of tree ten years ago and had stepped off ledge at work.

8. Chiropractor Olson's medical records indicate Petitioner treated with him from November 16, 2007 through October 9, 2009. The treatment records showed Petitioner consistently complained of low back and right hip pain that waxed and waned. The records showed that Petitioner was working upwards of 60 to 70 hours a week. It shows a gap in medical care from May of 2008 to August of 2008. On September 24, 2008, it was noted that Petitioner was carrying heavy sheet of metal downstairs when he experienced severe back pain. On December 22, 2008, it was noted that Petitioner's nephew had jumped off the couch on to his back, which increased his low back pain. On December 29, 2008, it was noted that Petitioner was painting and lifting furniture when he experienced moderate and intermittent back pain. On March 2, 2009, Petitioner reported moving an entertainment center at home when he experienced increased low back pain. On May 11, 2009, Petitioner reported he was doing yard work over the weekend when he had to lay down. He reported that he was back to work today, but he was experiencing an increase in pain. On July 28, 2009, Petitioner reported he had fallen a month ago and had injured his rib and right thigh and he experienced low back pain.

9. On July 30, 2008, Petitioner was seen at Midland Orthopedic Association. In the new patient information sheet, he noted that he had experienced a work related injury on July 11, 2008. He reported that he had picked up some rebar at work and had twisted and he checked a box that his condition was "maybe" work related. His medical history sheet indicated Petitioner had problems with his back and legs since October of 2007 which have been bothering him for about two years. On March 23, 2009, Petitioner reported experiencing a hernia as a result of a work injury. On October 23, 2009, Petitioner filed a workers' compensation claim, listed a date of accident as October 23, 2009 and noted he experienced multiple injuries. Petitioner subsequently underwent hernia surgery on November 18, 2009.

10. Petitioner testified he treated with Chiropractor Olson through October of 2009 and saw him for 50-60 visits. Petitioner reported that the manual adjustments helped but he continued to have pain in his right calf. During this period he continued to work. However, his legs kept on getting weaker. In October of 2009, Chiropractor Olson recommended he see a doctor. Dr. Carter, his primary care doctor, recommended he undergo a low back MRI and he referred Petitioner to Lake Shore Bone and Joint Institute. The November 3, 2009 Lumbar MRI showed that at the L3-4 level there was a small central disc protrusion along with mild central canal and moderate biforaminal stenosis. At the L4-5 level there is moderate right and mild left foraminal stenosis. At L5-S1 there is a broad disc herniation compression both exiting L5 nerves and equivocal bilateral L5 spondylosis.

11. In November of 2009 Petitioner was treating at Midland Orthopedics for a meniscus tear and Dr. Maday recommended low back injections which were done at Mercy Pain Management.

12. On November 19, 2009, Petitioner was seen by Dr. Strugala. The doctor noted that Petitioner presented for an evaluation of chronic low back pain. Petitioner reported he suffered

an injury to his low back at work in October of 2007 which occurred while lifting a rebar and twisting. He experienced pain in his low back with subsequent radiation to the right leg. He received chiropractic treatment in 2007 and noted some improvement although he continues to note symptoms extending into the right leg. He worked in 2008 in a somewhat demanding position. His symptoms never completely resolved. He has difficulty performing normal work activities such as lifting and performing work in a lumbar flexed position. His MRI showed multi-level degenerative disc disease most significantly at L5-S1 with a broad based disc herniation compression the bilateral L5 nerves. Dr. Strugala noted Petitioner's symptoms have been present for quite some time. He diagnosed Petitioner as having low back pain with an L5-S1 disc herniation. He referred Petitioner for an epidural steroid injection. On December 7, 2009, Petitioner received an epidural injection. On December 10, 2009, Dr. Strugala noted Petitioner's pain has diminished with epidural injection but it has not resolved. He then ordered physical therapy. On December 14, 2009, Petitioner received physical therapy at Accelerated. Again, Petitioner reported he originally injured his low back in November of 2007 while lifting and carrying rebar. He states he had experienced recurring episodes of low back and lower extremity symptoms since that time. Petitioner stated that most recently he began experiencing left lower extremity pain with lifting and carrying. His November 2009 MRI showed a L5-SI disc herniation. At present, Petitioner is complaining of intermittent pain in the posterior right calf. On January 11, 2010, Petitioner received a second epidural injection. During a January 14, 2010 follow up visit with Dr. Strugala, the doctor noted that Petitioner had a minor setback with second epidural. He should continue therapy and currently he is unable to return to work.

13. On February 8, 2010, Petitioner was seen at Lakeshore Bone and Joint Institute. Petitioner reported his pain started in November of 2007 and since then he has been unable to perform normal activities on and off. Petitioner reported his back pain was not a result of an injury. Rather, it was a result of working, carrying some heavy rebar and slipping while working as an iron worker. Petitioner reported his prior problem was just typical low back pain from work. Lastly, he stated he never had pain in his legs until 2007.

14. On February 22, 2010, Petitioner saw Dr. Thompkins who noted that Petitioner presented with axial back pain and more importantly bilateral leg symptoms. He has had severe right sided leg symptoms for almost a year. Now, he has left-sided calf symptoms that are getting better with non-operative care. Dr. Thompkins opined that Petitioner has mechanical instability at L5-S1 due to spondylolisthesis with a pseudo-bulge/herniation in the foramen causing compression of the nerve roots. He recommended a bilateral L5- S2 transforaminal injection.

15. On February 4, 2010 Petitioner followed up with Dr. Strugala who noted that Petitioner continues to experience leg symptoms despite physical therapy and two epidural injections. He referred Petitioner to Dr. Philips.

16. On March 2, 2010 Petitioner was evaluated by Dr. Phillips. Petitioner reported that while carrying rebar he slipped on a 4 x 4 piece of wood. It jammed him down which caused back pain. He stated he continued to work. The following week he was transferred to a different location which seemed to help but it still caused right calf pain with each manipulation. He reported that in all of August he worked with rebar and he had no pain but his right leg was fatigued. In March of 2009 he returned to working with rebar and his leg pain returned. He

states he returned to his primary care doctor who obtained a MRI which showed hip problems and a lumbar disc herniation. He states he saw Dr. Strugala who did injections and physical therapy and he was told to get a second opinion. He states he saw a doctor who told him he had a spondylosis; he would have to leave his line of work and he was too young for a fusion. Currently, Petitioner is describing minimal back pain and predominant bilateral leg pain, which is worse on the right side. Physical therapy and epidurals have not given him any lasting relief. He is now having difficulty walking even a block because of his leg pain. He last worked in November of 2009. His lumbar x-ray and MRI show Grade one L5-S1 spondylolisthesis. He has disc desiccation of most levels. He has foraminal narrowing at L5-S1. At L4-5, L3-4 and L2-3 there is significant congenital stenosis with facet degenerative changes and disc ostephyte combining to cause moderate spinal stenosis. Dr. Phillips opined that Petitioner's predominant symptoms are related to his multi-level lumbar stenosis. He also has underlying L5-S1 spondylolisthesis. They discussed surgery.

17. On March 29, 2010 Petitioner underwent surgery consisting of a L2-L3-Sl laminectomy-foraminotomy, L5-S I interbody fusion, L5-S I posterior spinal instrumentation and fusion. The post-surgical diagnosis was congenital spinal stenosis from L2 to Sl, spondylolisthesis with spondylolysis at L5-Sl.

18. Petitioner testified he was released to return to work in September of 2010. He last saw Dr. Phillips for his low back in February of 2011. Petitioner testified that since November 9, 2007 he had not had any additional injuries to Iris low back. He has not sought any additional treatment for his low back since February of 2011. He returned to work and he is now working as a non-working general foreman. The pain in his calf was gone after surgery. Currently, his strength is totally different. He still has pain and he still experiences some numbness from the bottom of his foot. He no longer seeks out jobs where he had to do rebar work or anything that takes a lot of bending or picking up. His back cannot take bending over and heavy lifting all day anymore.

19. On page four of the February 8, 2010 medical record from Lake Shore, Petitioner answered that his treatment is not the result of an accident. In the November 16, 2012 chiropractor records he answered he had had this problem for longer than a week. He agreed that at that time he complained of low back pain and right hip pain for three weeks. He agreed that three weeks from November 16, 2007 would have put the experience back to the end of October of 2007 and he further agreed that he was not working for Respondent at that time. He worked for Respondent from November 5, 2007 through November 16. 2007. He testified that he had a hernia claim in 2009 and if the application of adjustment of claim says multiple injuries he does not remember it. He signed but did not fill out the paperwork. He agreed that looking at Chiropractor Olson's May 1 1, 2009 entry it states that he had a fall that caused his low back pain. He agreed that on the questionnaire for Olson Chiropractic dated November 16, 2007 he checked the box saying he did not make a report of accident to his employer and he did not specify a date or time of the accident. He does not remember on the sign out sheet for November 9, 2007 checking the injury-free box. On the questionnaire for Olson Chiropractic where it asked whether or not there was an earlier accident, injury or condition that could have brought the problem about

or is related to the problem he stated "fall, auto injury, work injury, repetitive motion on the job, ironworker for ten years, fell out of tree ten years ago, stepping off the ledge at work and carry rebar". He also had a substantial an auto accident prior to November 9, 2007. The main treatment for the 1997 tree accident was for a laceration on his back and his kidney. He went to a back doctor to make sure it was okay, but from that date forward he worked until he got into ironworking. He then worked as an ironworker for ten years. After the August 2006 auto accident, he continued to work and he never obtained any treatment for his back. He does not remember whether or not he had any kind of treatment for his low back before November of 2007. The first time he had his lumbar spine x-rayed was when he fell out of the tree in 1997. He does not remember what those

x-rays showed. He agreed that he had reported episodic back pain throughout his life. He does not remember seeking medical care in or around 1997 when his leg went completely numb and it collapsed. He denied having an episode of getting out of a church van and collapsing. He agreed that page 39 of RX8 dated February 18, 1997 shows that he complained of the collapsing of his legs because they went completely numb and he also reported back pain throughout his life. He does not recall the doctor discussing the possibility of a spinal fusion at that time. He remembers the doctor saying he was too young and he did not want a fusion for his spondylolisthesis with a cracked vertebra. He does not know if Chiropractor Olson took x-rays of his low back. He agreed that in April of 2008 he did not seek chiropractic treatment for his low back and at this time he was working 60-70 hours a week. He agreed that he did not have any medical care for his low back from May of 2008 through August of 2008. There was a period that he did not see Dr. Olson because of his work schedule, his pain being manageable or the fact that he had used up his insurance. He agreed that in September of 2008 he experienced severe low back pain after carrying heavy sheet metal down a flight of stairs. He went back to chiropractic care at that time and his visits increased to seven times a month. He agreed that if the paperwork from Chiropractor Olson says he had increased low back pain because his nephew jumped off a couch onto his back in December of 2008, it would be correct. He then had a three month break in treatment in December of 2008 because he exhausted what he was allowed to spend on chiropractic treatment according to his insurance company. In March of 2009 he reported moving an entertainment center in his home which caused an increase in his low back pain on the left side. If the paper work shows it, he would agree that on March 23, 2009 he reported another work injury lifting some heavy objects. He then said it happened due to climbing on a truck and not lifting heavy objects. He probably remembers reporting to Chiropractor Olson that he experienced an increase in his low back pain when he was doing some yard work. He does not remember reporting in July of 2009 he experienced another fall from a ladder at work, but it is probably something he told the doctor. He remembers filing his Application for Adjustment of Claim in October of 2009 after he underwent his MRI and was told he had a herniated disc. He remembers filling out a questionnaire dated November 19, 2009 for Dr. Strugala at Midland Orthopedics in which he stated that the onset of his symptoms was in October of 2007 and he checked that "maybe" it was work related. He agreed that he completed a questionnaire on November 16, 2007 on RX5, pl for Dr. Olson in which he stated he was reporting typical low back pain from work and that he never had any leg pain. He agreed that he saw Dr. Ghanayem on August 20, 2010 and told him he was lifting rebar that was long and heavy and he slipped and had a twisting type of

injury to his back. He also denied any significant back problems prior to the November 2007 incident. He modified his duty and was really particular regarding what jobs he took after November 2007. He agreed that he engaged in welding in February 2008 and in March 2008 he worked 60-70 hours a week. He agreed that no doctor has imposed any

sort of work restriction on him since August of 2010. He did report that he resumed working out 4-5 times a week in June of 2010, but he claims he was actually doing therapy exercises and not working out. Currently, he is not taking any prescription medication for his low back. He denied the fact that any of the incidents that attorney talked about on cross-examination changed the pain he was experiencing in November of 2007. While he did cross out "no" on the Lake Shore Bone and Joint records as to whether it his treatment was the result of an accident, he did state on the form that the pain started in November of 2007; he stated that he was able to perform normal activities off and on since the injury and he stated that his pain started when he was working as an iron worker was carrying some heavy rebar and he slipped. On the November 19, 2009 Midland Orthopedic report he stated that the onset of his pain was October of 2007 and it had bothered him for about two years. He said he had picked some rebar at work and had twisted and had problems with his back and leg. On Dr. Olson's consultant history it was not his handwriting that said in response to earlier accidents/incidents that he sustained a fall, auto injuries, etc. He did write on there he had low back and hip complaints and that his symptoms were job related. He checked "no he did not have a report" because he did not have a handwritten report. He agreed that he testified he had no reason to believe that Dr. Olson documented something that was improper. He agreed that he when signed out on RX4 from November 13, 2007 through November 16, 2007 and did not mark the injury free box.

20. William Freiberg testified he was the field superintendent for Respondent. He is currently retired. If Petitioner had signed out noting he had an injury that date they would have gotten him immediate medical help. There might have been days where he might have gone until the afternoon of the following day at the latest to complete an accident report. He is not aware of any injury to Petitioner's low back while he was working for Respondent. He did not complete an accident report for Petitioner while he was working for Respondent in 2007. Mr. Freiberg agreed that his wife holds a 40% ownership in Respondent's company. He agreed that an injury could be reported either verbally or in writing. Sometimes the employees would get lax about signing in. It was a fight to get the guys to sign in and out. On November 9, 2007 there were three people who did not indicate their time out on the sign out sheet. There are quite a few incidents where people did not mark the injury-free check out box. If someone did not sign out or check injury-free, he would approach the man the following day and ask him why.

21. Paul Worsley testified he is the general foreman for Respondent. Petitioner worked for Respondent as a journeyman ironworker for 10 days to 2 weeks. He does not recall Petitioner mentioning an injury to his low back. Petitioner did not have any kind of low back complaints when he left the project. As far as he knows, Petitioner completed the job tasks without pain or discomfort. He does not recall Petitioner reporting any injury from November 5, 2007 through November 16, 2007. He does not recall Petitioner or any other

foreman reporting an injury for Petitioner. If the employees did not check the injured free box he would either track them down or check with them the next morning. He did this but apparently he did not do his job in this instance. He would imagine that there were times the guys would fill out the reports in the morning so they did not have to do it when they left the job at night.

22. Louis Grahovac testified he is a journeyman ironworker. He testified he saw Petitioner have an accident. He testified that almost everyone but the general foreman would complete the sign in/sign out sheet in the morning.

23. On July 14, 2010, Dr. Ghanayem evaluated Petitioner. He testified that he reviewed Petitioner's medical records. He noted that Petitioner has had a long history of low back problems that predate his alleged November 9, 2007 work injury. It appears he sought care from a chiropractor on November 16, 2007 and the November 9, 2007 work injury was not documented during that encounter. Although, there is some vague reference to work problems occurring three weeks before November 16, 2007, which would pre-date his first date of employment that took place on November 5, 2007. In addition, if Petitioner continued to work his full capacity as an ironworker, it is doubtful that any meaningful injury would have allegedly taken place on November 9, 2007. If he did suffer a low back injury from a slip and fall on November 9, 2007 the nature of that apparently unreported and un-witnessed event would have no bearing on his pre-existing low back condition as it relates to a long-standing spondylolisthesis and congenital stenosis. Dr. Ghanayem opined that the medical records generated in real time do not support a work injury occurring on November 9, 2007. It is also critical to have a proper medical understanding of Petitioner's underlying low back condition which is long-standing in nature was not traumatically induced or aggravated by the alleged November 9, 2007 injury. Dr. Ghanayem further opined that had Petitioner sustained an injury on November 9, 2007 a brief course of chiropractic care of some 8-12 visits in the first month followed by a second similar month would have been appropriate. He opined that chiropractic care beyond two months or 24 visits would have been excessive for the alleged November 9, 2007 work injury. In an August 20, 2010 follow-up report, Dr. Ghanayem found that Petitioner's history today seem to contradict the medical records generated in real time. Lastly, he noted that if one was still having ongoing symptoms related to lumbar stenosis secondary to spondylolisthesis it is doubtful that they could work full duty and unrestricted iron worker job for one to two years post injury.

24. At an October 1, 2010 follow-up visit with Dr. Phillips, the doctor noted that Petitioner is six months removed from his surgery and he is doing terrific. Petitioner has resumed work as a laborer and is managing this without any problems. He is now working as a road construction worker. He has also returned to working out in the gym and when he really pushes it he gets some achiness in his back.

25. At the February 25, 2011 follow-up visit with Dr. Phillips, the doctor noted that Petitioner is almost a year removed from his surgery. He has done terrific and is back working on the roads. He has minimal back discomfort. On physical examination

    Petitioner's lumbar is pain free on testing his range of motion. Petitioner's x-ray shows an intact fusion. The x-rays show he has diffuse degenerative changes throughout the lumbar spine.

26. On July 16, 2011 Petitioner was evaluated by Dr. Coe. Petitioner reported that in November of 2007 he was carrying a large piece of rebar when he stepped on a lose board which caused his ankle to roll and caused him to fall to the ground. He stated the rebar fell on top of him and he experienced low back pain. Petitioner denied any significant injuries to or symptoms from his low back prior to the November of 2007 work injury. He reported he would experience occasional backaches at work prior to that date, but they did not require any lost time from work or any significant medical treatment. Petitioner had reported that he continued to work following his lumbar injury and chiropractic treatment. He stated that he generally performed lighter duty work during the interval between his low back injury and his treatment with Dr. Strugala and other orthopedic specialists in 2009. Dr. Coe testified that there is no history that he obtained of a re-injury or additional injuries during this time period. Dr. Coe opined that Petitioner's November 2007 work injury aggravated his pre-existing congenital and developmental changes in his lumbar spine. It caused a disc herniation with the development of acute and chronic lumbar discogenic pain, myofascial pain and radiculopathy. Petitioner reported he attempted to remain at work, taking lighter jobs when available, carrying out home therapies and tolerating ongoing low back and lower extremity discomfort. His symptoms persisted and they ultimately caused him to seek medical treatment. Dr. Coe testified that based on the findings of his exam, it is his opinion that there is a causal relationship between the November 2007 work injury and Petitioner's current symptoms. He opined that Petitioner's work injury has caused a permanent disability to a person as a whole. Lastly he opined, it certainly is possible for an individual with lumbar spondylolysis and listhesis to continue to work and tolerate the pain and discomfort as described by Petitioner.

27. During the April 20, 2012 follow up visit, Dr. Phillips indicated Petitioner is two years removed from his surgery. He is back working full time and has resumed all his usual activities. He works out extensively in the gym. He has been taking Bromelain for what he describes as some residual scar tissue pain in his back and since he has been on this he has no pain at all. His x-rays show the fusion is well positioned. Petitioner is doing terrific after his surgery. He is going to continue with his normal activities. He will see Petitioner back every few years unless he has a problem.

The Commission strike the language in the Arbitrator's decision which reads, that "after reading in detail all of the above treatment, both before and after the accident, this Arbitrator is required to determine whether all of it, some of it or, if any of it is causally related to the November 9, 2007 accident including in this finding is whether there was an aggravation of a pre-existing condition". Next the Commission strikes the term "hired guns", which refers to the independent medical examiners from each side. Lastly, the Commission strikes the language that the Arbitrator elects to ignore the opinions of Drs. Ghanayem and Coe.

The Commission has reviewed the opinions of Drs. Ghanayem and Coe in light of the other evidence contained within the record and in doing so, the Commission finds that more weight should be assigned to the opinions of Dr. Ghanayem than those of Dr. Coe. Specifically, the Commission finds, similar to the Arbitrator, that contrary to Petitioner's testimony and contrary to history Petitioner provides to Dr. Coe, Petitioner has a more extensive pre-existing lumbar condition leading up to the November 9, 2007 work accident than Petitioner led the doctors to believe. The evidence clearly indicated that prior to November 9, 2007 Petitioner reported episodic back pain throughout his life. Petitioner's x-ray prior to November 9, 2007 indicated he had pars defects at the L5 level along with degenerative disc disease at the L2-3 and L3-4 levels and Dr. Dennis opined that Petitioner has a developmental problem most likely related to a stress fracture in his infancy or adolescence. While Petitioner testified that he does not remember whether he had any treatment for his low back or leg prior to November of 2007 and he claims that he does not recall the doctor stating that he was a surgical candidate, Dr. Dennis indicated in February of 1997, some nine months prior to the November 9, 2007 work accident, that Petitioner might be a candidate for a spinal fusion if his conservative treatment is not successful.

While Petitioner claims that he sustained a work accident on November 9, 2007 resulting in substantial pain and Mr. Grahovac testified that he witnessed the same, the record also indicates that Petitioner did not indicate that he sustained a work accident when he signed out that day. Petitioner continued to work long hours after the accident. Petitioner worked a whole week prior to seeking out any medical care. While it is somewhat questionable what the number three means on the questionnaire form Petitioner completed for Chiropractor Olson, Petitioner answered that he had had back and right hip pain for longer than a week and he testified it was more like three weeks, which would have placed his pain prior to the date he started working for Respondent. Additionally, Petitioner checked a box stating that he did not tell his employer that he injured himself at work. Nor did he specify a date and or time of accident. When Petitioner is asked if there is an earlier accident, injury or condition that could have brought on this problem, there is a whole list given spanning from falling out of a tree ten years prior to a work injury. Petitioner subsequently testified that he did not write down this history on the form but that he did sign the form. Petitioner claimed that there was a period that he did not see Dr. Olson because of his work schedule, his pain being manageable or he had "used up" his insurance. When Petitioner is asked on the July 30, 2008 new patient form if his pain is work related he checks "maybe". During the latter half of 2008 and early 2009 and

15IWCC0424

contrary to the history Petitioner provides to Dr. Coe, Petitioner provides a history of numerous instances in which he hurt his back while moving an entertainment center, doing yard work or having his nephew jump on his back during non-work hours as well as carrying sheet metal down stairs or climbing onto a truck, which may or may not have taken place during work hours. During said period, Petitioner has a hernia during work and indicates that on his application for adjustment of claim that he does not just have a hernia but he has multiple injuries. Shortly thereafter, Petitioner claims the pain in his low back and hips is starting to get worse and he is experiencing pain and tingling in his right leg. Only then does his primary care doctor order a lumbar MRI and refer him to a spine specialist where additional low back treatment is given. During this increase in treatment, Petitioner completes his application for adjustment of claim on January 11, 2010 some approximately two years after the November 9, 2007 date of accident. When Petitioner is seen at the Lakeshore Bone and Joint Institute on February 8, 2010 he claims that his low back condition did not resultfrom an injury and he never had pain in his legs until 2007 while also stating that he was working as an iron worker, was carrying some heavy rebar and had slipped. Lastly, Dr. Ghanayem testified that the medical records generated in real time do not support a work injury occurring on November 9, 2007. He further testified that if, assuming arguendo, he sustained an injury on November 9, 2007, Petitioner continued to work in his full capacity as an ironworker it is doubtful that he had a meaningful injury and any chiropractic care beyond the first two months would have been excessive in nature. Given all of the above, the Commission affirms the Arbitrator's finding that Petitioner failed to prove a causal connection exists between Petitioner's current condition of ill-being and the November 9, 2007 accident and need for the lumbar fusion surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of November 9, 2007 and Petitioner's condition of ill-being, his claim for compensation is hereby denied.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a notice of intent to file for review in Circuit Court.

DATED JUN 8 - 2015

MB/jm

o:4/9/15

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Mario Basurto

Stephen Mathis

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosa Ruiz,
Petitioner,

vs.

NO: 07 WC 37471
07 WC 37472
09 WC 27931

SKF Sealing Solutions,
Respondent.

15IWCC0425

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 causation re: left elbow and credit and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In Claim No. 07 WC 37471, the Commission finds that while Arbitrator Flores gave no credit in her July 17, 2014 Remand Arbitration decision, the parties agreed that Petitioner is entitled to an earlier credit of $36,408.90 for the payment of temporary total disability and/or maintenance benefits and to a credit under Section 8(j) for any amounts so paid under Respondent's group medical insurance plan. Said earlier credit was awarded at the time of the initial May 19, 2010 Section 19(b) hearing before Arbitrator Hennessy. Additionally, Petitioner is entitled to a credit of $10,124.40 in Claim No. 09 WC 27931 for a total credit of $46,533.30 due and owing for both claims.

In Claim No. 09 WC 27931, the Commission finds that there is sufficient language contained within the Commission's May 2, 2011 Review decision to indicate that the majority of the Commission found Petitioner's left elbow is casually related to the March 12, 2009 work accident. Specifically, the Commission finds while portions of pages three and four of the Commission's decision are vague in nature, the decision as a whole is sufficient to address the causation issue. The Commission notes that on page two and portions of page three, the Commission specifically addressed the causation issue. More specifically, on page two of the Commission's decision, the Commission states that in so finding (causal connection) it relied on the testimony of Petitioner, Mark David Payton as well as the expert opinion testimony of Dr.

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Lamberti. The Commission finds that this is both clear and specific in terms of the Commission's position regarding the causation issue. The Commission also infers, by virtue of fact that prospective medical was awarded and the dissent's comments regarding Dr. Lamberti's causation opinion, that the causation issue was addressed in the majority's decision. Additionally, while Respondent refers to Commissioner Lindsay's position in the dissent as basis for finding that Dr. Lamberti was given an incorrect hypothetical and that his opinion should not be used to support the issue of caudsation, the Commission notes that at the time that the hypothetical was posed during the deposition Respondent did not raise an objection to inaccuracy of the hypothetical. Moreover, the Commission finds that Respondent did not file a Section 19(f) Motion, claiming that the ambiguity is a scribner's error and Respondent did not raise this issue on appeal to the Circuit Court. As such, the Commission finds that its May 2, 2011 decision became final and law of the case principle was established in terms of the causation issue. While the Commission acknowledges that there is an ambiguity contained within the May 2, 2011 decision, the Commission finds that there is sufficient supporting language contained within the decision to determine the Commission's position on causation and to find that at this late stage Respondent has waived this issue and has not preserved the same. Thus, the Commission finds that as such Arbitrator Flores was correct in finding in her remand decision that the Commission had earlier found causation exists in terms of Petitioner's current left elbow condition and it relationship to the March 12, 2009 work accident and in proceed accordingly in determining the issues of unpaid medical and permanency.

IT IS THEREFORE ORDERED BY THE COMMISSION that in Claim No. 07 WC 37471 Respondent pay to Petitioner the sum of $454.30 per week for a period of 67 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 in Claim No. 09 WC 27931 Respondent pay to Petitioner the sum of $454.30 per week for a period of 27-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that in Claim No. 07 WC 37471Respondent pay to Petitioner the sum of $868.74 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that in Claim No. 09 WC 27931Respondent pay to Petitioner the sum of $1,931.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that in Claim No. 07 WC 37471 Respondent pay to Petitioner the sum of $408.87 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% loss of a man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that in Claim No. 09 WC 27931 Respondent pay to Petitioner the sum of $408.87 per week for a period of 75.9 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 30% loss of use of the left arm.

15IWCC0425

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 in Claim No. 07 WC 37471 Respondent shall have credit in the amount of $36,408.90 for all amounts paid to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that in Claim No. 09 WC 27931 Respondent shall have credit in the amount of $10,124.40 paid to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of Claim No. 07 WC 37471 to the Circuit Court by Respondent is hereby fixed at the sum of $15,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

Bond for the removal of Claim No. 09 WC 27931 to the Circuit Court by Respondent is hereby fixed at the sum of $35,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 8 - 2015

MB/jm

O: 5/7/15

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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUIZ, ROSA
Employee/Petitioner

Case# **07WC037471**

07WC037472
09WC027931

SKF SEALING SOLUTIONS
Employer/Respondent

15IWCC0425

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:

2932 LAW OFFICE OF KUGIA & FORTE PC
MARTIN KUGIA
711 W DUNDEE ST
WEST DUNDEE, IL 60118

0081 BRAUN LORENZ & BERGIN PC
MARK BRAUN
33 N LASALLE ST SUITE 1210
CHICAGO, IL 60602

15IWCC0425

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rosa Ruiz
Employee/Petitioner

v.

SKF Sealing Solutions
Employer/Respondent

Case # **07** WC **37471**

Consolidated cases: **07** WC **37472**
09 WC **27931**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **May 28, 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 July 30, 2007, April 5, 2007 and March 12, 2009, 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* sustain accidents that arose out of and in the course of employment.

Timely notice of these accidents *was* given to Respondent.

Petitioner's current condition of ill-being *is, in part,* causally related to these accidents as explained *infra.*

In the year preceding the injuries on July 30, 2007, April 5, 2007 and March 12, 2009, Petitioner earned $35,435.40; the average weekly wage was $681.45.

On the April 5, 2007 and July 30, 2007 accident dates, Petitioner was 45 years of age. On the March 12, 2009 accident date, Petitioner was 47 years of age. On all three dates of accident, Petitioner was *married* with 3 dependent children.

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

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

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 and for any and all other such benefits paid as agreed by the parties. *See* AX1.

Respondent is entitled to a credit of $0 and for any such further amounts as agreed by the parties under Section 8(j) of the Act.

ORDER

Temporary Total Disability

As agreed by the parties, Respondent shall pay Petitioner temporary total disability benefits of $454.30/week for 27 & 5/7th weeks, commencing August 22, 2012 through March 3, 2013, as provided in Section 8(b) of the Act. *See* AX1.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 30, 2007 through May 28, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of for such temporary total disability benefits that have been paid.

Medical Benefits

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule from MedSource ($1,091.00) and NCNS ($840.00) totaling $1,931.00 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for such 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.

Permanent Partial Disability: Person as a whole (Low Back – Case No. 07 WC 37472)

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to prove causal connection between her claimed low back condition of ill being and her accident at work. By extension, all other issues related to the low back are rendered moot and all requested compensation and benefits related to the low back are denied.

Permanent Partial Disability: Person as a whole (Left Shoulder – Case No. 07 WC 37471)

Respondent shall pay Petitioner permanent partial disability benefits of $408.87/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.

Permanent Partial Disability: Schedule injury (Left Arm/Elbow – Case No. 09 WC 27931)

Respondent shall pay Petitioner permanent partial disability benefits of $408.87 /week for 75.9 weeks, because the injuries sustained caused the Petitioner 30% loss of use of the left arm (elbow), as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

July 10, 2014
Date

JUL 17 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Rosa Ruiz
Employee/Petitioner

v.

SKF Sealing Solutions
Employer/Respondent

Case # **07** WC **37471**

Consolidated cases: **07** WC **37472**
09 WC **27931**

FINDINGS OF FACT

Procedural History

Petitioner's cases originally went to arbitration on May 19, 2010 at which time the first hearing was held pursuant to her Sections 19(b) and 8(a) petition. Petitioner's Exhibit[1] 6. The arbitration decision addressing all three of Petitioner's cases dated August 13, 2010 was timely reviewed by Petitioner. *Id.* The Commission issued its decision on May 2, 2011. *Id.* It appears from the Commission's records that a subsequent Circuit Court appeal was filed, but no order was entered on the merits rendering the Commission's decision final.

Of note, the Commission affirmed and adopted the Arbitrator's decision in Case No. 07 WC 37471 finding that Petitioner suffered an accident on July 30, 2007 to her left shoulder (denying any causation to any other body parts). *Id.* The Commission modified the awarded temporary total disability period to July 31, 2007 through November 18, 2008. *Id.* In Case No. 07 WC 37472, the Commission affirmed and adopted the Arbitrator's decision finding that Petitioner sustained an accident on April 5, 2007 to her low back, and that there was no lost time or additional medical care required for her back. *Id.* With regard to Case No. 09 WC 27931, the Commission reversed the Arbitrator's decision finding that Petitioner did suffer a repetitive trauma accident to her left elbow which manifested itself on February 12, 2009. *Id.* The Commission ordered Respondent to pay for the reasonable and necessary cost for a re-examination by Dr. Lamberti to determine the status of Petitioner's left elbow and any need for surgical intervention. *Id.* This Arbitrator is bound by the findings and conclusions[2] as reflected in the Commission's May 2, 2011 decision and, thus, hereby incorporates those by reference.

A second consolidated hearing was held before this Arbitrator on May 28, 2014. The issues in dispute in Case No. 07 WC 37471 are causal connection and the nature and extent of Petitioner's left shoulder injury. Arbitrator's Exhibit ("AX") 1. The issues in dispute in Case No. 07 WC 37472 are causal connection and the nature and extent of Petitioner's low back injury. *Id.* The issues in dispute in Case No. 09 WC 27931 are causal connection, Respondent's liability for certain unpaid medical bills, and the nature and extent of Petitioner's left elbow injury. *Id.*

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[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.

[2] "The rule of the law of the case is a rule of practice, based upon sound policy that, where an issue is once litigated and decided, that should be the end of the matter and 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." *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill.App.3d 1083, 1086-1087 (1st Dist., 1984). The Appellate Court went on to state that the "trial court order becomes the 'law of the case' only if there is a final and appealable order." *Id.*, (citation omitted).

In accordance with the law of the case, and in consideration of the evidence presented at this hearing, the Arbitrator makes findings on the disputed issues as stated herein.

Additional Evidence

Petitioner testified that after the last hearing Respondent authorized her to return to Dr. Lamberti for evaluation of the left elbow. The medical records reflect that Petitioner saw Dr. Lamberti on September 8, 2011. PX1 at 1-2, 11. Dr. Lamberti noted that Petitioner was tender on both epicondyles and he diagnosed her with medial and lateral epicondylitis and cubital tunnel syndrome. *Id.* He ordered an EMG of the left arm. *Id.* Petitioner underwent the recommended EMG on October 13, 2011. PX1 at 4-5. The EMG report indicates that there was no evidence of median neuropathy at the carpal tunnel, left cervical radiculopathy, or left ulnar neuropathy at the elbow. *Id.*

Petitioner returned to Dr. Lamberti on December 22, 2011 and reviewed the EMG results. PX1 at 9-10. He noted that her EMG was negative and indicated that he would not address either carpal tunnel syndrome or cubital tunnel syndrome, although she had vague neurologic symptoms in her hand. *Id.* He also noted that Petitioner had severe tenderness consistent with medial epicondylitis and some mild-to-moderate soreness on the lateral side. *Id.* He recommended surgery to address her medial and lateral epicondylitis, indicating the difficulty of recuperating from surgery to both. *Id.* Petitioner elected to go with surgery, however. *Id.*

Section 12 Examination – Dr. Belich

Prior to authorizing the elbow surgery, the Respondent sent the Petitioner back to Dr. Paul Belich for a repeat independent medical evaluation on February 23, 2012. RX2. At that time, Petitioner reported continued left elbow pain and progressive worsening of her symptoms since 2007, although she had not worked since that time. *Id.* Dr. Belich took additional history from Petitioner subsequent to his prior evaluations, reviewed additional medical records, examined Petitioner, and rendered various opinions. *Id.*

He diagnosed Petitioner with medial epicondylitis with possible chronic ulnar neuritis, left elbow. *Id.* He reiterated his opinions as stated in his prior reports that Petitioner's left elbow symptoms were unrelated to her alleged work event in 2007. Dr. Belich also noted that it was unusual for Petitioner to have such severe, unrelenting pain for five years with no improvement whatsoever in her clinical symptoms. *Id.* He noted that she was overly demonstrative, or dramatic, during his examination and that his objective findings during her examination did not correlate to her subjectively reported symptomatology at that time. *Id.* Dr. Belich acknowledged that Petitioner has some objective findings of a medial epicondylitis and indicated that a medial epicondylectomy could be tried, but he noted that the recommendation for a lateral procedure was not indicated and should not be performed. *Id.*

Continued Medical Treatment

Petitioner eventually underwent the surgery recommended by Dr. Lamberti on August 22, 2012. PX1 at 13-14. Pre- and post-operatively, he diagnosed Petitioner with left elbow medial epicondylitis and he performed medial and lateral epicondylectomies. *Id.*

Dr. Lamberti ordered post-surgery physical therapy to the left arm which Petitioner underwent at Sherman Hospital. PX1 at 15, 20-21. Petitioner also continued to follow up with Dr. Lamberti; on August 28, 2012 he noted that things were going well and she had her splint changed at Sherman Hospital. PX1 at 17. As of

September 4, 2012, Petitioner had mild ulnar-sided numbness, but her radial-sided numbness was much better and almost gone. PX1 at 18. He also noted good range of motion. *Id.*

By October 2, 2012, Petitioner was feeling weak, but doing much better and taking Advil for pain because the Norco was "too much." PX1 at 23. As of November 13, 2012, Dr. Lamberti released Petitioner back to work with a three pound lifting restriction and two daily breaks of 10 minutes each. PX1 at 24. On December 13, 2012, Dr. Lamberti placed Petitioner off work during four weeks of prescribed work conditioning. PX1 at 29-30.

Work Conditioning

Respondent offered several records from Athletico. RX6. In a work conditioning evaluation dated January 7, 2013, Petitioner reported left upper extremity pain, continued soreness in her left elbow, carrying/lifting heavy things causes pain down the inside of her elbow, feeling very weak in her left arm and that she will drop things because she is unable to hold them, pressure near the scar on her elbow where she experiences sharp pain, and pain with movement to bathe, dress or fix her hair. *Id.* Petitioner reported taking Advil for pain. *Id.*

The physical therapist noted Petitioner's active range of motion and the strength of her upper extremities. *Id.* Specifically, he noted loss of range of motion with pain as follows:

- shoulder flexion (158° on the right vs. 145° on the left)
- shoulder abduction (165° on the right vs. 120° on the left)
- shoulder internal rotation (right to T12 vs. left to L2)
- shoulder external rotation 40° on the right vs. 15° on the left)
- wrist flexion (75° on the right vs. 70° on the left)
- wrist extension (85° on the right vs. 80° on the left)
- grip strength (hand dynamometer) on the right at 15 pounds and at 5 pounds on the left

Id. Petitioner reported pain with all range of motion and strength testing and demonstrated weakness bilaterally left greater than right. *Id.*

On January 23, 2013, Petitioner returned to Athletico reporting pain at a level of 5-7/10 in the left elbow, a sharp pain on the inside of her left elbow especially near her scar, soreness at a level of 2/10 and left shoulder, soreness in the right shoulder and elbow at a level of 1/10, and that she does not have a lot of strength in her arms and feels like she cannot do a lot of activities both in work conditioning and at home. *Id.*

The physical therapist noted Petitioner's active range of motion and the strength of her upper extremities. *Id.* Specifically, he noted loss of range of motion with pain as follows:

- shoulder flexion (160° on the right vs. 135° on the left) showing a 2° improvement on the right and 10° loss on the left compared with her initial evaluation
- shoulder abduction (160° on the right vs. 135° on the left) showing a 5° loss on the right and a 15° improvement on the left compared with her initial evaluation
- shoulder internal rotation (right to T12 vs. left to L2) showing the same ability as her initial evaluation
- shoulder external rotation 55° on the right vs. 30° on the left) showing a 15° improvement on the right and 15° improvement on the left compared with her initial evaluation

- elbow flexion (140° on the right vs. 130° on the left) showing a 10° loss on the left compared with her initial evaluation
- wrist flexion (65° on the right vs. 60° on the left) showing a 10° loss on the right and 10° loss on the left compared with her initial evaluation
- wrist extension (85° on the right vs. 70° on the left) showing a 10° loss on the left compared with her initial evaluation
- grip strength (hand dynamometer) on the right at 10 pounds and at 1 pound on the left showing a 5 pound loss on the right and 4 pound loss on the left compared to her initial evaluation

Id. Petitioner also reported pain with all range of motion and strength testing and demonstrated weakness bilaterally left greater than right. *Id.*

Continued Medical Treatment and Functional Capacity Evaluation

When Petitioner returned to see Dr. Lamberti on January 24, 2013, he ordered a functional capacity evaluation. PX1 at 31.

Petitioner underwent the functional capacity evaluation on February 12, 2013. PX2. The evaluating physical therapist, Mr. Toman, determined that "[o]verall test findings, in combination with clinical observations, suggest the presence of low levels of physical effort on [Petitioner's] behalf." PX2 at 1. He also determined that "[o]verall test findings, in combination with clinical observations, suggest inconsistency the reliability and accuracy of [Petitioner's] reports of pain and disability." PX2 at 1-2. Finally, Mr. Toman determined that "[b]ased on [Petitioner's] physical effort and reliability of subjective reports findings, the evaluator cannot validate this examination as being a representation of her maximum function." PX2 at 2.

Of note, during strength grip testing of the right hand using the hand dynamometer Petitioner exhibited low effort and that her left hand grip scores produced "a lack of full effort on the left." PX2 at 12-13. Also, when tested for active right shoulder elevation, Petitioner noted significant apprehension whereas when a heart rate monitor was placed on her right wrist, "she elevated her right arm with ease and held it in sustained flexion for approximately 20 seconds (which was inconsistent with formal assessment). In addition, [Petitioner] could not push/pull with 5 pounds of force bilaterally, though was observed to push our facilities door open when exiting our facility and pull the door open when entering our facility, which required greater than 15 pounds of force." PX2 at 14.

Despite the invalidity of the examination results, Mr. Toman recommended the following as Petitioner's maximum functional capabilities to the extent that the functional capacity evaluation was intended to determine Petitioner's work restrictions: limited standing, walking and sitting on an occasional basis, limited material handling to within the sedentary physical demand level, and to avoid significant reaching, crouching, stooping and handling tasks. *Id.*

On June 25, 2013, Dr. Lamberti reviewed the functional capacity evaluation findings and, "[k]nowing her results, her grip strength and generally what her arm can do…" he recommended that Petitioner could work in an assembly-type position limited to tasks that were up to two pounds on a frequent/repetitive basis, up to five pounds on an occasional basis, and up to 15 pounds on a rare or infrequent basis (2-3 times per day). PX1 at 32.

Final Section 12 Examination – Dr. Belich

Respondent sent Petitioner back to Dr. Belich for an independent medical evaluation on February 14, 2013. RX2. Dr. Belich took additional history from Petitioner, reviewed additional medical records, examined Petitioner, and rendered various opinions. *Id.* He opined that Petitioner had an unsuccessful elbow surgery noting that Petitioner "continues to have the same amount of pain, functional disability, and behavioral-type chronic pain patterns that she had even prior to this surgery." *Id.* Dr. Belich recommended no further treatment and placed Petitioner at maximum medical improvement. *Id.*

Dr. Belich subsequently reviewed the results of Petitioner's functional capacity evaluation, a short letter from Dr. Lamberti, and a job description indicating that Petitioner's job required her to lift one pound rods and stack them in a receptacle that weighed 11 pounds. RX2. In an addendum, he opined that Petitioner "could perform this job with a two handed lift of 10 to 11 pounds[,]" based on Petitioner's sub-maximal functional capacity evaluation test results. *Id.*

In a second addendum dated May 6, 2014, Dr. Belich reiterated that, based on Petitioner's invalid exam and lack of maximum effort, "it certainly appears plausible to me that this patient could lift up to 20 pounds with a two handed lift, particularly at the waist level and table level as she is required to do." *Id.*

Video Surveillance

Respondent offered into evidence video surveillance of Petitioner on four dates: February 14, 2013, October 4, 2013, December 4, 2013 and December 5, 2013. RX5.

On February 14, 2013, the video depicts Petitioner holding keys and papers or a bundle in the flexed left arm, entering her car and guarding her left arm or holding it in a flexed position. *Id.* She then used her right arm to fasten her seatbelt and began driving with both hands. *Id.*

The October 4, 2013 footage at 11:22 a.m. depicts Petitioner walking with no apparent difficulty from her car to the rear of her house with both arms moving in an ordinary fashion at her sides. *Id.* At 11:36 a.m. she is seen walking toward her car with a coffee cup held in the left hand then transferred to the right. *Id.* At 12:33 p.m. Petitioner is seen sitting in a salon without significant observation of any upper body movement. *Id.* At 1:28 p.m. she is seen exiting the salon heading toward her car with unguarded motion of the left hand and arm. *Id.* At 1:37 p.m. Petitioner is seen pushing a grocery cart containing multiple white plastic bags of unknown weight and placed in her car, although the latter motions of placing the bags in her car are obscured. *Id.* She returned the grocery cart by pushing it with both hands and at one point pulling the empty shopping cart with her left hand only. *Id.*

On December 4, 2013, the video footage shows Petitioner at 7:51 a.m. handling garbage, bags of recycling materials, and containers with both hands. *Id.* Petitioner is seen lifting garbage and recycling bin covers well above shoulder level. *Id.* She is also seen lifting a plain wooden chair for disposal with both hands without any apparent restriction and with extension of both arms. *Id.*

Petitioner viewed the video surveillance and acknowledged that it showed her getting into the driver's seat of her car. When she sat in the driver's seat, Petitioner reached to the door with her right arm to close it. She testified that this was because of pain in her left arm. Petitioner also testified that, before her injury, she would use her left arm to close the driver's side door and fasten her seatbelt.

Education and Training

With regard to her education, Petitioner testified that he went to the 12th grade education in Mexico, but she did not obtain her diploma. She also testified that she did not obtain a G.E.D. in the United States, although she tried to do so.

Petitioner testified that she has no other certifications or training. She testified through a translator at trial. She testified that, while she is able to speak some English, it includes basic things such as good morning, how are you, how do you feel and short phrases. Petitioner also testified that she is able to write some English, such as inputting her name and address, height, marital status and number of children; however, she testified that she cannot write full paragraphs in English. Respondent offered its exhibit 7, which is an application for FMLA dated June 13, 2003. RX7. The application contains a paragraph written by Petitioner in English. *Id.* Petitioner testified that the remainder of the application was completed by a staff member of her doctor's office. *Id.* She signed and dated the application. *Id.* Petitioner acknowledged that she wrote these words in English, but explained that she copied the words in English that had been written down by someone for her in the doctor's office so that she could submit the application. *Id.*

Petitioner also testified that she was not employed anywhere at the time of her left elbow surgery and that she last worked on July 30, 2007, the date of her left shoulder and arm accident. She has not worked for anyone since last working for Respondent. Petitioner testified that her employment was terminated when Respondent's plant closed on March 22, 2009.

Job Search

After completing her medical treatment, Petitioner testified that she looked for work by going around in her neighborhood and sometimes she would use a Hispanic newspaper or ask her neighbors or friends if they needed personnel in the factories where they worked. She testified that she had the most experience working in a factory, but it is usually very heavy work required in a factory.

Petitioner offered her job search records into evidence. PX4. She testified that she found these places where she would go buy things and generally in the places known to her. For example, on March 28, 2014, Petitioner applied at a bakery. PX4 at 1. Petitioner testified that she went and spoke with the lady in charge, Yolanda, and she told Petitioner that she did not need anyone. Petitioner also applied at a place called Armando's, a grocery store where they sell food. *Id.* Petitioner testified that she asked a young man if they needed cashiers and the response was that they did not need any.

Petitioner testified that she applied at McDonald's and requested an application, but was told that the applications were done on the internet. PX4 at 2. She testified that she applied with help of her daughter, but they did not respond.

On April 3, 2014, Petitioner testified that she went to Quality Labor, a factory where they make balloons. PX4 at 2. She testified that she knows several ladies there and she was interviewed by Ms. Mercado who told her that she would need to work with boxes that weighed over 15 pounds and would need to use her arms. Petitioner testified that the application asked whether she could carry more than 20 pounds and Petitioner did not answer that question. She testified that Ms. Mercado said that they did need personnel, but that she did not believe that Petitioner was qualified for the job and she was not hired. *Id.* Petitioner also applied at Taco Bell that day. *Id.* Petitioner testified that she knows someone there and the lady told her that they needed workers so

the manager asked her questions and told her that he would call her back for an interview. Petitioner testified that she went to the Taco Bell location herself, but they never contacted her.

On April 23, 2014, Petitioner testified that she went to a Sbarro located in a mall food court and left an application which they told her they would give to the manager; Petitioner testified that she never heard back from them. PX4 at 5. Petitioner also applied at Dunkin' Donuts on Route 72 that day. *Id.* She testified that she called them and they told her to go there, which she did, but the person in charge was not there and they gave her the phone number for a woman named Suzy who did not return Petitioner's call.

Petitioner testified that she made contact with all of the other prospective employers listed in PX4, but no one offered her a job. On cross examination, Petitioner acknowledged that the first time that she looked for work was in February 2014.

Vocational Rehabilitation Opinions

Petitioner was evaluated by Craig Johnston ("Mr. Johnston") of Johnston Vocational Consulting on December 6, 2013 at the request of her attorney. PX3. Mr. Johnston has a Ph.D and is a certified rehabilitation counselor. *Id.*

Mr. Johnson met with Petitioner and reviewed her educational and employment history. *Id.* His report indicates that she attended high school in Mexico, but has no high school diploma. *Id.* Petitioner testified at trial that she attended high school in Mexico, but never passed the final tests in order to obtain a diploma. She also testified that she was later enrolled in the Spanish GED program in the U.S., but was unable to complete the program.

Mr. Johnston noted her prior employment in Mexico as a receptionist as well as her prior employment in the U.S at Walmart as a stock clerk where she reported that a co-worker provided her verbal instructions in Spanish and working temporary jobs cleaning houses and in the production setting. PX3 at 1. He noted that her last job for Respondent required her to stand all day working in the metal preparation department handling seals, and that she had to lift up to 50 pounds. *Id.*

Mr. Johnston based his vocational opinion on the restrictions imposed by Dr. Lamberti through June 25, 2013, Dr. Belich's February 14, 2013 and February 21, 2013 independent medical evaluation reports, and Petitioner's February 12, 2013 invalid functional capacity evaluation report. PX3 at 2. Ultimately, Mr. Johnston opined that, taking all relevant vocational factors into consideration, Petitioner is totally disabled from the workforce. PX3 at 3.

Respondent also offered a report dated May 14, 2014 regarding Petitioner's employability from Edward Minnich ("Mr. Minnich"), a certified rehabilitation counselor, per its request. RX3. Mr. Minnich did not personally interview Petitioner, but he reviewed various documents including an excerpt of Mr. Payton's transcript from the first hearing regarding Petitioner's job requirements, Petitioner's February 12, 2013 invalid functional capacity evaluation report, Dr. Lamberti's reports through June 25, 2013, and all four of Dr. Belich's reports from February 14, 2013 through May 6, 2014. *Id.* He also reviewed Mr. Johnston's report. *Id.*

In reaching his conclusions, Mr. Minnich focuses several issues. *Id.* First, he notes the inconsistencies identified in Petitioner's functional capacity evaluation results by the physical therapist. Next, he notes that the work restrictions imposed by Dr. Lamberti were offered despite Petitioner's invalid functional capacity evaluation results and he cites two publications standing for the proposition that a physician should take into

account the patient's capabilities as determined, in this case, by functional capacity evaluation results in returning a patient to work. *Id.* Mr. Minnich finds Dr. Lamberti's work restrictions to be unsupported by other medical evidence, the functional capacity evaluation results in particular. *Id.*

Finally, Mr. Minnich relies heavily on the opinions of Dr. Belich and reviews the report of Petitioner's vocational rehabilitation expert, Mr. Johnston, and takes issue with several of his conclusions. *Id.* Specifically, he takes issue with the fact that Mr. Johnston makes "[n]o mention of the glaring inconsistency that her surgery was to her left elbow and that this should have nothing to do with standing, sitting, walking, crouching and stooping[,]" and that his limitation of Petitioner's capabilities to sedentary work is based on Mr. Johnston's reliance on the invalid functional capacity evaluation results. *Id.* Mr. Minnich also takes issue with Mr. Johnston's conclusion that Petitioner was totally incapacitated from work based on her limited English language skills (given that she filled out various employment papers in English, lived in the U.S. for decades, and worked in the U.S.) and her limited education and training (given that she was employed as an assembler, sorter, and hand packer as noted in her employment application with Respondent). *Id.*

Mr. Minnich repeatedly notes that Petitioner's case is "wrought with inconsistencies" and reaches his ultimate conclusion that Petitioner would be able to work at some level (most likely light duty given the aforementioned issues with the bases on which Dr. Lamberti imposed work restrictions, relied upon by Mr. Johnston) assuming that she was motivated to do so, which he believed that she was not.

Additional Information

Regarding her current condition, Petitioner testified that when she tries to do her activities for example when she is making something simple to eat she cannot carry anything heavy (e.g., with a gallon of milk, a pan) with her left arm because she feels a pinch as though it was a needle going into her elbow from the inside to the outside and she loses strength. She has to hold it with her other hand or leave the item.

With regard to her shoulder, Petitioner testified that if she does not have a lot of activity she does not experience a lot of pain. Petitioner testified that she has to do very simple things for food, nothing where she has to chop because the next day or in the afternoon she will feel a lot of pain in her shoulder, elbow and her whole arm.

Petitioner testified that she takes Naproxen pain medication for her pain and inflammation. When she has a lot of pain, Petitioner testified that her doctor told her that she could also combine it with Advil.

Petitioner testified that she lives at home with her husband, her two children, and another son comes over the weekends because he is in college now. The two sons that live with her full time are 20 and 17 years old. Petitioner testified that her children do most of the cleaning, but each child washes their own clothes and they alternate cleaning the bathroom. Petitioner tries to help cleaning, but not too much. As an example, Petitioner testified that she tries to make something for her children to eat, very simple things; but when she does not feel well she will call her children and tell them to go to a Subway or tell her husband to go to the Mexican store because that day she did not prepare anything.

With regard to cleaning, Petitioner testified that she cleans the dishes that she uses and her husband will clean the bathroom after Petitioner puts cleaning fluid there. Or, for example, Petitioner will perform light disinfecting-type cleaning of the bathroom sink. If Petitioner tries to do more cleaning than that, for example when her kids have been too busy and the house is really dirty, she notices strong pain afterwards and the

following day she cannot move her arm because it gets very swollen; especially her elbow where she has a lot of pain and she feels tendonitis in both hands.

Petitioner also testified that there are certain activities that she used to do that she can no longer do. For example, she had a pool that she would help her husband clean, but she no longer does. They do not use the pool anymore because it is a lot of work and money. Inside the house, Petitioner used to bring garbage out or clean so that her home would look nice (like the cabinets), which she does not do anymore.

Petitioner further testified that she used to go out more with her husband and go dancing with friends or help at the food pantry at the church, but she no longer engages in these activities because the pain is uncomfortable. She can no longer pull the carts or carry the food that was being donated because it was too heavy.

With regard to the medical bills at issue, Petitioner testified that she is familiar with these charges for the MedSource bill, which is for a device that gives her "shocks" and calms her pain and the rigidity in her arm. Petitioner testified that Dr. Lamberti ordered this machine for her and she obtained it at Sherman where she was having therapy, which she still uses so that she does not have to take more medication. Petitioner testified that she uses this once a day usually in the evening or after she has a lot of activity.

Mark Payton

Respondent called Mr. Payton as a witness. Mr. Payton is the director of buildings and grounds. He was previously employed by Respondent from approximately May 2001 to September or October 2009. During time that Mr. Payton worked at Respondent, he knew Petitioner because she reported to him in the metal preparation department as a metal preparation operator.

Mr. Payton also testified that about Petitioner's duties at work for Respondent. However, the Arbitrator is bound by the findings and conclusions as reflected in the Commission's May 2, 2011 decision. As relevant to Petitioner's duties at work, about which Mr. Payton testified at the first hearing in these cases, the Commission has determined Petitioner's job description as follows:

> Petitioner credibly testified that her job required her to load circular, metal car seals into a machine for processing, unload them from the machine after processing, place seals in boxes, and lift the loaded boxes onto a skid. Before loading the metal seals into the machine, the seals were delivered to Petitioner in a large box. Petitioner removed the seals from the box. The seals contain a hole in the center which allowed her to insert them one by one onto a bar. She would then lift the loaded bar onto an iron rack. Each bar held 20 seals. Each rack held 20 bars. Petitioner testified she utilized "heavy" force to push the loaded rack to an area/machine we are the seals would be coated with chemicals. Petitioner testified that the seals vary in size. Generally, Petitioner loaded twenty 2 lb. seals on each bar and placed twenty bars in each rack. The topmost bar was as high as her head while the lowest bar was knee high. A loaded rack weighed approximately 45 lbs. after completion of the chemical process, Petitioner would pull the loaded rack out of the machine and unload the bars, tilting each parcel the seals could slide off. Petitioner testified that the 2 lb. seals came in boxes of 980 and she handled between three and five boxes of them per day (or approximately 2940 - 4900 seals per day). Once the seals were boxed up, she would lift the loaded boxes (weighing over 50 lbs.) onto a skid for transporting (just as she did on July 30, 2007, the date of accident in 07 WC 37471). Petitioner testified she had a partner and they would alternate the tasks of pushing and pulling the loaded rack to and from the coating machine.
>
> ...
>
> Respondent's supervisor, Mark Payton, acknowledged that Petitioner's job could require her to load up to twenty of the 2 lb. seals per bar and he further acknowledged that while he believed she only had to load 10 of the small seals per bar, there could have been a point in time when she was required to load twenty pieces per bar. He also agreed

that there were 980 of the 2 lb. seals per box and that it took "effort" to push the loaded racks. While Mr. Payton testified Petitioner was required to load/unload a lesser number of seals, the Commission finds that his description also suffices to establish the repetitive nature of Petitioner's job duties for Respondent.

PX6 at 2-3.

Mr. Payton also testified that that during the time that he worked with Petitioner he was in contact with her multiple times per day. Mr. Payton testified that he understood Petitioner when she spoke in English and had no problem speaking with her. He added that he does not speak Spanish. He testified that generally their conversations related to what parts to process and mechanical issues. Mr. Payton also testified that Petitioner would write in productivity logs the work that was accomplished and note any safety issues. RX4. He added that Petitioner would note output, how many parts or skids or pieces completed, safety issues such as a leaking pipe or a trip or slip hazard, etc. On cross examination, Mr. Payton acknowledged that the productivity logs did not require much writing, only numbers really.

After Petitioner stopped working in 2007, Mr. Payton continued as the supervisor of the department. The work continued after Petitioner stopped working through 2009 and it was available until the plant closed.

Petitioner testified that she had never seen this productivity log form and that she did not have to fill out any papers while employed for Respondent. *See* RX4. She testified that she did have to fill out very simple forms however (i.e., a safety checklist and operation log) that were very simple. She testified that these forms required her to input the part number, the time that she had finished it, and who made the part (because the person that picked up the box would scan it and document the number of the part, but that was not her job anymore).

Petitioner testified that she did not every have to write sentences describing problems with the machines. Immediately after the machine would break down, Petitioner testified that she would let the mechanic or Mr. Payton know about it and they would fix it. Petitioner testified that she did not ever have to write anything down describing how the machine had to be fixed. Petitioner testified that Mr. Payton would write the part number in and Petitioner would input that he finished the part and who did it (her and her partner) and other guys would fill in the rest of it. Petitioner testified that she would indicate the number of boxes that they did of certain parts and that the boxes had to be finished otherwise they would not count.

ISSUES AND CONCLUSIONS

After reviewing all of the evidence and due deliberation, the Arbitrator finds on the issues presented as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

First, the Arbitrator addresses Petitioner's claimed low back condition and finds that it is not causally related to her accident at work on April 5, 2007 (Case No. 07 WC 37472). In so concluding, the Arbitrator notes that no medical records were submitted evidencing ongoing treatment to the low back, Petitioner did not testify about any continuing problems or symptomatology in the low back at this hearing, and that the Commission, on May 2, 2011, affirmed and adopted the original Arbitrator's decision that Petitioner sustained an accident to her low back on April 5, 2007, but denied compensation for the injury. *Id.* Thus, the Arbitrator finds that Petitioner's claimed low back condition of ill being is not causally connected to her work accident. By extension, all other issues related to the low back are rendered moot and all requested compensation and benefits are denied.

Next, the Arbitrator finds that Petitioner's claimed current condition of ill being in the left shoulder is causally connected to her accident at work on July 30, 2007 (Case No. 07 WC 37471). In so concluding, the Arbitrator notes that the medical records submitted do not reflect treatment to the left shoulder; rather, Dr. Lamberti's records reflect a focus on Petitioner's left elbow condition. However, the Commission, on May 2, 2011, affirmed and adopted portions of the original Arbitrator's decision including findings that Petitioner had rotator cuff impingement, AC joint arthritis, and biceps tenderness resulting in the need for an arthroscopic surgery, a surgical approach with which Respondent's Section 12 examiner concurred. The Commission also awarded additional temporary total disability benefits to extend through November 18, 2008. At this hearing, Petitioner testified about continuing problems in the left shoulder including pain when she performs too much activity and a negative effect on the type and amount of activities of daily living that she can comfortably perform. Thus, the Arbitrator finds that Petitioner's claimed left shoulder condition of ill being is causally connected to her work accident.

Finally, the Arbitrator finds that Petitioner's claimed current condition of ill being in the left elbow is causally connected to her accident at work on March 12, 2009 (Case No. 09 WC 27931). In so concluding, the Arbitrator relies on the additional evidence submitted at this hearing which reflects that Petitioner continued to undergo medical treatment for her left elbow with Dr. Lamberti after the first hearing in this case and submitted to additional independent medical evaluations at Respondent's request. The Arbitrator also incorporates by reference the Commission's May 2, 2011 decision in which it determined that Petitioner's left elbow condition was causally related to a repetitive trauma injury sustained on March 12, 2009. Thus, the Arbitrator finds that Petitioner's claimed left elbow condition of ill being is causally connected to her work accident.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Petitioner seeks payment for an EMG charge of $840.00 and a Med Source charge of $1,091.00. The record reflects that the EMG ordered by Dr. Lamberti was approved as reflected in letter from Respondent's counsel. The record also reflects a bill and correspondence from Med Source for an "electrodes" or "stim xp" machine from referring physician Dr. Lamberti, which correlates to Petitioner's testimony that she received a device during physical therapy that gives her "shocks" and calms the pain and rigidity in her arm as ordered by Dr.

Lamberti. Thus, the Arbitrator awards payment of these charges to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive any credit for payments already made.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Low Back

As explained in the causal connection analysis above, no evidence was presented at this hearing regarding any ongoing disability to the Petitioner's back and, moreover, Petitioner's claim for compensation and benefits was denied at arbitration and affirmed by the Commission in its May 2, 2011 decision. Thus, no compensation is awarded with regard to Petitioner's back injury (Case No. 07 WC 37472).

Left Shoulder

Also as explained in the causal connection analysis above, the Arbitrator finds that Petitioner's claimed left shoulder condition of ill being is causally connected to her work accident. The Commission's decision affirmed the original Arbitrator's findings that Petitioner had rotator cuff impingement, AC joint arthritis, and biceps tenderness resulting in the need for an arthroscopic surgery. Petitioner also testified at this hearing about ongoing symptomatology that limits her ability to engage in various activities of daily living. Additional records produced at trial, including work conditioning notes, also reflect loss of range of motion and strength in the left shoulder as compared to the right shoulder. Thus, based on the record as a whole, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 10% loss of use of the person as a whole pursuant to Section 8(d)(2) for the injury to the left shoulder (Case No. 07 WC 37471).

Left Arm/Elbow

Finally, the Arbitrator finds that Petitioner has established permanent partial disability to the left arm as a result of her left elbow medial and lateral epicondylitis condition. While Petitioner asserts that she is permanently and totally disabled pursuant to Section 8(f) of the Act, and Respondent asserts that Petitioner has failed to establish any disability in the left arm, the Arbitrator views the evidence differently.

The Commission found that Petitioner sustained a repetitive trauma injury to the left elbow and it made detailed findings regarding Petitioner's job duties while employed by Respondent, which forever resolves those issues. Petitioner later received the requested medical treatment after the Commission's order of May 2, 2011 and continued to see Dr. Lamberti for treatment of her left elbow. She underwent lateral and medial epicondylectomies, post-operative physical therapy, and some work conditioning until Dr. Lamberti recommended a functional capacity evaluation and shortly thereafter imposed permanent work restrictions.

The parties' dispute with regard to the nature and extent of Petitioner's left elbow injury fundamentally centers on her credibility. The additional evidence proffered at this trial included Petitioner's own testimony, records regarding Petitioner's subsequent medical treatment, Respondent's independent medical evaluation opinions rendered by Dr. Belich, and the opinions of Mr. Johnston and Mr. Minnich regarding Petitioner's employability.

Petitioner's testimony at trial about her capabilities is, essentially, that she cannot perform most activities involving her left arm anymore without pain, if she can perform them at all. Respondent offered video surveillance of Petitioner on four dates engaged in general daily activities including grocery shopping, throwing

out garbage and driving generally with little use of her left arm. This footage shows Petitioner having some difficulty with the use of her left arm, primarily using her right arm to perform functions. It also shows Petitioner using her left arm and hand limitedly, such as while holding a coffee cup or on one occasion using both arms to throw away a simple wooden chair. While the footage shows her in a few instances carrying more than what appears to be over five pounds with both hands (i.e., when she is throwing away the chair which appears to be inconsistent with her functional capacity evaluation and work conditioning testing results) or reaching above shoulder level (i.e., while flipping over a garbage can lid), the footage does not show complete, free use of her left arm in the performance of significantly heavy range of motion and strength activities that would suggest she has no ongoing disability whatsoever in the left arm. In the Arbitrator's view, these activities are generally consistent with Petitioner's claim of ongoing disability, but not to the extent she claims.

Petitioner testified about a much more severe lack of ability in the left arm. However, objective evidence in the record reveals troubling variability in Petitioner's physical abilities that do not correlate to the extent of permanent and total disability due to the left arm injury as claimed. Indeed, Petitioner's shows inconsistencies in the use of her uninjured right arm and while using her lower extremities during testing.

An initial work conditioning evaluation performed on January 7, 2013 approximately five months after her surgery reveals loss of range of motion in the left upper extremity as compared to the right upper extremity that was specifically documented with regard to various activities (i.e., shoulder rotation, elbow, flexion, grip strength, etc.). Inexplicably, however, Petitioner's abilities in the left and right arms approximately two weeks later on January 23, 2013 changed somewhat dramatically.

She exhibited 2° improvement in shoulder flexion on the right and a 10° loss on the left, a 5° loss of shoulder abduction on the right and a 15° improvement on the left, a 15° improvement in shoulder external rotation on the right and 15° improvement on the left, a 10° loss of elbow flexion on the left, a 10° loss of wrist flexion on the right and 10° loss on the left, a 10° loss of wrist extension on the left, and a 4 pound loss of grip strength in the left hand as well as a 5 pound loss on the right. Certainly an individual's physical capabilities in an affected body part can vary from day to day resulting from a variety of factors, but these findings also reflect a decrease in ability in the uninjured right upper extremity. Taken in conjunction with Petitioner's functional capacity evaluation results, which Dr. Lamberti and Mr. Johnston sidestep in rendering their opinions, the record contains objective information that raises serious doubt about Petitioner's actual physical capabilities.

The results of Petitioner's February 12, 2013 functional capacity evaluation, which are extensively addressed by both parties, are undisputedly invalid. The report contains several caveats from the evaluating physical therapist, Mr. Toman, who highlighted "low levels of physical effort on [Petitioner's] behalf[,]" "inconsistency the reliability and accuracy of [Petitioner's] reports of pain and disability[,]" and he was ultimately unable to "validate this examination as being a representation of her maximum function." PX2 at 1-2.

Indeed, during strength grip testing of the right hand using the hand dynamometer Mr. Toman noted that Petitioner showed low effort and her left hand grip scores produced a lack of full effort. These findings further highlight the inconsistent grip strength test scores of Petitioner in the affected left arm and unaffected right arm during work conditioning testing just weeks earlier. Also, when formally tested for active right shoulder elevation Mr. Toman noted that Petitioner had significant apprehension whereas she was able to elevate her unaffected right arm with ease and hold it in sustained flexed position for approximately 20 seconds when he placed a heart rate monitor on her wrist. Mr. Toman specifically noted that this ability in the unaffected right arm was inconsistent with Petitioner's reported apprehension of moving her right arm during the formal assessment. Finally, Mr. Toman noted that Petitioner could not push/pull with 5 pounds of force bilaterally,

although she was observed pushing and pulling the facility entrance and exit doors which required greater than 15 pounds of force. This notation highlights the inconsistencies of Petitioner's reports with objective testing and highlights the inconsistencies viewed in the video surveillance including Petitioner pushing a grocery cart containing bags of unknown weight and later pulling the empty shopping cart with her left hand only; activities that Petitioner could not perform if Dr. Lamberti's limiting work restrictions are to be accepted at face value.

Thus, the Arbitrator finds that objective testing of Petitioner's physical abilities during the functional capacity evaluation and work conditioning as ordered by Dr. Lamberti render her testimony about the almost complete loss of range of motion and strength suspect and place the extent of Dr. Lamberti's work restrictions based on "[k]nowing her [functional capacity evaluation] results, her grip strength and generally what her arm can do…" in doubt. In so concluding, the Arbitrator acknowledges that the Commission found Dr. Lamberti's prior opinions to be more persuasive than those of Respondent's Section 12 examiners after the first hearing. However, the evidence adduced at this trial indicates that he assigned permanent restrictions in spite of objective evidence of Petitioner's capabilities as reflected in her functional capacity evaluation and work conditioning progress notes.

It is also noteworthy that Dr. Lamberti does not specifically note objective test findings of his own about Petitioner's capabilities throughout his treatment and simply opines that Petitioner could work in an assembly-type position limited to tasks that were up to two pounds on a frequent/repetitive basis, up to five pounds on an occasional basis, and up to 15 pounds on a rare or infrequent basis (2-3 times per day). On the other hand, Respondent's examiner, Dr. Belich, does not release Petitioner back to full duty work either. He estimates her capabilities to include lifting up to 20 pounds with a two-handed lift particularly below shoulder level. He recommended that she undergo a functional capacity evaluation to determine her capabilities and, presumably, he expected that Petitioner's physical capabilities could be based on valid test results. Given the inconsistencies noted above between objective evidence of Petitioner's capabilities and her subjective reports, the Arbitrator does not place more weight on the opinions of Petitioner's long-time treating physician, Dr. Lamberti, over those of Dr. Belich, but also finds that these physicians seem to agree—whether they realize it or not—that Petitioner cannot return to work for Respondent in the job definitively delineated by the Commission in its May 2, 2011 decision.

Finally, the parties provide the opinions of Mr. Johnston and Mr. Minnich regarding Petitioner's employability or lack thereof. Given the totality of this record, the Arbitrator is not persuaded by the opinion of Petitioner's vocational rehabilitation expert, Mr. Johnston, regarding Petitioner's lack of employability.

Mr. Johnston relies heavily on the permanent restrictions imposed by Dr. Lamberti despite the invalid functional capacity evaluation results that he reviewed and the lack of Dr. Lamberti's own objective findings to substantiate his permanent work restrictions. It also does not appear that Mr. Johnston had the benefit of Petitioner's work conditioning evaluations when rendering his opinions. On the other hand, Mr. Minnich relies heavily on the opinions of Respondent's Section 12 examiner, Dr. Belich, including Dr. Belich's findings during some evaluations that were addressed previously by the Commission in Petitioner's favor.

Both Mr. Johnston and Mr. Minnich agree that Petitioner did not complete high school in Mexico, that she did not attain her G.E.D. in the U.S. despite attempts in a Spanish language G.E.D. program, and that she has worked in the U.S. for decades. They diverge in terms of the extent of Petitioner's English language abilities. Given Mr. Payton's testimony regarding the requirements of Petitioner's job to write limited things in English while employed by Respondent, the record evidence reflecting Petitioner's English language writings, Petitioner's testimony at this hearing through an interpreter, and after careful observation of Petitioner at trial,

the Arbitrator finds that Petitioner is, as she contends, primarily a Spanish language speaker with limited English proficiency.

Mr. Johnston and Mr. Minnich also diverge with regard to Petitioner's work history and training, and whether Petitioner could perform duties beyond the sedentary level. As explained above, the inconsistencies in Petitioner's objective test results, particularly related to body parts that were unaffected by her injuries at work, raise serious doubt about the true extent of her abilities. Moreover, after reviewing the record the Arbitrator finds that Petitioner had a slightly more diverse work background as indicated by Mr. Minnich than that reflected in Mr. Johnston's report even if she was able to perform those duties as an assembler, sorter, and hand packer without much English language proficiency. In addition, it is notable that Petitioner did not search for work on her own after being released by Dr. Lamberti until over nine months later on March 28, 2014 and only then for two months through May 23, 2014. This supports Mr. Minnich's opinion that Petitioner is unmotivated to find work and further highlights the lack of effort noted by Petitioner's own work conditioning physical therapist and Mr. Toman, the functional capacity evaluator. In light of the foregoing, the Arbitrator finds that Mr. Johnston's assessment that Petitioner is totally disabled and unable to work to be unpersuasive.

In sum, based on the record as a whole—which reflects that Petitioner sustained a severe repetitive trauma injury to her left arm resulting in the need for medial and lateral epicondylectomy surgery resulting in disputed permanent restrictions that establish, nonetheless, that she cannot return to her job for Respondent with continued symptomatology, daily use of an assistive stimulator device, difficulty performing activities of daily living and lifestyle changes to accommodate those difficulties—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 30% loss of use of the left arm/elbow pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juel Harris,
Petitioner,

vs.

NO: 08 WC 45847

15IWCC0426

Aramark Management Services, LP,
Respondent.

DECISION AND OPINION ON REVIEW

Petitioner and Respondent appeal the decision of Arbitrator Simpson, finding pursuant to Section 6(c) of the Illinois Workers' Compensation Act, Petitioner failed to provide notice to Respondent regarding the alleged March 29, 2008 work accident. The issues on Review are whether Petitioner sustained an accidental injury arising out of an in the course of her employment on March 29, 2008, whether timely notice of the alleged March 29, 2008 work accident was given to Respondent, whether a causal relationship exists between the alleged March 29, 2008 work accident and Petitioner's present condition of ill-being, and if so, the extent of Petitioner's temporary total disability, the nature and extent of Petitioner permanent disability, the amount of reasonable and necessary medical expenses. The Commission, after reviewing the entire record, modifies the Arbitrator's decision and finds notice of the alleged March 29, 2008 accident was given under Section 8(j) of the Illinois Workers' Compensation Act. However, Petitioner failed to prove she sustained an accidental injury arising out of an in the course of her employment on March 29, 2008 and failed to prove a causal relationship exists between the alleged March 29, 2008 work accident and Petitioner's present condition of ill-being, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Commission adopts the statement of facts contained within the Arbitrator's September 17, 2004 decision and in addition includes the follow facts:

While Petitioner testified that she initially saw Dr. Stein, her primary care physician, and that he examined her and ordered an EMG, there were no medical records from Dr. Stein's March 14, 2008 office visit and no EMG submitted into the record. Dr. Treister notes in his February 14, 2009 independent medical report that this visit with Dr. Stein is missing from the subpoenaed records.

2. Petitioner is claiming her carpal tunnel condition manifested itself on March 29, 2008.

3. On March 29, 2008, Petitioner was seen at Evanston Northwestern HealthCare by Dr. Skidmore. He noted that Petitioner presents with numbness, tingling, burning and weakness in her right hand. She reports that she has had intermittent tingling and burning in the tips of her fingers for months. She also reported that on March 14, 2008 her primary care physician ordered an EMG and according to the Petitioner he ruled out neuropathy and carpal tunnel syndrome. She reports she came in today because she also feels pain in her right forearm and she had weakness in her grasp while working and moving lunch trays this morning. She denies shooting pain or similar issues in her feet. She states the tingling comes on at night, but with Advil she is able to sleep. Dr. Skidmore advised her to follow up with her primary care physician.

4. On April 3, 2008, Petitioner saw Dr. Stein who noted that the findings in the upper extremity are consistent with severe bilateral carpal tunnel syndrome. In addition, there are abnormalities seen in the ulnar and radial nerves, which he noted suggest a more widespread process of neuropathy and are likely related to diabetes. He further indicated that an examination of the lower extremity would be necessary to confirm this. He referred Petitioner to an orthopedic surgeon for a surgical consultation. He instructed Petitioner to wear carpal tunnel splints and he took her off of work until she was evaluated by a surgeon.

5. On April 14, 2008, Petitioner completed paperwork requesting a leave under the Family Medical Leave Act (FMLA). The FMLA paperwork is void of any indication her condition and/or leave is due to work.

6. On April 15, 2008, Petitioner completed a new patient questionnaire for Dr. Nasser in which she answered that her symptoms began on March 1, 2008, her condition was not work related and she consulted a physician on April 3, 2008.

7. Dr. Nasser noted that he first saw Petitioner on April 15, 2008 when Petitioner presented with pain and numbness in both wrists, which was much worse on the right. She had an EMG that showed severe bilateral carpal tunnel syndrome and possible multiple neuropathy. She is left handed but the right side is worse. She had pain in the wrist and palm. She has numbness and tingling in all five digits along with stinging pain. She also complains of right handed weakness and she cannot grip or grasp. Her clinical evaluation along with x-rays indicate carpal tunnel syndrome. However, this condition may be

complicated by a peripheral neuropathy related to her diabetes. He told her that the neuropathy could potentially affect the surgical outcome which is why he did not recommend surgery. However, they may have to resort to surgery if her occupational therapy fails.

8. On May 7, 2008 Petitioner underwent right carpal tunnel release surgery. There was no surgical report contained in the record. On June 18, 2008 Petitioner underwent left carpal tunnel release surgery.

9. At the July 14, 2008 post-surgical occupational therapy at Evanston Hospital, Petitioner reported having bilateral carpal tunnel syndrome over nine months ago. Currently, Petitioner is complaining of right ulnar nerve symptoms and right ring and small finger tingling secondary to the placement of her elbow while sleeping and resting. Petitioner is also complaining of numbness localized in the left scar. On August 6, 2008, Petitioner was found to have reached maximum benefit from therapy and she was discharged from the program.

10. On July 15, 2008 Dr. Nasser authors a To Whom It May Concern letter which stated that Petitioner may not do repetitive work as it may be the cause of her carpal tunnel syndrome.

11. On September 23, 2009 Dr. Nasser noted that Petitioner is still having pain and swelling in her left hand/wrist and is worried that she cannot really lift anything because she has been dropping objects without knowing it. Her physical examination is unchanged. She seems to have some ulnar nerve symptoms on the left side with a positive elbow flexion test. He recommended obtaining an EMG.

12. On October 30, 2008, Dr. Nasser noted Petitioner reports her hands feel better but she cannot do her work as she has pain with lifting and with repetitive motion. On examination, there are well healed incisions from the wrists and fingers and she is distally NVI. We gave her a note saying that since her restrictions cannot be modified and her job cannot accommodate her, she should stay off work. It also said Petitioner is limited to lifting no more than 5 pounds and is to perform no repetitive motion.

13. On October 17, 2008, Petitioner filed an Application for Adjustment of Claim. On November 5, 2008, Mike Hoing, the general manager for Respondent, completed a Form 45 report of accident. Petitioner introduced PX1, medical bills from North Shore University Health System, which showed Respondent paid these medical bills through October 21, 2009.

14. On June 11, 2012, Dr. Treister, a board certified orthopedic surgeon, was deposed. He would estimate that a quarter to a third of his practice is devoted to hand surgery and the

remainder of his practice is devoted to general orthopedics. He performs carpal tunnel surgery at least once every two weeks and often once a week. He only saw Petitioner once. He evaluated Petitioner on February 5, 2009. He reviewed Drs. Stein's and Nasser's records along with the records from Evanston Northwestern Healthcare Corporation and the evaluation by Dr. Vender. Petitioner reported she is a 60 year old insulin dependent diabetic with a history of peripheral vascular disease, retinopathy, coronary artery disease and hypertension. She had a MI, some transient ischemia and a previous cerebrovascular accident in 1989.

She said she was working in the kitchen at Evanston hospital starting in 1966 and by 1972 she had become a supervisor. In 2004 when Aramark took over, she switched her employment from Evanston Hospital to Aramark. On March 29, 2008, she began experiencing severe pain and numbness in both of her hands. She said her symptoms had been gradually progressing over the prior 10 month and they became severe and disabling around March 29, 2008. Between 1972 and September of 2007 she worked as a supervisor where she visually inspected the breakfast and lunch trays of patients. She had to lift the trays from a conveyor belt, transfer them to a slide and push them off to the next worker on the line who would then cover them and put them onto the carts for delivery to the patients' rooms. She would have to lift and inspect about 350 trays each for breakfast and then for lunch. The work involved a great deal of repetitive use of both wrists and hands. She told Dr. Treister her normal workday included also doing 2-3 hours of computer work where she handled schedules, made reports, answered e-mails, etc. Those activities all required repetitive use of both hands/wrists as well. Petitioner reported that even though she was performing repetitive activities between 1972 through September of 2007, she had little pain or numbness in her hands.

In September of 2007, her work activities were markedly altered. Her work was made heavier and it was more prolonged while the number of workers in the kitchen was decreased and she had to perform much more of the hands-on work herself. The company transferred to a room service line where the trays she had to inspect were heavier because they had built-in heat retention holders. She said she had to lift each tray, visually inspect it, cover it with a thick metal lid which weighed about 8 ounces. She estimated that each fully loaded tray weighed about 12 pounds. After preparing the trays, she would have to fill a cart with them. The cart held 18 trays at a time. She would push the full cart and bring in another cart to fill up. She said she was required to load 700-800 food trays a day. She was additionally still spending time on the computer checking employees' time records and responding to e-mails. In the last 2007 and early 2008, she noted more difficult using her hands and holding onto things. She dropped things out of her hands such as the food trays. She also began noticing pain, numbness and tingling in all of her fingers in both hands. Dr. Treister noted that on careful questioning, she stated she had experienced some numbness beginning about three years before his exam.

Petitioner said she had been diabetic since the age of 18. She had been on oral medication for a long time and she had been on insulin for about 15 years. She stated she had never had pain or numbness in her feet. She began to drop things, had trouble lifting things and had discomfort at night. On March 29, 2008, she became suddenly much worse. She claims that the several of her conditions changed when her job functions changed. Dr. Trester noted that despite the fact that the doctor's notes only made reference to symptoms in her fingers, he found Petitioner has symptoms of an ulnar nerve distribution of pain. Additionally, there was no reference in the doctor's progress note to Guyon's canal syndrome. Instead, it was noted that the carpal tunnel syndrome was complicated by peripheral neuropathy secondary to her diabetes mellitus. The patient told him that initially a Worker's Compensation claim was not made and the surgeries were performed under her private insurance. On September 23, 2008, Dr. Nasser documented persistent left-sided ulnar nerve symptoms and a positive left elbow flexion test, which suggests a possible cubital tunnel problem. Additionally, the patient complained that things are still falling out of her left hand without warning. Her work restrictions per Dr. Nasser were no lifting over five pounds with the left hand and no lifting over two pounds with the right hand (Dr. Nasser's note actually says no lifting more than 5 pounds), no repetitive movements and limited pushing, pulling and reaching. The patient was not accepted back to work with those restrictions. At the patient's last visit with Dr. Nasser, she complained of pain with any attempt at lifting and with any repetitive movements. Dr. Nasser indicated that her work restrictions could not be further modified and that if her job would not accommodate her, she should remain off work. Petitioner says she has not been able to return to any type of work since her injuries.

On examination, Petitioner told Dr. Treister her left hand/wrist was actually much improved but her non-dominant right hand remained weak and tender and it swells off and on. She also reported considerable numbness in the right ring and little finger. She often wakes up at night with numbness and tingling in her hands and wrists, which is greater on the right side. She claimed she could not do much housework because of her hands; she cannot drive for long periods of time (Petitioner testified at the arbitration hearing that she does not drive at all.) and she cannot lift more than a couple of pounds without having aching, pulling and painful sensations in her hands and wrists. She also complained of fine motor skill problems such as picking up coins or a credit card. She uses Advil at night to reduce her symptoms and to help her sleep. Dr. Treister opined that Petitioner probably had diabetic neuropathy but it is not clinically significant.

Dr. Triester opined that Petitioner developed bilateral carpal tunnel syndrome and very likely bilateral Guyon's canal syndrome. He opined that as a result of the highly repetitive job activities and to some degree her diabetic neuropathy, it made the condition occur and it left her with significant residual discomfort in her non-dominant right hand, which he diagnosed as Guyon's canal syndrome. Dr. Treister stated that he felt that the restrictions that were originally imposed upon the Petitioner by Dr. Nasser were unreasonable. He noted that Petitioner has not had any kind of testing done and while he

is not a great fan of FCEs this is the type of case which warrants the test. He recommended that Petitioner undergo surgery consisting of a release of the Guyon's canal and because they will already be in there they might as well expose and explore the median nerve. If they find that a more extensive release of the median nerve is needed to loosen up all of the tissue and they have a good result, then they should also perform a repeat decompression of the median nerve on the left side. If she underwent these additional surgeries, Dr. Treister opined that her prognosis would be to some degree improved, but she would not be normal. If she does not undergo further surgery, her prognosis would be poor. He opined that after this long a period of nerve irritation and aggravation he would probably not allow her to perform any highly repetitive work. She might eventually get to the point where she could do some lifting with her hands.

Dr. Treister opined that based on the history Petitioner gave to him, his experience taking care of patients with both carpal tunnel syndrome, Guyon's canal syndrome and peripheral neuropathy, knowing that patients with diabetes are more prone to developing these conditions, and knowing the condition develops with highly repetitive activities such as typing on a computer, assembling on an assembly line or capping plates all day long and moving trays, that Petitioner's bilateral carpal tunnel syndrome, which manifested itself on March 29, 2008, is causally related to her work.

On cross-examination, Dr. Treister agreed that one can develop carpal tunnel syndrome outside of work, that it is slightly more common for females to get carpal tunnel syndrome than males, that diabetes is a risk factor in developing carpal tunnel syndrome, and he is not aware of obesity being a risk factor in developing carpal tunnel syndrome. He found that at this time Petitioner does not have objective physical findings of diabetic neuropathy. He conceded that diabetic neuropathy played a part in her manifestations of carpal tunnel syndrome and Guyon's canal syndrome. He did not agreed that it requires a particular motion or posture of the hands to cause carpal tunnel syndrome and that one has to have both high force and high repetition to develop carpal tunnel syndrome.

15. Dr. Vender, a board certified orthopedic surgeon with a subspecialty in hand and upper extremity surgery, was deposed on September 21, 2012. In a typical week he sees an estimated 100 patients and performs 10 hand and/or arm surgeries a week. He evaluated Petitioner on December 18, 2008.

Petitioner reported she was 60 years old. She started developing symptoms in both upper extremities approximately a year prior, which included pain in the wrist, swelling, diffuse numbness and tingling. She had been diagnosed as having bilateral carpal tunnel syndrome. She had already undergone surgery on both sides. She had a satisfactory resolution of her pre-operative symptoms. Some symptoms persisted on the right side that are greater than the left side. On the right side, she noted some local wrist discomfort along with numbness and tingling in her ring and small finger. He examined Petitioner

and found her to be status post bilateral carpal tunnel release. He did not think there was any significant ulnar neuropathy at that time that would need to be addressed. He noted that her symptoms were more in the wrist and so he did not think her diffused wrist pain had anything to do with the carpal tunnel itself. He did not recommend any treatment at that time.

Dr. Vendor stated that Petitioner had risk factors in developing carpal tunnel syndrome, which are her age, gender and the fact that she is an insulin-dependent diabetic. He opined that diabetes is probably one of the few most important potential risk factors for the development of carpal tunnel syndrome. Another risk factor is increased body mass. He agreed that the presence of these factors in Petitioner increased the likelihood of her experiencing carpal tunnel syndrome. He opined that Petitioner has reached maximum medical improvement and she is capable of returning to her normal work and leisure activities.

When he was asked about whether there was a casually connection between her job and her carpal tunnel syndrome, Dr. Vender answered he was not given a detailed job description at the time of his evaluation. However, it was his impression at that time that she was more of a supervisor in a managerial position. Dr. Vender testified that he was subsequently given RX4, a written job description along with RX5, a CD demonstrating various activities. He reviewed both and found they were consistent with his prior conclusions and some of his prior assumptions. Specifically, it did not appear that this was a repetitive job. He testified that even if the activities demonstrated on the CD were to be increased by 25% this would not change his opinion, because the activities were routine, safe types of activities that were performed.

On cross-examination, he agreed that it was fair to say that he did not spend a considerable amount of time with Petitioner and he did not visit her work site. Instead, he relied on the accuracy of the written job analysis and the video.

Based on the above evidence in the record, the Commission finds that Petitioner provided defective notice to Respondent of the alleged repetitive trauma. However, by virtue having placed her claims under her group insurance and having the payment made through October 21, 2009, the Commission finds that Petitioner met the notice requirement under Section 8(j) of the Illinois Workers' Compensation Act.

The Commission notes that the Arbitrator, having found on the threshold issue notice that Petitioner did not adhere to the Act, did not address any of the remaining issues.

The Commission notes it is well recognized that the manifestation date can easily be attached to one of numerous events ie. the first date of treatment, the last date one is able to work, etc. The key is when Petitioner first understood she had a condition and that the

same was related to her work. Additionally, regardless of this fact that there can be numerous potential manifestation dates, the Act still holds Petitioner possesses the burden of properly attaching the manifestation date to her realization that her condition is related to work.

In this instances the evidence set forth several potential manifestation dates. Some of the dates are prior to the September 2007 change over to a room service style while other dates post-date the changeover. Petitioner testified at the arbitration hearing that the onset of pain/numbness/tingling occurred during the fall of 2007 and the breakdown that caused her not be able to work occurred on March 29, 2008, which is her proposed manifestation date. The evidence demonstrates that Petitioner was aware of and sought treatment for her condition on March 14, 2008, the week before the manifestation date. However, there was only a reference to this date contained in the record and the actual medical records from that date were not produced and made part of the record. The first history that is given is at the Evanston Emergency Room on March 29, 2008 when Petitioner complained of tingling/burning in the tips of her fingers for months. She next indicates on the FMLA form that her manifestation date is March 30, 2008. She reports to Dr. Treister on February 5, 2009 that her symptoms gradually progressed over the preceding ten months, which would result in a manifestation date of April of 2007 some five months prior to the changeover to a room service process. The Commission further notes that in Dr. Treister's deposition, he states that upon carefully questioning Petitioner she stated she experienced some numbness about three years before his exam, which would place it on/about February of 2006 and which is 1-1/2 years prior to the changeover and 2 years prior to the proposed manifestation date. Conversely, she told Dr. Vender on December 18, 2008 that the onset date was about one year ago, which would place the onset date in December 2007 and which would be approximately three months after the changeover in processing orders. Given the Appellate Court's holding in Oscar Mayer v Industrial Commission, 176 Ill. App. 3d 607 (1988) and the evidence contained in the record, it appears that Petitioner picked the date in which her condition broke down to a point where she could no longer work.

The Commission next turns to the issue of the basis for which Petitioner attributed her condition to work. Petitioner claims that the onset of her carpal tunnel syndrome occurred at the time of the changeover to a room service system. Given that premises, some of the dates noted above do not correspond to Petitioner's proposed onset date. The most troublesome are the two distinct histories Petitioner gives to Dr. Treister that pre-date Petitioner's alleged onset date anywhere from 5 to 24 months prior to the changeover in processing orders.

In terms of the changeover itself and the doctors' understanding of Petitioner's job duties, there are inconsistencies as well. Petitioner testifies that prior to the changeover she was the third person on the line checking the trays and pushing the trays to a loader. During this time, Petitioner also told Dr. Treister that she also worked on a computer

inputting information for 2-3 hours a day. After the changeover, Petitioner was the fourth person on the line where she allegedly picked up the trays while inspecting them, covered the trays with a lid and moved the trays to the rack. She also performed computer input one half an hour a day, which is something she did not tell Dr. Treister. Given her description, the physical handling of the trays rose while her typing decreased exponentially before and after the changeover. The accuracy of this is important both in terms of the fact that it is contradicted by Will Holgate's testimony and the job description/video as well as the foundational basis for the independent medical examiners' causation opinions. More specifically, Will Holgate testified and the job analysis supports the fact that a supervisor does not work on the tray line but only oversees the tray line or at most assist in the tray line for 20-30 minutes per meal for a total of two meals. While Petitioner claims that the trays weigh up to 12 to 15 pounds, she personally handles 600-800 trays a day and she performs this activity continuously from 5:00 a.m. to 1:00 p.m., when she breaks for lunch, the job description indicates that the trays are 8-1/2 to 9 pounds when full and 1/2 pound when empty, she had two 30 minute breaks and 180-220 meals are plated up during the breakfast/lunch period. A video was introduced into the record. Petitioner claims the video is not an accurate description since there are two crunch periods when the trays are bumper-to-bumper while the person in the video appears to be working at a leisurely pace. Given the fact that neither Drs. Treister nor Vender did an on-site review of the facilities and they only saw Petitioner on one occasion, it is important that the doctors have a correct understanding of Petitioner's job duties.

Taking each doctor in turn, it appears that both evaluating doctors' understanding of Petitioner's job duties is suspect. In terms of Dr. Treister, the Commission finds that Petitioner led him to believe that she is far more physically active that what the evidence bears out. Namely, she provides him with a complete history of her job duties both before and after the changeover. In doing so, she left him with the impression that she was typing far more than she is actually doing at the time of the onset of her symptoms. While she once spent 2-3 hours typing at the computer, she now only spends 1/2 of an hour performing this task. The Commission notes that this distinction is important because when Dr. Treister addresses the impact of Petitioner's job duties on her physically being he emphasizes how typing takes a toll on an individual's physical make-up.

In terms of physical handling of the tray, the volume of work that is performed, the weight Petitioner was subjected to and the amount of repetitive/forcefully movement Petitioner had to perform, Petitioner's presentation of her job duties to Dr. Treister is miles apart from Dr. Vender's understanding of her job duties. According to Dr. Treister, Petitioner is in the trenches operating as an equal partner to those on the food service line while Dr. Vender was told Petitioner was in a supervisory/managerial hand-off position. As such the Commission notes that there is a foundational weakness for both evaluators' causation opinions and weighs the same accordingly. The Commission further notes that with one possible exception, none of Petitioner's treating physicians express a causation opinion. At most, Dr. Nasser makes a late off-handed comment in July 15, 2008 To Whom

It May Concern letter that he is releasing Petitioner to light duty and that Petitioner's carpal tunnel condition "may" be related to work. Otherwise, Petitioner's treating doctors do not weigh in on the causation issue and the Commission is left, at best, with evaluator's causation opinions that are based on flawed understandings as to what Petitioner's job duties are, what Petitioner's pre-existing medical conditions consist of and how they affect her physical well-being.

The Commission notes that even though Petitioner is claiming her Worker's Compensation claim is due to repetitive trauma, she did not make this claim until several months into her treatment and after her surgeries had taken place. As previously indicated, the Commission is missing the initial treatment record from Dr. Stein. While Petitioner sought treatment from the Evanston's Emergency Room, Petitioner does not indicate that her condition is related to work. When Petitioner returns back to Dr. Stein, again there is no nexus made to work. Rather, Dr. Stein addresses the findings in the EMG scan as possibly being attributable to a widespread neuropathic condition likely related to Petitioner's diabetic condition. Petitioner subsequently seeks a leave of absence under FMLA and once again she does not attribute her medical leave to work. When Petitioner is asked by Dr. Nasser to complete a new patient questionnaire, Petitioner denies that she has a Worker's Compensation claim and further denies that her injury is work-related. Next, when she sees Dr. Nasser in person, she does not attribute her problem to work. Dr. Nasser's surgery, the assignment of liability to Petitioner's group insurance carrier and post-surgery occupational therapy are all performed before Petitioner files her Application for Adjustment of Claim on October 17, 2008 and claims a work related accident. Given the fact that a manifestation date is the date in which Petitioner and/or a reasonable person attributes their condition to work and Petitioner did not do so for some seven months and only did so after her treatment is completed, the Commission questions whether Petitioner properly proved up a manifestation date on March 29, 2008.

Moreover, while the Commission takes the Petitioner as it finds them, the Commission questions what the impact of Petitioner's long pre-existing diabetic condition, that has resulted in a loss of a toe, eye problems, neuropathy, had on the fact that she developed carpal tunnel syndrome. This increased risk due to her long standing diabetic condition, also has to be factored in with Petitioner's sex, age and weight, which all are non-occupational predisposing factors of a carpal tunnel condition. While early on Dr. Stein suggested an examination of Petitioner's lower extremity and while later on Dr. Treister recommended an EMG of Petitioner's upper extremity, neither of these proposed tests take place. As such the record in somewhat incomplete as to what, if any affect, the non-occupational diabetic/neuropathy conditions had on Petitioner's current condition of ill-being.

Given all of the above and with the understanding that Petitioner needs to prove all of elements of a repetitive trauma case just as she would have to in a specific trauma case, the Commission finds that Petitioner failed to prove her condition manifested itself

15IWCC0426

on March 29, 2008 and that the same is causally related to her to her alleged date of accident. The Commission finds that Petitioner's manifestation dates are all over the place, They both pre and post-date the changeover in her duties. The evidence indicates that Petitioner did not view her condition as being related to work until some seven months removed from her last day of work and only after her treatment had taken place. With the exception of a passing comment from one of her treating doctors, Petitioner's treating doctors did not opine that her condition was related to work. As such, Petitioner has to rely on an evaluator to support the causation element of the claim. The Commission finds that Dr. Treister's causation opinion, is only as good as the foundation upon which it is built upon. Given the flawed histories of her job duties, the duration in which she performed the same and the evidence that contradicts her histories, the Commission finds that Dr. Treister's causation opinion is lacking a proper foundational understanding and should not be sufficient to support the causation element of this claim. As such, the Commission finds Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment on March 29, 2008 and Petitioner also failed to prove a causal connection exists between her carpal tunnel condition and her work as of March 29, 2008.

IT IS THEREFORE ORDERED BY THE COMMISSION that pursuant to Section 8(j) of the Illinois Workers' Compensation Act, Petitioner provided notice to Respondent of the alleged March 29, 2008 work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on March 29, 2008 and since Petitioner failed to prove a causal relationship exists between the alleged March 29, 2008 accident and Petitioner's condition of ill-being, her claim for compensation is hereby denied.

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

DATED: JUN 8 - 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

O: 5/7/15

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STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DeAngelo Franklin,

Petitioner,

vs.

Nos. 13 WC 17504
14 WC 15629

East St. Louis Police Department,

15IWCC0427

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a police officer, described the accident on March 23, 2013, as follows: "I stopped a subject, detained him. I told him that he was under arrest. ¶ I asked a female officer for a set of handcuffs. *** The subject began to try to break free by pulling, jerking, and I began to try to pull him back. ¶ I was holding his belt *** and as he began to try to pull, I was trying to pull him back. He went down in a front leaning rest position, so did I while I was trying to pull him back. My [left] knee went straight down too and struck my knee." Three or four police officers then ran over and subdued the suspect.

The parties introduced into evidence an undated report Petitioner completed in connection with the accident, stating that he injured his low back, neck, arm, left shoulder and knee while arresting a combative suspect. Respondent introduced into evidence a number of police reports made in connection with the incident. A report from Petitioner states that he was a watch commander. His unit responded to a well known location for illegal drug sales. Petitioner exited his patrol car, stopped a suspect, and placed him under arrest. Petitioner put one hand on the suspect's wrist and held it because he did not have handcuffs. Officer Brooks came over to assist Petitioner and handed him handcuffs. The suspect "then attempted to break free and flee from [Petitioner;] he pushed and continued pulling and jerking away from [Petitioner] attempting [to] get free." Officer Perry and Sergeant Hubbard ran over and subdued the suspect. Another report from Petitioner describes the struggle between him and the suspect as follows: "I *** advised [the suspect] he was being placed under arrest ***. I placed one hand on his wrist and held it because I did not have any hand cuffs. ¶ The *** subject *** attempted to flee from me by pulling, jerking my arms forward multiple times before going to a leaning forwarded sprint position. I continued to hold and pull him back into me to stop [him] from fleeing the scene until Sergeant M. Hubbard & Officer R. Perry arrived to my location to assist me with the arrest." The report states that Petitioner sustained injuries to his right arm, left shoulder and low back.

A report from Officer Ricky Perry states the officers responded to a complaint that several individuals were loitering and selling drugs. After arresting two individuals, Officer Perry noticed Petitioner "attempting to do a patt [*sic*] down on a [suspect] in the center of the street ***. [Officer Perry] noticed the [suspect] attempted to flee from [Petitioner]. ¶ [Petitioner] had the [suspect] by the left wrist and [the suspect] attempted to flee *** from [Petitioner]. [Officer Perry] along with Sgt. Michael Hubbard ran to assist [Petitioner] at which time [they] forced [the suspect] to the ground where [he] was handcuffed." The report does not mention Petitioner falling or sustaining injuries.

A report from Officer T. Brooks states Petitioner stopped a suspect, did a pat down search, and was putting handcuffs on the suspect. "As soon as [Petitioner] started to put the first handcuff on the subject, he pulled away and tried to flee from him. [Petitioner] held on to the clothing of [the suspect], who was taken down to the ground in the roadway. [The suspect] began to fight while on the ground and would not comply with the orders given by [Petitioner] and Sgt. M. Hubbard *** to place his hands behind his back and to turn over onto his stomach." This report also does not mention Petitioner falling or sustaining injuries.

Petitioner admitted prior injuries to the low back and left knee, for which he treated with Dr. Matthew Gornet and Dr. Neil Munhofen. Petitioner further testified that after the accident, he followed up with Dr. Gornet and Dr. Munhofen. He also treated with Dr. Nathan Mall, who ultimately repaired the biceps tendon in the right arm. At Respondent's request, Petitioner was examined by Dr. Christopher Rothrock with respect to the right arm and left knee and Dr. David Robson with respect to the neck and back.

Petitioner then described the accident on February 15, 2014: "I got out of the [patrol] car, exited the car, and I slipped. ¶ The whole street and sidewalk was covered in ice. I laid there for a couple of minutes. It was the same side that I had had surgery on prior to, and it was just an awful heart wrenching pain." Petitioner explained that he had undergone a hip surgery four or five years earlier. The accident caused injuries to "[t]he knee, the hip and low back." Petitioner testified that he told his treating physicians about the accident. At the time of the arbitration hearing, he was still treating for his injuries. Petitioner introduced into evidence an accident report he completed on March 11, 2014, in connection with the accident he stated occurred on that date. In the report, Petitioner stated he injured his hip, knee and back when he exited a patrol car and fell on an icy pavement. Petitioner also introduced into evidence a letter from himself to the chief of police, notifying him of a work injury on February 15, 2014. Petitioner stated he slipped on ice after exiting his patrol car and fell on his right hip. He felt pain in the hip, low back and knee.

On cross-examination, Petitioner testified that he struck his left knee on the ground during the struggle on March 23, 2013, but did not fall. Petitioner acknowledged filing a number of workers' compensation claims against Respondent, including a claim in connection with an automobile accident in February of 2009, when he injured his neck, back, left knee and right foot. After the 2009 accident, Petitioner treated with Dr. George Paletta for the injuries to the left knee and with Dr. Gornet and Dr. Munhofen for the injuries to the neck and back. Dr. Paletta and Dr. Gornet performed surgeries. In April of 2011, Dr. Paletta declared Petitioner at maximum medical improvement with respect to the left knee, and in September of 2012, Dr. Gornet declared him at maximum medical improvement with respect to the neck and back. Both doctors released him to return to work full duty. Petitioner did not recall treating for any complaints relative to the left knee between April of 2011 and the accident on March 23, 2013. Likewise, Petitioner denied having any complaints relative to his neck or back between September of 2012 and March of 2013. Petitioner stated he worked full duty as a police officer between September of 2012 and the accident on March 23, 2013.

Upon further questioning, Petitioner denied the left knee bothered him after he returned to work. However, Petitioner admitted having continuing left knee complaints since 2004 and receiving treatment from multiple providers. When asked whether he had ongoing left knee complaints beginning in 1999 through right before the accident on March 23, 2013, Petitioner responded: "I've had some knee injuries on the job. They've either given me some anti-inflammatories and I was back to normal or either they gave me some physical therapy, and I was back to normal." Petitioner did not remember having ongoing complaints relative to the left knee or the knee giving out between April of 2012—when he testified during a hearing with respect to his prior left knee injuries, describing ongoing problems with the left knee—and the accident on March 23, 2013. Petitioner admitted having ongoing problems with the left hip before the accident on March 23, 2013.

Petitioner further testified on cross-examination that after the accident on March 23, 2013, he did not seek medical care until seeing his primary care physician, Dr. Mohammad Ahmed, on April 13, 2013. When asked how he felt during that time period, Petitioner responded: "My back was bothering me along with my neck and arm and knee." Petitioner admitted that he continued to work for Respondent full duty, qualifying that he might have taken some days off work. Shortly after seeing Dr. Ahmed, Petitioner returned to Dr. Munhofen, and on May 9, 2013, he returned to Dr. Gornet for treatment. Petitioner also treated with Dr. Timothy Lang, Dr. Mall and Dr. Steven Granberg. After the accident on February 15, 2014, Petitioner treated with Dr. Ahmed, Dr. Munhofen, Dr. Mall and Dr. Gornet.

Respondent introduced into evidence voluminous medical records showing Petitioner's left knee, low back, neck and left hip conditions before the accident on March 23, 2013. The medical records relative to the left knee and left hip show that in 1999 Petitioner treated with Dr. James Walentynowicz at St. Louis-Clayton Orthopedic Group after twisting the left knee while making an arrest. An MRI showed trace joint effusion, but no evidence of internal derangement. Dr. Walentynowicz diagnosed anterior strain with joint effusion. Petitioner also consulted Dr. Kevin Baumer at Orthopedic and Sports Medicine Associates, who diagnosed mild medial collateral ligament sprain. Petitioner's left knee condition improved significantly with physical therapy.

In October of 2004, Petitioner received emergency treatment for the injuries he sustained to the left knee as a result of being dragged by a car while attempting to make an arrest. In early 2005, Petitioner consulted Dr. Lyndon Gross at Orthopedic and Sports Medicine, who diagnosed a patellofemoral contusion. An MRI of the left knee performed January 14, 2005, showed mild to moderate chondromalacia of the patella and trochlea. Dr. James Sola at Illinois SW Orthopedics, who treated Petitioner's left knee condition in 2004 and 2005, thought the discomfort was related to the patellofemoral joint. Petitioner's symptoms improved significantly with conservative treatment. In September of 2005, Petitioner received emergency treatment for the injuries he sustained to the left knee when he fell while chasing a suspect. An MRI of the left knee performed December 1, 2005, showed marrow edema in the lateral femoral and tibial condyles due to bone bruising or contusion, and a small joint effusion. In late 2005, Petitioner consulted Dr. Philip George at St. Louis-Clayton Orthopedic Group, who diagnosed a knee sprain.

In July of 2008, Petitioner underwent emergency treatment after injuring his left knee in a car accident. Petitioner treated for the left knee injuries with Dr. Paletta at the Orthopedic Center of St. Louis, who diagnosed posttraumatic patellofemoral pain post "dashboard type injury" and recommended conservative treatment. Thereafter, Petitioner complained of persistent discomfort in the anterior aspect of the knee and within the knee joint. Dr. Paletta obtained an MRI arthrogram, which showed mild signal heterogeneity within the articular cartilage of all three compartments without a focal chondral defect. The ligaments, including the ACL, were intact. Petitioner's course of treatment was complicated by concomitant problems with the low back

and left hip. Dr. Paletta obtained a bone scan, which showed mild osteoarthritis of the pelvis and knees. During physical therapy in 2008 and 2009, Petitioner complained of persistent patellar pain. In June of 2010, Petitioner consulted Dr. Matthew Bayes at the Orthopedic Center of St. Louis on a referral from Dr. Paletta. Petitioner complained of sharp pain, which he rated a 3-7/10, mostly on the inside of the knee, with associated weakness and giving way. Dr. Bayes recommended viscosupplementation injections. On November 24, 2010, Petitioner returned to Dr. Paletta after undergoing viscosupplementation injections and surgery on the left hip. He complained of persistent pain in the anterior aspect of the knee, with grinding and catching. Regarding the left hip, he reported no improvement with the surgery. In December of 2010, Dr. Robert Brophy, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner complained of intermittent moderate, sharp pain in the left knee. Dr. Brophy diagnosed "anterior knee pain which has failed initial appropriate conservative management with anti-inflammatories, brace, physical therapy and injections." Dr. Brophy recommended a diagnostic arthroscopy.

On January 4, 2011, Dr. Paletta performed an arthroscopy with a lateral release. Dr. Paletta's intraoperative findings were as follows: "[T]he intraarticular anatomy [was] entirely normal. The articular surfaces of all three compartments were intact without evidence of acute traumatic chondral or osteochondral injury, chondromalacia, osteoarthritis, or other degenerative changes. Medial and lateral meniscus [*sic*] were normal. Cruciate ligaments were normal. There was a lateral strike to the patella as it engage[d] the trochlea at 20-30 degrees of knee flexion. This was consistent with excessive lateral patella facet compression syndrome. In addition, the lateral retinaculum was noted to be extremely thickened." Postoperatively, Petitioner reported doing well and progressing with physical therapy. Petitioner last saw Dr. Paletta on April 8, 2011, reporting minimal residual discomfort. Physical examination was benign. Postoperative physical therapy records show that at the time of his last visit, on April 29, 2011, Petitioner complained of anterior pain in the knee, which he rated a 3/10. He was apprehensive about returning to work full duty. Dr. Paletta released Petitioner to return to work full duty, effective May 2, 2011.

On December 1, 2011, Petitioner underwent an MRI of the left knee, which was ordered by Dr. Ahmed. The MRI showed no ACL pathology. The medical records from Dr. Ahmed show significant preexisting problems with the left knee since at least 2005, as well as chronic back and left hip pain. Of note is a record from February 1, 2013, stating Petitioner complained of severe back pain, chronic pain in the left knee and left hip, and an episode of neck pain the previous week. On physical examination, the cervical and lumbar musculature was tender to palpation, and the left knee was tender with range of motion testing. The left hip was also tender. Dr. Ahmed refilled Neurontin, Tramadol, Vicodin, Flexeril and Excedrin Extra Strength, and prescribed Prednisone.

The medical records relative to the low back and neck show that on August 11, 2008, Petitioner began treating with Dr. Gornet for pain in the low back, left buttock, left hip and down

the left leg, which he attributed to the work accident on July 2, 2008. A lumbar MRI performed September 22, 2008, was interpreted by the radiologist as showing a disc protrusion with an annular tear at L4-L5.[1] Dr. Gornet diagnosed an annular tear at L5-S1. After following up with Dr. Gornet on March 12, 2009, Petitioner did not return until November 4, 2010. A repeat MRI performed November 29, 2010, was interpreted by the radiologist as showing: a disc bulge with an annular tear at L5-S1; a "mild disc bulge at L4-5 with bilateral facet arthropathy and ligamentum flavum hypertrophy result[ing] in mild-to-moderate bilateral neuroforaminal stenosis;" and "an annular disc bulge at L3-4 [that] is asymmetric to the right where there is a shallow focal right posterolateral/foraminal disc protrusion nearly abutting the right L3 nerve root. Along with facet arthropathy and ligamentum flavum hypertrophy, there is moderate right and mild left neuroforaminal stenosis." Dr. Gornet diagnosed an annular tear and disc pathology at L5-S1, also noting "maybe some subtle changes at [L]4-5 but for the most part this looks very similar. [L]3-4 has progressed slightly with some mild loss of disc height compared to the films two years ago and a slight protrusion there." A discogram at L4-L5 and L5-S1 performed March 2, 2011, showed concordant pain at L5-S1 only. Dr. Gornet obtained another MRI on June 21, 2011. The MRI was interpreted by the radiologist as showing a disc herniation with annular tear at L5-S1 and minimal disc bulging at L3-L4. On July 6, 2011, Dr. Gornet performed a fusion surgery at L5-S1. Postoperatively, Petitioner complained of some achiness in the back, buttocks and left hip, and some symptoms in the legs. A lumbar CT scan performed October 6, 2011, showed "mild disc bulging at L3-4 and L4-5, along with mild facet arthropathy." During a follow-up visit on December 5, 2011, Petitioner reported doing much better. On February 2, 2012, Dr. Gornet released Petitioner to return to work on restricted duty. On April 23, 2012, Dr. Gornet released Petitioner to return to work full duty. On September 10, 2012, Petitioner followed up, complaining of "some symptoms on occasion." Dr. Gornet obtained a repeat MRI of the lumbar spine, as well as an MRI of the cervical spine because Petitioner complained of headaches. Dr. Gornet interpreted the lumbar MRI as showing "some mild changes at the L3-4 level and L4-5; but *** nothing overly bad," and the cervical MRI as not showing "anything of significance." He declared Petitioner at maximum medical improvement.

The medical records following the accident on March 23, 2013, show that on April 13, 2013, Petitioner saw Dr. Ahmed, complaining of a great deal of pain, especially in the right arm. Dr. Ahmed noted the following history: "He was on duty on the street and was arresting someone who pulled his right arm." Petitioner also complained of constant pain in the right [*sic*] knee, in regard to which Dr. Ahmed stated: "I have told the pt again and again to f/u with ortho and look into getting an opinion regarding R TKR." In addition, Petitioner complained "[h]is back is still no better and right [*sic*] hip hurts." Dr. Ahmed refilled Vicodin and Flexeril.

On April 19, 2013, Petitioner saw Chiropractor Munhofen, complaining of constant, moderate pain in the low back, left side of the neck, left foot and right elbow. He gave a history of injury while trying to restrain a combative suspect, which caused pain in the right arm, left shoulder, low back and some pain in the left knee. Dr. Munhofen noted: "Past medical history

[1] The radiologist noted a segmentation anomaly. Dr. Gornet considered that level to be L5-S1.

reveals no evidence of same or similar complaints." Thereafter, Petitioner regularly received chiropractic treatment from Dr. Munhofen, reporting no significant, lasting improvement and adding complaints of pain in the hips and both sides of the neck.

On May 9, 2013, Petitioner saw Dr. Gornet, complaining of low back pain "central down both legs into his anterior thighs and knees." He also complained of pain at the base of the neck, as well as "headaches to his right trapezius, right shoulder and down his right arm into his biceps and forearm." Dr. Gornet noted: "[The patient] has had a previous lumbar spinal fusion. He had done well and had returned to work full duty. He still had a mild degree of neck and back pain." Petitioner attributed his current symptoms to the accident on March 23, 2013. On physical examination, Dr. Gornet noted a decrease in the right biceps strength. X-rays showed no signs of instability or other significant changes in the cervical or lumbar spine. Dr. Gornet stated: "I have discussed with the patient the whole concept of a structural problem in his spine. Based on my knowledge of this patient, clearly this current accident has aggravated any underlying condition he had. ¶ My main concern is that a portion of his symptoms appear to be new and different from anything he has had in the past and I have recommended an MRI of his cervical and lumbar spine to sort this out." Dr. Gornet prescribed medication and kept Petitioner on full duty.

On May 23, 2013, Petitioner followed up with Dr. Ahmed, complaining of persistent pain in the left knee, left hip and back. Dr. Ahmed refilled Vicodin and Flexeril. On June 25, 2013, Petitioner mainly complained of a cyst in the right wrist and pain in the right forearm. He also complained of pain in his abdomen, groin and back. Dr. Ahmed refilled Vicodin and Flexeril and referred Petitioner to Dr. Lang to evaluate the cyst.

A lumbar MRI performed June 27, 2013, was interpreted by the radiologist as follows: "Slightly increased size of central broad-based herniations at both L3-4 and L4-5 with persistent left lateral recess L3-4 and central L4-5 annular tears. There is slightly worsened L3-4 central canal and foraminal stenosis, both of which remain mild. L4-5 mild central canal and foraminal stenoses are minimally increased as well." A cervical MRI also performed June 27, 2013, was interpreted by the radiologist as follows: "Persistent annular disc bulge at C4-5 without focal herniation. No new disc bulge or herniation, central canal or foraminal stenosis is detected."

Also on June 27, 2013, Petitioner followed up with Dr. Gornet, mainly complaining of "low back pain central to both buttocks, both legs into his thighs" and stating he felt "as bad as he was before surgery." He also complained of "neck pain into his now more left trapezius and left shoulder, intermittently in his right arm with still pain in his forearm." Dr. Gornet interpreted the MRIs as showing "disc pathology with may be a central herniation at the L3-4 level with what also may be a central herniation at L4-5. The L3-4 level appears to be increased in magnitude and severity compared to his previous films of 9/10/12. This is also true for what I believe is the previous films at the L4-5 level." Dr. Gornet further thought Petitioner had a small herniation on the left at C5-C6, but the cervical spine was less of a problem than the lumbar spine. Dr. Gornet recommended epidural steroid injections and kept Petitioner on full duty.

On July 11, 2013, Petitioner followed up with Dr. Ahmed, complaining of pain in the right forearm and back, with numbness and weakness in the legs. Dr. Ahmed refilled Flexeril.

On July 19, 2013, Dr. Granberg, a pain management specialist, performed transforaminal epidural steroid injections on the left at L3-L4 and L4-L5. On August 9, 2013, Dr. Granberg performed transforaminal epidural steroid injections on the right at L3-L4 and L4-L5.

On August 1, 2013, Petitioner saw Dr. Lang, an orthopedic surgeon, on a referral from Dr. Ahmed. Dr. Lang diagnosed a rupture of the right biceps tendon and localized swelling, mass or lump in the right wrist. He opined the right biceps tendon rupture was work-related.

On August 29, 2013, Petitioner followed up with Dr. Gornet, reporting no significant relief with the injections. Dr. Gornet recommended a discogram to determine whether Petitioner sustained a new disc injury as a result of the altercation. Further, Dr. Gornet referred Petitioner to Dr. Mall to evaluate the right biceps. Dr. Gornet kept Petitioner on full duty and stated: "Clearly, I believe his current symptoms are causally connected to his work injury and altercation."

On August 30, 2013, Dr. Clinton Smith, a certified independent chiropractic examiner, issued a records review report at Respondent's request. Dr. Smith noted that Dr. Munhofen in his initial post-accident clinical note stated there was no previous history of injury or similar complaints. Dr. Smith noted: "This is contrary to this examiner's involvement in other work related injury reviews of [Petitioner] in his employ by the [Respondent]. Additionally, extensive lumbar surgery was performed July 6, 2011. It is evident a cage fusion was performed at the L5-S1 level by Dr. Matt Gornet on that date." Dr. Smith further noted inconsistent assessments of Petitioner's subjective and objective findings in Dr. Munhofen's medical records and that there was no evidence Dr. Munhofen ever referred Petitioner for any formal lumbar spine rehabilitation. Dr. Smith reviewed the MRI findings and found "no evidence that this particular injury caused new or worsened spinal degeneration or stenosis." Regarding causal connection, Dr. Smith opined: "Evidence establishing a causative relationship between the accident of March 23, 2013 and presentation to Dr. Munhofen for care on April 19, 2013 is demonstrated." Regarding medical necessity of the treatment provided by Dr. Munhofen, Dr. Smith opined: "[A]ll of the care provided by Dr. Munhofen for this soft tissue injury from April 19, 2013 through June 11, 2013 is documented as related to the injury. Past that point, outcomes would provide necessity for referral for strengthening via formal rehabilitation." Dr. Smith opined that Petitioner only minimally improved under Dr. Munhofen's care, and recommended a formal rehabilitation evaluation.

An MRI of the right elbow performed September 3, 2013, showed a partial tear at the distal insertion of the biceps tendon with instrasubstance split. Also on September 3, 2013, Petitioner saw Dr. Mall, an orthopedic surgeon, on a referral from Dr. Gornet. Dr. Mall recorded

the following mechanism of injury: "[The patient] was making an arrest and did not have handcuffs with him and he was holding the arm and the perpetrator's jeans at the same time. As he was holding him, the perpetrator was trying to get away from him and he had to resist this and actually began falling and felt a burning sensation in his right elbow as well as a pain in his left knee." Petitioner complained of pain in the right forearm and left knee. Physical examination of the left knee showed the following: "The left knee has some mild medial joint line pain with palpation. He has a mildly positive McMurray's examination. His ACL and PCL are intact with negative anterior and posterior drawer. He has no increased pain or opening with varus and valgus stress testing bilaterally. He has no patellar apprehension. He has mild patellofemoral crepitus." Dr. Mall recommended physical therapy and released Petitioner to return to work on restricted duty.

On September 5, 2013, Dr. Robson, a spine surgeon and chief of surgery at Missouri Baptist Medical Center, examined Petitioner at Respondent's request. Petitioner reported the incident on March 23, 2013, caused him to fall forward and injure his neck, right arm and low back. Petitioner further reported only minimal help from the chiropractic treatment. Physical examination of the neck and back was unremarkable. Dr. Robson compared the lumbar MRI study from June 27, 2013, to the prior study from September 10, 2012, and saw no interval changes at L3-L4. With respect to the cervical spine, Dr. Robson saw no evidence of disc herniation on the MRI from June 27, 2013, or the MRI from September 10, 2012. Dr. Robson diagnosed cervical and lumbar strain and recommended non-steroidal anti-inflammatory medication and physical therapy. Dr. Robson opined: "I believe the patient had a temporary exacerbation of lower back and neck pain. The present condition of the patient's neck is a cervical strain without any cervical disc herniation. The present condition of the patient's lower back is a L3-4 degenerative disc, which has been present since the September 10, 2012 MRI. This has not changed in any capacity nor has his L5-S1 fusion." Dr. Robson further stated: "I believe once the patient has had physical therapy and antiinflammatories for his neck and lower back he will be at maximum medical improvement. I would recommend one month of physical therapy and release at maximum medical improvement regarding his cervical and lumbar strain." Dr. Robson did not anticipate any permanent disability from the neck and low back injuries.

On October 1, 2013, Petitioner followed up with Dr. Mall, reporting no improvement. With respect to the right arm, Dr. Mall recommended an injection of platelet rich plasma before considering surgery. An MRI of the left knee performed October 1, 2013, showed the proximal ACL was attenuated in thickness in the intercondylar notch, which could represent a chronic ACL tear. On October 29, 2013, Dr. Mall opined the work accident caused an ACL tear, explaining: "[The patient] never had any subluxation events or knee pain prior to his work related injury that occurred when he was making an arrest and holding the perpetrator. He did feel pain at that time during this arrest and subsequently had a left knee effusion." Dr. Mall recommended ACL reconstruction surgery.

On November 14, 2013, Dr. Rothrock, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner reported injuring his right elbow and left knee while arresting a combative suspect on March 23, 2013. Dr. Rothrock opined the right arm condition was causally connected to the accident and recommended surgery. Regarding the left knee condition, Dr. Rothrock noted a history of prior problems and opined: "[A] medical causal relationship does NOT exist between [the patient's] work related injury and the persistent pain and dysfunction about his left knee. [The patient] does not have signs or symptoms or physical exam findings or MRI findings indicating an acute ACL tear as a result of his work related injury, and he continues to suffer with his pre-existing patellofemoral pain and dysfunction, which was temporarily exacerbated by his work related injury. He has reached the point of maximal medical improvement in regards to the work related injury that he sustained to his left knee, and he has not sustained any permanent partial disability as a result of his work-related injury."

On December 27, 2013, Dr. Mall reviewed Petitioner's MRI of the left knee from 2009 and the report from Dr. Rothrock. With respect to the MRI findings, Dr. Mall stated: "I would agree that [the patient's] MRI from 2009 which I did not have access prior to today does demonstrate similar appearance of the ACL indicating an ACL rupture off the femoral side. This appears to be based on his exam a partial tear versus a full thickness tear of the ACL." Dr. Mall continued to recommend an ACL reconstruction, given Petitioner's occupation as a police officer. Dr. Mall acknowledged that a lot of the symptoms in the knee appeared to be patellofemoral in nature. However, he opined Petitioner also suffered from subtle ACL instability. Regarding causal connection, Dr. Mall stated: "To Dr. Rothrock's point that this is a chronic problem that was not related to the March 23, 2013 I would agree that he did have evidence of an ACL tear and similar appearance on this MRI during the 2009 MRI that was performed. However, oftentimes in the situation of ACL deficiency a patient that was previously asymptomatic from this can develop instability symptoms." Lastly, Dr. Mall performed a platelet rich plasma injection into the biceps tendon.

On February 4, 2014, Petitioner followed up with Dr. Mall, reporting some improvement from the injection, but not enough to return to work full duty. He also complained of symptomatic instability in the left knee. With respect to the right arm, Dr. Mall recommended surgery. With respect to the left knee, Dr. Mall stated: "I did have him go over to a physical therapy office nearby for both a KT1000 test to better put a numeric value on his ACL instability as well as to allow him to do some of the activities that causes him pain such as squatting type of activities, use of the leg press, and stair stepping. He did go over for this and did note that he had continued pain with these squatting, lunging, and stair step type of maneuvers. This indicates that the majority of his pain associated with the left knee is related to patellofemoral pain. However, this patellofemoral pain and quadriceps weakness that causes patellofemoral pain could very well be likely due his ACL insufficiency and lack of confidence in the left knee. If he does not have confidence in the left knee due to ACL instability then he may have a subtle limp on this side that can produce quadriceps insufficiency for those activities. Therefore, I think that some of his pain while not likely to improve with surgery is somewhat related to his ACL insufficiency

which could be eliminated [with] surgical intervention." Regarding causal connection, Dr. Mall stated: "Clearly, [the patient] does have symptomatic instability currently. He has a positive pivot shift which is the most specific and sensitive test for ACL insufficiency. I do not have all of his prior records to know what his pivot shift was before but clearly he has a positive pivot shift today on examination and has since his most recent injury. I believe that he had a partial injury back in 2009 while he was in his car accident that was deemed work related and that in the most recent altercation he likely had additional partial tearing of the ACL and now has developed instability related to this. Therefore, I do believe that this recent work injury has caused him to become symptomatic from his ACL tearing and likely requires an ACL reconstruction at this point."

After the accident on February 15, 2014, Petitioner saw Dr. Munhofen on February 21, 2014, complaining of "moderate degree of frequent dull pain in both sides of his lower back, both sides of his neck, and right elbow. The patient reports there is a worsening of the pain in both sides of his lower back, both sides of his neck, and right elbow." He rated the low back pain a 6/10 and neck pain a 4/10. Petitioner did not mention the accident on February 15, 2014. The last chiropractic note from Dr. Munhofen is dated March 12, 2014. Petitioner still complained of "moderate level of dull pain which occurs frequently in both sides of his lower back, both sides of his neck, and right elbow."

On March 13, 2014, Dr. Mall performed a right distal biceps debridement, partial repair and platelet rich plasma injection, and took Petitioner off work.

On March 25, 2014, Petitioner returned to Dr. Gornet. Dr. Gornet stated: "We feel that he may have an injury at either L3-4 and L4-5 from a low back and neck standpoint, we had him at full duty. He is obviously off work for his work related injury on his shoulder. Dr. Mall is treating him for his shoulder as well as potentially his knee. From my standpoint, there is no reason to do any further workup or treatment until he is recovered from both of these. *** [W]e still believe he may have an active problem in his low back, but this has been placed on hold until these other issues are sorted out. Again, this continues to be related to his work injury of 3/23/13." Dr. Gornet's note does not mention the accident on February 15, 2014.

On April 3, 2014, Petitioner saw Dr. Ahmed, who noted: "[The patient] [f]ell on ice 2/15/14 on the street when got out of his car (was on duty) and fell on the left side, has low back pain and left hip. He had previous back and left hip surgery in the past and the worry is if he has reinjured his back and left hip, most likely has muscular injury." X-rays of the lumbar spine showed no fracture or dislocation. X-rays of the left hip showed mild osteoarthritis and increased calcifications, compared to the study from August of 2010. Dr. Ahmed refilled Flexeril and Hydrocodone and instructed Petitioner to follow up with an orthopedic surgeon regarding the calcifications.

Dr. Gornet testified via evidence deposition on January 23, 2014, that as a result of the accident on March 23, 2013, Petitioner "could have irritated a disc in his neck or his low back." Upon further questioning, Dr. Gornet stated: "I believe that [the patient] has a disc injury in his neck as well as his low back, in particular C5-6 in his neck as well as L3-4, L4-5 in his low back" as a result of the accident. Dr. Gornet explained: "Clearly, this gentleman has preexisting treatment in his low back including a spinal fusion anteriorly. I believe he has some preexisting disc degeneration at some of the adjacent levels. I believe that he suffered a new disc injury at L3-4, possibly L4-5 as part of the altercation. I believe that he has a subtle disc injury at C5-6 in his cervical spine in dealing with his neck pain. ¶ *** I believe that he has some very, very mild preexisting cervical degeneration, but I believe that also is a new injury at C5-C6." Dr. Gornet's recommendation at the time was for "further evaluation of his low back to see if there's something reasonable that can be done to assist in managing his pain and discomfort since the accident." Dr. Gornet disagreed with the opinion of Dr. Robson that Petitioner had only suffered a temporary aggravation of his low back and neck pain, explaining that "there's no indication that [the patient] has had resolution of his symptoms back to their baseline." Dr. Gornet maintained that "further evaluation should be performed," although he was unsure whether further treatment should be performed. Dr. Gornet believed "there is potential to help [the patient] improve his symptoms."

On cross-examination, Dr. Gornet admitted that in September of 2012, he anticipated continued degeneration of Petitioner's entire spine as part of the aging process. The following colloquy then occurred:

> "Q. The MRI of the low back that was done June 27 of 2013, the radiologist indicated that there was a slight increased size of the central broad-based herniation at L3-L4.
>
> A. Correct.
>
> Q. Did you have an opinion as to what the cause of the initial herniations [was]?
>
> A. *** I thought what was listed on the 2010 MRI was related to degeneration, and so the initial disc pathology, the subtle bulges, loss of disc height, and change in disc hydration was due to degeneration at L3-4.
>
> Q. Would that have been the reason for the increased size that was found on the MRI on June 27 of 2013?
>
> A. Well, that's not my opinion. My opinion is that it changed in size related to this current accident. Remember, we had had an MRI from June of 2010, a subsequent MRI from September 2012, and there had been no change, but

yet we fast-forwarded to a period of eight months later and now there's a change, and I believe the reason for that change is directly related to the accident he described in March of 2013.

Q. You've just testified that you do not feel there were any changes on the MRI that was reviewed in September of 2012, but the pathologist [*sic*] did report some mild changes, correct?

A. No. What we believe is there was pathology consistent with degeneration, and that pathology was consistent with the previous MRI we discussed in 2010. There were changes on the MRI, meaning it wasn't completely normal, but there wasn't an interval between June of 2010 and September of 2012. I know the language was confusing how I said it, but that's what I'm referring to. So in other words, you are correct. There was a disc bulge at L3-4 in the September of 2012 MRI. That disc bulge was also present on the previous scan of 2010. Was there an interval change between the two? I didn't think so. I felt the description and the mild changes, meaning disc pathology present at L3-4, was related to degeneration at that point. But subsequent to that there has been an interval change in the MRI from September of 2012 until June of 2013, and that interval change at L3-4 I relate to the new altercation."

Dr. Gornet also related to the accident the slight worsening of the central canal and foraminal stenosis at L3-L4 and L4-L5. Dr. Gornet acknowledged the interval changes could be due to degeneration; however, that was not his opinion.

With respect to the findings at C4-C5, Dr. Gornet did not feel "there was anything significant" at that level. Rather, he felt there had been an interval change at C5-C6, which he related to the work accident, even though he was "not overly impressed" with the disc pathology at C5-C6. Dr. Gornet qualified: "But right now his neck was getting better and we didn't go any further to evaluate that, so I really don't have any further information to give you on his neck." Lastly, Dr. Gornet recommended continued chiropractic treatment with Dr. Munhofen "if it keeps [the patient] working full duty and he's seen on an occasional basis, maybe two to four times a month. *** If he's seeing him three times a week, I don't believe there's really a strong reason for that to continue at that high level because it would not really be producing benefit."

Dr. Robson testified via evidence deposition on February 20, 2014, that he did not see any interval changes in the MRI studies from September 10, 2012, and June 27, 2013. He disagreed with Dr. Gornet's interpretation of slight worsening of the findings at L3-L4 and L4-L5. With respect to the cervical MRI findings, Dr. Robson testified the MRI from June 27, 2013, showed some straightening of the normal lordosis, which could be indicative of a muscle spasm. There were no disc bulges or herniations. Dr. Robson opined Petitioner did not require treatment beyond anti-inflammatory medication and physical therapy. Regarding causal connection, Dr.

Robson continued to opine the work accident "caused the symptoms involving [the] neck and [the] low back." Some of Petitioner's symptoms could be attributed to his preexisting conditions. Dr. Robson recommended against additional chiropractic treatment, unless it was comparable to physical therapy.

On cross-examination, Dr. Robson explained that by "temporary exacerbation" he meant an exacerbation that can take weeks to months, but less than a year, to resolve. When asked to comment on Petitioner's cervical and lumbar symptoms failing to resolve within almost a year after the accident, Dr. Robson responded: "[T]he lumbar spine certainly had preexisting pathology that we all agree on to some extent at L3-4 and at L5-S1. I would say that anything that may have happened as a result of that accident probably returned to a baseline level by the time I saw him even. Now as far as the neck is concerned, he strained it, I saw him less than a year following the accident so I can't really comment on how he is today, but if he's still symptomatic today he may have some underlying *** muscle spasm or something, but there is really nothing to do for it." Dr. Robson further stated: "I'm really not giving him much on the lumbar spine. Any spine such as he has with the changes at L3-4 which is kind of a setup for problems in the future and a postoperative situation at L5-S1, I would say virtually 100 percent of those people have intermittent spine symptoms for their whole life with or without whatever happened in March of 2013."

Dr. Mall testified via evidence deposition on February 18, 2014, that Petitioner's presentation "wasn't initially consistent with an ACL tear, meaning not the most common complaints we see with an ACL." However, Dr. Mall thought "there was a partial tear, and then that maybe completed or at least became symptomatic." Dr. Mall acknowledged the pre-accident MRI of the left knee "looked fairly similar" to the post-accident MRI, "maybe a little bit additional injury to the ACL." On physical examination, Dr. Mall noted some instability in the knee. A KT-1000 test showed "five millimeters of increased anterior translation or forward translation of the tibia on the femur *** so that's an indication of actually a full-thickness ACL tear, when there's more than five millimeters *** or more of translation. That's an indication of an unstable ACL." Dr. Mall acknowledged that a component of the symptomatology was related to patellofemoral pain, which is a nonoperative problem. Regarding causal connection, Dr. Mall opined: "[S]ubsequent to that work-related injury on 3-23-13, [the patient] did develop symptoms and is complaining of both patellofemoral pain symptoms but also knee instability where he does feel like his knee gives way or doesn't feel stable on his knee. And those are symptoms that are new following the injury. ¶ And so therefore I do believe that those symptoms are related to his work injury and that he likely did either complete his ACL tear that was already partially torn or at least created from being an asymptomatic partial-thickness ACL tear to now being a symptomatic partial-thickness ACL tear." Dr. Mall recommended an ACL reconstruction surgery because of Petitioner's occupation as a police officer.

On cross-examination, Dr. Mall testified that during the initial visit in September of 2013, Petitioner did not give a history of prior problems with the left knee. Petitioner's knee presented

a diagnostic challenge, but Dr. Mall was fairly confident in his diagnosis. When asked whether his causal connection opinion would change if Petitioner had a 14 year history of left knee complaints prior to the work accident, Dr. Mall responded: "I think it depends on what the instability symptoms were causing from, and so *** you can have instability symptoms from quadricep weakness that can cause patellofemoral pain, and those two can be interrelated. *** ¶ And so if his symptoms of instability were related to quadricep weakness, then I would say my causation wouldn't change. His symptoms of instability were related to the fact that he *** had a torn ACL and he was having *** instability symptoms related to that, then potentially yes."

Dr. Rothrock testified via evidence deposition on March 5, 2014, that on physical examination the ACL appeared functional, although "not perfect." X-rays of the knee showed normal, age appropriate findings. Dr. Rothrock compared the MRI from February of 2009 to the MRI from October 1, 2013, noting no interval changes. Dr. Rothrock maintained the MRI from October 1, 2013, did not show any acute findings, and the findings relative to the ACL "could be in the bounds of normal." Dr. Rothrock reiterated his opinion that Petitioner continued to suffer from preexisting patellofemoral pain. Dr. Rothrock did not recommend surgery on the ACL "because *** it did not feel, nor him clinically describe instability." Dr. Rothrock also did not recommend any restrictions relative to the left knee condition.

On cross-examination, Dr. Rothrock maintained the accident temporarily exacerbated Petitioner's preexisting patellofemoral pain. Dr. Rothrock conceded Petitioner's complaints were not consistent with the left knee condition returning to baseline. However, Dr. Rothrock did not think Petitioner's complaints were due to the work accident aggravating his preexisting knee problems. Dr. Rothrock explained: "[The patient] had an operative report by a surgeon, who I respect and trust that, essentially, was performed for persistent patellofemoral pain in 2011. And there were no real significant findings that I document consistent with anything that would cause chronic problems. It was, essentially, a diagnostic knee arthroscopy and a lateral release that was performed. And from that moment on 2011 to now I don't see any significant changes on the MRI therefore, I can't say that anything new has happened as a result of the work-related injury." Dr. Rothrock maintained Petitioner would not benefit from an ACL reconstruction because he did not have instability.

The Commission notes that Respondent has accepted liability for the injuries to Petitioner's right arm. In dispute are the injuries to the low back, neck, left knee and left hip. The Commission finds Petitioner's testimony confusing and inconsistent. The Commission further notes that Petitioner was not forthright with Dr. Mall and Dr. Munhofen about his significant preexisting conditions.

The Commission notes significant preexisting low back, left knee and left hip problems, as well as complaints relative to the neck. Petitioner had previously undergone surgeries on the low back, left knee and left hip, and complained of persistent symptoms after the surgeries. A clinical note from Dr. Ahmed from February 1, 2013, states that Petitioner complained of severe

back pain, chronic pain in the left knee and left hip, and an episode of neck pain during the previous week. Cervical and lumbar musculature was tender to palpation, and the left knee was tender with range of motion testing. The left hip was also tender. Dr. Ahmed continued Neurontin, Tramadol, Vicodin, Flexeril and Excedrin Extra Strength, and prescribed Prednisone. The mechanism of injury on March 23, 2013, as described by Petitioner and eyewitness police officers, does not suggest significant injuries to the low back, neck, left knee or left hip.

The Commission finds the opinions of Dr. Gornet and Dr. Mall to be lacking in solid basis. The opinions of Dr. Gornet border on speculative, and the opinions of Dr. Mall presuppose a preexisting partial ACL tear, which Dr. Mall opined worsened or became symptomatic as a result of the accident on March 23, 2013. However, as Dr. Rothrock pointed out, Dr. Paletta did not find an ACL tear during the arthroscopy in 2011. The Commission relies on the opinions of Dr. Rothrock, Dr. Robson and Dr. Smith, and finds that the accident on March 23, 2013, only temporarily aggravated Petitioner's preexisting conditions of the left knee, low back and neck. Regarding the left hip, the Commission finds that Petitioner failed to prove any aggravation of the preexisting condition.

Turning to the medical expenses and prospective medical care, the Commission finds that Dr. Ahmed was Petitioner's first choice of medical providers, and Dr. Munhofen was his second choice of medical providers. Dr. Lang was the first choice referral. The Commission finds that Dr. Gornet was Petitioner's third choice of medical providers, and Dr. Mall and Dr. Granberg were third choice referrals. The Commission denies the medical bills outside Petitioner's first two choices of medical providers and their referrals. As to the disputed medical bills from Petitioner's first two choices of medical providers and their referrals, the Commission relies on the opinions of Dr. Rothrock, Dr. Robson and Dr. Smith, and awards the medical bills in evidence as follows: from Dr. Ahmed for the visits from April 13, 2013, through July 11, 2013; from Dr. Munhofen for the treatment from April 19, 2013, through June 11, 2013; and from Dr. Lang. The Commission denies prospective medical care for the low back, neck, left knee and left hip conditions.

Regarding the accident on February 15, 2014, the Commission notes that contrary to Petitioner's claim of being in severe pain after the accident, he did not seek immediate medical care and failed to provide a history of accident to Dr. Munhofen, Dr. Gornet or Dr. Mall, although he did give a history of accident to Dr. Ahmed two months later. The Commission finds that Petitioner failed to prove he sustained any injury to his neck or left knee. With respect to the low back and left hip, the Commission notes preexisting problems, questions regarding Petitioner's credibility, and lack of an expert opinion on causal connection. The Commission therefore finds that Respondent is not liable to pay benefits in connection with the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2014, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay, pursuant to §§8(a) and 8.2 of the Act, the medical bills in evidence from Dr. Ahmed for the visits from April 13, 2013, through July 11, 2013, from Dr. Munhofen for the treatment from April 19, 2013, through June 11, 2013, and from Dr. Lang.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is vacated.

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: JUN 8 - 2015
o-04/29/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

FRANKLIN, DEANGELO
Employee/Petitioner

Case# **13WC017504**

14WC015629

15IWCC0427

EAST ST LOUIS POLICE DEPT
Employer/Respondent

On 8/11/2014, 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

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62220

15IWCC0427

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DEANGELO FRANKLIN
Employee/Petitioner

v.

EAST ST. LOUIS POLICE DEPT.
Employer/Respondent

Case # 13 WC 17504

Consolidated case: 14 WC 15629

An *Application for Adjustment 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 **Collinsville**, 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: Has Petitioner reached maximum medical improvement?

FINDINGS

On the dates of accident, **March 23, 2013** and **February 15, 2014**, 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*** sustain accidents that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the respective injuries, Petitioner earned **$39,000.00**; the average weekly wage was **$750.00**.

On the dates of accident, Petitioner was **41** and **42** years of age (respectively), ***single*** with **0** dependent children.

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

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

Respondent 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 the reasonable and necessary medical services delineated in the Memorandum of Decision of Arbitrator, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner has not reached maximum medical improvement. Respondent shall authorize and pay for the medical treatment recommended by Petitioner's treating physicians, 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 of Arbitrator

07/22/2014
Date

ICArbDec19(b)

AUG 11 2014

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

15IWCC0427

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DEANGELO FRANKLIN
Employee/Petitioner

v.

Case # 13 WC 17504
Consolidated Case: 14 WC 15629

EAST ST. LOUIS POLICE DEPT.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, DeAngelo Franklin, is a Police Officer for Respondent, the East St. Louis Police Department's patrol division. He filed two separate Applications for Adjustment of Claim for injuries sustained on March 23, 2013 and February 15, 2014. (Arbitrator's Exhibits 2 and 3). On March 23, 2013, Petitioner injured his back, neck, left shoulder, right arm, and left knee during a resisted arrest. Petitioner was performing a sweep for illegal activity on said date when he detected several subjects that began to flee. Petitioner detained one of the subjects and attempted to place him under arrest. When he did, the subject attempted to flee and Petitioner grabbed hold of the subject's belt. The subject continued to resist and pulled away, causing Petitioner to fall down with him and strike his left knee.

Petitioner was again injured at work on February 15, 2014, while retrieving his jacket from the back seat, when he exited his patrol car, slipped on ice, and fell on his left side, injuring his back, hip and left knee. Petitioner testified that he experienced "heart wrenching pain" as this side of his hip was operated upon four to five years ago. Petitioner completed incident reports following both of his accidents and the clerical errors contained therein were clarified before the Arbitrator. Respondent did not dispute accident or notice for either claim and the matters were consolidated before the Arbitrator. Respondent disputed causal connection for all injuries, with the exception of the injuries to Petitioner's arm.

Petitioner sought treatment with many of the same physicians that treated him for prior injuries to his neck, knee, back and hip. Petitioner also testified that prior to the undisputed accident that occurred in March 2013, he had been released from his physicians and was working full duty. Petitioner testified that he hoped his symptoms would resolve, but the symptoms from his injuries did not abate.

Following the March accident, Petitioner attempted to manage his injuries with conservative care from his family physician, Dr. Mohammed Ahmed, and his chiropractor, Dr. Neil Munhofen, before returning to an orthopedic specialist. Dr. Ahmed prescribed narcotic pain medication after noting Petitioner's complaints of right arm, left knee, lower back, and hip pain. (Petitioner's Exhibit (PX) 3). Petitioner's chiropractor likewise noted that Petitioner injured both his upper and lower body while dealing with a combative suspect. Petitioner's chief complaints, however, were his low back pain, and the pain which developed in the left side of his neck. Petitioner also reported moderate pain and numbness in his left foot and sharp consistent pain in his right elbow.

Dr. Munhofen's physical examination demonstrated positive findings of injury in Petitioner's lumbar and cervical region demonstrating obvious strain and muscle spasm of Petitioner's cervical region, lumbosacral region, and elbow, with secondary diagnoses of acute cervicobrachial syndrome and lumbar neuritis/radiculitis. Dr. Munhofen managed Petitioner's injuries conservatively. (PX 4).

When conservative modalities failed to alleviate Petitioner of his symptoms, he sought orthopedic care. Petitioner returned to Dr. Gornet (the orthopedic surgeon who performed his previous spinal fusion). Dr. Gornet noted that before Petitioner's March 23, 2013 work accident, Petitioner had done well and returned to full duty work. Following the accident, however, symptoms of pain in Petitioner's neck, shoulder, arm and back surfaced, persisted, and worsened with any activity, including lifting and prolonged sitting or standing. Dr. Gornet had a thorough knowledge of the structure of Petitioner's spine and, based on his knowledge of Petitioner, he stated that the March accident clearly aggravated Petitioner's underlying condition. Dr. Gornet recommended an MRI. (PX 5, 05/09/13).

Petitioner's MRI was performed and interpreted by Dr. Matthew Ruyle. Dr. Ruyle compared Petitioner's new MRI to his former MRI and noted that the size of Petitioner's central broad-based herniations at both L3-4 and L4-5 had increased with persistent left lateral recess, L3-4 and central L4-5 annular tears, and worsening of the central canal and foraminal stenosis at L3-4. Dr. Ruyle believed Petitioner's cervical MRI to be unchanged. (PX 6). When Petitioner returned to Dr. Gornet, he reported that he felt as bad as he did in the past before surgery. Dr. Gornet also examined Petitioner's MRI films himself and also identified an increase in the magnitude and severity of Petitioner's pathology at L3-4 and L4-5. Dr. Gornet recommended transforaminal and epidural steroid injections for the lumbar spine. Dr. Gornet, however, was able to identify a small herniation on the left in Petitioner's neck at C5-6, best seen on foraminal #18. As Petitioner's back problem was more prominent than his cervical injury, Dr. Gornet addressed the lumbar spine first. (PX 5, 06/27/13).

Petitioner returned to Dr. Gornet on August 29, 2013, with no improvement in his condition from his injections. Although Petitioner's discogram was negative at L4-5, Dr. Gornet wished to repeat Petitioner's discogram at L4-5 as well as L3-4 to determine whether Petitioner had a new disc injury as a result of his work injury. (PX 5, 08/29/13). Dr. Gornet also noted that Petitioner saw another sports medicine physician for persistent elbow pain, Dr. Timothy Lang, who felt that Petitioner may have a biceps tendon rupture and recommended an MRI scan. (PX 5, 08/29/13; PX 8). Dr. Lang noted that Petitioner's elbow pain was irresolute and advised Petitioner that since his elbow had not improved within the last three months, he may require surgery. (PX 8). Dr. Gornet referred Petitioner to Dr. Nathan Mall for further evaluation and potential treatment. Dr. Gornet again stated his belief that Petitioner's current symptoms were causally connected to his work injury. (PX 5, 08/29/13).

Dr. Mall saw Petitioner on September 3, 2013, and noted the history of Petitioner's accident, symptoms and treatment. The right elbow physical examination demonstrated limited range of motion, pain with resisted motion and pain with palpation along the biceps tendon. Examination of Petitioner's knee showed response to McMurray's examination and patellofemoral symptoms. Dr. Mall obtained an MRI of Petitioner's right elbow, which showed a longitudinal split within Petitioner's tendon with edema. Dr. Mall recommended physical therapy for both Petitioner's elbow and knee and possibly injection of Petitioner's biceps tendon before surgery, pending the results of physical therapy and anti-inflammatory medication. (PX 9, 09/03/13). Petitioner returned to Dr. Mall on October 1, 2013, and reported worsening of his knee pain with physical therapy. There was no improvement in Petitioner's right elbow/biceps pain. Dr. Mall recommended injection of Petitioner's elbow for his partial biceps tendon tear and tendinitis and an MRI of Petitioner's knee to rule out a tear of the meniscus. (PX 9, 10/01/13).

Petitioner's new MRI showed no tear of the medial meniscus. (PX 6, 10/01/13). After comparing Petitioner's MRI in 2009 to the MRI obtained October 1, 2013, Dr. Mall believed that Petitioner's March 2013 accident aggravated his left knee ACL rupture, causing new symptoms of instability. Dr. Mall noted that Petitioner's feeling of instability was not felt prior to the March 23, 2013 work incident. He also noted Petitioner's patellofemoral symptoms, which were causing Petitioner difficulty pain when climbing stairs or having his knee bent for a prolonged period of time. Dr. Mall recommended ACL reconstruction. (PX 9, 12/27/13). In terms of medical necessity for further treatment and examination, Dr. Mall noted the following:

> However, often times in the situation of ACL deficiency a patient that was previously asymptomatic from this can develop instability symptoms. I did ask Mr. Franklin to try to differentiate between patellofemoral pain and instability which can be caused by quadriceps weakness and true ACL deficiency. Clearly, I believe that his pain and symptoms related to bending his knee, stairs and steps, and keeping his knee bent for prolonged periods of time is related to patellofemoral pain. These are the classic symptoms related to patellofemoral pain. However, he does state that he also has pain and symptoms with cutting and pivoting types of activities. This is a subjective finding that is difficult to corroborate with other than by taking the patient to the operating room for examination under anesthesia. Even then if patients have a positive pivot shift does not necessarily mean that they have instability with doing their activities such as straight-ahead running, walking, and that type of activity. Clearly, an ACL is not needed for these activities, however, my concern with Mr. Franklin is that if he were to try to run and escape a fugitive that if his ACL gives way on him that this could put his life in danger. He clearly has done a good job with physical therapy and improved his quadriceps strength significantly from the first time I saw him . . . he has done everything that we have attempted to do in terms of improving this by doing the physical therapy, improving his quadriceps strength significantly, and yet continues to have the pain and instability. Therefore, my concern is that this is related to his ACL dysfunction. This is the reason for recommending ACL reconstruction in that I do not think we can completely resolve his symptoms any other way at this point . . . having subtle ACL instability can result in subtle quadriceps weakness that continue to have [sic] the patellofemoral pain despite his best efforts with physical therapy.

(PX 9, 12/27/13).

Dr. Mall administered a PRP injection into Petitioner's biceps tendon where he was having the most pain. (PX 9, 12/27/13).

Petitioner's complaints persisted when he returned on February 4, 2014. Petitioner reported temporary improvement following his PRP injection, but his persistent pain returned. He continued to experience symptomatic instability in the left knee. Physical examination of the knee remained abnormal. Dr. Mall recommended a cortisone injection of Petitioner's knee to differentiate whether or not Petitioner's problem was intraarticular or simply patellofemoral pain. He continued to recommend ACL reconstruction, and noted that based on both research and his own personal experience, MRI findings and findings on physical examination often do not correlate in ACL surgery candidates with successful outcomes. He stated that Petitioner's accident in March superimposed further injury upon Petitioner's 2009 ACL injury, which culminated in the instability necessitating ACL reconstruction. With regard to the elbow, Dr. Mall felt that Petitioner would benefit from a

tendon debridement and either another PRP injection or a coating of platelet rich gel over the tendon at the time of surgery. (PX 9, 02/04/14).

On March 13, 2014, Petitioner underwent right distal biceps debridement, partial repair and PRP injection. (PX 10). Petitioner was released to light duty work on March 26, 2014. (PX 9, 03/26/14). Petitioner remained under care for his left knee. (PX 9, 04/22/14).

Petitioner returned to Dr. Gornet on March 25, 2014, following surgery with Dr. Mall. Petitioner was recovering from shoulder surgery, and Dr. Mall continued to treat Petitioner for his shoulder as well as his knee. Dr. Gornet continued to believe that Petitioner had an active problem in his low back; however, this was "placed on hold" until treatment for Petitioner's concurrent problems were sorted out, and Petitioner was scheduled for a follow up appointment. With respect to Petitioner's prospective lumbar care, Dr. Gornet stated, "Again, this continues to be related to his work injury of 3/23/13." (PX 5, 03/25/14).

Respondent requested a records review from Dr. Clinton Smith, who believed that there was a causal relationship between Petitioner's accident on March 23, 2013 and his condition, but disagreed with the methods used and the length of Petitioner's course of treatment. He recommended that Respondent seek an independent medical examination to evaluate Petitioner. He was not provided any records prior to Petitioner's evaluation on May 9, 2013, or after August 5, 2013. (RX 4).

Respondent had Petitioner examined by Dr. David Robson pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). Dr. Robson testified by way of deposition for his neck and back injuries. (RX 5). Dr. Robson testified that Petitioner was very nice and cooperative, and that he had no reason to disbelieve Petitioner recitation of his accident or his report of symptoms. (RX 5, p. 33). Dr. Robson saw Petitioner on September 5, 2013, and believed the examination was normal. (RX 5, pp. 7-9). He reviewed Petitioner's medical records and films and only identified what he believed to be pre-existing conditions or normal findings. (RX 5, pp. 10-15). He was unable to appreciate the worsening of the central canal and foraminal stenosis at L3-L4 and L4-L5 identified by Dr. Gornet. (RX 5, p. 13). He felt that Petitioner only sustained a cervical strain and lumbar strain as a result of the March 23, 2013 accident. (RX 5, pp. 15, 17). His only recommendation for Petitioner's injuries was rest, anti-inflammatory medication and physical therapy, including chiropractic care. (RX 5, pp. 15, 17-18). He testified that even though Petitioner still suffered persistent symptoms of pain, his accident resulted in nothing more than a temporary exacerbation of his condition and he required no further evaluation or treatment for same. (RX 5, pp. 16-18). He believed that Petitioner should manage his condition at home with over-the-counter pain medication. (RX 5, p. 19).

Dr. Robson was not in possession of any of Dr. Gornet's treatment records after Petitioner's second visit on June 27, 2013. (RX 5, p. 22). On cross-examination, he acknowledged that following Petitioner's visit with Dr. Gornet on September 10, 2012, there was no mention of either cervical or lumbar spine pain; but shortly after the accident on March 23, 2013, Petitioner began having symptoms in his neck and back. (RX 5, pp. 23-24). While he disagreed with Dr. Gornet's assessment of Petitioner's MRIs, he agreed that physicians should treat patients and not MRI findings. (RX 5, pp. 24-26). He conceded that if Petitioner was still having symptoms over a year later, then by definition Petitioner's injuries would not qualify as a temporary exacerbation. (RX 5, pp. 29-30). He ultimately agreed that Petitioner's cervical spine *had not* returned to pre-injury status, but remained of the belief that Petitioner's lumbar spine returned to baseline. (RX 5, p. 30). He testified within a reasonable degree of medical certainty that Petitioner's cervical spine condition was causally related to his undisputed March 2013 work accident. (RX 5, p. 32).

On November 14, 2013, Respondent had Petitioner's elbow and knee evaluated by Dr. Christopher Rothrock pursuant to Section 12 of the Act. (RX 7, pp. 5, 7-9). He testified that his physical examination

demonstrated abnormalities in Petitioner's right elbow and the ACL of Petitioner's knee. (RX 7, pp. 11-12). He did not believe, however, that Petitioner's knee abnormalities warranted surgery. (RX 7, p. 12). He acknowledged that the x-rays taken in his office did not show any degenerative findings in Petitioner's left knee. (RX 7, p. 13). However, he believed that since Petitioner's new MRI showed no substantial difference visible to the eye and Petitioner treated for knee pain with a prior injury, there was no change in Petitioner's condition. (RX 7, pp. 14-18). Dr. Rothrock, however, did not believe that Petitioner suffered from instability and did not believe that Petitioner required any restrictions. (RX 7, p. 18). Dr. Rothrock agreed with Dr. Mall's diagnosis of Petitioner's arm condition and agreed that Petitioner required surgery for that condition. (RX 7, pp. 18-19).

On cross-examination, Dr. Rothrock agreed that Petitioner had no prior history of pain or dysfunction as it relates to his right elbow prior to the accident of March 23, 2013; and he agreed that Petitioner's right elbow condition and treatment is causally related to the March 2013 accident. (RX 7, pp. 22-24). He also acknowledged that Petitioner was released with respect to his knee by Dr. Paletta on May 2, 2011, without any restrictions. (RX 7, p. 23). He further testified that in his review of the medical records he did not see any complaints from Petitioner about his left knee after May 2, 2011, up until the accident on March 23, 2013. (RX 7, pp. 23-24). He believed that the accident in March 2013 only served as a temporary exacerbation of Petitioner's pre-existing knee condition. (RX 7, p. 26). He testified, however, that temporary exacerbations only last between one to three months. (RX 7, p. 26). When asked about pain lasting longer than three months, he testified that the condition is not a temporary exacerbation, and the pain simply cannot be accounted for. (RX 7, p. 27). He acknowledged that the medical records show that symptoms continue and Petitioner's condition has not returned to baseline, or the way it was before the March 2013 accident, some eight months later. (RX 7, pp. 27-28). Dr. Rothrock testified that Petitioner was a pleasant and cooperative during the examination and stated that he had no reason to disbelieve Petitioner's account of the accident or his current symptoms. (RX 7, p. 28).

Dr. Gornet testified that he is a board spine specialist and graduate of Johns Hopkins School of Medicine. (PX 13, pp. 5-6). He sees approximately 100 patients per week and performs between 5 to 10 surgeries depending upon the complexity of the interventions. (PX 13, p. 7). Dr. Gornet has known Petitioner and his condition since Petitioner was referred to him by Dr. Munhofen in 2008. (PX 13, p. 8). Dr. Gornet testified that prior to March 23, 2013, Petitioner was working full duty and Petitioner had been placed at maximum medical improvement (MMI). (PX 13, pp. 8-9). He only saw Petitioner as a part of a yearly follow-up for his lumbar fusion. (PX 13, p. 9). When Petitioner returned following his March 2013 work accident, Petitioner's status had transmuted from occasional mild residual discomfort to significant pain traveling down both legs and neck pain which caused headaches and emanated into his right trapezius, right shoulder, right biceps, and right forearm. (PX 13, pp. 10-11). He testified that his knowledge of Petitioner's condition before and after the event of March 2013 provided him with unique information regarding Petitioner's condition above and beyond any clinical assessment. (PX 13, pp. 12-13). He testified that he identified an increase in the magnitude and severity in Petitioner's lumbar pathology at L3-4 and L4-5. (PX 13, pp. 13-14). He also identified herniation in the cervical spine on the left side at C5-6. (PX 13, pp. 13-14).

Dr. Gornet testified that based upon the history of Petitioner's injury, his thorough knowledge of Petitioner's condition before and after the March 2013 accident, and all of the imaging studies obtained, he diagnosed Petitioner with a disc injuries in the neck at C5-6 and lumbar spine at L3-4 and L4-5. (PX 13, p. 14). He testified that Petitioner's current condition of ill-being is causally related to the March 2013 work accident as an aggravation of his pre-existing condition versus new injury in his lumbar spine and a new injury in Petitioner's cervical spine. (PX 13, p. 15). In comparing Petitioner's MRI scans, he testified that there was a change in Petitioner's cervical spine on the left side at the indicated level which marked a new injury. (PX 13, p. 16). Dr. Gornet testified that these changes are not temporary and continued to recommend further evaluation

of Petitioner's condition. (PX 13, pp. 18-21). He also testified that continued chiropractic care for Petitioner would be reasonable if same would allow Petitioner to continue to function at a high level. (PX 13, pp. 39-40).

Dr. Mall also testified by way of deposition. (PX 14). Dr. Mall testified that he treats the ankle, knee, elbow, shoulder, and hip, and also performs carpal and cubital tunnel syndrome surgeries as well. (PX 14, pp. 4-5). He specializes in high-level sports medicine surgeries as a corollary of his fellowship at Rush University. (PX 14, pp. 4-5). Petitioner was referred to Dr. Mall by Dr. Gornet for evaluation for persistent elbow and knee pain following his work injury. (PX 14, p. 7). Petitioner had no prior history of symptoms or treatment for his arm. (PX 14, pp. 8-9). With respect to Petitioner's knee, Petitioner had a prior ACL injury that had become symptomatic, or a partial tear that became completed, and patellofemoral pain. (PX 14, pp. 9, 12, 15). This was evident by Petitioner's development of instability subsequent to his work accident. (PX 14, pp. 13-14). Dr. Mall specifically sought additional testing by a therapist called a KT-1000 that generates an actual objective number to quantify or qualify the extent of anterior or forward translation of Petitioner's knee, which is a measurement of instability. (PX 14, p. 14). This test demonstrated five millimeters of increased anterior translation or forward translation of the tibia on the femur on the left knee as opposed to Petitioner's right knee. Dr. Mall testified that these results are an indication of ACL instability and a full-thickness ACL tear. (PX 14, p. 14). Dr. Mall noted that these symptoms of instability were a new development following the March injury. (PX 14, pp. 17, 50). Dr. Mall believed that this instability was driving Petitioner's patellofemoral pain because Petitioner has continued to have this pain despite extensive non-operative treatment which should have resolved Petitioner's problem:

> . . . And so we have had him continue to do physical therapy for that patellofemoral pain, and unfortunately he's continued to have that pain. So typically it doesn't take this long to get better from patellofemoral pain, so my concern is that there's some level of knee instability that may be contributing to that patellofemoral pain, meaning that he's limping around or he feels that his knee is not stable, and so he's not putting as much force to that quadriceps, and then that quadriceps is remaining to be weak, [sic] and that may be contributing to why he's not able to get over that patellofemoral pain.

(PX 14, p. 15).

Dr. Mall concluded that Petitioner's biceps and knee conditions were causally related to the undisputed March 23, 2013, accident. (PX 14, pp. 16-17).

CONCLUSIONS OF LAW

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

A claim under the Act is not denied simply because of a pre-existing condition. The law holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665, 672 (2003) (emphasis added). "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Comm'n*, 309 Ill. App. 3d 1037, 723 N.E.2d 846 (3d Dist. 2000). If a pre-existing condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro*, cited *supra; Rock Road Constr. v. Industrial Comm'n*, 37 Ill.2d 123, 227 N.E.2d 65, 67-68 (1967); *see also Illinois Valley Irrigation, Inc. v. Industrial Comm'n*, 66 Ill.2d 234, 362 N.E.2d 339 (1977); *St. Elizabeth's Hospital v. Ill. Workers' Comp. Comm'n*, 371 Ill. App. 3d 882, 864 N.E.2d 266, 272-273 (5th Dist. 2007).

Circumstantial evidence, especially when entirely in favor of the petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n,* 260 Ill. App. 3d 92, 96–97, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 93 Ill.2d 59, 66, 442 N.E.2d 908 (1982). Causal connection between work duties and injured condition may be established by chain of events including workers' compensation claimant's ability to perform duties before date of accident and inability to perform same duties following date of accident. *Darling v. Industrial Comm'n*, 176 Ill. App. 3d 186, 530 N.E.2d 1135 (1st Dist. 1988).

The un-rebutted facts show that prior to Petitioner's work accidents, he was working full-duty without restrictions and was not actively seeking any treatment for his prior injuries. This is acknowledged and agreed upon by all physicians. Petitioner testified at trial that he remains on light duty and continues to experience symptoms for which recommended treatment remains outstanding. It is also clear that Petitioner has not returned to his pre-accident level of function. While Respondent's examiners claim that the most Petitioner sustained as a result of his work accident is a sprain and temporary exacerbation of his pre-existing conditions in the knee and lumbar spine, both were forced to acknowledge during cross-examination that by their own definition, Petitioner's increase in symptoms was not temporary. Additionally, the record is clear that after the March 2013 accident, Petitioner presented new complaints of instability within his knee. Based upon the foregoing, the Arbitrator does not give weight to the opinions of Dr. Rothrock or Dr. Robson regarding Petitioner's knee or lumbar spine. There is a clear, unbroken chain of causal connection between Petitioner's accident, onset symptoms, treatment, and the recommendation for further treatment and evaluation of his lumbar spine and knee. The Arbitrator agrees that the physicians who evaluated Petitioner both before and after his work accidents are in a better position to evaluate the change in Petitioner's structure, agrees with their opinion regarding causation, and finds that Petitioner's undisputed work accident aggravated his pre-existing condition.

Respondent does not dispute causal connection for Petitioner's elbow injury, but disputed causal connection regarding all other injuries. However, the examiner which rendered an opinion regarding Petitioner's cervical spine admitted during cross-examination that Petitioner's cervical spine *had not* returned to pre-injury status and testified within a reasonable degree of medical certainty that Petitioner's cervical spine condition was causally related to his undisputed March 2013 work accident, in accordance with the opinion of Petitioner's treating physician, Dr. Gornet. Therefore, the Arbitrator relies upon the opinion of Dr. Gornet regarding Petitioner's cervical spine.

Although there are no specific opinions regarding Petitioner's most recent undisputed accident in February 2014, which was consolidated for consideration with Petitioner's March 2013 claim, it is a traumatic accident for which no medical testimony is required to establish a causal connection. *Westinghouse Elec. Co. v. Industrial Comm'n*, 64 Ill.2d 244, 356 N.E.2d 28 (1976). It is plainly apparent to the Arbitrator, and would likewise be to any reasonable person, that a slip and fall would clearly aggravate any prior injuries and/or cause new injuries. In analyzing and establishing causal connection between Petitioner's condition and the March 2013 work accident, it is clear that Petitioner was not experiencing any problems before his work-related incident; Respondent did not present any evidence of an intervening cause to break the chain of causation between either of these work-related incidents. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his undisputed work accidents of March 23, 2013, and February 15, 2014.

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

Issue (K): Is Petitioner entitled to any prospective medical care?; and

Issue (O): Has Petitioner reached maximum medical improvement?

The Act requires employers to provide all reasonable and necessary medical care required to diagnose, relieve, or cure the effects of an injury that is causally related to a work accident. *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill. App. 3d 705, 691 N.E.2d 13 (2d. Dist. 2000); *F & B Mfg. Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (1st Dist. 2001).

Petitioner has not reached MMI. Petitioner testified at trial that he had appointments scheduled and that he continues to treat for his symptoms. None of Petitioner's physicians have released him from care. Dr. Gornet placed Petitioner's cervical treatment on hold in order to address his more serious lumbar problems first. The recommended surgery for Petitioner's knee had not yet been performed. Therefore, Petitioner unquestionably has not received all reasonable and necessary care to which he is entitled under the Act in order to cure or relieve the effects of his injuries. Although Respondent disputes much of Petitioner's recommended course of treatment based on the opinions of its examiners, these physicians have only examined Petitioner once and have a limited understanding of Petitioner's condition as a whole. The Arbitrator believes that in this instance, these determinations are best left to Petitioner's treating physicians, who have had familiarity with Petitioner's status and health for many years and have operated on Petitioner previously.

Respondent is therefore ordered to authorize and pay for the treatment recommended by Petitioner's treating physician, including but not limited to surgery; and pay for the medical expenses already incurred, as enumerated in Petitioner's Exhibit 1 (see below), subject to the medical fee schedule, Section 8.2 of the Act:

Dr. Mohammed Ahmed	$	1,179.00
Beltline Chiropractic	$	7,154.00
Dr. Matthew Gornet/The Orthopedic Center of St. Louis	$	1,140.00
Walgreens Pharmacy	$	32.02
MRI Partners of Chesterfield	$	9,057.00
Dr. Steven Granberg	$	3,454.00
Dr. Timothy Lang/Wood Mill Orthopedics Ltd.	$	$40.00
Dr. Nathan Mall/Regeneration Orthopedics	$	8,523.00
Injured Workers' Pharmacy (IWP)	$	263.19
Timberlake Surgery Center	$	9,331.53
Premier Anesthesia	$	900.00
ProRehab	$	11,874.40
SSM Physical Therapy	$	--
TOTAL:	**$**	**52,948.14**

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelli Leabu,

Petitioner,

15IWCC0428

vs.

NO: 11 WC 47940

The Lingerie Football League, LLC, d/b/a Chicago Bliss, and Illinois State Treasurer as Ex Officio Custodian of the Injured Workers' Benefit Fund,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of fact and conclusions of law

The Commission finds:

1. Petitioner was 27 years of age at the time of the June 2, 2014 Hearing. She began working for Respondent in 2010. She was a cornerback for the Chicago Bliss of the Lingerie Football League. This is a full contact league and players wear helmets, shoulder pads, elbow pads and knee pads.

2. On January 20, 2011 Petitioner was injured in practice when she bumped knees with another player. She sustained an injury to her ACL and meniscus. Prior to the

accident date, Petitioner had never had a right knee injury.

3. Petitioner reported her injury to her coach and Michaela, the teams' personal trainer. The following day, Petitioner reported to Dr. Jessica Conway, her primary physician in Cleveland, Ohio. An MRI was recommended. Petitioner returned to Chicago and saw Dr. Khanna on January 27, 2011, who also recommended an MRI and took Petitioner off of work. She was diagnosed with a possible right knee ACL tear.

4. The MRI on January 27, 2011 revealed a complete ACL tear, bucket handle tear of the medial meniscus, a horizontal cleavage type tear of the medial meniscus and a partial thickness tear or severe contusion of the origin and proximal fibers of the gastroenemius muscle.

5. On March 5, 2011 Petitioner returned to Ohio and treated with Metro Health Systems. She still had knee pain. She was referred to a Dr. Stern on March 22, 2011. On that date she was recommended for physical therapy and another MRI. She then followed up with Dr. Conway on March 24, 2011. On that date surgery was recommended.

6. Petitioner began one month of physical therapy on March 29, 2011. The therapy did not decrease her right knee pain.

7. On June 24, 2011 another MRI was performed and revealed a buckle handle tear of the medial meniscus with displacement of the meniscal fragment, a radial tear of the lateral meniscus and a high grade partial tear of the ACL.

8. On July 26, 2011 Metro Health Systems prescribed surgery. Petitioner was unable to work for the league at that time and underwent surgery September 21, 2011 with Dr. Wilber.

9. Petitioner underwent physical therapy from September 28, 2011 through January 17, 2012. This therapy did help Petitioner.

10. On November 11, 2011 Petitioner only completed 15 minutes of therapy, as she arrived late. She also missed both previous therapy sessions due to traffic and oversleeping.

11. On November 14, 2011 it is noted that once Petitioner can perform certain activities she will be 50% closer to returning to playing football.

12. On December 8, 2011 it is noted that Petitioner has missed the last 3-4 weeks of therapy due to school.

13. On January 17, 2012 it is noted that Petitioner was out of the country, which is why she was unable to attend therapy. It is noted that she had been doing cardio (elliptical and stairmaster) and weight lifting exercises at the gym. She had not been performing her agility exercises, however.

14. Petitioner was allowed to begin straight line running on January 24, 2012. She was also released from care by Metro Health Systems on that date and was told to return in 2 months to be reevaluated.

15. Petitioner has not sought any treatment for her right knee since her January 24, 2012 release date, nor did she return for a reevaluation. She has not returned to play for Respondent.

16. Currently Petitioner tries to workout 3-4 times per week. She does strength training. She will attempt to jog for one mile, and occasionally plays volleyball with friends in the summer. She is unable to run now because she still has pain, popping and occasional swelling. She takes aspirin for the pain. She used to run 5 miles per day.

The Commission affirms the Arbitrator's findings of accident, causal connection, medical expenses and penalties and fees. However, the Commission views the issue of permanent partial disability in a slightly different light than does the Arbitrator, and thus modifies the award from a 40% loss of a person as a whole down to a 30% loss of use.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 52-4/7 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 temporary total disability benefits that have accrued from 1/20/11 through 1/24/12, and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 150 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 30% loss of use of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $341.00 for services rendered by Advanced Occupational Medicine, $345.00 for services rendered by Cleveland Clinic and $15,263.00 for services rendered by Metro Health Medical Center, for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Penalties and fees are hereby denied.

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

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

15IWCC0428

IT IS FURTHER ORDERED BY THE COMMISSION that the award is entered against the Injured Workers' Benefit Fund (IWBF) to the extent allowed under section §4(d) of the Act; the IWBF has the right to recover benefits paid from Respondent and Respondent shall reimburse the IWBF for any compensation obligations of Respondent that are paid by the IWBF.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $71,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 8 - 2015
O: 4/9/15
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEABU, KELLI
Employee/Petitioner

Case# **11WC047940**

15IWCC0428

LINGERIE FOOTBALL LEAGUE D/B/A CHICAGO BLISS AND THE STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE
JOSHUA RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

LINGERIE FOOTBALL LEAGUE D/B/A
CHICAGO BLISS
833 S SUNSET BLVD
WEST HOLLYWOOD, CA 90069

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0428

Case # 11 WC 47940

Consolidated cases: -----

Kelli Leabu
Employee/Petitioner

v.

The Lingerie Football League d/b/a Chicago Bliss and the State Treasurer as ex officio custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, 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. ☒ Did an accident occur that arose out of and in the course of 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

15IWCC0428

On **January 20, 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 **$4800.00**; the average weekly wage was **$300.00**.

On the date of accident, Petitioner was **24** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** 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

Temporary Total Disability

- Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 52 4/7 weeks, commencing 1/20/2011 through 1/24/2012, as provided in Section 8(b) of the Act.

- Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 1/20/2011 through 1/24/2012, and shall pay the remainder of the award, if any, in weekly payments.

- Respondent shall be given a credit of $0.00 for temporary total disability benefits that have been paid.

Medical benefits

- Respondent shall pay reasonable and necessary medical services of $15,949.00, as provided in Section 8(a) and 8.2 of the Act.

- Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $341.00 to Advanced Occupational Medicine, $345.00 to Cleveland Clinic, and $15,263.00 to MetroHealth Medical Center, 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.

15IWCC0428

Permanent Partial Disability: Person as a whole

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.

Penalties

The Arbitrator declined to make any award with respect to fees and/or penalties.

Injured Workers' Benefit Fund

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

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

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

Signature of Arbitrator

8/26/14
Date

SEP 2 - 2014

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

15IWCC0428

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KELLI LEABU	)	
	)	
Petitioner,	)	
	)	
	)	No. 11 WC 47940
vs.	)	
	)	
	)	
THE LINGERIE FOOTBALL LEAGUE d/b/a "CHIGAGO BLISS" and the STATE TREASURER as ex officio of the INJURED WORKERS' BENEFIT FUND	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The Petitioner provided the Arbitrator with an Affidavit of Service. (PX. 2). The Arbitrator finds that the Petitioner provided notice of the June 2, 2014, hearing date to the Respondent, Lingerie Football League, and complied with Section 7030.20(c)(1) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission in providing a completed "Request for Hearing" form. Accordingly, this matter properly proceeded *ex parte* without the Respondent, Lingerie Football League, present.

The Petitioner is a 27-year-old female who currently works and resides in Cleveland, Ohio.

The Petitioner began working for the Respondent, Lingerie Football League, in 2010. The Petitioner produced a copy of the employment contract and introduced the employment contract as Petitioner's Exhibit #4. The contract is entitled "Lingerie Football League, Chicago Bliss, 2010/2011 Season – Player Agreement." (PX. 4, pp.1). The Petitioner signed the employment contract in Chicago, Illinois and was assigned to play for the Chicago Bliss football team. At that time the Petitioner was 24-years-old, single with no dependents.

The Petitioner testified that playing for the Respondent entailed playing full contact football. The Petitioner testified that the Respondent provided her with a helmet, shoulder pads, knee pads, elbow pads, and a uniform. If the Petitioner lost these supplies, she would be fined. (PX. 4). The Petitioner testified that she was required to attend mandatory practices two days per week and to attend a monthly game. If the Petitioner did not attend these mandatory practices or games, she would be fined by the Respondent. Further, the Petitioner could be fined for many other "infractions" under the contract including being "out of shape".

The Petitioner testified that she felt that this job was dangerous and that other players had been hurt previously.

The Petitioner testified that she played under the presumption that the Respondent maintained workers' compensation insurance and that she had insurance under her employment contract.

The Petitioner testified that she was paid $300.00 per week by the Respondent. The Petitioner testified that Respondent withheld income tax on the Petitioner's earnings and issued the Petitioner a W-2.

On January 20, 2011, the Petitioner was "scrimmaging" at a mandatory Chicago Bliss practice. Petitioner was running a play, engaged in full contact football, when her right knee collided with a teammate's knee. The Petitioner went home and iced her right knee that night.

The Petitioner testified that she notified her coach, Mr. Matt Sinclair, and her trainer, Michaela.

On January 21, 2011 the Petitioner returned home to Cleveland, OH, for a scheduled appointment with her primary care physician, Dr. Jessica Conway. The medical records from that visit indicate that the Petitioner reported she was playing football in Chicago the day before when she collided knee-to-knee with another player. (PX. 7, pp. 7). Dr. Conway noted Petitioner sustained an injury to the ACL and meniscus. (*Id.*)

On January 27, 2011, the Petitioner was sent by the Respondent to see Dr. Rajeev Khanna at Advanced Occupational Medicine Specialists. Dr. Khanna noted that Petitioner complained of pain to the right knee after knocking knees with another player at practice on January 20, 2011. (PX. 8, pp. 4). Dr. Khanna's records indicate that the Petitioner had "hyperextended" her right knee previously that season but that she was pain free before the current injury. (*Id.*) Dr. Khanna diagnosed a possible right knee ACL tear, recommended an MRI of the right knee and kept the Petitioner off work. (*Id.*)

On January 27, 2011, the Petitioner had an MRI performed on her right knee at Athletic Imaging. The MRI revealed a complete ACL tear, a bucket handle tear of the medial meniscus, a horizontal cleavage type tear of the medial meniscus and a partial thickness tear or severe contusion of the origin and proximal fibers of the gastroenemius muscle. (PX. 9, pp. 5).

The Petitioner testified that she reported her injury to three of the Respondent's representatives via email. The Petitioner sent an email at Heather Theisen and Maggie Pearson on January 31, 2011, inquiring as to whom she could contact regarding her injury. (PX. 5, pp. 9). An email reply on the same day from Health Theisen, the Respondent's "Creative Director", asked who the Petitioner reported the injury to. (*Id.* at 8). The Petitioner replied to that email on January 31, 2011, and indicated that she reported her injury to Michela Pagano, the team trainer. (*Id.* at 7-8). Ms. Theisen replied on February 1, 2011, and copied Mr. Jeremy Fisher. (*Id.* at 7). Mr. Jeremy Fisher, whose email signature indicates that he is the Respondent's "Medical Coordinator," replied on February 1, 2011, chastising the Petitioner for not having an MRI performed earlier in time and indicated that if she is covered under the Respondent's insurance she should save all of her bills. (*Id.* at 6).

The Petitioner and Mr. Jeremy Fisher exchanged emails and on February 14, 2011, Mr. Fisher indicated that Dr. Khanna would be able to perform surgery for the Petitioner (despite not having a surgical recommendation at that time) and if the Petitioner chose to treat somewhere else, her bills would not be covered. (PX. 5, pp. 1).

The Petitioner testified that the Respondent has not had any contact with her since the February 14, 2011, e-mail exchange with Jeremy Fisher.

On March 5, 2011, the Petitioner reported to MetroHealth Medical Center (hereinafter "MetroHealth") in Cleveland, Ohio. The Petitioner complained of pain over her right knee from playing basketball a month prior when she knee butted and injured her right knee. (PX. 10, pp. 29). The Petitioner was instructed to follow up with the orthopedics department. (*Id.* at 30).

When questioned at trial why she reported a different mechanism of injury, the Petitioner explained that when she initially sought medical care she believed that the Respondent's insurance would pay her medical bills; they did not.

Petitioner explained that she believed that if she reported a different history to MetroHealth (that she was playing basketball with her boyfriend at the YMCA) she would receive treatment despite not having insurance.

On March 22, 2011, the Petitioner visited MetroHealth's orthopedic clinic. The medical records indicated that the Petitioner was playing basketball with her boyfriend at the end of January 2011 when she sustained a direct blow to her knee. (*Id.* at 36). Physical therapy was recommended. (*Id.*).

The Petitioner began physical therapy at MetroHealth on March 29, 2011, and completed physical therapy on April 20, 2011. (*Id.* at 50-88) The Petitioner testified that this physical therapy did not help her significantly.

On June 7, 2011, the Petitioner returned to MetroHealth and a repeat MRI was recommended. (*Id.* at 104). A June 24, 2011, MRI of the right revealed a buckle handle

tear of the medial meniscus with displacement of the meniscal fragment, a radial tear of the lateral meniscus and a high grade partial tear of the ACL. (*Id.* at 108)

On July 26, 2011, the Petitioner followed up at MetroHealth and surgery was recommended to treat what the doctor diagnosed as a near complete ACL tear and meniscal tear. (*Id.* at 115).

On September 21, 2011, the Petitioner underwent a right ACL reconstruction and meniscus repair at MetroHealth. (*Id.* at 117). Post-surgical instructions included no lifting over 10 lbs. and the use of crutches. (*Id.* at 144).

On September 27, 2011, the Petitioner followed up at MetroHealth and physical therapy was recommended. (*Id.* at 151). The Petitioner had a course of physical therapy performed at MetroHealth from September 28, 2011, through January 17, 2012. (*Id.* at 157-270). The Petitioner was again instructed to avoid contact to the knee and avoid high intensity sports. (*Id.* at 222).

On January 24, 2012, the Petitioner followed up with MetroHealth at which time it was noted that the Petitioner was still not running. (*Id.* at 271). The Petitioner was instructed to return in two months and advised that she could begin running. (*Id.*).

The Petitioner did not seek follow up care after that date.

The Petitioner testified that she had no prior issues with her right knee. The Petitioner was an avid runner before this injury and now cannot run more than a mile. The Petitioner continues to have pain in her knee for which she takes aspirin and over-the-counter medication. The Petitioner testified that she has been instructed by her doctors not to participate in sports.

The Petitioner continues to receive medical bills in the mail. The Respondent did not pay any of the medical bills. The Respondent failed to pay Petitioner any benefits while the Petitioner was off work.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Respondent was operating under the Illinois Workers' Compensation Act. The Petitioner testified that she signed an employment contract in the State of Illinois. Under Section 1(b)(2) of the Act, the signing of an employment contract in the State of Illinois is sufficient to confer jurisdiction. Further, the Respondent held practices and games in the State of Illinois and was doing business in the State of Illinois. Jurisdiction is proper in this case.

The Illinois Supreme Court has held that for an uninsured employer to be liable under the Act, they must be engaged in an "extra hazardous" business or enterprise. Fefferman v. Indust. Comm'n., 375 N.E.2d 1277, 1279 (1978). Section 3 of Act provides enumerated occupations that are covered because they are deemed to be "extra hazardous", but that list is not exclusive. The Arbitrator finds that the nature of work that the Petitioner was performing for the Respondent was extra hazardous. The Petitioner was participating in full contact, tackle football with minimal padding. The Petitioner testified credibly that she felt the job was dangerous and that she was working under the assumption that she was covered under the Illinois Workers' Compensation Act. The Illinois Appellate Court has held that "professional football players are skilled workers contemplated under the statute." Albrecht v. Indust. Comm'n.,648 N.E.2d 923, 927 (Ill.App. 1st Dist. 1995).

The Arbitrator finds that the Petitioner and Respondent were operating under and subject to the Illinois Workers' Compensation Act.

B. Was there an Employee-Employer relationship?

The Arbitrator finds that there was an employee-employer relationship. The Petitioner produced an employment contract between herself and the Respondent. (PX. 4). The contract refers to the Petitioner as an independent contractor. "It has been held that the label given by the parties in a written agreement will not be dispositive of the employment status, but that the facts of the case must be considered to determine what the individual's employment status is." Roberson v. Indust. Comm'n., 225 Ill. 2d 159, 183 (2007).

Whether a worker is considered an employee or an independent contract, is dependent upon the following factors:

1. The right to control the manner in which work may be done;
2. Method of payment;
3. Right to discharge;
4. Skill required to perform the work; and,
5. Who provides the tools, materials or equipment.

Of these factors, the right to control the manner in which the work is done is the most important in determining the relationship. Yellow Cab Co. v. Indust. Comm'n.,(1992) 238 Ill. App. 3d 650, 652 (1st Dist. 1992).

The evidence establishes the following: The Respondent controlled the time and place of the practices and games. Participation in these activities was mandatory. (PX. 4). If the Petitioner did not participate in the practices or games she would be fined by the Respondent and possibly terminated.

The Petitioner was paid by the Respondent and provided a W-2. The Respondent did not provide a 1099 to the Petitioner which indicates employee status and not an independent contractor arrangement.

The skill to perform the work is a specialized skill.

The employment contract provides that the Respondent can discharge the Petitioner at any time without cause. (PX. 4, pp. 8).

Finally, the Respondent provided all equipment including helmets, shoulder pads, knee pads, and elbow pads in addition to a uniform. The providing and wearing of a uniform is indicative of control and vitiates the independent contractor argument. Ware v. Indust. Comm'n., 318 Ill. App. 3d 1117, 1126 (1st Dist. 2000)

Based on the evidence, including the credible testimony of the Petitioner, the Arbitrator finds that an employee-employer relationship existed between the Petitioner and the Respondent.

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

The Petitioner played football for the Respondent. The Petitioner's employment contract dictates that the Petitioner was required to participate in mandatory practices. The Petitioner testified that during one of these mandatory practices the Petitioner "knocked knees" with a teammate causing her knee injury.

The Arbitrator was able to observe the demeanor of the Petitioner and considered Petitioner to be a credible witness.

The Arbitrator notes the inconsistency with respect to the different mechanism of injury that Petitioner reported to MetroHealth. When questioned at trial as to *why* she reported a different mechanism of injury, the Petitioner explained that when she first sought medical care she believed that the Respondent's insurance would pay for her care.

In an effort to get her medical treatment approved, Petitioner reported her injury to three of the Respondent's representatives via e-mail. Petitioner e-mailed Heather Theisen and Maggie Pearson on January 31, 2011. (PX. 5, pp. 9). An email reply on the same day from Health Theisen, the Respondent's "Creative Director", asked who the Petitioner reported the injury to. (*Id.* at 8). The Petitioner replied to that email on January 31, 2011, and indicated that she reported her injury to Michela Pagano, the team trainer. (*Id.* at 7-8). Ms. Theisen replied on February 1, 2011, and copied Mr. Jeremy Fisher. (*Id.* at 7). Mr. Jeremy Fisher, whose email signature indicates that he is the Respondent's "Medical Coordinator," replied on February 1, 2011, chastising the Petitioner for not having an MRI performed earlier in time and indicated that if she is covered under the Respondent's insurance to save all of her bills. (*Id.* at 6).

The Petitioner and Mr. Jeremy Fisher exchanged emails on February 14, 2011 when Mr. Fisher indicated that Dr. Khanna would be able to perform surgery for the Petitioner (despite not having a surgical recommendation at that time) and if the Petitioner chose to treat somewhere else, her bills would not be covered. (PX. 5, pp. 1).

The Petitioner testified that the February 14, 2011, e-mail from Mr. Fisher was the last time she had any contact with any of Respondent's representatives. Respondent never paid any of Petitioner's medical bills.

Petitioner explained that the reason she gave a *different* mechanism of injury to MetroHealth because she believed she needed to do so in order to obtain treatment despite not having health insurance.

The Arbitrator believes Petitioner's explanation as to why she reported a different mechanism of injury to MetroHealth. At the hearing, the Arbitrator had the opportunity to carefully observe the Petitioner. The Arbitrator scrutinized the Petitioner's testimony and demeanor, including her explanation as to why she reported a different mechanism of injury to one of her treaters, and found Petitioner to be credible.

In light of the evidence adduced at trial, including Petitioner's consistent reports as to her mechanism of injury in her *initial* treatment, *before* she learned that Respondent would not pay any of her medical bills, the Arbitrator finds that Petitioner was injured in an accident that arose out of and in the course of her employment by the Respondent.

D. What was the date of the accident?

The Arbitrator finds that the date of accident was January 20, 2011. The Petitioner testified credibly to this fact and the Petitioner's initial medical records document this specific date.

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

Timely notice of the accident was provided to the Respondent. The Petitioner credibly testified that she notified her coach and trainer on the date of accident. Further, email exchanges between the Petitioner and league employees produced at trial indicate that the Respondent was aware of the Petitioner's accident within the 45 days notice requirement prescribed by law.

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

The Petitioner's current condition of ill-being is causally related to the accident. 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. Pulliam Masonry v. Industrial Comm'n., 77 Ill.2d 469, 471 (1979). The Petitioner testified credibly that she injured her right knee on January 20, 2011. Since that date the Petitioner has received consistent medical care with respect to her right knee. The Petitioner was working for the Respondent, sustained a work accident, and was unable to perform her duties for the Respondent following it. The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the work accident.

G. What were Petitioner's earnings?

The Arbitrator finds that the Petitioner earned $300.00 per week. The Petitioner testified credibly to this fact at trial and no evidence to the contrary was presented.

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

The Arbitrator finds that the Petitioner was 24 years of age at the time of the accident. The Petitioner testified to this fact and produced her Amended Application of Adjustment of Claim that established that her birthday is July 30, 1986. (PX. 1). She was injured on January 20, 2011, making her 24 years old at the time of injury.

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

The Arbitrator finds that the Petitioner was single with no dependents at the time of the accident. The Petitioner testified to this fact and her Amended Application for Adjustment of Claim supports it. (PX. 1).

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

The Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary and the Respondent has not paid all appropriate charges. As a result of the Petitioner's work accident the Petitioner required doctor's visits, diagnostic testing, medication, physical therapy and surgery to repair the Petitioner's right ACL tear and meniscal tears. This course of treatment is reasonable and necessary in light of the Petitioner's significant objective medical findings.

Further, the Petitioner produced medical bills that show that the Respondent has not paid the Petitioner's medical bills. (PX. 6). Accordingly, the Arbitrator awards the Petitioner's medical bills as delineated in Petitioner's Exhibit #6.

K. What temporary benefits are in dispute?

The Petitioner is awarded TTD benefits from January 20, 2011, through January 24, 2012, a period of 52 4/7 weeks. The Petitioner's medical records and credible testimony at trial establish this as the period of temporary total disability.

The Petitioner credibly testified that she received no compensation from the Respondent following her injury. Accordingly, the Arbitrator awards the Petitioner TTD benefits from January 20, 2011 through January 24, 2012, a period of 52 4/7 weeks, payable at the statutory minimum TTD rate of $220.00 per week.

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

The Arbitrator finds that the Petitioner has been injured to the nature and extent of 40% loss to the Person as a Whole.

In situations where the Petitioner is unable to perform the customary duties of his pre-accident employment after his injury but does not sustain a loss in earning capacity, an award under Section 8(d)(2) is proper. Gallianetti v. Indust. Comm'n., 315 Ill. App. 3d 721, 724 (2000). The Arbitrator finds that based on the Petitioner credible testimony and medical records, the Petitioner is unable to return to her position for the Respondent and cannot engage in the same duties/activities.

The Petitioner testified that prior to her injury she was an avid runner but since the injury cannot run more than a mile without pain. The Petitioner's medical note of November 8, 2011, at MetroHealth indicates that the Petitioner is to avoid contact or high intensity sports, which is the nature of her employment by the Respondent. (PX. 10 at 222.).

The Petitioner testified that she suffers pain, swelling and "popping" in her knee since the accident.

Petitioner has not lost any earning capacity as a result of this accident.

Accordingly, the Arbitrator finds a 40% loss to the Person as a Whole under Section 8(d)(2) is proper.

M. Should penalties and fees be imposed upon the Respondent?

The Arbitrator has reviewed the evidence in the record and declines to award any that penalties and fees.

N. Is Respondent due any credit?

The Respondent is due no credit and produced no evidence at trial.

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

Gerardo Mendoza,

Petitioner,

15IWCC0429

vs.

NO: 11 WC 19340

Illinois Workers' Compensation Commission
and Andy Frain,

Respondent.

DECISION AND OPINION ON REMAND

This matter had previously been heard and the Decision of the Arbitrator had been filed October 18, 2013. Both Petitioner and Respondent filed a timely Petition for Review. The Commission affirmed the Decision of the Arbitrator on all issues: causal connection, medical expenses, temporary total disability, vocational rehabilitation assessment and maintenance.

Petitioner subsequently sought review in the Cook County Circuit Court, which remanded the case for further consideration of the evidence so that the Commission could provide findings in support of its ruling on causal connection.

FACTUAL BACKGROUND

Petitioner worked security for Respondent. His duties included searching and frisking employees, as well as documenting the information of trailers that were driven onto the premises. He would also quickly look inside each trailer to make sure it was empty. Petitioner searched employees in a shelter area. At the time of his hire in 2010, Petitioner informed Respondent of his permanent restrictions stemming from a previous accident.

On May 10, 2011, Petitioner had clocked out after his shift. He was on his motorcycle to

leave when another employee began driving down the wrong lane and hit him head on. Petitioner flew off of the bike and landed on concrete 4 feet away.

Petitioner treated at the LaGrange Memorial Hospital emergency room later that day. He complained of back and bilateral leg pain. A past history of a spinal fusion was noted. Lumbar x-rays revealed post-surgical changes from a May 2, 2008 fusion at L4-5 and L5-S1. The need for this fusion stemmed from a January 30, 2008 work accident.

On May 11, 2011, Dr. Dugar treated Petitioner, and diagnosed muscle strains and contusions. He also recommended physical therapy and took him off of work. On May 13, 2011 a Dr. Khan noted low back, right shoulder, right knee and left shin pain complaints by Petitioner. He diagnosed a trapezius muscle spasm and a cervical strain with right sided radicular symptoms. On May 17, 2011 Dr. Khan opined that Petitioner could return to light duty work on May 19th. Respondent did not offer Petitioner any such work, however.

Petitioner was terminated by Respondent on May 23, 2011 due to a failed drug test. No drug test records were introduced into evidence, however.

Petitioner was familiar with a Dr. Lorenz from a previous injury, and decided to treat with him again on June 8, 2011. Dr. Lorenz noted Petitioner's previous lumbar fusion, and indicated that since then, Petitioner had been "doing fine" until the accident in question. Dr. Lorenz continued physical therapy and recommended an MRI of the neck, which Petitioner underwent on June 9, 2011. Dr. Lorenz then referred Petitioner to a pain doctor, Dr. Gruft, and a Dr. Lipov for injections. Petitioner did treat with Dr. Gruft, but not Dr. Lipov.

On November 28, 2011 Petitioner reported improvement due to therapy and complained of only "a little trigger point on the right" and some low back achiness with excessive activity. Dr. Lorenz found a resolved cervical strain, cervical spondylosis and an L4-S1 fusion. Dr. Lorenz discharged Petitioner from care and released him to permanent light duty, in accordance with a Functional Capacity Evaluation performed in 2009, which restricted Petitioner to no lifting over 17 pounds frequently, no lifting over 50 pounds occasionally, sitting limited to 60 minute intervals, standing limited to 30 minute intervals and occasional bending. Petitioner was also deemed to have reached maximum medical improvement on this date.

ORDER ON REMAND

Based on the evidence, the Commission affirms the Arbitrator's ruling in total, and specifically affirms the causal connection ruling, which denied maintenance benefits for Petitioner.

The evidence reveals that Petitioner had permanent restrictions in place prior to being hired by Respondent in 2010. Subsequently, he was able to work full duty for Respondent until the accident in question. Petitioner received treatment related to the accident in question, and by November 28, 2011 had reached maximum medical improvement, and was released back to work under his aforementioned permanent restrictions. Accordingly, causal connection to the

15IWCC0429

accident in question terminates on that day. With Petitioner back to his pre-accident (and pre-employment) condition, Respondent is not responsible for vocational rehabilitation, and thus is not responsible for any maintenance benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 18, 2013 is hereby affirmed and adopted.

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

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

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

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

DATED: JUN 8 - 2015
DLG/wde
O:5/28/15
45

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Barry McGuire,

Petitioner,

15IWCC0430

vs.

NO: 01 WC 60272

Chrysler, LLC, f/k/a Daimler Chrysler,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition under §19(h)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of a wage differential award, and being advised of the facts and law, denies Respondent's motion as stated below. This matter was previously been heard by Arbitrator Akemann with a Decision filed May 12, 2009. The matter came before Commissioner Lamborn for hearing on September 10, 2014. The Petition came before the Commission April 9, 2015 in Chicago.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

From the Arbitration Hearing:

1. On June 13, 2001 Petitioner was a Production Operator for Respondent.

2. On that date at work, he slipped and fell, landing on his right heel.

3. Petitioner underwent multiple surgeries on his right foot and ankle, but could not really return to work. At the time of the April 23, 2009 Arbitration hearing, Petitioner was using a Cam boot and crutches. He testified that he used these devices whenever he was out and about from his house.

4. The Arbitrator and the Commission both ruled that there was no medical evidence

that Petitioner could perform anything other than sedentary work. A wage differential award of $508.00 per week beginning April 24, 2009 was granted based on said rulings.

5. At the hearing, Respondent requested additional time to obtain an IME, an FCE and for the Plant Manager to testify that jobs were available at the plant. These requests were denied by both the Arbitrator and the Commission, stating that granting such would be prejudicial. Subsequently, Respondent filed this §19(h)/§8(a) Petition, alleging that since the Commission's January 6, 2010 Decision, Petitioner's condition has materially changed for the better.

6. Respondent noted that Petitioner testified at the April 2009 hearing that he was using crutches and a Cam boot to walk. However, at the time of this §19(h)/§8(a) hearing, he was not using either. Petitioner stated he was able to get around for an hour without the cane. A limp in his gate is present depending on how long he has been on his feet.

7. Petitioner stated that leaning on crutches or walking with a CAM boot caused him back problems, as his back had been previously fused due to an unrelated occurrence. He now uses a cane when on his feet for long periods, otherwise he just makes do.

8. Petitioner began visiting with a Dr. Jejurikar for his foot in April 2009. Dr. Jejurikar was not treating Petitioner, he was simply observing the wound, measuring it, and re-wrapping it. Petitioner has not seen Dr. Jejurikar since October 29, 2012, however, because he did not want to undergo an additional surgery. Dr. Jejurikar discussed this additional surgery with Petitioner to close a wound on his Achilles. However, he told Petitioner that the likelihood of success for the surgery was a "shot in the dark." Due to the uncertainty Petitioner declined the surgery.

9. Dr. Jejurikar, consistently noted from May 2009 through October 2, 2012 that Petitioner had an open wound on his heel. On October 2, 2012 Dr. Jejurikar noted that Petitioner's condition had not substantially changed over the past 5 years.

10. On October 29, 2012 Dr. Jejurikar measured Petitioner's wound at 9 millimeters by 6 millimeters. During the September 10, 2014 Commission hearing, it was measured to be 6 millimeters by 6 millimeters.

11. Emmet St. Andre is a representative of Respondent's Workers' Compensation administrator. Upon testifying he admitted that Petitioner had not been offered a job with Respondent since his accident. Further, he admitted that, if an employee presented with an open wound, Respondent's doctor would exam it to determine if they were clean enough to work in the plant.

12. Gary Staudacher, a Private Investigator, observed Petitioner via surveillance on several dates between April-June of 2010. He never observed Petitioner with a boot or other assistive device. His surveillance of Petitioner revealed him standing and

walking and pushing a shopping cart without the use of a cam boot, crutches or cane. He also observed Petitioner lifting up a few flats of flowers or tomatoes, as well as some pots.

13. Mr. Staudacher also observed Petitioner prior to the Arbitration hearing in 2009. He acknowledged that his activity in 2010 was similar to that of his 2009 activity.

14. Dr. Coe examined Petitioner January 13, 2014. Dr. Coe noted that Petitioner walked with a limp, with a stiff right foot or ankle. He found no evidence of symptom magnification. Petitioner had a chronic wound with fluid seeping out of it. Dr. Coe was also able to see the Achilles tendon through the open wound, which was susceptible to infection. He also noted atrophy in Petitioner's right leg.

15. Dr. Coe opined that Petitioner's condition had not materially changed since the January 6, 2010 Commission Decision, as he was still suffering from a chronic open and draining wound. The condition was stable, but permanent.

16. Dr. Coe stated that the wound was still open because the borders of the wound would begin to heal, but would break down again when Petitioner walked and stretched the wound out. He recommended that Petitioner limit activities that would stretch or pull the wound open. This includes walking on uneven surfaces. He also opined that Petitioner should not be standing and working on his feet throughout the day.

17. Dr. Holmes examined Petitioner on September 7, 2010 and May 14, 2012 at Respondent's behest. After the September 2010 exam, Dr. Holmes opined that he did not believe Petitioner's ulcer had improved since 2009. He also did not know if Petitioner's symptoms had improved since 2009.

18. During the May 2012 visit, Dr. Holmes noted that the lesion was smaller, but Petitioner's physical condition had not improved. Nevertheless, he opined that Petitioner no longer required sedentary work restrictions.

19. Petitioner states that his foot pain has increased since the 2009 hearing. If he is on his feet for over 90 minutes, he feels a stabbing sensation on the top of his foot, along with a pulsating feeling and a hot shooting pain up to his hip. Petitioner mentioned this to Respondent's physicians as well as a Dr. Coe, who his Counsel sent him to January 13, 2014.

20. Darrin Harris works for Respondent, but is also Petitioner's son-in-law. He testified that Petitioner does not ambulate as well today as he did at the time of the 2009 Arbitration hearing.

Based on the evidence, the Commission denies Petitioner's §19(h)/8(a) Petition. There is no indication of a material improvement in his condition. Petitioner's treating doctor, Dr. Jejurikar, consistently noted from May 2009 through October 2, 2012 that Petitioner had an open wound on his heel. On October 2, 2012 Dr.

Jejurikar noted that Petitioner's condition had not substantially changed over the past 5 years.

Dr. Coe also opined that Petitioner's condition had not materially changed since January 2010, as Petitioner was still suffering from a chronic open and draining wound.

The surveillance tapes do nothing to bolster Respondent's claim. In fact, Respondent's own investigator, Mr. Staudacher, acknowledged that the video footage of 2010 was consistent with the activities performed in the 2009 surveillance video which was offered at arbitration. Thus, Petitioner's activity level had not increased subsequent to said hearing.

Furthermore, Petitioner's son-in-law testified that Petitioner does not ambulate as well today as he did in 2009, and is less active now.

Lastly, Respondent's own IME physician, Dr. Holmes, testified that in September 2010 he did not know if Petitioner's symptoms had improved since 2009. In May 2012 he opined that Petitioner's physical condition had not improved. Accordingly, it is unconscionable for Dr. Holmes to opine that, with no material change in Petitioner's condition between 2009 and 2012, Petitioner had improved from being limited to sedentary duty to medium demand level duty.

Based on the trial testimony, medical evidence and video evidence, the Commission finds that Respondent has failed to sufficiently allege a material improvement in Petitioner's condition since the January 6, 2010 Commission Decision affirming that Petitioner could only perform sedentary work. Thus, the Commission denies Respondent's §19(h)/8(a) Petition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Petition under §19(h)/8(a) to reduce Petitioner's benefits is hereby denied.

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

DATED: JUN 8 - 2015
O: 4/9/15
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Peverelle,
Petitioner,

vs. No: 13 WC 14290

Gibson Area Hospital,
Respondent.

15IWCC0431

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, temporary total disability, and prospective medical treatment, and being advised of the facts and law, modifies the Arbitrator's award of temporary total disability, and otherwise affirms and adopts the July 7, 2014 Section 19(b) Decision of Arbitrator Maureen Pulia, which is attached hereto and made a part hereof.

Petitioner, a 31 year old surgical technician, alleged she was injured cleaning an operating room on December 20, 2012. She testified that as she was moving the hospital bed into the hallway, she experienced pain in her low back and left leg. Petitioner sought treatment later that day in Respondent's Emergency Room. Those records show she described injuring her back pushing a cart, with an onset of pain in her low back and bilateral legs when she subsequently squatted down to pick up something. At the arbitration hearing, Petitioner denied that description of the mechanism of injury and attributed the difference between her testimony and Dr. Geada's report to a language difficulty. Dr. Geada diagnosed Petitioner with low back strain with radicular symptoms and placed her on light duty, avoiding bending, twisting, pushing, or pulling over 25 pounds and to sit half of the time she worked.

Petitioner followed up with Dr. Fletcher at SafeWorks on December 28, 2012. Dr. Fletcher recorded a history of accident in which Petitioner was pushing an operating room bed when she developed low back pain radiating down her left leg. On January 7, 2013, Petitioner complained of increasing radicular pain in her left foot and lower leg with numbness and tingling in her left foot, toes, ankle, and shin/calf. Petitioner began physical therapy and remained on light duty. A January 10, 2013 MRI revealed a central disc protrusion at L5-S1 without nerve root impingement or significant foraminal compromise. However, Petitioner complained of numbness and pins and needles sensation in her left foot which intermittently radiated into her left leg as well as shooting back pain to Dr. Fletcher on January 14, 2013. He diagnosed a lumbar strain and L5-S1 disc herniation, ordered epidural steroid injections, and maintained her on light duty. After Petitioner reported no improvement with two injections, Dr. Fletcher opined she had failed conservative treatment and recommended fusion surgery. He continued Petitioner's light duty work restriction and referred her to Dr. Singh.

Respondent requested a utilization review of Petitioner's request for fusion surgery, and Dr. Erickson felt the etiology of Petitioner's symptoms had not been clearly shown; he opined surgery was not appropriate or medically necessary, as she indicated no improvement with steroid injections, and the MRI showed no encroachment on nerve roots.

Petitioner consulted with Dr. Singh at Midwest Orthopedics at Rush on March 18, 2013. Dr. Singh diagnosed degenerative disc disease and a central disc protrusion, and recommended anterior lumbar interbody fusion at L5-S1.

On April 12, 2013, Petitioner followed up with Dr. Fletcher, who continued to recommend surgery and renewed his orders for physical therapy and light duty restrictions.

Dr. Beatty performed a Section 12 examination at Respondent's request on May 14, 2013. The doctor opined that Petitioner suffered from pre-existing degenerative disc disease and noted Waddell signs on his exam. Dr. Beatty noted the unwitnessed work accident, together with the Waddell's signs and short term of employment before the accident, and he attributed Petitioner's complaints to her degenerative disc disease. He opined Petitioner had reached maximum medical improvement as to her work injury. Dr. Beatty attributed any inability to perform that job to her pre-existing degeneration. With respect to that condition, he opined that Petitioner could work modified duty and surgery was appropriate.

Petitioner followed up with Dr. Fletcher on several occasions from July 31, 2013 through May 5, 2014, complaining of worsening symptoms despite another round of physical therapy. The doctor continued Petitioner on light duty until January 9, 2014, when he expressed concern about *cauda equina* and authorized Petitioner off work. She remained off work through the date of hearing, May 30, 2014.

After considering the entire record, and for the reasons set forth above, the Commission modifies the Arbitrator's award of temporary total disability. Prior to hearing, Respondent stipulated that Petitioner should be entitled to benefits for 19-2/7 weeks, from January 8, 2013 through May 23, 2013. Petitioner claimed she was entitlement to 72-3/7 weeks of temporary total disability benefits, the period from January 8, 2013 through May 30, 2014, the date of hearing.

15IWCC0431

Arbitrator Pulia correctly noted that the only time period disputed for purposes of temporary total disability was from May 24, 2013 through May 30, 2014.

At hearing, Petitioner testified she had been employed by Respondent for only two months at the time of her accident. Tr. 26. During that time, she worked only as needed, so she had only worked at Respondent's hospital "a couple of times" before her accident. Tr. 71. She testified the Respondent was aware that she concurrently worked at Christie Clinic, and she described her work at Christie Clinic as sedentary. She testified that even though she was on light duty and had not been prescribed completely off work from May 24, 2013 until January 9, 2014, she was unable to work at either job during that period because she couldn't sit or stand for more than five minutes without increasing pain. Tr. 63. Petitioner further testified that Christie Clinic had refused to allow her to return to work on light duty, because they considered her a liability to them with her injury. The Commission notes that Petitioner offered no evidence of her inability to perform either job, other than her own testimony. Dr. Fletcher clearly believed that she would be able to return to work with appropriate restrictions, and Petitioner's job at Christie Clinic was well within her light duty restrictions. There is no evidence that Petitioner missed any work with Respondent during that period, since she only worked when she was needed and had only worked a couple times before her injury.

The Commission first finds the Petitioner is not entitled to temporary total disability for her inability to work for Respondent during the period of light duty from May 24, 2013 through January 9, 2014. The Commission also finds that Petitioner failed to prove that she was entitled to temporary total disability benefits for the period during which she missed work at Christie Clinic due to her light duty restrictions. There was no supporting documentation or witness to corroborate Petitioner's testimony that her concurrent employer, Christie Clinic, would not permit her to perform her regular job during this period of light duty. The Commission observes that the physicians' prescribed medical restrictions belie her asserted level of restricted work ability, and further observes the light duty work restrictions are full duty for her regular sedentary-level job.

The Commission finds that Petitioner failed to prove that she suffered a loss of income from Respondent or Christie Clinic as a result of her light duty restrictions. Accordingly, the Commission therefore modifies the Arbitrator's award of temporary total disability to exclude benefits from May 24, 2013, the day following Respondent's termination of temporary total disability benefits based upon Dr. Beatty's Section 12 opinion, through January 9, 2014, when Dr. Fletcher ordered Petitioner totally off work.

The Commission therefore reduces the Arbitrator's award of temporary total disability benefits from 72-3/7 weeks to 39-4/7 weeks, for the periods from January 8, 2013 through May 23, 2013 (19-3/7 weeks) and from January 10, 2014 through May 30, 2014 (20-1/7 weeks) and excluding the period during which Petitioner remained on light duty following Respondent's termination of temporary total disability benefits, from May 24, 2013 through January 9, 2014.

All else is affirmed and adopted.

15IWCC0431

IT IS THEREFORE ORDERED BY THE COMMISSION that the July 7, 2014 Decision of the Arbitrator is modified with regard to the period for which temporary total disability is awarded, as described above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $409.25 per week for a period of 39-4/7 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 reasonable and necessary medical expenses related to Petitioner's lumbar spine injury, as contained in Petitioner's Exhibit 21 and as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for reasonable and necessary medical services, including the anterior L5-S1 fusion and post-operative treatment recommended by Dr. Singh, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 8 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/07/15
jdl/dak
68

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

PEVERELLE, LAURA
Employee/Petitioner

Case# **13WC014290**

GIBSON AREA HOSPITAL
Employer/Respondent

15IWCC0431

On 7/7/2014, 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:

3269 SPIROS LAW PC
MATT PINNER
2807 N VERMILLION ST SUITE 3
DANVILLE, IL 61832

1401 SCOPELITIS GARVIN LIGHT ET AL
VICTOR SHANE
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

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), 8(a)

LAURA PEVERELLE,
Employee/Petitioner

v.

GIBSON AREA HOSPITAL,
Employer/Respondent

Case # **13** WC **14290**

Consolidated cases: _____

15IWCC0431

An *Application for Adjustment 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 **Urbana**, on **5/30/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/20/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$6,138.88**; the average weekly wage was **$613.88**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$7,751.08** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$2,000.00** for an advance on 3/15/14, for a total credit of **$9,751.08**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $409.25/week for 72-3/7 weeks, commencing 1/8/13 through 5/30/14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services for petitioner's lumbar spine from 12/20/12 through 5/30/14, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services for the anterior L5-S1 fusion and post-operative treatment recommended by Dr. Singh, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

6/29/14
Date

ICArbDec19(b)

JUL 7 - 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 31 year old surgical technician, alleges she sustained an accidental injury to her back that arose out of and in the course of her employment by respondent on 12/20/12. Petitioner was hired by respondent on 10/3/12. Petitioner also worked at Christie Clinic since December 2006.

As a surgical technician petitioner would scrub and set up for each surgical case. She would assist the doctor during the surgery, and then clean up the room after the surgery was complete. She would assist in moving patients onto the recovery bed, move instruments into the sterilizer, clean the surgical room, and set it up for the new patient. Petitioner testified that on 12/20/12 she felt good, had no back pain, pain in her lower extremities, or numbness and tingling. Petitioner's duties as a surgical technician required her to lift 20 pounds or more. Things that she did that weighed more than 20 pounds included moving heavy surgical trays, helping move the patients to and from the surgical beds, and holding the patient's arm or leg in surgery. Petitioner testified that she must be physically able to move the patient and assist the doctor.

Petitioner testified that on 12/20/12 she was cleaning the surgical room after the procedure. She stated that as she was moving the surgical bed out into the hallway she experienced pain in her back and leg. She stated that the bed she was pushing weighed a couple hundred pounds and would not go straight when pushed.

That same day petitioner presented to the emergency room for treatment. Petitioner gave a history of working in the emergency room and pushing a patient bed when she twirked her back and when she squatted down to pick up something from the floor is when she felt the pain. She complained of pain shooting into her bilateral legs. She denied any numbness or tingling. The doctor's report contains essentially the same history. However, Dr. Geada's report states that petitioner was pushing a cart and felt a twinge or pull to her lower back and has had pain since then. He noted that she tweaked her back when she was pushing the cart and squatted down to pick up something from the floor. He noted that petitioner complained of pain mostly to the small of her back, with a shooting sensation down both legs, mostly on the left. Dr Geada noted that there is no clear history of previous back injury, although when asked petitioner stated that she did not hurt her back lately. Petitioner has a history of rheumatoid arthritis, obesity, and lupus anticoagulant. Dr. Geada examined petitioner and assessed lower back strain with radicular symptomatology. Petitioner was instructed to follow-up with Dr. Sundaram. Petitioner was placed on light duty, and told to avoid bending, twisting, pushing or pulling over 25 pounds. She was

also instructed to work with sitting 50% of the time. X-rays of the lumbosacral spine revealed mild straightening of the lumbar lordosis with questionable bony spur over L5 – S1 posteriorly.

On 12/28/12 petitioner underwent her initial evaluation for occupational therapy and treatment of her lumbar pain by Dr. Fletcher. Petitioner gave a history of experiencing back pain while at work on 12/20/12 she was pushing/pulling an operating room bed. Petitioner complained of low back pain that radiates down her left leg. Petitioner underwent three visits and on 1/7/13 petitioner called and stated that she was having increased radicular pain in her left foot and lower leg. She stated that her numbness and tingling started in her big toe, but after standing at work for an extended period of time it had gone to her complete left foot, toes, ankle and shin/calf area. Petitioner was concerned that her symptoms were getting worse. Petitioner was continued on modified duty work.

On 12/31/12 petitioner began a course of physical therapy at 217 Rehab and Performance Center. Petitioner underwent therapy through 2/14/14.

On 1/8/13 petitioner followed up with Dr. Fletcher. Petitioner complained of increased pain and was taken off work by her employer until she followed up with Dr. Fletcher. She complained of numbness and tingling in her left leg. Dr. Fletcher noted that petitioner's past medical history was significant for back strain/pain on 7/20/12, and arthritis. Dr. Fletcher restricted petitioner to modified work duties.

On 1/10/13 petitioner underwent an MRI of her lumbar spine. The impression was posterior central disc protrusion at L5 – S1 without nerve root impingement or significant foraminal compromise. On 1/14/13 petitioner followed up with Dr. Fletcher. Petitioner complained of numbness and pins and needles feeling in her left foot which intermittently radiated into her left leg. She reported a sharp shooting pain in her mid to lower back with movement. She complained of a constant aching back pain. Dr. Fletcher assessed a lumbar strain, and L5-S1 disc herniation. Dr. Fletcher ordered epidural steroid injections. Petitioner remained on light duty work. On 1/21/13 petitioner underwent a lumbar epidural steroid injection. Petitioner did not experience much relief. On 2/4/13 petitioner underwent a repeat lumbar epidural steroid injection. On 2/12/13 petitioner complained of low back pain with a sharp pinching pain. She also reported experiencing numbness and a pins and needles sensation in her left leg. Dr. Fletcher noted that petitioner showed no signs of improvement after the two injections, and therefore did not order a third injection. He was of the opinion that petitioner had failed conservative treatment, and was in need of a discectomy. Dr. Fletcher referred petitioner to Dr. Singh. Petitioner was continued on modified duty work.

On 4/3/13 Dr. Erickson performed a utilization review of petitioner's request for a fusion at L5 – S1. He was asked to review specific medical records and provide an opinion on whether or not the proposed treatment consisting of a fusion at L5 – S1 was appropriate and medically necessary for the diagnosis and clinical findings. Dr. Erickson was of the opinion that a lumbar fusion at L5 – S1 was not appropriate or medically necessary. He was of the opinion that petitioner's etiology to her symptoms had not been clearly demonstrated based upon the diagnostic tests. He was further of the opinion that petitioner's failure to have significant improvement with the epidural steroid injections, and also in light of the fact that the MRI scan showed no significant encroachment upon the nerve roots, that the petitioner's radicular symptoms were coming from the lumbar spine at the L5 – S1 level. Additionally he was of the opinion that there had been no documentation of any instability at L5 – S1 to indicate that mechanical pain from instability of the L5 – S1 is the cause of her pain. Therefore, Dr. Erickson believed a fusion would not be indicated for the care or treatment of petitioner's injuries.

On 3/18/13 petitioner presented to Dr. Singh at Midwest Orthopedics at Rush. Petitioner gave a history that when she was working as a surgical technician on 12/10/12 she was pushing and pulling an operating room bed and experienced a sudden onset of low back pain and left leg pain. Petitioner reported that her pain comes on suddenly and is constant in nature. Following an examination Dr. Singh diagnosed degenerative disc disease and central disc protrusion. He was of the opinion that petitioner had exhausted all conservative and nonoperative treatments and he was recommending an anterior lumbar interbody fusion at L5 – S1.

On 4/12/13 petitioner followed up with Dr. Munoz for her autoimmune disorder. They discussed her recent laboratory workup. She stated that she was feeling tired and fatigued. She complained of aching muscles in the back of both thighs and calves. Dr. Munoz noted that since he saw petitioner in December she had been complaining of severe low back pain with radiation to the lower extremities. He noted that her low back pain was limiting her activities. He also noted that her hands were achy and her feet felt numb.

On 4/15/13 petitioner followed up with Dr. Fletcher. Dr. Fletcher recommended an anterior lumbar interbody fusion at L5 – S1. He continued petitioner on modified duty work and in physical therapy.

On 4/18/13 Dr. Singh drafted a letter to Ms. Kaelin at ICT Illinois Compensation Trust, after they denied his recommendation for surgery. He stated that he had the opportunity to review the Physician Review Network independent medical review specialist report on petitioner. He noted that the

conclusion was that petitioner had no indication for an L5 – S1 fusion based on a lack of mechanical instability. Dr. Singh felt that this was rather ironic, given that petitioner was recommended for epidural injections because of her radiculopathy. Yet when the same symptoms persisted, an L5 – S1 fusion was not indicated by this doctor. Dr. Singh noted that the examiner did not personally review the MRI, but only reviewed the MRI report. He noted that if he had reviewed the MRI films he would have noticed that there is a significant retrolisthesis with disc space collapse and bilateral foraminal narrowing with central disc protrusion. Dr. Singh noted that central disc protrusion is a direct result of the disc space collapse. He noted that the L5 – S1 disc space collapse results in the foraminal narrowing, which results in her lower extremity symptoms. Dr. Singh noted that he recommended an L5 – S1 fusion to be performed by an anterior approach. Dr. Singh asked that they reconsider their denial of the surgery and reconsider authorization for petitioner.

On 5/14/13 petitioner underwent a Section 12 examination performed by Dr. Robert Beatty. In addition to an examination Dr. Beatty performed a record review. Petitioner gave a history of moving a bed by herself and experiencing low back pain on 12/20/12. Dr. Beatty noted that the records he reviewed indicated that petitioner had had a back strain in July 2012. Petitioner denied that she had a back strain and wondered where that fact came from. Petitioner testified that in July 2012 she did have a baby, but had no back problems with her pregnancy. Following his examination and record review Dr. Beatty was of the opinion that petitioner had degenerative lumbar disc disease before the work accident. He was of the opinion that petitioner had Waddell signs on exam including positive testing on simulated axial compression axial rotation, as well as more than 40° difference between sitting and supine straight leg raising. Dr. Beatty noted that the unwitnessed work accident combined with the positive Waddell signs made him suspicious as to exactly how severe her pain was. He opined that he found no compelling objective evidence, other than temporal connection, that there is an ongoing back problem as a result of a work injury. In his opinion the ongoing back problem is related to her pre-existing degenerative changes, and she has no current condition or diagnosis related to the 12/20/12 work injury. Dr. Beatty opined that an anterior lumbar fusion surgery is reasonable, but not related to the 12/20/12 work injury. He opined that it is related to her pre-existing degenerative lumbar disc disease. Dr. Beatty opined that petitioner had reached maximum medical improvement with regards to her work injury and no further treatment was needed. He was of the opinion that petitioner could return to work full duty as a surgical technician. He stated that any inability to return to work full duty would be related to her pre-existing degenerative lumbar disc disease that is not related to her work injury. With respect to that condition, he was of the opinion that she could work modified duty.

On 7/31/13 petitioner followed up with Dr. Fletcher. She stated that on 7/28/13 she had a flareup of her pain (neck to low back). She complained of an aching, burning, shooting low back pain. She reported increased pain on the left side of her low back. Following an examination Dr. Fletcher was of the opinion that petitioner had L5 – S1 radiculopathy, and left-sided L5 S1 disc herniation. Dr. Fletcher was of the opinion that petitioner needed the surgery recommended by Dr. Singh. He continued petitioner on modified work duties.

Petitioner followed up with Dr. Fletcher on 8/16/13 and 10/16/13. On 10/16/13 petitioner reported that her symptoms were worse. Dr. Fletcher ordered an updated MRI. He continued petitioner on modified duty and in physical therapy. On 11/6/13 petitioner followed up with Dr. Fletcher. He noted that she had undergone another round of physical therapy with no major help. He was of the opinion that she needed the surgical intervention recommended by Dr. Singh. Dr. Fletcher noted that in early 2012 petitioner had undergone some treatment for her thoracic pain. He opined that this problem has nothing to do with her current complaints. Dr. Fletcher continued petitioner on light duty work. On 1/9/14 petitioner returned to Dr. Fletcher. He examined her and continued her on modified duty work. On 2/12/14, 3/10/14, and 5/5/14 petitioner followed up with Dr. Fletcher. He was of the opinion that petitioner needed surgery as she had failed conservative treatment. He was concerned about cauda equina as she has had bowel and bladder issues. He noted that her condition was clearly related to her work injury. Dr. Fletcher authorized petitioner off work.

On 10/17/13 the evidence of Dr. Singh was taken on behalf of the petitioner. Dr. Singh testified that when he saw petitioner and asked her if she had ever had problems with her back before, she stated that she did not have any similar problems. Dr. Singh testified that in his office notes of 3/18/13 there was a typographical error when he indicated that the accident was on 10/10/12. He stated that the correct accident date was 12/20/12. Dr. Singh opined that the accident on 12/20/12 caused an aggravation of her pre-existing degenerative condition in her lumbar spine. Dr. Singh opined that petitioner was in need of an anterior lumbar fusion. Dr. Singh noted that he found no positive Waddell signs when he examined petitioner. Dr. Singh was of the opinion that petitioner has a central L5 – S1 disc bulge and loss of disc height at L5-S1. He was of the opinion that this loss of disc height at L5 – S1 would correlate with foraminal narrowing that would occur with disc height loss. Dr. Singh was of the opinion that these factors led him to believe that the petitioner had disc height loss at L5 and S1, and radiculopathy from that which was manifesting her discogenic pain. This information combined with the fact that petitioner had transient relief with her epidural injections made him believe that petitioner would benefit from an L5

– S1 fusion, and this procedure would be reasonable and necessary. Dr. Singh opined that the need for the surgery was caused by the injury on 12/20/12.

On cross-examination Dr. Singh was of the opinion that if petitioner had a back strain in July 2012 that she would not need a lumbar back fusion as a result of it. He was of the opinion that a fusion is necessary for radiculopathy due to disc space collapse, not a muscular strain. Dr. Singh agreed that petitioner's disc space collapse predated her work injury, but not her radiculopathy.

On 2/24/14 the evidence deposition of Dr. Beatty was taken on behalf of the respondent. Dr. Beatty was of the opinion that petitioner had pain in her back but did not have radiculopathy. He was also of the opinion that the fusion at L5 – S1 was reasonable, however it was not connected to her work incident. Dr. Beatty was of the opinion that petitioner's disc space collapse clearly predated her work injury, which means that the underlying cause of her pain was prior to her alleged moving of the bed on 12/20/12. Dr. Beatty stated that petitioner never gave him a history of moving a cart and bending over to pick something up when she injured her back.

On cross-examination Dr. Beatty stated that he did not review the medical records of the Gibson Area Hospital emergency room on 12/20/12. He stated that he relied upon information provided him by respondent's representative. Dr. Beatty agreed that based on petitioner's history, that her lower extremity symptoms began on the date of the workplace accident and have not relented since. Dr. Beatty agreed that trauma may cause a previously asymptomatic degenerative disc disease to become symptomatic. Dr. Beatty agreed that he found decreased sensation over the medial and lateral aspect of her left ankle.

Prior to her injury on 12/20/12 petitioner had seen Dr. Munoz on 10/4/12 for a reevaluation. She had complaints of pain in her hands with stiffness, and also her knees, as well as the mid back and low back. Petitioner gave birth to a baby boy on 7/18/12. He noted that petitioner had low back pain with some radiation to the left thigh during her pregnancy. An examination of the lumbar spine showed mild soreness with flexion and lateral bends. It was noted that petitioner's low back pain syndrome needed some investigation at that point. X-rays of the lumbar spine were ordered. Dr. Munoz was of the opinion that he might recommend some exercises for her low back pain. X-rays of the lumbar spine showed no acute osseous abnormality. On 12/12/12 petitioner followed up with Dr. Munoz. Petitioner had no complaints of lumbar back pain. Dr. Munoz noted that the x-rays of the thoracic spine showed minimal spondylosis, and the x-rays of the lumbar spine were unremarkable.

Petitioner testified that she did not tell the doctor in the emergency room on 12/20/12 that she was pushing a cart. She testified that she said she was pushing the bed from the operating room. She testified that while she was pushing the bed she pulled her back. She stated that it was then worse when she tried to pick something up off the floor. Petitioner denied any prior back problems since 2004. She stated that at that time she injured her upper back and neck. She denied any radiating pain down her left leg.

Petitioner testified that she was paid through 5/19/13. She stated she has not received any payment since that date. Petitioner testified that the one and only incident she sustained to her low back was on 12/20/12. With respect to Dr. Munoz's record dated 10/4/12 she stated that she reported to him that she had mid back pain and pointed to her mid back area. She stated that she had difficulty communicating with Dr. Munoz, and because of that he put down in his records low back instead of mid back. Petitioner admitted that she did have some back pain with radiation to the left thigh while she was pregnant, but this pain was nowhere near the same pain she had following the accident.

Petitioner testified that she no longer works for Christie Clinic. She stated she was not allowed to return to work with restrictions. Petitioner testified she cannot stand or sit without pain.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner testified that on 12/20/12 she injured her low back while she was trying to push a surgical bed, that weighed a couple hundred pounds, into the hallway. She testified that she had difficulty pushing it straight because it wanted to go sideways. She stated that her body was in an awkward position while she was pushing it, and she felt pain in her back. Petitioner then experienced more pain when she squatted down to pick something up from the floor,

Petitioner sought treatment that same day. She presented to the emergency room. The history she gave to the nurse when she first presented was consistent with her testimony at trial. She stated that she was pushing a patient bed when she twirked her back, and when she went squatted down to pick something up from the floor she felt the pain. She complained of pain shooting down her bilateral legs.

The history Dr. Geada noted that same day in the emergency room was that she was pushing a cart and felt a twinge or pull to her lower back and has had pain since then. However, the accident histories documented by Dr. Fletcher, Dr. Singh and Dr. Beatty were the same as was provided to the nurse in the emergency room and her testimony at trial.

This accident was unwitnessed, and respondent offered no credible evidence to rebut petitioner's testimony of how the accident occurred. The respondent placed alot of weight on the history documented by Dr. Geada that petitioner was pushing a cart. However, the arbitrator finds the history documented by the nurse in the emergency room on 12/20/12 and the history documented by all the other examining and treating doctors is consistent, which the arbitrator finds more credible than the one documented history of Dr. Geada that petitioner was pushing a cart instead of a operating room bed. The arbitrator finds the use of "cart" versus "bed" in one medical history insufficient to find petitioner was not consistent in providing an accident history to her treaters and examiners.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury to her low back that arose out of and in the course of her employment by respondent on 12/20/12.

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

The petitioner claims her current condition of ill-being as it relates to her low back causally related to the injury she sustained on 12/20/12. Respondent claims petitioner had a preexisting degenerative low back condition and had problems with it as recently as October of 2012, and therefore her condition of ill-being after 12/20/12 is related to her preexisting lumbar spine condition and not the injury she sustained on 12/20/12.

Petitioner has a history of rheumatoid arthritis, obesity, and lupus anticoagulant. Prior to the injury on 12/20/12 petitioner had followed up with Dr. Munoz, her rheumatologist, on 10/4/12 for reevaluation. Among her complaints were mid and low back pain. Petitioner reported some low back pain with radiation to her left thigh during pregnancy. There was no indication that petitioner had bilateral radiation to her toes. Petitioner gave birth in July of 2012. An examination of the lumbar spine at that time showed mild soreness with flexion and lateral bends. Dr. Munoz ordered an x-ray of the lumbar spine and was of the opinion he might recommend some exercises for her low back. X-rays of the lumbar spine showed no acute osseous abnormality. Despite these isolated low back complaints, when petitioner followed-up with Dr. Munoz on 12/12/12 she had no lumbar back complaints, and the x-rays of her lumbar spine were unremarkable.

It was not until after the injury on 12/20/12 that petitioner had severe pain in her low back and bilateral radiculopathy. It was also not until after the accident on 12/20/12 that petitioner was restricted to modified duty work. Petitioner had never had an MRI for her low back until after the accident on 12/20/12, and no surgery had been recommended. On 1/10/13 the MRI showed a posterior central disc

protrusion at L5 - S1 without nerve impingement or significant foraminal compromise. Following this MRI and failure to improve with conservative treatment that included physical therapy and epidural steroid injections, an anterior L5-S1 fusion was recommended.

Dr. Fletcher was of the opinion that petitioner's prior problems in 2012 were not casually related to her current condition of ill-being as it related to her low back after the accident on 12/20/12. Dr. Singh opined that the accident on 12/20/12 caused an aggravation of her preexisting degenerative condition in her lumbar spine. Dr. Singh found no positive Waddell signs on examination.

The only doctor to opine that petitioner's current condition of ill-being as it relates to his lumbar spine is not causally related to the accident on 12/20/12 is Dr. Beatty, respondent's examining position. Dr. Beatty was of the opinion that petitioner had back pain, but not radiculopathy. He was of the opinion that her disc space collapse predated the accident. Dr. Beatty also based his opinion on his finding that petitioner had positive Waddell signs on examination, her accident was not witnessed, and he found no compelling objective evidence, other than a temporal connection that there was an ongoing back problems as a result of a work injury.

Having found the petitioner sustained an accidental injury to her lumbar spine on 12/20/12, that her preexisting back pain was worse after the accident on 12/20/12, that she developed symptoms of bilateral radiculopathy only after the accident on 12/20/12, only needed to be on modified duty work as a result of the accident on 12/20/12, and only needed surgery after the accident on 12/20/12, the arbitrator finds the opinions of Dr. Fletcher and Dr. Singh more credible and consistent with the credible evidence than Dr. Beatty. As such, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that her current condition of ill-being as it relates to her low back and radiculopathy is causally related to the injury she sustained on 12/20/12. The arbitrator found the petitioner's history credible. The arbitrator also adopts the opinions of Dr. Singh. The arbitrator finds that even if petitioner had a back strain in July of 2012 and had complaints of low back pain in October of 2012, the follow-up report of Dr. Munoz on 12/12/12 showed that just 8 days before the accident on 12/20/12 petitioner had no complaints of back pain.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury to her lumbar spine and that her current condition of ill-being is causally related to the injury she sustained on 12/20/12 the arbitrator finds all treatment petitioner received for her lumbar

spine from 12/20/12 through 5/30/14 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 12/20/12.

Based on the above, as well as the credible evidence the arbitrator finds the Respondent shall pay reasonable and necessary medical services for petitioner's lumbar spine from 12/20/12 through 5/30/14, as provided in Sections 8(a) and 8.2 of the Act. The arbitrator further finds the respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Petitioner is claiming that she is entitled to the anterior L5-S1 fusion recommended by Dr. Singh. The arbitrator also notes that both Dr. Fletcher and Dr. Beatty opined that this surgery was necessary, even though Dr. Beatty opined that it is not causally related to the accident on 12/20/12. The only doctor to find this prospective surgery was not reasonable and necessary was Dr. Erickson, who simply performed a utilization review. Dr. Erickson did not examine petitioner or review the actual films of the MRI of petitioner's lumbar spine.

Having found petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury to her lumbar spine, that her current condition of ill-being is causally related to the injury she sustained on 12/20/12, that all treating and examining doctors (Fletcher, Singh and Beatty) opined that the prospective surgery is reasonable and necessary, even if not causally related to the injury on 12/20/12, the arbitrator finds the petitioner is entitled to the anterior L5-S1 fusion and post-operative treatment recommended by Dr. Singh.

Based on the above, as well as the credible evidence, the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses associated with the anterior L5-S1 fusion and post-operative treatment recommended by Dr. Singh, pursuant to Sections 8(a) and 8.2 of the Act.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims she was temporarily totally disabled from 1/8/13-5/30/14. Respondent claims petitioner was temporarily totally disabled from 1/8/13-5/23/13. Therefore, the arbitrator will look only at the period from 5/24/13 through 5/30/14. Petitioner was restricted to light duty work from 12/21/12 through 2/11/14. Petitioner presented unrebutted testimony that after presenting her light duty restrictions to respondent she was told there was not light duty work available. She also stated that her employer at Christie Clinic did not want her to work while on restrictions. On 2/12/14 petitioner was taken off work

pending surgery. Respondent cut off petitioner's temporary total disability benefits on 5/23/13 based on the opinions of Dr. Beatty.

Having adopted the opinions of Dr. Fletcher and Dr. Singh, finding them more credible than those of Dr. Beatty, and finding petitioner's current condition of ill-being as it relates to her low back causally related to the injury she sustained on 12/20/12, the arbitrator finds the petitioner is entitled to temporary total disability from 1/8/13 through 5/30/14.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner was temporarily totally disabled from 1/8/13-5/30/14, a period of 72-3/7 weeks. The respondent shall be given credit for the $7,751.08 it has already paid in temporary total disability benefits, and the $2,000 advance it paid on 3/15/14. Respondent shall pay any remaining temporary total disability benefits due and owing pursuant to Section 8(b) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Weir,
Petitioner,

vs. No: 08 WC 36478

15IWCC0432

Cerro Flow,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, temporary total disability, and the nature and extent of the permanent disability, and being advised of the facts and law, modifies the Arbitrator's finding of causal connection and award of permanent partial disability. In addition to these modifications, the Commission vacates the Arbitrator's award of temporary total disability and medical expenses, and otherwise affirms and adopts the July 1, 2014 Decision of Arbitrator Edward Lee, which is attached hereto and made a part hereof.

Petitioner, a 59 year old maintenance worker, repaired all types of machinery at Respondent's plant. On July 18, 2008, PA-C Colon at Midwest Occupational Medicine ("MOM") evaluated Petitioner for an injury to his low back, sustained when he was picking up a plate weighing 30-40 pounds earlier that day. PA-C Colon diagnosed acute lumbosacral strain and restricted Petitioner to light duty. Petitioner continued to treat conservatively with the company physicians at MOM and remained on light duty until September 30, 2008, when Dr. Ruiz at MOM determined that there was a lack of physical evidence to verify Petitioner's subjective complaints and discharged him from care.

Petitioner testified he had been treating concurrently with the doctors at MOM and Dr. Huynh at Barnes Jewish Wohl Clinic, to whom he reported a consistent history of accident. Petitioner also reported occasional shooting leg pain, especially while working. On October 22, 2009, the Clinic referred Petitioner for an MRI, which revealed a fragmented herniated disc at L5-S1 impinging on the S1 nerve root. Petitioner was referred to a spine surgeon, Dr. Brown.

Dr. Brown evaluated Petitioner on May 21, 2010 and noted complaints of severe back pain radiating down his right leg. A myelogram performed on June 2, 2010 showed extensive multilevel degenerative disc disease with stenosis from L2 through L5 and diffuse bulges from L2-S1. Dr. Brown first ordered a series of epidural steroid injections, and later lumbar decompression surgery. On July 8, 2010, he performed decompression and laminectomy from L2 through S1. After post-operative rehabilitation, Petitioner returned to full duty work for Respondent on November 19, 2010.

Dr. Brown opined at deposition that Petitioner suffered from significant multilevel degenerative disc disease, resulting in central canal stenosis and a broad-based disc bulge impinging on S1 nerve roots. Dr. Brown diagnosed lumbar stenosis, which he described as usually a degenerative process. However, he opined that it could be exacerbated by acute events and estimated there was a 10% chance that Petitioner's July 18, 2008 accident accelerated his degenerative condition. On cross-examination, Dr. Brown testified that the diagnostic tests showed no evidence of acute trauma and admitted that Petitioner's degenerative disease would have progressed with or without the accident. He also admitted that he could not say with any reasonable degree of medical certainty that the condition for which Petitioner required surgery was related to his work accident. The doctor found that the accident might have caused a temporary aggravation of Petitioner's degenerative condition, but opined that it might also have set off a chain of back spasms that accelerated the degenerative process. He noted that when someone has the degree of degeneration Petitioner has, any type of physical activities, including activities of daily living, could aggravate the condition.

Respondent offered the Section 12 opinion of Dr. Chabot, who examined Petitioner on October 12, 2011. Dr. Chabot opined that Petitioner's degenerative condition pre-existed his work accident. The doctor noted that Petitioner had been diagnosed by occupational medicine and Dr. Huynh at Wohl Clinic with a work-related back strain which, according to Petitioner's medical records, appeared to have resolved quickly with conservative treatment. However, in March 2009, five months after his discharge from MOM and eight months after the accident, Petitioner's complaints worsened significantly, and his leg pain, which had been primarily unilateral, became bilateral. Dr. Chabot noted the diagnostic tests revealed multi-level advanced degeneration, disc dessication and disc space collapse with bulging at multiple levels, as well as facet degeneration. Dr. Chabot opined these conditions were caused primarily by genetic and idiopathic factors and agreed with Dr. Brown that almost any physical activity could worsen Petitioner's profound degeneration.

15IWCC0432

Arbitrator Lee found Petitioner's current condition of ill-being causally connected to his work injury on July 18, 2008 and awarded all medical expenses related to treatment of the degenerative lumbar condition, including surgery and post-operative care, a total of $55,763.48. The Arbitrator also awarded 19-3/7 weeks temporary total disability benefits, the period from the surgery to the full duty return to work, and permanent partial disability benefits of 12.5% loss of use of the person as a whole.

Petitioner appealed the Arbitrator's permanency award, arguing that he suffered at least 25% loss of use of the person as a whole. Respondent cross-appealed, seeking review of the Arbitrator's finding of causal connection and his award of medical and temporary total disability benefits as well as a reduction of the award for permanent partial disability.

Dr. Brown admitted via his deposition that there was only a 10% chance that the muscle spasm that resulted from Petitioner's work accident set off a series of spasms that over time accelerated and aggravated his degenerative condition, so as to require injections and surgical intervention. Dr. Chabot opined that Petitioner suffered only a lumbar strain as a result of the work accident and that all medical treatment after his September 30, 2008 discharge from MOM was related to his ongoing degenerative condition, rather than to his work injury. The Commission finds Dr. Brown's causation opinion too speculative to support a finding of causal connection between Petitioner's July 18, 2008 work accident and his current condition of ill-being, and further finds Dr. Chabot's causation opinion more persuasive than Dr. Brown's admittedly speculative opinion.

After considering the entire record, and for the reasons set forth above, the Commission finds that Petitioner's current condition of ill-being is not causally related to his July 18, 2008 accident. The Commission finds that Petitioner suffered a back strain as a result of his work accident, and that injury resolved shortly after the date of injury. The Commission therefore vacates the award of medical expenses incurred after Petitioner's discharge from MOM on September 30, 2008. The Commission likewise vacates the Arbitrator's award of 19-3/7 weeks of temporary total disability benefits, based upon the Commission's finding that Petitioner's post-September 2008 medical treatment was not causally related to his work accident. The Commission further finds that the Arbitrator's award of 12.5% loss of use of the body as a whole is excessive under the facts as interpreted by the Commission and is therefore reduced to 7.5% loss of use of the body as a whole.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the April 4, 2014 Decision of the Arbitrator is modified with regard to the issues of causal connection and the award of permanent partial disability, as described above. The Arbitrator's awards of temporary total disability and medical expenses are hereby vacated.

15IWCC0432

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's finding of causal connection is modified to reflect the Commission's determination that Petitioner's work injury, a lumbar strain, was resolved by the time of his discharge from treatment by MOM on September 20, 2008. All subsequent medical treatment and temporary total disability are causally related to Petitioner's ongoing degenerative condition, rather than to his July 18, 2008 work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $456.49/week for a period of 37.5 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 7.5% loss of use of the person as a whole.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 9 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/07/15
jdl/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

WEIR, ROBERT
Employee/Petitioner

Case# **08WC036478**
08WC014250

CERRO FLOW
Employer/Respondent

15IWCC0432

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:

1580 BECKER SCHROADER & CHAPMAN PC
TODD SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

ROBERT WEIR
Employee/Petitioner

v.

CERRO FLOW
Employer/Respondent

Case #08 WC 36478

Consolidated cases: **08 WC 14250**

15IWCC0432

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 28, 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 _____

15IWCC0432

FINDINGS

On July 18, 2008, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $39,562.50; the average weekly wage was $760.82.

On the date of accident, Petitioner was **59** 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 $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of whatever the parties stipulated (see stipulation sheet) under Section 8(j) of the Act.

ORDER

The Arbitrator finds Petitioner's accident of July 18, 2008 arose out of and was in the course of his employment with Respondent.

The Arbitrator finds Petitioner's current condition of ill-being is causally related to his injury of July 18, 2008.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $55,763.48, as provided in Sections 8(a) and 8.2 of the Act.

The Rehabilitation Institute of St. Louis	$636.00
Washington University Physicians	$10,921.00
Barnes Jewish Hospital	$44,206.48
TOTAL	**$55,763.48**

Respondent shall pay Petitioner temporary partial disability benefits of $507.21 for 19 3/7 weeks commencing July 6, 2010 through November 18, 2010, as provided in Section 8(b) of the Act. The Arbitrator basis this finding based upon the medical records, the parties stipulations and the testimony of the Petitioner.

Respondent shall pay Petitioner permanent partial disability benefits of $456.49/week for 62.5 weeks because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

6/29/14
Date

Petitioner works in maintenance for Respondent repairing all types of machinery at the plant. Petitioner was initially seen on July 18, 2008 at Midwest Occupational Medicine, the company doctor, for an injury to his low back when he was picking up a plate weighing between 30 and 40 pounds when he had acute and sudden pain in his low back. (PX 1 at 1). Their assessment was acute lumbosacral strain to the low back. (Id.) Petitioner began working on light duty and returned to follow-up with Midwest Occupational Medicine on July 28, 2008. (PX 1 at 6). On September 9, 2008, the Petitioner was placed in physical therapy three times a week for three weeks because of the continued problems in his right lower back. (PX 1 at 10). On September 30, 2008, Midwest Occupational Medicine indicated there was a lack of physical evidence to verify subjective complaints.

Petitioner was being seen at the same time at Barnes Jewish Wohl Clinic by Dr. Huynh. A history was taken showing July 18, 2008 having some back pain, was at work, picking up something at work, felt pop in back. Occasionally some pain shooting down legs bilaterally. (PX 3 at 1). Petitioner was seen by Dr. Huynh again on October 6, 2008, noted to still have pain with exertion with a diagnosis of low back pain injury at work, resolving, no current worrisome symptoms, continue supportive treatment. (PX 3 at 7). Dr. Huynh indicated Patient will go to PT if not improved at next visit, defers at this time. (Id.) Petitioner next saw Dr. Huynh on October 6, 2008, still complaining of on-going low back pain. (PX 3 at 9).

Petitioner then saw Dr. Huynh on March 16, 2009 indicating that he had been having radiating pain from his back, down both legs, right worse than left. (PX 3 at 10). Dr. Huynh diagnosed low back pain, likely sciatica. (PX 3 at 11). A referral form plan of care revealed Patient is a 60 year old with history of back injury on July 18, 2008 who has had sciatica. (PX 3 at 13). Petitioner was seen again by Barnes Jewish Clinic relating back pain which doesn't bother patient until he starts working, low back pain when he walks, gets pain down into right leg and occasionally into left leg. If he lifts something heavy, gets severe pain in back into leg. (PX 3 at 20). Dr. Huynh's assessment was low back pain; X-rays with mild DJD (degenerative joint disease), likely mild radiculopathy with pain into right greater than left leg. (PX 3 at 21). On October 22, 2009 the Clinic referred Petitioner for an MRI. (PX 3 at 23). The MRI revealed a fragmented herniated disc impinging on the S1 nerve root with Petitioner still having complaints of low back pain and pain shooting down the right leg. Dr. Huynh referred Petitioner to a spine surgeon, Dr. Justin Brown. (PX 3 at 28).

Dr. Justin Brown, a spine surgeon, took a history which revealed Petitioner had an injury on July 18, 2008 when he was trying to remove a part from unloader and felt a pain in his back. (PX 4 at 1). At that time, Petitioner experienced severe pain radiating across his back from the right to the left and since then has had pain that radiates down his right leg. (Id.) Petitioner states he frequently experiences exacerbations of this pain that happens one to three times a week when he develops severe shooting pain down the leg and it becomes difficult to walk. (PX 4 at 1). Petitioner underwent a series of lumbar epidural injections. (PX 17). Petitioner then underwent surgery on July 8, 2010 wherein the doctor performed an L2-3, L3-4, L4-5 bilateral interlaminar decompressions (involving partial bilateral laminectomies of superior 5 and inferior 4, superior 4 and inferior 3, superior 3 and inferior 2) with resection of ligamentum flavum and S1 complete bilateral laminectomy and decompression. (PX 18 at 1).

Dr. Justin Brown testified his impression after reviewing the MRI and myelogram was pretty significant multilevel degenerative disc disease, which resulted in central canal stenosis and also Petitioner appeared to have a broad based disc bulge, that seemed to be potentially impinging on the S1 nerve roots on both sides. (PX 21 at 8). Dr. Brown recommended surgery in the form of lumbar decompression. (Id.) Dr. Brown stated the description of the event that he has from Dr. Chabot's notes indicated the back pops and then he immediately

thereafter has back pain which is solely localized to the back. It isn't until sometime thereafter that I see in the notes that he had pain affecting the leg as well. That being the case, yes, we could conjecture that this contributed to or maybe accelerated the degeneration of his spine, but this would be an indirect correlation. A herniated disc which immediately compressed a nerve root would be a direct correlation. A back spasm episode, which is what this more describes, would be an indirect correlation that could have resulted in an acceleration of the degenerative process that was already going on over the next few years. (PX 21 at 13).

Respondent's Section 12 Examiner, Dr. Michael Chabot indicated he felt any activity could aggravate a condition with such profound degeneration which possibly could include his work activity. (RX 1).

Dr. Brown testified his opinion was the injury of July 2008 could have contributed, but I would say that this gentleman would have progressed with his degenerative disease of the spine with or without the work injury. It may have simply presented earlier as a result of the injury. (PX 21 at 18). Dr. Brown further testified the accident would not be the dominate or primary cause, however, there was still the possibility of it contributing to exacerbation or more rapid development of the symptoms necessitating surgery. (PX 21 at 20, 21). When questioned whether or not the work incident was a temporary aggravation, Dr. Brown replied, "I think the aggravation would correspond with the on-going back strain symptoms. So if that back strain came and went within that week and never reoccurred, then we would say yes, that incident did not correspond with significant contribution to his degeneration. The fact that it seems to pop up over and over and over again, thereafter, makes you wonder if this initial event didn't set off a sort of chain predisposing more back spasms and these back spasms accelerated the process. (PX 21 at 21, 22).

Petitioner testified he did not have any previous back problems prior to the accident of July of 2008. Dr. Brown noted that this would be the best piece of evidence that would help our case one way or another would be able to find out whether or not he had an episode like this prior to 2008. (PX 21 at 23). Dr. Brown clarified that he was going to stick with his original summary that it again, this is not a direct or direct cause and effect, he did not herniate a disc at the time of lifting the thing up which resulted in his disability but it did result in a back strain which then perpetuated sort of chronically thereafter. That sort of back strain can accelerate degenerative spine problems. (PX 21 at 24, 25). When asked if Petitioner had no prior episode prior to his accident on July 18, 2008, then that would even further firm up his opinion concerning acceleration of a pre-existing condition due to the accident. Dr. Brown indicated if Petitioner had no further and no prior episodes of back pain, then yes, that would contribute to him believing that this is an exacerbating factor. (PX 21 at 27).

Petitioner testified that he has returned to full duty with Respondent. Petitioner testified he is more guarded in how he moves post-surgery and has had to limit some activities because of discomfort.

The Arbitrator finds the following:

1. The Arbitrator finds Petitioner's accident of July 18, 2008 arose out of and was in the course of his employment with Respondent. The Arbitrator basis this finding on the testimony of Petitioner and Dr. Justin Brown. Petitioner testified he had no previous injuries to his low back prior to July 18, 2008. Since the accident, Petitioner low back pain has been constant and led him to the surgery performed by Dr. Brown on July 8, 2010.

2. The Arbitrator finds Petitioner's current condition of ill-being is causally related to his injury of July 18, 2008. The Arbitrator basis this finding on Petitioner's testimony that he had no prior back problems and testimony by Dr. Justin Brown indicating the accident accelerated Petitioners preexisting low back condition.

3. Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule $55,763.48, as provided in Sections 8(a) and 8.2 of the Act.

The Rehabilitation Institute of St. Louis	$636.00
Washington University Physicians	$10,921.00
Barnes Jewish Hospital	$44,206.48
TOTAL	**$55,763.48**

4. Respondent shall pay Petitioner temporary partial disability benefits of $507.21 for 19 3/7 weeks commencing July 6, 2010 through November 18, 2010, as provided in Section 8(b) of the Act. The Arbitrator basis this finding based upon the medical records, the parties stipulations and the testimony of the Petitioner.

5. Respondent shall pay Petitioner permanent partial disability benefits of $456.49/week for 62.5 weeks because the injuries sustained caused the12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Dated: 6/29/14

Arbitrator Edward Lee

JUL 1 - 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angel Renta,
Petitioner,
vs.

NO: 12 WC 12129
13 WC 03613

City of Chicago - Dept. of Aviation,
Respondent,

15IWCC0433

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 for temporary total disability, permanent disability and medical expenses and nature and extent of permanent disability and being advised of the facts and law, corrects a clerical error and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the clerical error in the Arbitrator's Decision by striking #12 WC 12129 from the Decision. Petitioner filed an Application for Adjustment of Claim on April 5, 2012 alleging a date of accident of April 1, 2012 with claimed injury to his neck and back. Petitioner's attorney was Sheldon I. Minkow & Associates. The claim was given #12 WC 12129 and was assigned to Arbitrator Flores. Petitioner filed an Application for Adjustment of Claim on February 6, 2013 alleging a date of accident on December 18, 2012 with an occurrence of tripping on metal strap on step and claiming injury to his left rotator cuff, arm and hand. Petitioner's attorney was David F. Szczecin & Associates. The claim was given #13 WC 3613 and was initially assigned to Arbitrator Black, but was later re-assigned to Arbitrator Flores based upon a consolidation of the cases.

On June 18, 2013, Arbitrator Flores approved the settlement of case #12 WC 12129. That same date, Arbitrator Flores asked in writing, "What happened to the consolidated 2013 case? Should I expect another settlement contract?" Attorney David F. Szczecin & Associates subsequently filed a Motion to Sever Consolidated Cases #12 WC 12129 and #13 WC 3613. Arbitrator Flores granted this Motion on November 25, 2013.

15IWCC0433

Case #13 WC 3613 was heard on February 11, 2014 by Arbitrator Hegarty. Arbitrator Hegarty's Decision was filed with the Commission on April 7, 2014. However, #12 WC 12129 was included along with #13 WC 3613 on the Decision. The Commission finds that this clerical error should be corrected by striking #12 WC 12129 from the Arbitrator's Decision. Respondent filed a Petition for Review with both numbers #12 WC 12129 and #13 WC 3613. The Commission finds this was in error and should have only been #13 WC 3613. Case #13 WC 3613 is the only case that was reviewed. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 7, 2014 is hereby affirmed and adopted, except for correction of the clerical error noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $656.94 per week for a period of 8-1/7 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 $5,921.00 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 Respondent pay to Petitioner the sum of $590.77 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 of the person as a whole to the extent of 5%.

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.

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

DATED: JUN 9 - 2015
MB/maw
o05/07/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RENTA, ANGEL
Employee/Petitioner

Case# **12WC012129**

13WC003613

CITY OF CHICAGO-DEPT OF AVIATION
Employer/Respondent

15IWCC0433

On 4/7/2014, 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:

5319 DAVID F SZCZECIN & ASSOC LTD
ANDREW A GALICH
205 W RANDOLPH ST SUITE 1801
CHICAGO, IL 60606

0766 HANNESSY & ROACH PC
WILLIAM F O'BRIEN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0433

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angel Renta
Employee/Petitioner

v.

City of Chicago - Dept. of Aviation
Employer/Respondent

Case # **12 WC 12129**

Consolidated cases: **13 WC 03613**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **February 11, 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 _____

FINDINGS

On **December 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$51,215.84**; the average weekly wage was **$984.92**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **5** 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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $656.94/week for 8 1/7 weeks, commencing December 18, 2012 through February 18, 2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $0 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule of $288.00 to MercyWorks, $1,558.00 to Northwest Orthopedics, and $4,075.00 to Archer Open MRI, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $0 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $590.77/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.

Signature of Arbitrator

4/7/14
Date

APR 7 - 2014

15IWCC0433

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANGEL RENTA, **Petitioner,**	)	
vs.	)	**No. 12 WC 12129** **13 WC 03613**
CITY OF CHICAGO – DEPT. OF AVIATION. **Respondent.**	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

Petitioner was employed by the City of Chicago, Department of Aviation at O'Hare International Airport as an Aviation Police/Security Officer. Petitioner acknowledges a prior rotator cuff repair. Part of Petitioner's job required checking incoming commercial vehicles and service trucks at station posts and patrolling the Airport. On December 18, 2012, Petitioner, who was thirty-nine years old (39), was assigned to Post 11 to inspect incoming vehicles. Post 11 was a booth situated on an island with a roadway on either side of the island. Post 11 was not open to the public. On December 18, 2012, Petitioner took his lunch break and was relieved by Officer Chavez who assumed the Post 11 duties. Petitioner testified as he was returning from lunch he observed a vehicle waiting at Post 11 for inspection. Petitioner testified that he rushed to get inside the Post 11 booth in order to inspect the waiting car and to relieve Officer Chavez. Petitioner testified that he stepped up a single metal step and as he opened the door to Booth 11, his foot was caught on a metal "threshold" strip located at the base of the sliding door. Petitioner landed on his left side, injuring his left arm, left shoulder, left wrist, and left knee.

Officer Chavez, who was inside Post 11 at the time Petitioner fell, helped Petitioner up and called the supervising officer, Sergeant Nalls. Paramedics were called and Petitioner was transported to Resurrection Medical Center's emergency room where x-rays of his left shoulder and left wrist were negative for fracture. Petitioner was released, the pain medication Norco was prescribed and his arm was placed in a sling. Petitioner was ordered to follow-up with Dr. Rimington for an orthopedic evaluation in two (2) days. (PX 1) On December 20, 2012, Petitioner was seen at Mercy Works. Petitioner was diagnosed with a left shoulder sprain,

medication was prescribed and Petitioner was instructed not to use his left arm. A steroid injection in the left shoulder was administered. (PX 2)

On December 21, 2012, Petitioner consulted with T.R. Rimington, M.D., an orthopedic physician who noted both x-rays taken on the day of the accident were negative for fracture. Petitioner reported a prior rotator cuff repair in 2003 or 2004. Petitioner reported no shoulder problems between the prior surgery and the accident at issue. Petitioner reported pain levels to his left shoulder at 8/10. Dr. Rimington noted decreased range of motion in the left shoulder. The doctor diagnosed a left shoulder sprain with biceps tendinitis and wrist pain. Dr. Rimington administered a steroid injection to the left biceps tendon. A wrist brace was recommended and a no-work order was issued for two (2) weeks. (PX 3)

On December 28, 2012, records from MercyWorks indicate that Dr. Edwardo Cabrera administered a steroid injection to the Petitioner's left shoulder. (PX 2)

On January 4, 2013, Dr. Rimington noted that Petitioner had two (2) days of relief from the last shoulder injection followed by left shoulder pain. The doctor noted a positive Speed's Test, O'Brien Test, positive impingement tests and mild weakness of the rotator cuff in the supraspinatus. Dr. Rimington recommended an MRI arthrogram to rule out a possible labral or rotator cuff tear. The doctor continued his no-work order for two (2) weeks. (PX 2)

MRI studies were performed on February 20, 2013. (PX 4)

Dr. Rimington reviewed the MRI images, advising Petitioner by phone on March 15, 2013 that the "the rotator cuff does, indeed, appear intact." The doctor agreed with the written report that the images showed increased signal in the labrum. (PX 3)

The Arbitrator notes that Petitioner did not include the February 20, 2013 MRI report, only the bill.

On April 2, 2013, Petitioner returned to Dr. Rimington with ongoing complaints of pain in the left shoulder. The doctor noted that Petitioner was unable to fully lift the shoulder, and was getting some "clicking" in the shoulder. The doctor again analyzed the February 20, 2013 MRI and found that there was a small tear in the superior labrum. Dr. Rimington diagnosed a left shoulder sprain with superior labral tear and biceps tendinitis. The doctor administered a steroid injection in the shoulder. Dr. Rimington recommend a formal therapy program for 1 month for the rotator cuff, and possibly revision surgery with arthroscopy and evaluation of the rotator cuff (PX 3).

Petitioner testified that while he was off work between December 18, 2012 and February 14, 2013, he received no benefits from Respondent. Petitioner testified that he returned to work on February 14, 2013 out of financial necessity Dr. Rimington had not released him back to work.

According to Petitioner, he did not follow-up with Dr. Rimington after April 2, 2013 and has had no additional medical care with respect to his work injuries because Respondent will not pay for his medical bills. Petitioner testified he wants further medical treatment.

Petitioner alleges that the accident was caused: 1. by his rushing and 2. by tripping on a surface that failed to have anti-skid protection.

Petitioner testified that he continues to suffer pain to his left shoulder that increases with changes in the weather.

Byron Patton, Aviation Safety Director for the City of Chicago, testified for the Respondent stating he examined the step on December 19, 2012 for the City of Chicago. Respondent introduced photographic evidence of the accident area through Mr. Patton. (R group Ex. 4) Mr. Patton did not find any defect on or around the stair or threshold at issue. In Mr. Patton's opinion, there was an anti-skid material on the step on the day of Petitioner's accident.

OPINION AND ORDER

Accident and Causal Relationship to the Injury

A claimant must prove by the preponderance of credible evidence that an injury both arose out of and was in the course of employment in order to receive compensation under the Act. "In the course of" refers to the time, place and circumstances under which the accident occurred, while "arising out of" refers to the origin or cause of the accident that gave rise to the injury. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill.2d 478, 483 (1989). It is uncontested that Petitioner was at his usual place of work, during business hours, satisfying the "in the course of" element.

For an accidental injury to arise out of employment, its origin must be in some risk connected with or incidental to the employment. The fact that Petitioner's duties took him to a place of injury and that, but for his employment he would not have been there is insufficient to support a finding that his injuries arose out of the employment. For an accidental injury to arise out of one's employment, its origin must be in some risk connected with or incidental to the employment. *Caterpiller Tractor v. Industrial Commission,* 367 Ill.App.3d 102, 106, 853 N.E.2d 799 (1st Dist. 2006) While slips on staircases have, in some instances, been deemed compensable, taking stairs themselves is a neutral risk. There must be some other cause for a fall to deem that a work-related accident. *First Cash Financial Services v. Industrial Commission*, 367 Ill.App.3d 102, 106, 853 N.E.2d 199 (1st Dist. 2006)

Here, the Petitioner slipped on a threshold area after climbing a single step. In and of itself a misstep is not uniquely associated with Petitioner's employment. Petitioner cites two potential work related causes for his slip and fall accident: first, the lack of a non-skid surface on the

stair/threshold area and second, that he was in a hurry. With respect to an alleged defect on the stair, Respondent's witness Bryan Patton, Safety Director for the City of Chicago – Aviation Department, credibly testified that there was no defect on the stair/threshold area and that the stair did have an anti-skid material on the day of Petitioner's slip and fall.

The other potential cause, that Petitioner was in a hurry, is supported by the evidence. Petitioner testified that as he was returning from lunch, he noticed a vehicle waiting outside the Post 11 booth for inspection. Petitioner testified that he rushed to get inside the Post 11 booth in order to inspect the waiting vehicle and to relieve his partner, Officer Chavez. Considering all of the evidence presented, the Petitioner's objective of resuming his work duties, in light of a waiting car and the desire to relieve Officer Chavez, did justify Petitioner rushing to Post 11. The Arbitrator found Petitioner's testimony at trial to be credible. Based on Petitioner's credible testimony the Arbitrator finds enough evidence of an increased risk based on the Petitioner's speed when he returned to Post 11 on December 18, 2012, and therefore finds that the accident arose out of and in the course of Petitioner's employment by Respondent.

The Arbitrator further concludes that Petitioner's current condition of ill being is causally related to the injury. The Arbitrator bases this finding on the medical records from Resurrection Hospital, Mercy Works, and Dr. Rimington all of which provide consistent notes and histories with respect to the work accident and Petitioner's subsequent injuries. (PX 1, 2, 3)

The Arbitrator viewed surveillance footage of the Petitioner and did not find it compelling.

Notice

The Arbitrator finds that timely notice was given of the accident. This is based on Petitioner's Exhibit 5 and Respondent's Exhibit 1 which were prepared on December 18, 2012. Both reflect notice of the accident was given to Respondent on the day it happened.

Medical Services

Petitioner's medical records reflect that Petitioner sustained an injury that required medical care and treatment. Treatment included diagnostic studies, a sling, a brace, and steroid injections. (PX 1, 2, 3)

Petitioner submitted medical bills from Mercy Works for $288.00, Northwest Orthopedics for $1,558.00, and Archer Open MRI for $4,075.00. All bills remain unpaid.

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary and that Respondent has not paid all appropriate charges for all reasonable and necessary medical services. The Respondent is ordered to pay each medical bill pursuant to Section 8(a) and subject to the limits of Section 8.2 of the Act.

Temporary Benefits

Petitioner was off work from the date of the accident December 18, 2012 until February 13, 2013, pursuant to his treating doctor's orders. (PX 1, 2, 3) The Arbitrator finds that Petitioner is entitled to TTD benefits of $656.94/week for 8 weeks, or $5,255.52.

Nature and Extent of the Injury

Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. 820 ILCS 305/8.1b(b) states the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim,

With regards to paragraph (i) of Section 8.1b of the Act:

i. Petitioner did not undergo an AMA Impairment Examination.

With regards to paragraph (ii) of Section 8.1b of the Act:

ii. Petitioner's occupation is an Aviation Police/Security Officer. Petitioner's duties include inspecting vehicles and patrolling the airport. The Arbitrator notes that the Petitioner's permanent partial disability is greater based on the fact that his occupation requires physical labor with significant arm and shoulder activities.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner was thirty-nine (39) years old at the time of the accident on December 18, and forty (40) years old as of the date of the hearing. No evidence was presented as to how Petitioner's age impacted upon his disability.

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 his pre-accident employment with Respondent as a Police Officer. Petitioner has functioned in his pre-accident capacity since his return to work.

v. With regards to paragraph (v) of Section 8.1(b) of the Act:
The Arbitrator finds the Petitioner has demonstrated evidence of disability. Petitioner credibly testified that he continues to suffer pain in the left from his accident. Petitioner's complaints are corroborated in the treating medical records: Petitioner received four (4) steroid injections to the left shoulder between December 20, 2012 and April 2, 2013; April 2, 2013; On Petitioner's last visit to Dr. Rimington on April 2, 2012, the doctor noted "clicking" as wells as Petitioner's pain and inability to fully lift his left shoulder. Dr. Rimington diagnosed a "left shoulder sprain with superior labral tear and biceps tendinitis" based on February 20, 2013 MRI, Dr. Rimington recommended physical therapy for 1 month for the rotator cuff, and possible revision surgery with arthroscopy and evaluation of the rotator cuff. Petitioner's complaints, supported by the treating medical records, substantiate a disability pursuant to Section 8(e).

Pursuant to Will County Forest Preserve District v IWCC, 2012 Ill.App. Lexis 109, Petitioner's injuries to the left shoulder justifies an award on the person as a whole. The shoulder is distinct from the arm and permanency for a shoulder injury should be awarded pursuant to Section 8(d)2.

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 the factors for which evidence was presented, the Arbitrator concludes that Petitioner has sustained a 5% permanent loss to the person as a whole, or twenty-five (25) weeks of PPD benefits.

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

Victor Roa,
Petitioner,
vs.
City of Chicago-Dept. of Water,
Respondent,

NO: 12 WC 30694

15IWCC0434

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 25, 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: JUN 9 - 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:5/7/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROA, VICTOR
Employee/Petitioner

Case# **12WC030694**

15IWCC0434

CITY OF CHICAGO-DEPT OF WATER
Employer/Respondent

On 11/25/2014, 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 0.07% 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:

4564 ARGIONIS & ASSOCIATES
PHIL J GOYETTE
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0010 CITY OF CHICAGO-DEPT OF LAW
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

15IWCC0434

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

Victor Roa
Employee/Petitioner

v.

City of Chicago-Dept of Water
Employer/Respondent

Case # **12** WC **30694**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **November 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. ☐ 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 **Petition for Attorneys Fees.**

FINDINGS

On **July 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 **$75,296.00**; the average weekly wage was **$1448.00**.

On the date of accident, Petitioner was **65** 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 **$32,271.27** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$32,271.27**.

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 $965.33/week for 32 6/7 weeks, commencing July 13, 2012 through February 27, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $32,271.27 for temporary total disability benefits that have been paid. This results in a credit of **$552.28** against permanent disability for the overpayment of temporary disability.

Respondent shall pay reasonable and necessary medical services of $175.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 16.125 weeks, because the injuries sustained caused the 30% loss of the Right Leg, as provided in Section 8(e) of the Act. After credit for the prior settlement in cases 05 WC 22153 and 06 WC 24563 of 22.5% loss of the Right Leg, Petitioner is entitled to a current award of permanent partial disability of **7.5%** loss of the **Right Leg**.

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

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

Signature of Arbitrator

November 25, 2014
Date

ICArbDec p. 2

NOV 25 2014

Statement of Facts

On July 12, 2012, Petitioner Victor Roa was employed by Respondent City of Chicago, Department of Water as a construction laborer. He had been employed by the City of Chicago since June 16, 1998. On July 12, 2012, he was working assisting a bricklayer. Petitioner testified that he picked up a bag of mortar mix weighing about 80 pounds to carry to the work location. There was a hoist lid open on the ground and, as he was carrying the bag, his right foot caught the open lid and he twisted his right knee. Petitioner testified that he felt pain in his right knee like a nerve. Petitioner testified that he reported this to the bricklayer, who called 911, and to his supervisor Mike Divito.

Petitioner testified that he was taken to Little Company of Mary Hospital. He had an x-ray, was given a pain medication and had his leg packed in ice. He then saw Dr. Diadula at Mercyworks. He was given a brace and taken off work. He was sent to Mercy Hospital for an MRI. Petitioner testified that he had an ultrasound and another MRI at McNeal Hospital.

The MercyWorks records were admitted as Petitioner's Exhibit 4. The records record the history of accident as testified to by Petitioner. The history states that he fell into an uncovered hole and fell forward twisting his right knee. The diagnosis was right knee sprain, right foot strain, and right calf strain. Petitioner was taken off work. Petitioner was seen on July 16, 2012 with 10/10 pain. There was swelling, limited flexion, diffuse tenderness in the right knee. An MRI was recommended. Petitioner returned on July 26, 2012. The complaints and findings remained the same. The MRI had not been completed. The diagnosis was "Right knee sprain, R/O meniscal tear or ligament tear." Petitioner advised he was seeing his PMD.

Petitioner testified that he saw Dr. Primus on August 2, 2012 for continued pain in his leg and cramps in his leg. Petitioner testified that he had shots and a synvisc injection. Petitioner testified that the treatment did not help for more than a couple of days. Petitioner testified that he had physical therapy for a month or two. He went three times per week. He was released to work with a 100 pound lifting restriction.

Dr. Primus records were admitted as Petitioner's Exhibit 1. Petitioner's initial visit on August 2, 2012 records a consistent history of accident with complaints of pain, popping, clicking and giving way. The record includes a prior history of knee surgery in 2005 and a steroid injection 1/12. Dr. Primus notes the MRI performed shows evidence of posterior horn medial meniscus tear, ACL mid-substance tear, PCL intra-ligamentous edema and degenerative osteoarthritis. The assessment on that date was knee pain, meniscus tear, contusion and secondary localized osteoarthritis. Steroid injections and viscosupplementation were discussed as treatment options. Steroid injection was performed on August 23, 2012. Steroid and initial synvisc injections were performed on September 30, 2012. Dr. Primus recommended initiation of physical therapy in his note dated November 23, 2012. Physical therapy was performed at Flexeon from November 27, 2012 through January 25, 2013 (Px 4). Petitioner was fitted with a hinged brace on December 21, 2012.

On January 25, 2013, Petitioner returned to Dr. Primus for follow up. He continued to advance complaints of pain when sitting or standing too long, or driving for periods of time. He was there to discuss the possibility of knee replacement surgery. He stated that wearing the knee brace allows him to walk with less pain. The diagnosis was osteoarthritis. Follow up was scheduled for one month to evaluate return to work, FCE or surgery. On March 1, 2013, Dr. Primus recommended an FCE with MMI to be considered at follow up. On March 15, 2013, Petitioner last saw Dr. Primus. No FCE is reported. The plan was for knee replacement surgery. Petitioner testified that he has not seen Dr. Primus since March, 2013 and has not had any surgery.

Petitioner testified that he had a prior knee injury in 2005 while employed by the Respondent in the Electrical Department. He was on a light pole when the covering slipped and he twisted his right knee. Petitioner testified that he was treated by MercyWorks and underwent outpatient arthroscopic surgery by Dr. Troy. On

cross examination, Petitioner testified that the accident was in January, 2005. He did not recall a second accident in May 2006. Petitioner testified that he received a settlement of 22.5% loss of use of the right leg. Respondent's Exhibit 1 is the Commission computer printout documenting the settlement of 22.5% of the right leg in case 05 WC 22153 and 06 WC 24563 on April 11, 2007.

The records of MercyWorks for treatment for dates of injury on January 27, 2005 and May 10, 2006 were admitted as Respondent's Exhibit 4. The records confirm the accident on January 27, 2005 as testified to by Petitioner. He was initially diagnosed with a strain of the right knee and underlying degenerative joint disease. An MRI was read as showing a tear of the posterior horn of the medial meniscus. He was referred to Dr. Troy as his choice. Petitioner underwent arthroscopic surgery on April 22, 2005. On May 11, 2005 the note records that Petitioner is doing very well with some discomfort when he is doing strengthening exercises. He was to return to work on May 16, 2005 and was discharged.

The May 10, 2006 note records an injury when Petitioner's right foot went through a rotted trailer floor. He had abrasions to the right leg. Examination of the right knee reported no effusion or increase of color, normal range of motion with mild crepitation and mild positive varus stress test. Diagnosis was strain and abrasions. While Petitioner continued full duty work, he was treated with continued right knee pain. He was referred to physical therapy on June 9, 2006. Petitioner was last treated on July 27, 2006. At that time he admitted to tolerable pain in the knee on a daily basis. An MRI on July 25, 2006 was compared with the March, 2005 MRI and read as showing the same findings consistent with degenerative joint disease, old meniscal tear, chronic partial tear of the ACL and buckling of the PCL, chondromalacia, osteoarthritis and patellar tendonopathy. Petitioner was returned to full duty work and discharged from care.

Petitioner testified that he had no treatment for his knees since 2008 or 2009. Petitioner testified that he had worked full duty until his July 12, 2012 accident. Petitioner testified that before that accident he had soreness, particularly in winter. Petitioner testified that since his return to work following his July 12, 2012 accident he is still a laborer but is slower. Petitioner testified that he has pain if he sits too long. He needs to push up on the arms of a chair to get up. He holds the rail going up stairs and goes one step at a time. Petitioner testified that he can kneel or squat, but that getting up is harder. Petitioner testified that he is slower and more cautious that before. He takes Advil two to three times per week, and uses Bengay in the mornings. Petitioner testified that before July 12, 2012 he would have discomfort in his knee once or twice per week and now it is three times per week. Petitioner testified that he has no current medical appointments scheduled for his right knee and has no new prescription medications. Petitioner testified that he was told to wear the brace as needed. Petitioner testified that he wears the brace all the time.

Petitioner was examined by Dr. Marc Breslow at Respondent's request (Rx 2) on February 13, 2013. Dr. Breslow reviewed the treatment records from the date of the accident to January 29, 2013 and the July 26, 2012 MRI of the right knee. The history taken includes the prior work accident and treatment. He noted complaints of intermittent knee pain with bracing, ice and Aleve. Dr. Breslow references treatment with Dr. Aaron Rosenberg at Midwest Orthopedics at Rush who discussed that Petitioner had an arthritic knee and required a knee replacement. Current complaints were a sharp, aching, cramping sensation in the right knee on a daily basis, worse with activity. Dr. Breslow opined that Petitioner had chronic knee symptoms secondary to osteoarthritis. He opined that this was a preexisting condition and that the present symptoms were the natural progression of the arthritic process. He opined that this diagosis was not causally connected to the accident. He is of the opinion Petitioner is a candidate for a knee replacement. He opines that Petitioner would be best served in a sedentary position avoiding climbing, squatting, kneeling. In his addendum report dated June 7, 2013, Dr. Breslow opined that the July 12, 2012 did not accelerate or aggravate the condition. The incident was a temporary exacerbation of the pre-existing condition. He opined that Petitioner was at MMI.

Dr. Primus addressed the IME report in his March 15, 2013 notes. He states that the IME assessment is inaccurate as the patient was essentially operating for the last several years working full duty with an asymptomatic arthritic knee that became symptomatic after the fall (Px 1).

Conclusions of Law

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

Following the close of proofs, Respondent withdrew the dispute as to the causal connection of the petitioner's current condition and treatment to date.

The evidence establishes that Petitioner had a preexisting right knee condition as a result of the prior 2005 injury and surgery. The medical records document the prior treatment including the arthroscopic surgery and additional care through July 27, 2006. A July 25, 2006 MRI of the right knee is reported to show multiple degenerative conditions. But Petitioner was released to perform his full duties and did so until the accident on July 12, 2012. He testified that he has had no treatment for his knee since 2008 or 2009. Dr. Breslow's report refers to statements made by Dr. Aaron Rosenberg concerning a future need for a knee replacement, but no records of any treatment or opinions of Dr. Rosenberg were submitted and there is no date noted for when this statement may have been made. Dr. Breslow's February 13, 2013 report lists the records reviewed, and does not include any records of treatment before the July 12, 2012 date of accident.

Petitioner testified that he had occasional pain in his right knee before the accident, but testified to an increase in the both the frequency and severity of the complaints since the undisputed accident on July 12, 2012. He has testified to increased difficulties in performing his job duties. The Arbitrator finds this testimony credible.

Based upon the testimony of the Petitioner and review of the medical records, the Arbitrator finds the opinion of Dr. Primus more persuasive that that of Dr. Breslow. The Arbitrator finds that as a result of the accidental injuries sustained on July 12, 2012, Petitioner suffered an aggravation of his pre existing condition in his right knee. The Arbitrator finds that the treatment rendered and the Petitioner's current condition of ill being as described in the medical records and testified to by the Petitioner is causally connected to the accidental injuries sustained on July 12, 2012.

In support of the Arbitrator's decision with respect to J (Medical), the Arbitrator finds as follows:

Petitioner's Exhibit 3 reflects an account balance to Dr. Primus for the services rendered on August 23, 2012 and October 26, 2012 totaling $175.00. The statement confirms insurance payment made and adjustments taken. Respondent's Exhibit 3 states that no payment was made for the August 23, 2012 $80.00 charge for the injection of mepivacaine or the October 23, 2012 $95.00 charge for the patient visit. The Arbitrator finds that these services were reasonable and necessary. Respondent shall make payment of these charges totaling $175.00 pursuant to Section 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to L (Nature and Extent), the Arbitrator finds as follows:

Petitioner's accident occurred after September 1, 2011 and therefore assessment of permanent partial disability must be assessed pursuant to the provisions of Section 8.1b of the Act.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a construction laborer at the time of the accident. Petitioner has been able to return to work in his prior capacity as a result of said injury, but testified that he is slower and has more

difficulty in performing his duties. The Arbitrator notes the job is a heavy laboring position. Because of this, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 65 years old at the time of the accident. Because of his age, and his pre existing knee condition it would be expected that he will have more difficulties but not necessarily as a result of the accidental injuries, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to his regular work for Respondent. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Dr. Primus records of Petitioner's complaints and treatment including the cortisone injections and synvisc injections. The Arbitrator notes the diagnosis and MRI findings of a meniscal tear and osteoarthritis. The Arbitrator notes Petitioner's testimony of his current condition and his continued use of a brace to perform his duties. Because of this, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of Right Leg pursuant to §8(e) of the Act. Petitioner has a prior settlement of 22.5% for which Respondent is entitled to credit. Petitioner is entitled to additional permanent partial disability of 7.5% loss of use of the Right Leg.

In support of the Arbitrator's decision with respect to N (Credit), the Arbitrator finds as follows:

The parties have stipulated to the period of temporary total disability and the amount of benefits paid. The Respondent has overpaid benefits due by $552.28. Said amount shall be a credit against the permanent partial disability awarded herein.

In support of the Arbitrator's decision with respect to O (Pending Petition for Attorneys Fees), the Arbitrator finds as follows:

A petition for fees was filed by attorney Carl S. Salvato in this matter. That Petition was presented on May 12, 2014 and continued to case disposition. Mr. Salvato received notice of the hearing but was not present at the trial of this matter. The Arbitrator makes no findings at this time as to the Petition for Fees and Costs. Said Petition will need to be either resolved by the parties or presented for resolution to the appropriate hearing officer for resolution.

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

Ed Lindthicum,

Petitioner,

15IWCC0435

vs.

NO: 12 WC 08384

City of Chicago Heights,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 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.

15IWCC0435

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

DATED: JUN 9 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 6/4/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LINDTHICUM, ED
Employee/Petitioner

Case# 12WC008384
15IWCC0435

CITY OF CHICAGO HEIGHTS
Employer/Respondent

On 12/5/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4239 LAW OFFICES OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

4217 DEL GALDO LAW GROUP LLC
GEORGE S SPARTARO ESQ
1441 S HARLEM AVE
BERWYN, IL 60402

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 15IWCC0435

Ed Lindthicum
Employee/Petitioner

v.

City of Chicago Heights
Employer/Respondent

Case # 12 WC 8384

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **September 25 and 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. ☐ Did an accident occur that arose out of and in the course of 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 15IWCC0435

On **February 10, 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 as explained *infra*.

In the year preceding the injury, Petitioner earned **$29,120.00**; the average weekly wage was **$560.00**.

On the date of accident, Petitioner was **67** years of age, ***married*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$26,811.84** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$26,811.84 and for all other amounts paid to** Petitioner **as agreed by the parties**. *See* AX1.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $373.33/week for 84 & 5/7th weeks, commencing February 11, 2012 through September 25, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from February 11, 2012 through September 25, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $26,811.84 and for all other amounts paid to Petitioner as agreed by the parties for temporary total disability benefits that have been paid. *See* AX1.

Medical Benefits

Respondent shall pay reasonable and necessary medical services for bills submitted into evidence that remain unpaid, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $336.00/week for 10.75 weeks, because the injuries sustained caused the 5% loss of the right leg, as provided in Section 8(e) of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $336.00/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

December 4, 2013
Date

DEC 5 - 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Ed Lindthicum
Employee/Petitioner

v.

City of Chicago Heights
Employer/Respondent

Case # **12** WC **8384**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing are causal connection, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, Petitioner's entitlement to a period of temporary total disability benefits, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Petitioner testified that he was employed by Respondent on the date of accident and had been so employed for two years in a part time position and then for one year in a full time position as a code inspector. Petitioner testified that his job duties were to inspect commercial and residential homes for code violations. He drove in a small car provided by Respondent to reach these locations.

Petitioner testified that he was at work on February 10, 2012 and started his shift at around 9:00 a.m. He testified that his accident occurred around 3:00 p.m. near 13th and Chicago (going northbound) near Bloom high school in the city of Chicago Heights. Petitioner testified that he was driving in lane closest to the center and he saw another vehicle in a collision before it occurred in the inner lane going southbound about 40-50 yards from him. Petitioner testified that the other vehicle, a large SUV, started spinning like a top and it kept coming toward him because it was snowing that day. Petitioner testified that he could not avoid the accident because there were also cars on his left side. He testified that he "t-boned" the SUV and that the impact was pretty heavy. Petitioner testified that they went into the SUV and they had to cut him and his passenger out of the car.

After the collision, Petitioner testified that he thought he had broken his right leg and he tried to push himself out but could not so emergency personnel pulled him out. Petitioner testified that he had cuts and bruises, and his back was also hurting. Petitioner testified that he told fire department personnel about his condition and they would not let him move; they stopped him and put him on a board and took him to St. James hospital.

Petitioner testified that he told the hospital doctor what happened and he underwent x-rays of the right knee and back. Petitioner was there for several hours and he was referred to his regular doctor the next day. The medical records reflect that Petitioner went to St. James Hospital where he complained of thoracic and low back pain, right knee, right hip and right hand pain. PX9. He also presented with multiple contusions. *Id.* After various x-rays, of the lumbar spine, knee, pelvis, right hand and hip, Petitioner was diagnosed with musculoskeletal strains and discharged. *Id.*

Petitioner testified that he went home and did well until the next morning when he was in a lot of pain in his right leg and low back. Three days later, Petitioner testified that he went to his primary care physician, Dr.

[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.

Singh, who prescribed two pain medications for his back and knee and referred him to a back specialist. PX10. Petitioner testified that he did not go to the specialist immediately because (his employer) wanted to know when he was going back to work. Petitioner eventually saw specialists about one month after the accident; Dr. Markerian for the knee and Dr. Anwar for the back.

The medical records reflect that Petitioner saw Dr. Anwar on February 27, 2012. PX1. Petitioner reported pain in his lower back radiating into his right leg, pain in the right knee, and neck pain. *Id.* Dr. Anwar made various differential diagnoses, prescribed pain medication, kept Petitioner off work, and ordered a lumbar MRI and right knee MRI. *Id.*

Petitioner underwent the MRIs on February 29, 2012 at Advanced MRI South Holland. *Id.* The interpreting radiologist noted that the lumbar MRI revealed an infrarenal-abdominal aneurysm, mild multilevel disc bulges at L4-5 and L5-S1 without significant central or foraminal compromise, and 1 mm retrolisthesis of L5 on S1 with uncovering of the disc margin. *Id.* The right knee MRI revealed an MCL sprain that was not completely ruptured or redundant, a small joint effusion, and finding that may represent a small nondisplaced tear of the posterior horn of the medial meniscus. *Id.*

Petitioner returned to Dr. Anwar on March 7, 2012. *Id.* After a review of the MRI films, Dr. Anwar diagnosed Petitioner with lumbar radiculitis, sciatica of the bilateral legs, a 1 mm disc bulge at L5-S1, right-sided knee pain, mild-to-moderate disc bulges at L3-4, L4-5, and L5-S1 without significant central foraminal compromise and mild facet arthropathy, suspected L5 lumbar radicular pain, an infrarenal-abdominal aneurysm, a sprain of the MCL with small joint effusion, and a small nondisplaced tear of the posterior horn of the medial meniscus. *Id.* He recommended a series of bilateral L5-S1 transforaminal injections under fluroscopy, a consultation with an orthopedic specialist for his right knee, and a consultation with a vascular surgeon for the aneurysm. *Id.*

Petitioner then saw Dr. Anwar's partner, Dr. Markarian, an orthopedic specialist, for his right knee on March 29, 2012 at Chicago Pain & Orthopedics. PX4. Dr. Markarian diagnosed Petitioner with a medial meniscal tear and recommended arthroscopic surgery consisting of a partial medial menisectomy versus repair of the right knee. *Id.*

The following day, Petitioner underwent the first series of recommended bilateral transforaminal injections at L5-S1 with Dr. Anwar on March 30, 2012. PX2. He followed up with Dr. Anwar on April 9, 2012 at which time he reported 30-40% relief after the injections. *Id.* Petitioner also returned to Dr. Markarian on April 26, 2012 at which time he put knee surgery on hold pending treatment for the aneurysm. PX4. Dr. Anwar had also recommended further injections for the back, but these were also kept on hold until resolution of the incidental abdominal aneurysm as noted on May 7, 2012. *Id.* Petitioner remained off work at Dr. Anwar's orders. *Id.*

When Petitioner returned to Dr. Markarian on June 7, 2012, he discharged Petitioner without right knee surgery, noting that Petitioner's right knee condition had improved in the interim with full range of motion and good strength. PX4.

On August 8, 2012, Petitioner underwent the second series of bilateral transforaminal injections at L4-5 and L5-S1 with Dr. Anwar. PX2. He continued to follow up with Dr. Anwar reporting some improvement; however Dr. Anwar continued to order a few more series of injections to alleviate Petitioner's back pain. *Id.* In the interim, on August 16, 2012, Petitioner also returned to Dr. Markarian reporting that his right knee pain had returned. PX4. Petitioner also reported that now he wanted to proceed with the arthroscopic surgery, but he

required medical clearance from his vascular surgeon after a recent bypass surgery. *Id.* Petitioner did not have the surgery and did not return to see Dr. Markarian. *Id.*

On September 19, 2012, Petitioner returned to Dr. Anwar and underwent a third series of bilateral transforaminal injections at L4-5 and L5-S1. PX1. On October 31, 2012, Petitioner underwent a fourth series of bilateral transforaminal injections at L4-5 and L5-S1. *Id.* On December 12, 2012, Petitioner underwent a final series of bilateral transforaminal injections at L4-5 and L5-S1. *Id.*

On January 23, 2013, Petitioner saw Dr. Anwar and reported some improvement in the low back condition as well as continued right knee pain and inability to bear weight on the right side. PX1. Dr. Anwar recommended a right knee injection, which Petitioner underwent on the same date. PX1; PX2.

Petitioner testified, and the medical records reflect, that he continued to follow up with Dr. Anwar through April of 2013 when he was diagnosed with an unrelated medical condition, stage 4 lung cancer, which was diagnosed after he underwent his first aneurism operation and the doctors saw three swollen lymph nodes. He testified that by December they got larger and in February he underwent a biopsy of the lymph nodes which were diagnosed as cancerous. Petitioner testified that he began chemotherapy the first week of May or June of 2013 and continues in that treatment through the present.

Petitioner testified, and the medical records reflect, that he saw Dr. Anwar on June 5, 2013 and that he suggested that Petitioner suspend ongoing lumbar injections during chemotherapy. PX2. Alternatively, Dr. Anwar prescribed physical therapy for Petitioner's ongoing back and knee pain, ordered continued Norco for pain, and kept Petitioner off work. *Id.* Petitioner testified that he did not pursue physical therapy because the services were not authorized by the workers' compensation insurer, because he stopped receiving benefit checks (his last check was received in May of 2013), and because he was broke and did not have the money to pay for physical therapy.

Petitioner testified that he had no further medical treatment for the low back or right knee after June 5, 2013. He testified that Dr. Anwar kept him off work pending the outcome of his chemotherapy and indicated that he could return to him thereafter to discuss a treatment plan. *See also* PX2. Petitioner testified that he is still off work and undergoing chemotherapy.

Regarding his current condition, Petitioner testified that his right knee does not bother him, but he still has back pain and takes pain medication which was recently changed by the chemotherapy doctor from hydrocodone and cyclopenzaprine to morphine. Petitioner testified that his low back pain did not change in any way from the date of the accident through starting his cancer treatment and that the pain medication that he takes does help with his low back pain, but that he is always on pain medication. Petitioner also testified that he cannot stand for more than 20-30 minutes, especially due to radiating pain in the left leg, without experiencing pain. He described his ongoing low back pain to be at a level of 2-5/10, but testified that it was worse when he was on hydrocodone with the pain being at a level of 6-7/10 daily. Petitioner testified that he had no lower back pain at any time prior to the accident.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's claimed current condition of ill-being is causally related to the injury sustained at work on February 10, 2012. In so concluding, the Arbitrator finds Petitioner to be highly credible after careful observation at trial, in light of his testimony on direct and cross examination and given the consistency of his testimony with the medical records submitted into evidence reflecting no prior low back or right knee conditions until his accident at work necessitating his subsequent medical care. Thus, based on the record as a whole, the Arbitrator finds that Petitioner has established a causal connection between his current condition of ill-being in the low back and right knee and the injury sustained at work.

In support of the Arbitrator's decision relating to Issue (J), whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

As noted above, the parties do not dispute the reasonableness or necessity of the medical care that Petitioner underwent related to his low back or right knee. Rather, Petitioner claims that the medical bills submitted into evidence have not been paid in full. No evidence was submitted by Respondent regarding the medical bills that it paid, but it claims that all reasonable and necessary bills have been paid in full. Based on the record as a whole including the parties' stipulations at trial, the Arbitrator finds that the reasonable and necessary medical bills incurred by Petitioner and submitted into evidence are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act if it has not already done so and that Respondent shall be entitled to a credit for any such payments already made.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In this case, the medical records and Petitioner's testimony confirm that he was placed off work and kept off work pursuant to Dr. Anwar's orders related to Petitioner's intractable low back pain, radicular leg pain, and intermittent right knee pain. While Petitioner was also off work while undergoing treatment for unrelated conditions, the evidence establishes that Petitioner was also off due to the *sequelae* of his work-related injuries (i.e., due to low back pain and/or right knee pain and medical treatment). Thus, based on the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period claimed from February 11, 2012 through September 27, 2013.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Based on the record as a whole[2]—which reflects that Petitioner developed two disc bulges, low back pain and radicular leg pain after his accident that were somewhat alleviated by conservative measures but nonetheless remained intractable and after which Petitioner was not released to return to any work by his physician—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 12.5% loss of use of the person as a whole. Additionally, based on the record as a whole—which further reflects that Petitioner sustained a medial meniscal tear of the right knee that was treated very conservatively and showed marked improvement followed by a return of right knee pain that had subsided by the time of trial—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 5% loss of use of the right leg pursuant to Section 8(e).

[2] The Arbitrator notes her consideration of Section 8.1b of the Act, which addresses factors to be considered in determining the extent of permanent partial disability for injuries occurring on or after September 1, 2011, and also notes that no AMA report was admitted into evidence at trial. 820 ILCS 305/8.1b (LEXIS 2011).

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

Edward White,

Petitioner,

15IWCC0436

vs.

NO: 11 WC 11563

Illinois Department of Employment Security,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of 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. 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 26, 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.

15IWCC0436

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:

DLG/gaf JUN 9 - 2015
O: 6/4/15
45

David L. Gore

Stephen Mathis

Mario Basurto

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

WHITE, EDWARD
Employee/Petitioner

Case# **11WC011563**

15IWCC0436

IL DEPT OF EMPLOYMENT SECURITY
Employer/Respondent

On 6/26/2014, 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:

5024 SOYODE AT LAW
FEMI SOYODE
10824 ROYAL GLEN DR
ORLAND PARK, IL 60467

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

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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 26 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

15IWCC0436

Case #11 WC 11563

Edward White
Employee/Petitioner

v.

Illinois Department of Employment Security
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **October 30, 2013, November 25, 2013, December 27, 2013, December 30, 2013, January 27, 2014, and February 18, 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?
B. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **March 17, 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 **$$40,012.00**; the average weekly wage was **$$769.46**.

On the date of accident, Petitioner was **42** years of age, ***single*** 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

M.B.

Respondent shall pay Petitioner temporary total disability benefits of **$512.98**./week for **2 6/7th** weeks, commencing **March 17, 2011** through **April 6, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$1,010.00**, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Milton Black

Signature of Arbitrator

M.B.

June 26, 2014

Date

JUN 26 2014

FACTS

Petitioner, Edward White, was employed as an adjudicator for the Illinois Department of Employment Security (IDES) office located at 47th Street and Cottage Grove (715 East 47th Street) in the City of Chicago. His duties were to process unemployment claims for eligibility, award, or denial. Petitioner was shot while returning

to his building from a break on March 17, 2011. Petitioner claims that he was at increased risk. Respondent has disputed compensability. Four witnesses, including Petitioner, testified.

Petitioner's first witness was Denise Edge. She testified that she was a manager at the facility. She testified that she had worked at other IDES locations. She testified that the location at 47th Street and Cottage Grove was a hostile environment. She testified that she had seen windows kicked out and fights on the street in the general area. She testified that there was a heavy police presence due to a shooting about one half block away. She testified that staff members usually escorted each other out. She testified that it was policy for employees to wear badges. She testified that security at that branch consisted of one unarmed security guard. She testified that employees were entitled to two 15 minute breaks per day and were not required to leave the building but that many employees left the building to buy food or smoke cigarettes.

Petitioner's second witness was Monica Williams. She testified that she worked at the facility handling minor adjudications. She testified that she was familiar with the neighborhood and has personally known the area to be highly dangerous. She testified that employees were entitled to two 15 minute breaks per day, that employees were not permitted to stay at their work stations during a break, and that many employees chose to leave the building to get food at local stores and restaurants. She testified to violence and police activity in the area. She testified that there was a nearby transient hotel with probable drug activity and a lot of loitering. She testified that she saw Petitioner lying on the ground after he was shot and called 911.

Petitioner's third witness was Edgar Martin. He testified that the neighborhood seemed deprived and was a hostile area. He testified that he felt less safe there than other places. He testified that they were always reporting shootings and that a young man had been killed 1 to 2 blocks away. He testified that the neighborhood was a dangerous high risk area. He said that behind the building there was lots of alley violence. He testified that prior to March 17, 2011 safety was always a concern to him and that he always looked behind his back. He testified that he was with Petitioner when the shooting occurred and that he (Edgar Martin) suffered a gunshot wound to the back of his head behind his ear as they returned from the Save-A-Lot across the street. He testified that they were 5 feet away from the door when they were shot. He testified that Petitioner then fell on parked cars. He testified that he ran into the building, informed others that the Petitioner had been shot and was lying bleeding, and that Petitioner was brought into the office as an ambulance was called. He testified that they were both wearing a badge with a state identification.

The final witness to testify was Petitioner. He testified that the neighborhood was hostile and that the unarmed security guard had no deterrent effect. He testified that there were interactions and altercations with clients because they would not get what they wanted. He testified that he knows the neighborhood was violent with a lot of police activity and murders. He testified that some fights would spill into the building. He testified that prior to March 17, 2011 he witnessed acts of violence. He testified that he was working at the facility as a program worker and adjudicator. Petitioner testified that he was not required to leave the facility for break but that he decided to walk to the Save-A-Lot to get food. He testified that he and Edgar Martin were wearing employee badges while on break. He testified that they were shot just in front of the facility. He testified that he was carried in by his fellow co-workers and that an ambulance was called.

Petitioner was taken to Stroger Hospital where he received attention to his gunshot wound. Petitioner was ambulatory after the injury and the wound was to the right posterior proximal mid-line thigh with palpable retained missile in the antero-lateral right proximal thigh. Imaging revealed no bony injury, and clinical examination showed no signs of vascular injury. The gunshot wound was irrigated with saline and a dressing was applied. Petitioner was discharged home in stable condition with follow up instructions. On April 6, 2011 the bullet was surgically removed, and he was released to work without restrictions (RX4, PX2). Petitioner testified that he does not use a cane or assistive device for walking.

Petitioner sought follow-up care at the Veterans Administration Medical Center. Those records document that he reinjured a prior left wrist sprain when he fell after getting shot (PX1). Petitioner testified that the injury has caused psychological damage. Petitioner stated that he did not return to work and that he has become homeless. Petitioner testified that the gunshot incident, his subsequent homelessness, and the way his employer has handled his workers compensation claim have caused him extreme stress. The Veterans Administration medical records document that Petitioner has symptoms consistent with posttraumatic stress disorder (PX1).

ACCIDENT

All of the witnesses testified credibly that they worked in a high crime area and that they were apprehensive for their own safety. That portion of the testimony was not rebutted. When he was shot Petitioner was at an increased risk.

Therefore, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment.

CAUSATION

The medical records document three injuries, a gunshot wound to the right thigh, an aggravation of a sprain injury to the left wrist, and posttraumatic stress disorder.

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injuries.

MEDICAL

Petitioner has submitted one unpaid medical bill, $1,010.00 from the City of Chicago for ambulance services. This is clearly a reasonable, necessary, and related bill for emergency transport to hospital due to a gunshot wound.

Therefore, the Arbitrator finds that Respondent is liable for the bill.

TEMPORARY TOTAL DISABILITY

Petitioner claims that he is entitled to temporary total disability from the date of accident through the hearing date. He has never returned to work and has alleged that it is due to posttraumatic stress disorder. On April 6, 2011, Petitioner was released to work without restrictions at the conclusion of the treatment for his gunshot wound. There is no other medical authorization for time off of work. Although Petitioner has sustained a left wrist injury and posttraumatic stress disorder, no medical professional has authorized him to be off of work as result of those injuries.

Therefore, the Arbitrator finds that Petitioner is entitled to temporary total disability for the period from March 17, 2011 through April 6, 2011.

NATURE AND EXTENT

Respondent's proposed finding alleges that there is no permanent injury. However, a permanency determination is not properly a part of an emergency proceeding.

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

Albert Montgomery,
Petitioner,

vs.

NO: 12WC 19390

Megabus USA, LLC.,
Respondent,

15IWCC0437

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, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 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: JUN 9 - 2015

Joshua D. Luskin

o042215
CJD/jrc
49

Ruth W. White

Dissenting Opinion

I must respectfully dissent and would reverse the Arbitrator's finding regarding accident. Petitioner is a bus driver who testified, and the evidence shows, that he lost consciousness while getting off the bus. Respondent argues that Petitioner had a seizure and the Arbitrator found that his loss of consciousness episode stemmed from an idiopathic condition and fell under the

category of personal risk. The Arbitrator found that "standing" was not a greater risk than the general public and:

> There is no evidence that the circumstances of Petitioner's employment, as a bus driver, significantly contributed to the injury, by placing him in a position increasing the effects of the fall. There is only evidence that petitioner sustained a loss of consciousness, due to an uncertain internal cause.

(Dec. at 8). However, this is not correct. There actually is evidence in the record to support a work-related cause. On May 22, 2012, when Petitioner was in the hospital and a battery of tests did not support any cardiac or neurologic causes, the neurologist, Dr. Jawidzik, opined about whether Petitioner suffered from syncope versus seizure:

> Unclear what the etiology of the event was without better history form witnesses. **I favor syncope at this point, as it occurred after [Petitioner] had been seated for 3 hours driving the bus and [Petitioner] did not have disorientation/confusion afterwards. Likely he had pooling of venous blood in the legs, and when he stood he passed out. I suggested to him that he wear compression hose when driving for long periods of time.**

(Px1, Emphasis added).

The discharge summary indicates a final diagnosis of "syncope, likely vasovagal" and Petitioner was discharged with no medications. A separate discharge note, written by an R.N., indicates, "Neuro MD at the bedside recommends for [Petitioner] to be out from work for a couple days before returning to bus driver duty."

The medical records do include some references to a possible seizure; namely that the "EMS reported that a witness claimed to have seen [Petitioner] making convulsant movements while unconscious." However, neither the paramedics nor this "witness" were ever interviewed by the physicians so they are not very reliable. This is particularly true since Petitioner's co-driver during that trip, Kimberly Benton, testified that after she unloaded the luggage from the rear of the bus, she saw that Petitioner was on the ground unconscious and called 911. Although she may have looked away at times for "seconds," she was within 10 feet of Petitioner and observed him for approximately ten minutes until the paramedics arrived.

Ms. Benton testified that she had witnessed three other people have seizures in the past. In her opinion, Petitioner was not having a seizure because he was laying flat, there was no movement, and his eyes were closed. She did not think it was possible that he was having a seizure.

The evidence shows that Petitioner had no prior history of seizures and has not had any episodes of loss of consciousness since that day. All of the tests were negative and do not support a finding that Petitioner had a seizure. The only witness who testified regarding the event stated affirmatively that Petitioner did not have a seizure. While it is practically impossible for Petitioner to be able to prove that he did not have a seizure, the evidence suggests that it is more likely that he did not.

I would note that Dr. Kehinde, the neurologist at Rush Medical Center, wrote that "[w]hile his normal exam and studies are reassuring, we are unable to say with certainty that [he] did not suffer a seizure given the reported description of the event." Based on that, Respondent's

physician, Dr. Paloyan, wrote that "the implication is that a seizure could have caused the event." However, on January 24, 2013, Dr. Dorman, a neurologist, diagnosed "syncope and collapse…etiology unclear, but no sign of cardiac etiology or seizure despite extensive workup. **Description of events today most consistent with vasovagal episode.**" Furthermore, on February 13, 2013, Petitioner was examined by agreement of the parties by Dr. Michael Smith, Director of the Rush Epilepsy Center, who also reviewed Petitioner's records and wrote:

> There is no evidence that he has an active neurological process going on. **There is no evidence that he has epilepsy or that his clinical event in May 2012 was an unprovoked seizure.** I have no evidence that he should not be allowed to drive a bus due to this episode in May 2012. His risk for seizures is the same risk as to the general population.

Again, while it is impossible to rule out a seizure, the medical opinions in this case do support a finding that Petitioner experienced a vasovagal syncopal episode due to driving the bus for three hours and having a "pooling of venous blood in the legs, and when he stood he passed out" as was opined by Dr. Jawidzik. This would indicate that Petitioner's job was a causal factor in this episode and his loss of consciousness arose out of his employment.

Based on the above, I would find that Petitioner sustained a compensable accident that arose out of and in the course of his employment and that he is entitled to medical expenses, temporary total disability, and permanency benefits.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONTGOMERY, ALBERT
Employee/Petitioner

Case# **12WC019390**

MEGABUS USA LLC
Employer/Respondent

15IWCC0437

On 4/11/2014, 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

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
SEAN M ABERNATHY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0437

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

ALBERT MONTGOMERY,
Employee/Petitioner

Case # 12 WC 19390

v.

Consolidated cases:

MEGABUS USA, 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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on February 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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

15IWCC0437

FINDINGS

On 5/22/2012, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $30,845.36; the average weekly wage was $593.16.

On the date of accident, Petitioner was 55 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 $0.00.

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

ORDER

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

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

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

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

15IWCC0437

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; 5) penalties; 6) attorney's fees; and 7) the nature and extent of Petitioner's injury. See, AX1.

Albert Montgomery (the "Petitioner") in this matter was employed as a bus driver for Megabus, (the "Respondent"). The petitioner testified he began working for Megabus on August 31, 2011 and was working for Respondent on the date of accident, May 22, 2012. Petitioner testified that his duties involved driving a passenger bus, refueling the bus, performing DOT inspections and complying with DOT regulations. Petitioner also testified that he shared driving duties with his co-driver. When he was not driving, Petitioner would observe his co-driver and assist passengers on the bus.

Petitioner testified that his usual and customary route began in Chicago, Illinois and ended in St. Louis, Missouri. Petitioner testified that, on the way from Chicago to St. Louis, his co-driver would drive from Chicago to McLean, Illinois. At that point, Petitioner and his co-driver would take a break at a rest stop in McLean, Illinois. After the rest stop, the Petitioner testified that he would complete the drive from McLean to St. Louis, Missouri.

Petitioner testified that on May 21, 2012, he and his co-driver, Ms. Kimberly Benton, drove from Chicago to St. Louis, Missouri. Petitioner testified that they left Chicago with Ms. Benton driving the bus and he acting as a co-driver; sitting in the seat directly behind Ms. Benton. Petitioner testified that McLean, Illinois was approximately one hundred and fifty (150) miles from the departure point in Chicago, Illinois. Petitioner testified that upon reaching McLean, the bus stopped at a rest area and they took a break. Petitioner testified that the length of the breaks varied, but was generally twenty (20) minutes. Petitioner testified that he was able to get food at the rest stop in McLean, if he so chose.

Petitioner testified that after the break in McLean, Illinois, he assumed the driving responsibilities from Ms. Benton. Petitioner then drove the rest of the trip from McLean to St. Louis, Missouri. He testified that the distance was approximately one hundred fifty (150) miles and that his active driving time was approximately two and one-half (2½) hours. Petitioner testified that they left Chicago at approximately 12:00 a.m. on May 21, 2012 and arrived in St. Louis at between 5:30 a.m. and 6:00 a.m., on May 21, 2012.

Petitioner testified that upon arriving in St. Louis, he and Ms. Benton checked into a hotel known as the Drury Inn, where he had his own room. Petitioner further testified that he was familiar with the Drury Inn because he had stayed there on previous occasions. Petitioner testified that he received a stipend for food of approximately $30.00 per day and ate breakfast upon his arrival. Petitioner testified that he was free to rest and relax as necessary, as if he was at home. Petitioner also testified

that he had a period of approximately eighteen (18) hours to sleep, eat and generally rest as necessary, between trips.

Petitioner testified the next trip began at approximately 12:45 a.m. on May 22, 2012 and that he had no disabilities prior to leaving St. Louis, Missouri. Petitioner testified that Ms. Benton drove the first leg the trip from St. Louis, Missouri to McLean, Illinois. Petitioner testified that while Ms. Benton was driving to McLean, he sat in a seat directly behind her and acted as a co-driver. Upon reaching McLean, Illinois, they again took an approximately twenty (20) minute break and were able to get food, as necessary. Petitioner testified to drinking a Mountain Dew soda while in McLean and after the break, he switched with Ms. Benton and became the driver of the bus. Petitioner testified that he then drove from McLean, Illinois to Chicago, Illinois, a distance of approximately one hundred fifty (150) miles.

Petitioner testified that the bus arrived in Chicago and they parked at the intersection of Canal and Jackson. Petitioner then let his co-driver, Ms. Benton, off the bus to unload luggage from the luggage compartment. Petitioner testified that Ms. Benton physically entered the luggage compartment to unload the luggage and that when a person is inside the compartment, they cannot see outside. Petitioner testified that he allowed the passengers to debark from the bus. He testified that he remained seated for approximately five to six (5-6) minutes to complete paperwork. He testified that he rose from his seat and lost consciousness.

Petitioner testified that his next memory was riding in the ambulance. Petitioner was taken to Rush University Medical Center emergency department. There, Petitioner made a statement that he remembered driving a bus with the next memory being riding in an ambulance. He mentioned that over the past few days he had been feeling very tired, but otherwise reported being well. The emergency room record showed petitioner stated he did not experience lightheadedness, dizziness, visual changes, chest pains, sweating or shortness of breath, while driving the bus.

Petitioner testified that he had an episode of cardiac tachycardia as a child, which was evidenced in the medical reports. He also testified to having been born with asthma, which he testified that he outgrew. This is also shown in the medical records. In addition, Petitioner testified to having a history of migraines.

The Rush University Medical Center records indicate that witnesses at the scene, reported Petitioner demonstrating seizure activity. Petitioner testified he was diagnosed with syncope, or a fainting episode, in the emergency room. Petitioner testified that Dr. Cotomi Kehinde was unable to say with certainty, whether or not Petitioner had suffered a seizure.

Petitioner testified that he was not permitted to return to his work as a driver for Megabus until he underwent a series of diagnostic tests. Petitioner testified to being evaluated by physicians, including

cardiologists and neurologists. Petitioner also testified to not having group medical insurance on May 22, 2012.

On February 13, 2013, Petitioner presented to Dr. Michael Smith, a neurologist, for an examination by agreement of the parties. Dr. Smith opined Petitioner was medically capable of driving a bus. Petitioner then underwent a Department of Transportation physical examination on March 13, 2013. Petitioner was cleared to return to work for Respondent, which he did on March 15, 2013; and testified that he worked successfully without incident from March 15, 2013 through December 31, 2013. Petitioner testified he was terminated as of December 31, 2013, due to an incident where he allegedly left passengers behind.

Petitioner testified that, during his time off work from Megabus, he applied for and received unemployment benefits. Petitioner testified that, in applying for unemployment benefits, he stated he was physically capable and willing to work. Petitioner testified that he certified that he was willing, ready and able to work, during the time he collected unemployment benefits.

Petitioner presented Ms. Kimberly Benton as a witness, who appeared due to Petitioner's subpoena. Ms. Benton testified that she was petitioner's co-driver and that she worked with him during the round trips from Chicago to St. Louis, on May 21, 2012 and May 22, 2012. She testified that she drove approximately one hundred and fifty (150) miles from Chicago to McLean, Illinois, on May 21, 2012. She also testified that Petitioner acted as her co-driver during that time. She testified that Petitioner then drove the bus from McLean, Illinois to St. Louis, Missouri.

She further confirmed that she and petitioner stayed at the Drury Inn in St. Louis, where the drivers were permitted to sleep and eat. She testified that there was an 18-hour period, between the time she and Petitioner arrived in St. Louis on May 21, 2012, to the time they left at 12:45 a.m. on May 22, 2012.

Ms. Benton testified that she drove from St. Louis, Missouri to McLean, Illinois on May 22, 2012 and took a break in McLean. She confirmed that Petitioner purchased a soda and that he drove from McLean to Chicago, Illinois.

Ms. Benton testified that she debarked to unload the luggage upon arriving in Chicago and that in order to unload the luggage; she had to physically enter the luggage compartment. She testified that she could not see outside of the compartment, as she was unloading luggage for approximately ten (10) minutes. Ms. Benton testified that she did not see the Petitioner fall but that she saw him on the ground after exiting the compartment.

Ms. Benton testified that she called 911 upon seeing Petitioner on the ground. She testified that she turned around, away from the Petitioner, but as far as she could tell, he was not shaking or seizing and

his eyes did not roll up. He was simply laying still on the ground, which he did for approximately ten minutes, until the paramedics came.

Petitioner also presented Ms. Vernita Carter as a witness, who testified that she has lived with the petitioner since November of 2013 and that he has been healthy with no signs of seizure activity. She also testified that since she has been living with the petitioner, he has been working for Megabus.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and in the course of the 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).

Claimant testified he lost consciousness and fell after standing from the driver's seat of a bus he had been driving for Respondent. However, the Petitioner failed to demonstrate that his employment for Respondent placed him in a position increasing the effects of the alleged idiopathic fall.

An injury arises out of employment only if it originates in some risk connected with or incidental to the employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63 (1989). The mere fact a Petitioner's employment duties took him to the place of injury and, but for his employment, he would not have been there, is insufficient to support a finding his injuries arose out of his employment. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 485-86 (1989); *Caterpillar Tractor Co v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989). The Illinois Supreme Court

rejected the positional-risk doctrine in the seminal case of *Brady v. L. Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 548-60 (1991).

Illinois courts classify "risk" into three different categories. *Illinois Institute of Technology v. Industrial Comm'n,* 314 Ill. App. 3d 149 (1 Dist. 2000). These categories are employment risks, personal risks and neutral risks. Employment risks lead to injuries that occur as direct results of the risks inherent in the job activities. Accidental injuries resulting from neutral risks are compensable if the employment duties increase the risk of injury to the employee beyond that of the general public. A neutral risk is neither employment-related nor purely personal to the Petitioner. Idiopathic conditions are purely personal to the Petitioner and fall under the classification of personal risk. Examples include epileptic seizures, fainting spells, or some disease that is internal or inherent to the Petitioner. *Builder's Square, Inc. v. The Industrial Comm'n*, 339 Ill. App. 3d 1006 (3 Dist. 2003).

Petitioner testified that he lost consciousness. The cause of him losing consciousness is unclear. The Petitioner could only speculate to the cause of him losing consciousness. The emergency room record noted petitioner stating he did not experience lightheadedness, dizziness, visual changes, chest pains, sweating or shortness of breath, while driving the bus. The medical records also indicate witnesses referring to Petitioner exhibiting seizure activity at the scene prior, to the arrival of paramedics. The medical records also show the Petitioner was diagnosed with syncope, or a fainting event. The medical records further outline that petitioner had a history of migraine headaches and had previously been treated for tachycardia and asthma, early in life. The medical records and trial testimony indicate that it is equally likely that the Petitioner experienced a syncope event, a seizure or another inherent medical condition leading to a loss of consciousness. Whatever the exact cause, Petitioner's loss of consciousness and fall stem from an idiopathic condition and fall under the category of personal risk. *Oldham v. Industrial Com. of Illinois*, 139 Ill. App. 3d 594 (1985).

An idiopathic fall may be compensable when the petitioner's employment significantly contributed to the injury by placing the employee in a position increasing the dangerous effects of the fall. *Nabisco Brands Inc. v. Industrial Commission*, 266 Ill. App. 3d 1103 (1st Dist. 1994). However, this petitioner failed to demonstrate his position as a bus driver, contributed to his injury. Indeed, the petitioner testified he was unable to recall the exact circumstances of his fall and was only able to speculate as to the cause of his alleged fall, i.e. fumes from traffic and undue heat. Petitioner testified that he got up and lost consciousness. The next thing he remembered was waking up in an ambulance, in transit to the hospital. This is supported by the emergency room record from Rush University Medical Center, which detailed that the Petitioner described remembering driving a bus with the next memory being riding in an ambulance.

While the Petitioner testified to standing up after having driven the bus, "The act of standing itself, however, does not establish a risk greater than those faced outside of work. The need to stand was not unique to [Petitioner's] work." *Oldham v. Industrial Com. of Illinois*, 139 Ill. App. 3d 594 (1985). The

Rush University emergency room records also detailed that "[Petitioner] mentioned that over the past few days he had been feeling tired, but otherwise report[ed] being well. He did not experience lightheadedness, dizziness, visual changes, chest pains, sweating, [and] shortness of breath while driving the bus."

Petitioner's witness, Ms. Kimberly Benton testified she was inside of the bus' luggage compartment at the time of Petitioner's fall and did not witness it. She testified that Petitioner was already on the ground outside of the bus when she exited the luggage compartment. Ms. Benton's testimony failed to show the circumstances of Petitioner's alleged fall.

It is well settled in law that a petitioner must establish, beyond the preponderance of the evidence, the time, place and circumstances of an injury *with specificity* in order to show a compensable injury. See, *International Harvester v. Ind. Comm'n.*, 56 Ill. 2d 84 (1973); *Illinois Bell and Telephone Co. v. Ind. Comm'n.*, 131 Ill. 2d 478 (1989) (*emphasis added*). Here, Petitioner has failed to establish the circumstances of his alleged injury with specificity.

It is also well settled that a petitioner bears the burden of proving the essential elements of his claim by a preponderance of the evidence. Causal relationship may not be based on conjecture or speculation, but rather upon the credible evidence contained in the record, including medical records and details about the accident. *Sanitary District of Chicago v. Industrial Commission*, 343 Ill. 236 (1931).

The petitioner has failed to prove the circumstances of his alleged injury. There is no certainty as to why Petitioner fell or the exact circumstances of his fall. The emergency room records even differ as to where Petitioner fell. The records show Petitioner "was seen to fall upon getting off the bus after apparent LOC [loss of consciousness]." There is no evidence that the circumstances of Petitioner's employment, as a bus driver, significantly contributed to the injury, by placing him in a position increasing the effects of the fall. There is only evidence that petitioner sustained a loss of consciousness, due to an uncertain internal cause. The Petitioner could not remember anything between driving the bus and riding in the ambulance. Ms. Benton testified that she did not witness the fall. Petitioner's allegations against Respondent are based upon on conjecture and speculation.

The Arbitrator finds that Petitioner sustained an idiopathic fall and concluded that Petitioner has failed to demonstrate, beyond the preponderance of the credible evidence, that his employment contributed to the injury by placing him in a position increasing the dangerous effects of the fall. The Petitioner also failed to prove credible evidence of a causal relationship between his idiopathic fall and his work for Respondent. A finding of causal relationship may not rest on conjecture or speculation.

In light of the foregoing, the Arbitrator finds that the Petitioner failed to prove, by a preponderance of the evidence, that he sustained accidental injury arising out of and in the course of his employment by

Respondent; therefore no benefits are awarded, pursuant to the Act. The Arbitrator having found that no accident was proven, shall not address the remaining issues, as they are moot.

15IWCC0437

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC19390
SIGNATURE PAGE

Signature of Arbitrator

April 10, 2014
Date of Decision

APR 11 2014

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

Darrell Bagwell,
Petitioner,

vs. NO: 08 WC 34117

Nestle USA, Inc.,
Respondent.

15IWCC0438

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 benefit rates, causal connection, reasonableness and necessity of medical expenses, temporary total disability, nature and extent of the permanent disability, penalties and fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof..

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 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 $16,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 9 - 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-03/03/15
jdl/wj
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BAGWELL, DARRELL
Employee/Petitioner

Case# **08WC034117**

10WC017310

NESTLE USA INC
Employer/Respondent

15IWCC0438

On 3/12/2014, 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 0.08% 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:

0564 WILLIAMS & SWEE LTD
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SHAUN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

DARRELL BAGWELL,
Employee/Petitioner

v.

NESTLE USA, INC.,
Employer/Respondent

Case # 08 WC 34117

Consolidated cases: 10 WC 17310

15IWCC0438

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was consolidated with claim no. 10 WC 17310 and heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Peoria**, on **November 25, 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: _____

15IWCC0438

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,120.58**; the average weekly wage was **$636.94**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **two** 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 **$108,230.40** for TTD, $ **20,226.75** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of **$128,457.15**, for both matters.

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 **$424.63**/week, for **38-6/7** weeks, commencing **June 3, 2008** through **March 1, 2009,** as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of **$459.00** for services rendered by Primus Trauma Care, LLC, as provided in Sections 8(a) and 8.2 of the Act.

All awards of permanency, and permanent partial disability shall be addressed in case no. 10 WC 17310, which is consolidated and heard with this matter.

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

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

JOANN M. FRATIANNI
Signature of Arbitrator

March 10, 2014
Date

MAR 12 2014

15IWCC0438

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

On June 2, 2008, Petitioner worked for Respondent in the taffy lines. Petitioner also worked at the Mt. Zion Missionary Baptist Church in Galesburg as a pastor. Petitioner testified that he worked full duty on the Taffy Line with no medical restrictions. This job required him to stand 8 hours and lift 40-60 pounds. On June 2, 2008, Petitioner was dumping taffy that weighed 50-60 pounds from the floor to his chest. After doing this, he experienced pain in his back and leg.

On June 4, 2008, Respondent referred Petitioner to Health Point. A history of injury was recorded that corroborated Petitioner's testimony. Petitioner complained of back pain that ran down his left leg into his groin area. Petitioner then saw physicians at BroMenn Occupational Medicine who prescribed a lumbar MRI. The MRI was performed on June 11, 2008, and revealed disc bulging at L4-L5 with a broad based left posterolateral and lateral disc herniation, along with moderate to severe spinal stenosis. The herniation contacted the left L4 nerve root. (Px5)

Following the MRI, Petitioner was referred to see Dr. Kattner, an orthopedic surgeon, who prescribed surgery following an examination of June 26, 2008. Dr. Kattner diagnosed a herniated disc at L4-L5. On September 2, 2008, Dr. Kattner performed surgery in the form of a left lateral discectomy at L4-L5 and microdiscectomy.

Post surgery, Petitioner was rehospitalized due to difficulty in urinary retention. On September 18, 2008, a visit at BroMenn Hospital reflected continuing problems with urinary retention. Petitioner was then referred to see Dr. Leak, a urologist, that same day. Dr. Leak felt he had acute prostatitis most likely due to the insertion of a catheter during surgery.

Post surgery, Petitioner saw Dr. Kattner on September 23, 2008. Petitioner complained of a burning sensation to his left foot. On October 21, 2008, he complained of a spastic left leg and was prescribed physical therapy. On December 2, 2008, Dr. Kattner prescribed additional physical therapy and Ultracet. On January 13, 2009, Dr. Kattner felt Petitioner could return to work part-time, and on February 24, 2009 prescribed two weeks of work hardening.

Petitioner returned to work for Respondent on March 1, 2009. He then worked until March 23, 2009, when he sustained a new or second accident, which is the subject matter of case no. 10 WC 17310, which was consolidated and heard with this matter.

Dr. Kattner testified by evidence deposition on April 10, 2013. Dr. Kattner testified the incident of June 2, 2008 was causally related to the back condition he treated with surgical intervention. Dr. Kattner further testified that he did not nick any bladder or bowel during the surgery.

Based upon the above, the Arbitrator finds that the condition to the lumbar spine so treated by Dr. Kattner is causally related to the accidental injury of June 2, 2008. Based further upon the above, the Arbitrator finds that all claims made by Petitioner for other conditions of ill-being, including damage to his bladder or bowel area, is not causally related to the accidental injury of June 2, 2008.

G. What were Petitioner's earnings?

A wage statement was introduced into evidence reflecting earnings and an average weekly wage of $636.94 while in the employment of Respondent. Petitioner claims concurrent earnings in this matter.

When a claimant is concurrently employed, all earnings must be considered when calculating wages pursuant to Section 10 of the Act. Wages are included from a second employer only if known by the first employer at the time of the accident.

In this case, Respondent was aware that Petitioner was a pastor. Whether Respondent was aware that Petitioner had a specific paying job as a pastor is less clear. Petitioner introduced into evidence payments received for his pastoral work which included a discrimination charge. He also filed a request with Respondent for religious accommodation (Px31) and a charge of discrimination. The parties settled that claim. In all the evidence in the form of documents introduced before this Arbitrator, none indicate Petitioner was seeking time off for a paying job. During testimony, it was brought out that Petitioner stated in his own words that those pastoral wages were "none of their business," meaning Respondent's. Finally, Respondent subpoenaed tax and wage records from Mt. Zion Baptist Church. Those records were not provided. Petitioner testified he did not provide these records to Respondent on the advise of another attorney who was not his workers' compensation attorney.

Petitioner presented the testimony of a financial secretary at the Mt. Zion Baptist Church, Ms. Kim Mitchell. Ms. Mitchell testified she prepared checks made out to Petitioner that she signed.

Based upon the above, and the wage statement (Px20, Rx3) in evidence, the Arbitrator finds the average wage to be $636.94 per week in this matter. Based further upon the above, there does not appear to be adequate proof that Respondent was aware Petitioner was being compensated for a second job at the time of this accident. The Arbitrator can only speculate that if Petitioner had complied with the subpoena for such records, such records would have proven such knowledge. Under these circumstances all claims for concurrent wages made by Petitioner are hereby denied.

J. Were 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 introduced into evidence the following unpaid medical charges that were incurred after this accidental injury:

Primus Trauma Care, LLC	$ 459.00

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator finds the above medical charges represent reasonable and necessary medical care and treatment that is causally related to this accidental injury. Respondent is found to be liable to Petitioner for same, subject to the provisions of the medical fee schedule. Respondent is entitled to credit for any amounts paid from these charges.

All other medical bills introduced into evidence in these matters will be addressed in case no. 10 WC 17310, which was consolidated and heard with this matter.

K. What temporary benefits are in dispute?

The parties do not dispute that Petitioner as a result of this accidental injury was temporarily and totally disabled from work commencing June 3, 2008 through March 1, 2009. Petitioner returned to work on March 1, 2009 for Respondent.

Petitioner claims additional lost time commencing March 24, 2009, which is the subject matter of and is addressed in companion claim no. 10 WC 17310, which was consolidated with this matter.

Based upon the above, the Arbitrator finds that as a result of this accidental injury, Petitioner was temporarily and totally disabled from work commencing June 3, 2008 through March 1, 2009, and is entitled to receive compensation from Respondent for this period of time.

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

See findings of this Arbitrator in "F" above.

As indicated above, Petitioner sustained a subsequent accident on March 23, 2009, which is the subject matter of and is addressed in companion claim no. 10 WC 17310, which was consolidated with this matter.

M. Should penalties or fees be imposed upon Respondent?

See findings of this Arbitrator in "F" above.

Based upon said findings, all claims made by Petitioner for penalties and attorneys in this matter are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

India Furdge,
Petitioner,

vs. NO. 11 WC 27824

15IWCC0439

Renaissance Park South,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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. 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 on September 5, 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.

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.

15IWCC0439

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

DATED: JUN 9 - 2015

Joshua D. Luskin

o-05/20/15
jdl/wj
68

Ruth W. White

DISSENT

I must respectfully dissent from the majority's decision to affirm the Arbitrator's finding that the Petitioner's condition of ill-being was not causally connected to her injury on July 16, 2011.

I would find that her condition of ill-being was causally connected to her injury on July 16, 2011, and she is entitled to temporary total disability from July 16, 2011, until the Arbitrator's hearing date. I would further find that Respondent is liable for payment of all medical bills related to treatment of these injuries.

Petitioner was walking with a tray of food assisting a resident with a meal. She slipped on liquid on the floor landing forcefully on her left knee. (Transcript 13-14) The following day Respondent sent her to Dr. Mullings where they noted Petitioner had no prior history of injury to her left knee. She was diagnosed with a patellar contusion and restricted to seated duty. (Petitioner Exhibit 1, Pgs. 7-11)

Petitioner, as is her right, decided to seek further treatment at Chicago Pain and Orthopedic Institute on July 20, 2011, only 2 days after seeing the company doctor. She complained of throbbing and shooting pain in the anterior left knee which was worse while walking and standing. An MRI was ordered on July 21, 2011, which appeared to show a tear of the medial meniscus and mild chondromalacia of the patella. (Petitioner Exhibit 2, Pgs. 56-59)

Petitioner was referred to Dr. Markarian of Orthopedic Associates of Naperville who recommended an arthroscopic partial medial meniscectomy. This surgery was performed on August 4, 2011, and it showed that Petitioner had a grade IV chondral defect over the medial facet of the patella with patellar tilt and a grade IV lesion over the weight bearing surface of the medial femoral condyle as well as a lateral meniscus tear and synovitis. The surgery performed was an arthroscopic lateral retinacular release, chondroplasty and partial lateral meniscectomy. (Petitioner Exhibit 3, Pgs. 24-28)

Following this surgery, Petitioner still experienced a sharp, aching and throbbing pain in her left knee that was worsening. On October 13, 2011 Dr. Markarian performed another arthroscopic surgery where he repeated the lateral release of the patella and resurfaced the medial femoral condyle. (Petitioner Exhibit 3, Pgs. 7-13)

Petitioner continued to complain of pain in her left knee and on March 1, 2012 Markarian noted that there was an impingement of the fat pad in her left knee and he provided her a shot of Lidocaine. She had some improvement, but her pain came back, and so on April 14, 2012 he performed arthroscopic debridement of her fat pad to correct the impingement. (Petitioner Exhibit 2, Pgs. 16-22)

Petitioner testified that she experienced "a little" improvement in her condition following that surgery but she still experienced sharp, shooting pains in her left knee. (Transcript Pg. 19)

On November 27, 2012, Petitioner decided to seek another medical opinion and began treating at the University of Illinois in Chicago. On December 12, 2012, she was referred to Dr. Gonzalez for a possible removal of the hardware in her knee. (Transcript Pg. 21)

Dr. Gonzalez saw the Petitioner on January 1, 2013 and based on a bone scan which showed an increase in uptake, he was concerned about a loosening of the hardware in her left knee. Gonzalez recommended a total knee replacement. (Petitioner Exhibit 6, Pg. 205)

The total knee replacement was performed on January 31, 2013. However, Petitioner still complained of pain. Dr. Gonzalez performed manipulation under anesthesia on 3/14/13 and adhesions were released during this procedure. Petitioner was provided a cortisone injection on August 28, 2013 but still noted pain after two days. Gonzalez referred Petitioner to Dr. Rakic at a pain clinic. (Petitioner Exhibit 6, Pgs. 201-210)

Dr. Wolin, the Petitioner's IME doctor as well as Dr. Markarian opined that Petitioner's knee condition was aggravated by her fall. They both expressed their disagreement with Dr. Walsh, the Respondent's IME doctor, who found that the Petitioner's current condition was not causally connected to the accident. (Petitioner Exhibit 4, Pg. 17, Petitioner Exhibit 8, Pgs. 2-3)

Clearly, the Petitioner had no complaints involving her left knee before this injury. All the orthopedic specialists agree that she had pre-existing osteoarthritis in her left knee. However she was able to work at her regular job which required heavy lifting prior to this accident. A previous condition of good health, an accident, and a subsequent injury resulting in disability suggests the condition of ill-being is causally connected to the injury. International Harvester v. Indus. Comm'n, 93 Ill.2d 59, 64 (1982)

Petitioner's treating doctor, Dr. Markarian, and her examining Dr. Wolin, both agree that her osteoarthritis in her left knee was aggravated by her fall that led to the need for treatment and the various surgeries. Dr. Wolin's opinion should also be accorded a great deal of deference. He is a well-known and well-regarded knee surgeon who the Commission knows as a credible expert. Dr. Walsh is well known to the Commission as a doctor who is frequently retained by various Respondents' who habitually concludes there is no causation between claimant's injuries and their conditions. I find their testimony more credible than that of Dr. Walsh.

15IWCC0439

Dr. Walsh focused on the fact that Petitioner had pre-existing condition of osteoarthritis without seriously considering whether her fall would have aggravated it. He focused on her non-occupational factors, such as her weight, without acknowledging whether her injury was a causative factor of the resulting injury. Sisbro, Inc., v. Indus. Comm'n, 207 Ill.2d 193, 200 (2003) Therefore, I would have reversed the Arbitrator's findings of no causal connection between Petitioner current condition of ill-being and the accident.

Charles J. DeVriendt

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

FURDGE, INDIA
Employee/Petitioner

Case# **11WC027824**

RENAISSANCE AT HALSTED
Employer/Respondent

15IWCC0439

On 9/5/2014, 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:

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

0863 ANCEL GLINK
ERIN BAKER
140 S DEARBORN ST 6TH 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)

India Furdge
Employee/Petitioner

v.

Renaissance at Halsted
Employer/Respondent

Case # 11 WC 27824

15IWCC0439

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **08-20-2014**. 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 **Vocational Rehabilitation**

FINDINGS

On the date of accident, **07/16/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$17,578.08**; the average weekly wage was **$338.04**.

On the date of accident, Petitioner was **33** years of age, **single** with **4** dependent children.

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

Respondent shall be given a credit of **$1196.12** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1196.12**.

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

ORDER

The arbitrator finds that the petitioner's current condition of ill-being is not causally related to her employment for the Respondent. Therefore, any request for compensation, vocational rehabilitation, or additional treatment is denied.

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

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

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

David A. Kane
Signature of Arbitrator

September 5, 2014
Date

ICArbDec19(b)

4830-2050-6654, v. 1

SEP 5- 2014

ARBITRATION DECISION – ATTACHMENT

I. FINDINGS OF FACT

India Furdge ("Petitioner") testified that on July 16, 2011, she was employed at Renaissance Park South ("Respondent"), a nursing home, as a CAN. On July 16, 2011, Petitioner slipped and fell on water while carrying a tray of food to a resident. Petitioner landed on her left knee. Petitioner testified that immediately after the accident, she felt a lot of pain. Petitioner stated that the accident occurred in the morning and that she was able to work the rest of the day.

Following the work accident, Petitioner did not seek medical attention until July 18, 2011, when she went to the Excel Occupational Clinic. (R.X.4). Dr. Kami Millings examined the Petitioner and noted that range of motion was normal, but there was mild swelling of the knee in the medial and intrapatellar area. (R.X.4). Dr. Millings obtained an x-ray of the left knee, which showed mild bony sclerosis along the medial joint line and mild joint space narrowing, with no obvious fracture. (R.X.4). Dr. Millings diagnosed Petitioner with a left patellar contusion. (R.X.4). Dr. Millings also stated, "There is some question of symptom amplification as she has no strength deficits and no range of motion deficits, but reports significant pain even at rest..." (R.X.4).

Petitioner testified that she then began treating with Dr. Jain. The initial report with Dr. Jain on July 20, 2011 also shows only a diagnosis of a left knee sprain and contusion. (P.X.2).

On August 4, 2011, Petitioner underwent a left knee arthroscopy with lateral retinacular release, chondroplasty of the medial femoral condyle and

the patella, and a partial lateral menisectomy. (P.X.3). On October 13, 2011, Petitioner underwent a second arthroscopy of the left knee, arthroscopic lateral release, and an open resurfacing of the medical femoral condyle. (P.X.3). Petitioner then underwent a third left knee arthroscopy and debridement of the fat pad. (P.X.3). Dr. Markarian performed all three surgeries. (P.X.3.)

On October 2, 2012, Dr. Markarian issued a notice of work status slip, in which he released Petitioner to return to regular duty, full time work and noted that MMI had been attained. (R.X.10).

Petitioner testified that after Dr. Markarian released her, she chose to continue treating with Dr. Gonzalez. Dr. Gonzalez performed a total knee replacement in January, 2013. (P.X. 6). Petitioner underwent another operation with Dr. Gonzalez on March 14, 2013, in the form of left knee manipulation under anesthesia. (P.X.6). Petitioner testified that additional surgery has been recommended but she is not interested in another surgery.

Petitioner testified that she is currently 5'7" and 213 pounds, but that she weighed more at the time of the accident. Petitioner stated that she lost weight in February of 2014 when she underwent weight loss surgery. Dr. Jain's medical records from July 20, 2011, four days after the accident, indicate that Petitioner was 5'6" and 280 pounds. (P.X.2). It appears that Petitioner's weight stayed consistently in that range until the weight loss surgery in 2014, as Dr. Walsh noted she was 5'7" and 287 pounds during the May 12, 2012 IME. (R.X.1). Additionally, the operative report from the weight loss surgery on February 13, 2014, indicates that Petitioner was morbidly obese with a body mass index of 40. (R.X. 8). At trial, Petitioner

testified that she decided to undergo weight loss surgery to lose weight and help with her left knee pain. Petitioner stated that Dr. Gonzalez, Dr. Markarian, and her primary care doctor all advised her to lose weight to help with her knees.

Petitioner testified that she currently has sharp, shooting pain in the left knee, going up the thigh. Petitioner stated that her pain is eased by pain medication, but that the medication makes her drowsy. Petitioner testified that she uses a cane to help her walk, as prescribed by Dr. Gonzalez. Petitioner testified that she last saw Dr. Gonzalez in March, 2014, and he advised her to follow up in one year. Petitioner stated she has not returned to work since the accident. Petitioner also stated that she has not looked for work since the accident.

Petitioner testified that at the request of the Respondent, she underwent an IME with Dr. Walsh on May 7, 2012. (R.X.1). In his report, dated May 12, 2012, Dr. Walsh determined that "at best, the patient suffered a knee contusion with the incident described in July 2011." (R.X.1). Further, he found that the patellar tilting, grade IV lesion, osteoarthritis, and crepitation were all pre-existing conditions, noting "certainly the patellar tilting seen by Dr. Markarian is not causally related to the knee contusion. This is a pre-existing condition which is developmental in origin." (R.X.1). Dr. Walsh found that it is **not at all likely** that the Petitioner could have developed grade IV changes in her knee as a result of the contusion in July, 2011. *(emphasis added)* (R.X.1). He also found it **not at all likely** that the accident caused an aggravation or acceleration of her osteoarthritic disease. *(emphasis added)*. (R.X.1). Dr. Walsh noted that if Petitioner had so badly damaged her knee joint that she would

require knee resurfacing, she would have had more than mild swelling when she was first evaluated by Dr. Jain. (R.X.1). Additionally, Dr. Walsh went on to state that Grade IV changes do not occur within one month of an injury, indicating that the grade IV changes seen preexisted the July 2011 accident. (R.X.1). He determined that her current diagnosis of fat pad impingement was not caused by the accident, and the degenerative changes in her knee are related to her weight, with no causal relation to the injury described. (R.X.1). Dr. Walsh also found that Petitioner did not require a knee arthroscopy as a result of her knee contusion sustained on July 16, 2011. (R.X.1).

Dr. Walsh determined that Petitioner's ongoing work restrictions were not reasonable or necessary as a result of her knee contusion. (R.X.1). Further, he determined that more likely than not, she required no additional medical or orthopaedic intervention and most certainly does not require a third surgical intervention. (R.X.1). Dr. Walsh stated that Petitioner has no permanent limitation or restriction and is more likely than not at MMI with regards to the July 16, 2011 injury. (R.X.1). Dr. Walsh opined that Petitioner only required 3 to 4 weeks off work as a result of her knee contusion and that the ongoing work restrictions were not reasonable or necessary as a result of the work accident. (R.X.1).

Petitioner then underwent an FCE on September 24, 2012, which found that Petitioner was capable of working at the light physical demand level. (R.X.3, P.X.9). The FCE noted that Petitioner presented an inconsistent effort, and stated, "...these inconsistencies indicate a sub-maximal effort was given. Therefore the true capabilities of Ms. Furdge remain unknown at this time.". (R.X.3, P.X.9). Dr. Markarian then released

Petitioner with permanent restrictions set forth in the FCE on October 2, 2012. (R.X.10).

Petitioner then underwent an IME with Dr. Wolin on January 31, 2014, at the request of Petitioner's attorney. (P.X.8). Dr. Wolin diagnosed her with osteoarthritis of the knee and opined that the work episode was a contributing factor in her surgeries. (P.X.8). He suggested that Petitioner was not at MMI and recommended further treatment per Dr. Gonzalez's recommendations. (P.X.8).

Dr. Walsh then rendered an IME addendum on May 27, 2014. (R.X.2). Dr. Walsh stated that his opinion has not changed at all. (R.X.2). He found that Petitioner "most certainly did not require knee replacement because of the slip and fall." (R.X.2). Dr. Walsh went on to find no evidence that Petitioner even suffered a fracture as a result of the accident. (R.X.2). He found that Petitioner clearly had a pre-existing condition and that the injury, more likely than not, did not aggravate or accelerate the pre-existing osteoarthritic disease. (R.X.2). Dr. Walsh stated that none of the care and treatment since the May 12, 2012 IME was causally related to the accident and that all care was related to the osteoarthritis and obesity. (R.X.2). He stated that the accident was not at all a contributing factor to the need for surgery. (R.X.2). Dr. Walsh stated that Petitioner is morbidly obese and that her weight contributed to her condition. (R.X.2). Dr. Walsh expressly disagreed with Dr. Wolin's opinions. (R.X.2).

II. CONCLUSIONS OF LAW ON DISPUTED ISSUES

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

The Arbitrator finds that the Petitioner's current condition of ill-being in her left knee is not causally related to her accident while employed for the Respondent.

The Arbitrator notes that Dr. Walsh's opinion was quite definite in finding no causal connection. Dr. Walsh found it that Petitioner only suffered a knee contusion as a result of the accident and that he found that it is not at all likely that the Petitioner could have developed grade IV changes in her knee as a result of the contusion in July, 2011. *(emphasis added)* (R.X.1). He also found it not at all likely that the accident caused an aggravation or acceleration of her osteoarthritic disease. (R.X.1).

Dr. Walsh gave numerous reasons for his opinion finding no causal connection. Dr. Walsh noted that if Petitioner had so badly damaged her knee joint that she would require knee resurfacing, she would have had more than mild swelling when she was first evaluated by Dr. Jain. (R.X.1). Additionally, Dr. Walsh went on to state that Grade IV changes do not occur within one month of an injury, indicating that the grade IV changes seen preexisted the July 2011 accident. (R.X.1). Dr. Walsh also determined that her current diagnosis of fat pad impingement was not caused by the accident, and the degenerative changes in her knee are related to her weight, with no causal relation to the injury described. (R.X.1).

Petitioner's own treater released her to full duty work and found her to be at MMI on October 2, 2012. (R.X.10). The Arbitrator notes that

Petitioner chose to continue treating although both Dr. Walsh and Dr. Markarian found her capable of working and at MMI. (R.X.1,2,10).

The Arbitrator agrees with the opinions of Dr. Walsh, and notes that Petitioner's weight caused her knee problems. The Arbitrator notes that throughout the vast majority of treatment, Petitioner's weight was around 280 pounds, with a BMI of 40. The Arbitrator finds that there is no question that Petitioner's weight caused her ongoing knee problems. Petitioner even stated at trial that her own treaters, Dr. Markarian, Dr. Gonzalez, and her primary care physician, urged her to lose weight to help her knees.

Further, the Arbitrator questions the credibility of Petitioner based the July 18, 2011 note from Excel Occupational Health Clinic and the FCE results. In the July 18, 2011 Excel note, Dr. Millings only diagnosed Petitioner with a contusion and noted, "There is some question of symptom amplification as she has no strength deficits and no range of motion deficits, but reports significant pain even at rest..." (R.X.4). Additionally, the FCE noted that Petitioner presented an inconsistent effort, and stated, "...these inconsistencies indicate a sub-maximal effort was given. Therefore the true capabilities of Ms. Furdge remain unknown at this time.". (R.X.3, P.X.9). The Arbitrator finds that the lack of full effort and presence of symptom magnification call into question Petitioner's credibility.

The Arbitrator finds that based on the above, and after considering the entire record,, Petitioner's current condition is not related to the July 16, 2011 accident at work. Therefore, any claim for additional treatment or benefits is denied.

Due to the Arbitrator's finding on causal relationship, all other issues are rendered moot.

Therefore, claim for compensation is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eldon, Hohulin,

Petitioner,

15IWCC0440

vs.

NO: 14 WC 3275

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 8, 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: JUN 9 - 2015
O5/19/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

HOHULIN, ELDON
Employee/Petitioner

Case# **14WC003275**

MITSUBISHI MOTORS NORTH AMERICA INC
Employer/Respondent

15IWCC0440

On 8/8/2014, 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:

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

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
MARTHA GELY-KRUTO
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0440

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)

ELDON HOHULIN,
Employee/Petitioner

Case # **14 WC 03275**

v.

Consolidated cases:

MITSUBISHI MOTORS NORTH AMERICA, 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 **D. DOUGLAS MCCARTHY**, Arbitrator of the Commission, in the city of **BLOOMINGTON**, on **July 18, 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

15IWCC0440

FINDINGS

On the date of accident, **July 19, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 with respect to his right shoulder ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $ **75,933.95**; the average weekly wage was $ **1,518.67**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $ **13,595.16** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **13,595.16**.

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

ORDER

Petitioner failed to prove his current condition of ill being as it relates to the right shoulder is causally related to the July 19, 2013 accident. Therefore the request for right shoulder surgery as prescribed by Dr. Seidl is denied.

Credits

Respondent shall be given a credit of $ **13,595.16** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **13,595.16**.

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

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

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

D. Dyke McCarthy
Signature of Arbitrator

Aug 7, 2014
Date

AUG - 8 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELDON HOHULIN,

Petitioner,

v.

MITSUBISHI MOTORS NORTH AMERICA, INC.,

Respondent.

Court No. **14 WC 03275**

FINDINGS OF FACT

The Petitioner was 54 years old at the time of the work accident of July 19, 2013. He had been employed by the Respondent for almost twenty-three (23) years. For the past eleven (11) years he worked as a maintenance electrician.

He testified that on the date of the accident he was assigned to replace an electric motor with a co-worker. He did not know how heavy the motor was. Petitioner testified he climbed up a ladder. His co-worker was across from him on a different ladder. Petitioner checked to see whether he could lower the motor by himself and tested its weight. Once he concluded he could lift the motor he grabbed it and passed it to his co-worker with his arms fully extended through the ladder. Petitioner then took a step down. He testified that he once again fully extended his arms at chest level through the ladder to grab the motor from his co-worker.

When his co-worker passed the motor back to Petitioner he felt a pop in his right arm and had immediate pain. He fell that his arm gave up.

Petitioner testified he was taken to the company clinic and he explained what had happened (RX1). He was examined and diagnosed with a biceps tendon rupture. There was no mention of an injury to the right shoulder (PX4; RX1). He was then immediately taken to the St. Joseph Medical Center Emergency Room (PX1). At St. Joseph's, Petitioner indicated he had pain in the right mid-

upper arm area. He was diagnosed with a right biceps tendon tear. There were no complaints of or treatment for a shoulder injury. Petitioner was to follow up with Dr. Robert Seidl (PX1; PX2).

Petitioner saw Dr. Seidl on July 23, 2013 (PX2 page 14). Dr. Seidl took a history of the accident and examined Petitioner. On examination, Petitioner was alert and oriented. His neck was non-tender. The skin at the upper extremity was without observed abnormality, but there was obvious bruising at the elbow. He was tender to palpation over the radial head and had deformity consistent with a distal biceps tendon rupture. His rotator cuff strength was 5/5 supra and infraspinatus (PX2). Dr. Seidl referred Petitioner for an MRI, which confirmed the diagnosis of a distal biceps tendon rupture. At that time Dr. Seidl felt it was reasonable to proceed with biceps tendon repair (PX2).

Petitioner underwent right distal biceps tendon repair on July 31, 2013 (PX2 page 4). Petitioner testified that after surgery his arm was placed in a sling and two (2) days later he was placed on a hard-shell cast. Petitioner testified the cast went from his armpit to his fingers and it did not cover his right shoulder. Petitioner continued to follow up with Dr. Seidl and on August 23, 2013 a Doppler was obtained as Petitioner had significant swelling in his arm. The Doppler was negative and there was no evidence of DVT (PX2 page 12; PX3 page 32). He was placed in a posterior splint and his staples were removed.

Petitioner testified that he began feeling pain in the right shoulder area after he was fitted with his new cast in early August. He further testified he was unable to sleep due to the pain. However, the physical therapy records from Advocate Eureka Hospital, which are barely legible, do not reference shoulder complaints until October 14, 2013. (PX3) The initial evaluation, performed on September 3, 2013, contains no reference to the shoulder. The therapy goals are all related to the elbow and wrist. The October 14, 2013 progress summary does reference the shoulder, and it is apparent that the Petitioner had been receiving treatment for the shoulder. The Arbitrator cannot

discern from the therapy notes exactly when that treatment began, but notes that Dr. Seidl discontinued the arm splint on September 9, 2013. (PX 2)

At his next follow-up visit of October 14, 2013 Dr. Seidl noted Petitioner's range of motion and strength were improving. He also noted symptoms of impingement. Petitioner was to follow up p.r.n. (PX2 page 9). Petitioner testified that he mentioned his shoulder pain to Dr. Seidl on prior visits, but there was no reference to the shoulder in the doctor's notes prior to this visit. Petitioner chose to undergo an injection into the right subacromial space. There were no complications (PX2).

Petitioner next saw Dr. Seidl on November 11, 2013. On examination, Petitioner had full range of motion and the tendon looked good. The shoulder had good range of motion, there was negative impingement and good cuff strength at 5/5 supra and infraspinatus (PX2 page 8). Dr. Seidl diagnosed Petitioner with a healing right biceps tendon rupture and possible rotator cuff pathology. Petitioner was to continue rehab and avoid heavy lifting. He was returned to work with a 25-pound lifting restriction for two (2) months and no restrictions after January 11, 2014 (PX2 page 8). Petitioner testified he returned to work in a light duty capacity and his restrictions were honored by Respondent until he returned to full duty work on January of 2014.

On February 20, 2014 Petitioner returned to Dr. Seidl. He was doing well in regards to his right distal biceps tendon repair. However, he complained of right shoulder pain (PX2 page 7). Petitioner had a positive impingement sign and limited motion. Dr. Seidl recommended an MRI. On February 28, 2014 Petitioner followed up with Dr. Seidl. The MRI showed a partial thickness tear of the right rotator cuff (PX2 page 6). At this time Dr. Seidl recommended right shoulder arthroscopy with a subacromial decompression.

Petitioner testified that on March 28, 2014 he was evaluated by Respondent's section 12 physician, Dr. Michael Lewis (RX2). Petitioner testified he gave Dr. Lewis a history of how his accident occurred and that Dr. Lewis examined him. Dr. Lewis noted Petitioner had returned to

work on January 11, 2014 in a full duty capacity. Petitioner denied pain in his right elbow, but complained of moderate, sharp pain in his right shoulder area. On examination, Dr. Lewis noted a well-healed incision of the right elbow. There was no swelling or atrophy in the shoulder area. Abduction and forward flexion of the right and left shoulder was 180 degrees (RX2 page 2).

Dr. Lewis opined Petitioner was status post repair of ruptured distal right biceps tendon with excellent result. He believed no further medical treatment was necessary for Petitioner's injury to his biceps tendon. Dr. Lewis also opined Petitioner had a partial tear of his right shoulder based on the MRI findings (RX2 page 4). However, it was Dr. Lewis' opinion the right shoulder tear was not related to Petitioner's work injury of July 19, 2013 in view of the significant delay between the date of injury and the onset of any complaints in regards to the right shoulder. Dr. Lewis also was of the opinion that wearing a heavy cast would not be a cause of impingement syndrome or a partial rotator cuff tear. (Id)

Conclusions of Law

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

The Arbitrator finds Petitioner failed to prove by a preponderance of the evidence his current condition of ill-being is related to the July 19, 2013 work accident as it relates to his right shoulder.

The Petitioner testified that he did not begin having shoulder pain until after he was placed in a long cast following his surgery. Dr. Seidl's notes indicate the casting was done on August 2, 2013. The Petitioner saw Dr. Seidl twice more during the month of August and there is no reference in the doctor's notes of any shoulder problems. He was seen for an initial physical therapy visit on September 3, and again there were no shoulder references. It was not until October 14 that any mention of the shoulder appears in the medical records. While it is clear that some shoulder complaints were made in therapy before that date, it is also clear that they were made over one month after the cast was placed on the Petitioner's arm.

Dr. Seidl opined in his note of February 28, 2014 that the Petitioner's shoulder injuries were causally related to his accident. However, it is clear from that note that Dr. Seidl did not have an accurate basis for his opinions. First of all, he said the Petitioner told him his symptoms were present on the day of his accident. The Petitioner testified on both direct and cross examination that his symptoms did not begin until after he was casted following surgery. He also told the medical department at Mitsubishi on October 15 that his shoulder issues began when wearing the cast. (PX4) Dr. Seidl did not give an opinion as to whether the cast was related to the injury, but Dr. Lewis opined that it was not.

The Arbitrator believes that if the accident was causally related to a partial thickness tear of the rotator cuff along with impingement syndrome, the Petitioner would have complained of it and sought treatment long before October 14, 2013, when it was first noted in the medical records.

Accordingly, the Petitioner has failed to prove a causal relationship between the accident and the shoulder injury.

K. Is Petitioner entitled to prospective medical care?

Having found no causal connection between Petitioner's current condition of ill-being as it relates to his right shoulder and the work accident of July 19, 2013 the Arbitrator denies Petitioner is entitled to prospective medical care specifically arthroscopic surgery to the right shoulder as prescribed by Dr. Seidl.

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

Shreada Miller,
Petitioner,

15IWCC0441

vs.

NO: 13 WC 33471

Chicago Transit Authority,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

DATED: JUN 9 - 2015
O5/19/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, SHREADA
Employee/Petitioner

Case# **13WC033471**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

15IWCC0441

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:

0996 WILLIAM B MEYERS & ASSOC
NICHOLAS A RUBINO
100 W KINZIE ST SUITE 325
CHICAGO, IL 60654

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS ESQ
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

SHREADA MILLER
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # **13** WC **033471**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the City of **Chicago**, on **April 11, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **09/24/2013**, 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 **$63,481.60**; the average weekly wage was **$1,220.80.**

On the date of accident, Petitioner was **44** years of age, ***Single*** with **0** dependent children.

ORDER

- Petitioner did not sustain an accident that arose out of and in the course of her employment for Respondent.

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

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

Signature of Arbitrator

6/23/14
Date

JUN 24 2014

15IWCC0441

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shreada Miller,	)	
Petitioner	)	
	)	
vs.	)	**No. 13 WC 33471**
	)	
Chicago Transit Authority,	)	
Respondent	)	
	)	

ARBITRATOR'S DECISION

Statement of Facts

Petitioner is a 44-year-old Bus Operator employed by respondent, Chicago Transit Authority ("CTA"). Since 2006, Petitioner has been assigned out of the "Kedzie" garage with her daily duties consisting of driving a bus and transporting passengers on her assigned routes.

On September 24, 2013, Petitioner was assigned to the #7/Harrison Street route which runs east to Congress Plaza and west to Central. When Petitioner's shift started, she was to relieve another driver and assume the eastbound #7/Harrison route at Harrison & Kedzie, the designated relief point.

Petitioner testified that she arrived at her relief point at approximately 10:15 a.m. and was on the north-side sidewalk when her assigned bus pulled up in front of the police station on the south-side of Harrison just east of Kedzie. There is a bus stop directly in front of the police station at this particular relief point. Petitioner testified that because police cars were parked in front of the station, the driver that Petitioner was to relieve ("Pernell") stopped the bus in the only east-bound moving lane, approximately 2-3 feet from the curb. Once aboard the bus, Petitioner took the driver's state and began the 5-10 minute "pre-pull out" routine of preparing the bus in order to assume its operation. Petitioner testified that this routine would take approximately 5-10 minutes.

Petitioner testified that while she was going through her routine she heard banging on the side of the bus and banging on the door when a plain clothed/undercover police officer appeared and stood in the front doorway demanding that she move the bus "right now". Petitioner stated she would have to contact control to which the officer responded that he didn't care who she had to call but if she didn't move the bus right away she would get a ticket. Petitioner testified that the officer was standing at the front door for 1-2 minutes before he walked away.

Petitioner testified that shortly thereafter a second plain clothed officer (wearing his badge around his neck) came to the front door and told her to "move this bus, you black bitch" and that he also referred to her as a "stupid black bitch". Petitioner testified when the 2nd officer used that language she was "hurt" and "embarrassed", she was scared and feared for her life. Petitioner went on to explain that she felt hurt because no one had ever spoken to her that way, she was embarrassed because there were passengers on the bus and she was scared because the police officer spoke to her that way when they are supposed to be the ones you call to protect you. Petitioner testified that neither of the police officers boarded the bus and that the total amount of time that there was an exchange between her and the officers was 5-6 minutes.

Petitioner testified that after the incident, she pulled the bus away from the relief point and continued to drive to the east- end point of her route, Congress Plaza. Petitioner testified that she was crying and called the control center to report what had happened.

Petitioner introduced into evidence a document entitled "Becs Event Details" which details that Petitioner contacted control center at 11:29:25 and stated:

> *"An unidentified Chicago Police Officer who was in an unmarked squad car boarded the bus eastbound Harrison/Kedzie at 1027 hours yelling racial obscenities "black bitch move this bus right now". The operator was making a relief and was attempting to set the bus up. The operator called the control center and reported the incident after arriving at Congress Plaza Terminal. The operator will see manager at the end of the work day. No injuries, damages or arrest reported...".* (P. Ex. 4).

Petitioner completed her route by driving westbound from Congress Plaza back to Harrison/Kedzie, across the street from the police station. From there she walked back to Kedzie garage which is down the street; it took Petitioner 2-3 minutes to walk to the garage.

Once at the Kedzie garage, Petitioner reported the incident and completed a "Miscellaneous Incident Report" in which she identified the incident as "*Verbal Assault by Police*". Petitioner described the incident as follows:

> *"Making Relief at 1027 police cars were parked alongside the Bus Stop Curve the Policeman got outta there Squad Car start calling me all types of Derogatory Names Bitches Degrading me said they were going to give me a ticket. I began my Route because I was scared and feared the officer and Call Control to Report the Incident.* (R. Ex.1) [1]

Petitioner testified that she discussed the event with a manager and he suggested that she go file a complaint at the police station which Petitioner went on to do. The

[1] Other reports were admitted into evidence referring to verbal harassment/obscenities toward Petitioner by the undercover police officer. (R. Ex. 2,3; P. Ex. 4)

complaint that Petitioner filed was for "verbal assault" by the undercover police officer. (PX. 5) That complaint is still pending.

On September 26, 2013, an "Employee Interview Record" form was completed and noted the Petitioner's comments as follows:

> *"Operator Stated After The Incident On 09/24/13 She Is Under Too Much Stress, On 09/25/13 At 1030 Hours One Of The Same CPD Officer Was Following Her In His Car. Operator Is Too Nervous To Drive And Want To Claim IOD Due To Stress and Nerviousness."* (PX. 4)

On September 26, 2013, Petitioner presented to Concentra Medical Center. The chart notes that Petitioner complained of being nervous and shaky. The history of event was consistent with Petitioner's trial testimony. Medical records noted Petitioner to have a flat effect, very upset with constant crying. Petitioner was assessed as having an anxiety stress reaction, taken off of work and recommended to be evaluated by a psychologist for counseling, Dr. Frederick Bylsma. (PX 1; RX. 5)

On September 30, 2013, Petitioner was evaluated by Dr. Bylsma of Neuropsychological Services for an initial 60 minute interview along with psychological testing that lasted for 180 minutes.

Petitioner testified that was the only day she had any psychological testing. Petitioner gave a history of the incident to Dr. Bylsma consistent with her trial testimony.

Petitioner expressed to the doctor that she was afraid of the police officer and after she pulled away the unmarked car and 2 other police cars also travelled down Harrison Street behind her. Petitioner also stated that the next day after making a relief at the same spot in front of the police station she saw an unmarked police car also travelling eastbound on Harrison Street for some distance. Petitioner explained that this made her increasingly scared and anxious and wondered if she could be or would be harmed at some point. It was noted that Petitioner... *"understands this is not a logical conclusion, but she cannot convince herself that it will not happen."* Thereafter Dr. Bylsma surmised that Petitioner was very anxious and hypervigilant of policemen-the conflict of periodically needing police assistance to remove unruly passenger and her current fear of them would affect her work activities.[2] Dr. Bylsma diagnosed Petitioner with "Anxiety State" and prescribed psychotherapy sessions to address her stress and anxiety symptoms.

On October 7, 2013, Petitioner followed up with Dr. Bylsma who reviewed the results of the psychological testing and noted that Petitioner "denied symptoms that would satisfy

[2] Petitioner testified that in her approximate 15 years of employment as a bus operator she had to call for assistance on three occasions due to kids fighting on the bus. When police responded to the call the information that they took was the Petitioner's badge number and bus number-they were not apprised of who the operator was before responding to the call.

a DSM-IV diagnosis of Post traumatic Stress Disorder." The diagnosis rendered was "Anxiety State".

On October 14, 2013, Lydia Richardson, PsyD, noted that Petitioner had a history of childhood trauma. Petitioner was provided with psycho-education about posttraumatic stress, treatment techniques and basic information about therapy. Petitioner was diagnosed with Posttraumatic Stress Disorder is given.

On October 21, 2014, Petitioner presented to Lydia Richardson and was diagnosed with Anxiety Reaction to a Traumatic Stressor.

On March 19, 2014, Petitioner first treated with Dr. Niby Mathew and was prescribed was Lexapro 10 mg and Xanax .25 mg.

As of the hearing date Petitioner has not returned to work after her initial treatment at Concentra Medical Center.

The CTA bus video hard-drive was admitted into evidence depicting the event that occurred on September 24, 2013. The video provides seven different vantage points, depicting activity on and off the bus. (RX 6) The Arbitrator had an opportunity to review the footage and notes the following events: the male bus operator pulled up to the relief point, when the bus pulls to its stop there is one squad car parked on the curb side; the male bus operator exits the bus and Petitioner boards the bus and takes the driver's seat; while the male bus operator walks west on the sidewalk towards Kedzie; there are three adult passengers on the bus (a lady in a light blue jogger's outfit with a stroller who has just boarded, a man in dark clothing siting on the driver's side on the bench seat and a lady in the very back of the bus on the passenger side); there are 2 undercover officers -#1 is wearing a long sleeved light colored shirt and jeans with his badge hanging around his neck -#2 wearing tan pants and a short sleeved white shirt; officer #1 appears at the front door for approximately 10 seconds wherein he is seen talking to Petitioner; officer # 1 and #2 can be seen at the front door for approximately 30 seconds wherein both are seen talking at Petitioner; Petitioner closes the front door and drives away; the squad car pulls out directly behind the bus and the unmarked car directly behind the squad car.

Opinion and Order

C. Accident

Petitioner claims that mental stress was a causative factor of her mental injury. This type of claim is referred to as a "mental-mental" case. The Illinois Supreme Court reviewed the law in mental stress cases in *Pathfinder v. Industrial Commission,* 62 Ill. 2d 556, 343 N.E. 2d 913 (1976). In *Pathfinder,* the claimant pulled a co-worker's severed hand out from a punch press machine and immediately fainted. Medical records documented that Petitioner was treated for anxiety and received sedating drugs. The Court concluded that a Petitioner 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." *Id* at 563, 917.

In *General Motors Parts Division v. Industrial Commission,* 168 Ill. App. 3d 678, 522 N.E. 2d 1260, 119 Ill. Dec. 401 (1rst Dist. 1988), the First District concluded that *Pathfinder* does not permit recovery for every non-traumatic psychological injury from which an employee suffers merely because the employee can identify some work-related event which contributes in part to his/ her anxiety/stress or depression.

In *Hand v. CC Services Inc.,* 02 IIC 0049, the Commission denied benefits to a Petitioner arising out of an incident in which an individual yelled at Petitioner in a threatening manner. Petitioner, an insurance agent, testified that in the course of taking a statement from a client at the client's home, regarding the death of the client's 5-year-old child, a neighbor began yelling at the Petitioner. The neighbor was angry at the Petitioner and Petitioner's employer, the insurance company, for forcing the client to relive the tragic death of the client's child. Petitioner testified that while the neighbor was physically threatening, no physical contact ensued.

The arbitrator denied benefits, reasoning in part that the fact that the Petitioner was yelled at by a bystander in a threatening manner did not expose Petitioner to any greater risk than that of the general public. The Commission affirmed finding the claim to be noncompensable.

In *Chicago Board of Education v. Industrial Commission*, 169 Ill. App. 3d 459, 523 N.E. 2d 912, 120 Ill. Dec.(1st Dist. 1988) the Petitioner claimed a deterioration of his emotional well-being resulting from incidents of on the job stress (chaos in the classroom, unmanageable students and a fear for his life). Although the Petitioner alleged he feared for his safety the Appellate Court denied his claim for compensation. The Court reasoned that there are events and conditions capable of producing stress in every employment environment. It was not enough for the employee to believe, although mistakenly, the conditions exist. To allow compensation for any mental disease and disorders caused by on-the-job stressful events or conditions would open a floodgate for workers who succumb to the everyday pressures of life. *Id* at 466, at 917, at 6. The evidence must show that the mental disorder resulting from non-physical trauma arose in a situation of greater dimensions that is not common and necessary to all or to a great many occupations. *Id* at 466-468.

In the instant case, it seems likely that any type of vehicle, whether a delivery truck, school bus, etc., blocking the only moving lane of traffic on Harrison, that blocked the unmarked police car in question, would have been meet with harsh words from the officer(s). The Petitioner's fear after the fact that she could be or would be harmed by the officer(s) was not a logical conclusion –her fear does not exist in reality from an objective standpoint. There was no evidence to suggest that any police vehicle travelling behind the bus Petitioner operated on September 24, 2013, was anything other than police officers proceeding east bound after having been blocked by the parked bus. The

evidence does not suggest that Petitioner was or has been singled out by the Chicago Police Department that would lead to a logical response of fear on her behalf.

In *Skidis v. Industrial Commission*, 309 Ill. App. 3d 720, 722 N.E.2d 1163, 243 Ill. Dec. 94 (5th Dist. 2000) the Petitioner's claim for her resulting psychological condition after subjected to derogatory racial and sexual slurs at the work place was denied benefits under the Act. The Court held that the claimant failed to demonstrate her condition was the product of anything other than the normal stress associated with employment, and such alleged grievous conduct did not qualify as "sudden, severe emotional shock" that would be deemed compensable. The Court went on to state that the similar issue was addressed in the *General Motors* case where the employee claimed that a supervisor verbally assaulted him with use of profanity and racial slurs that caused a claimed psychological injury. The Court in *General Motors* denied compensation as a matter of law ruling that the alleged verbal abuse was non-traumatic and not out of proportion to the incidents of normal employment activities. [3]

The Illinois Worker's Compensation Commission has also found that allegations of verbal abuse fail to rise to the level of compensability. In *Lucille Dominguez v. Il. Dept. of Public Aid*, 09 IWCC 1010 Petitioner's job duties included locating and enforcing child support orders. Petitioner alleged that a client she was interviewing verbally attacked her when she screamed and swore at her, causing Petitioner to become emotionally upset. The Commission affirmed and adopted the Arbitrator's Decision that held that although emotional for Petitioner, the confrontational verbal abuse did not rise to the level of a "severe emotional shock which produces immediate disability" pursuant to *Pathfinder*.

Likewise, in *Twanda Jones v CTA*, 11 IWCC 1255, Petitioner alleged that a passenger boarded her bus and became irate calling her a bitch and threatened to bust her in the head while she stood next to her with her fists balled up. The Commission found that Petitioner was involved in a verbal altercation with a female passenger and that such altercation does not rise to the level of compensability under a mental-mental theory of recovery.

The Arbitrator finds that Petitioner did not sustain an injury that arose out of and in the course of her employment in that she was not exposed to the kind of sudden, severe, emotional shock contemplated by the above- mentioned cases.

[3] The Court went on to state .... "Compensation for nontraumatic psychic injury cannot be dependent solely upon the peculiar vicissitudes of the individual employee as he relates to his general work environment."

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

Maureen Morin,
Petitioner,

15IWCC0442

vs.

NO: 08 WC 2820

Williams Specialty Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

DATED: JUN 9 - 2015
O5/19/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORIN, MAUREEN
Employee/Petitioner

Case# **08WC002820**

WILLIAMS SPECIALTY SERVICES
Employer/Respondent

15IWCC0442

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:

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E ULRICH
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

15IWCC0442

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Maureen Morin
Employee/Petitioner
v.
Williams Specialty Services
Employer/Respondent

Case # **08 WC 02820**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Gerald Granada, Arbitrator of the Commission, in the city of New Lenox on April 3, 2014 and in the City of Geneva on June 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. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On December 7, 2007, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this 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 $73,632.00; the average weekly wage was $1,416.00 and at the time of hearing, she would have earned $1,630.00 a week if she continued to work as a Union Painter.

On the date of accident, Petitioner was 33 years of age, married with no dependent children.

ORDER

Petitioner failed to prove accidental injuries arising out of and in the course of her employment and, therefore, 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

7/23/14
Date

JUL 24 2014

15IWCC0442

This is a claim alleged by the Petitioner for injuries sustained while working for the Respondent on December 6, 2007. Petitioner is claiming psychological injuries stemming from an alleged sexual assault by a co-worker on said date of accident. The issues in dispute are: 1) accident, 2) causation, 3) average weekly wage, 4) TTD/TPD, 5) medical expenses, 6) penalties & attorney fees, and 7) permanency. The arbitration hearing began on April 3, 2014 in New Lenox. Additional testimony and the closure of proofs took place on June 10, 2014 in Geneva.

The following individuals testified during the course of the arbitration hearing:

1) Maureen Morin – the Petitioner;
2) John Victor Berg – Petitioner's father;
3) Morgan Burnett – former co-worker and the alleged assailant;
4) Pete Piazza – former chief investigator for the Will County State's Attorney's Office and current Deputy Director of the Illinois Secretary of State Police;
5) James Madonis – former co-worker / union steward and current President of Union Local 33;
6) Chris Montle – Operations Manager for Respondent;
7) Rickey Bishop – Job Superintendent for Respondent.

STATEMENT OF FACTS

The petitioner became a Painter after a three-year apprenticeship in 1999. She was working as a Union Painter for Respondent Williams Specialty Services at the Exelon Nuclear Plant at the time of the alleged incidents. In order to work at the nuclear plant, she went through a screening process that included a background check, and then went through a week of testing and training to include psychological testing, understanding the workplace and the risks. The petitioner testified that in order to have access to the Exelon premises, you were issued a photo ID and if you failed to bring that ID to work, you would not be able to access the premises. Witnesses Morgan Burnett and James Madonis confirmed the photo ID and the inability to have access to the premises without it. Chris Montle and Ricky Bishop also testified to the fact that all employees and trades had to wear the photo ID while working on the premises. The petitioner testified that she went through additional training with Williams Specialty Services to include sexual harassment training. She testified that they were advised to report all sexual harassment. Morgan Burnett, James Madonis, Chris Montle and Ricky Bishop confirmed the sexual harassment training and the fact that all sexual harassment was to be reported immediately.

The petitioner testified that each morning, prior to the start of work, there were daily meeting attended by supervision and the painters covering the work to be performed and whether or not there were any issues or problems. These daily morning meetings were confirmed by Ricky Bishop, James Madonis, Morgan Burnett and Chris Montle.

During the period of time in question, there was Exelon supervision, supervision by Williams Specialty Services, union representation and ten to twelve painters of which there were two women, Maureen Morin and Kerry Wilson. In addition, there were other trades and employees of Exelon working at the facility.

The petitioner testified that union painters were male dominant and that she was able to work in that environment for eight years. Morgan Burnett confirmed the fact that union painters were male dominant but

testified that painters such as Kerry Wilson had no problems because painters were judged by their performance and Kerry Wilson was excellent.

The petitioner testified that she started working for Williams Specialty Services at the Exelon Nuclear Plant in September of 2007. Morgan Burnett was also working there at the time. She had no contact with Mr. Burnett in September of 2007. She wasn't working with him at this time and had no conversations with him. She testified that she worked approximately three weeks and was layed off.

The petitioner testified that after the lay off, she returned on November 12, 2007. When she returned, she was prepping floors. When asked when her first working contact with Mr. Burnett was, she was unable to give a date. When asked how long they worked together before the first incident, she was unable to recall a time frame.

The petitioner testified to the following sexual discussions or contact with Mr. Burnett:

1. On or about December 2 or 3, 2007, exact date not known, she testified that Mr. Burnett accused her of looking at his butt when he was bent down taping and begrudgingly after being pushed continuously on the subject, she laughed and agreed with him. There was no physical touching at this time. The petitioner did not report the incident to her Union Stewart, Williams Specialty Services or Exelon supervision. She testified that she did discuss Mr. Burnett's conduct with a female co-employee, Kerry Wilson.

2. On December 6, 2007, she described an incident where Mr. Burnett asked her to go to the tool room and when inside, he blocked the door, and leaned in and kissed her. She felt panicked and trapped and so she kissed him back. Petitioner testified that she did not tell Williams Specialty Services' supervision about the incident but that she did, shortly thereafter, tell Jim, the Union Steward, about the incident. The Union Steward was working around a loud machine and that she told him "Morgan is trying to kiss on me." She told him she did not know what to do. She indicated there were "cameras everywhere and what was he thinking?" She testified that the Union Steward told her "what were you thinking? Morgan has a wife and has kids." Her response was that she also "has a husband and a kid." She testified that he kind of laughed at her. Jim Madonis testified that he never had such a conversation with Maureen Morin, he never laughed at her indicating that he would lose his job, and that he was not the Union Steward until December 14 or 15, some eight to nine days after the alleged kissing incident.

3. The petitioner testified that after the kissing incident, every time she turned around, her back was up against the wall. "Whenever he wanted to kiss me, he would demand to kiss me back and he would demand me to kiss him." She testified that during this period of time, he was also asking her about how she liked to perform sex. During this time, the petitioner never advised her Union Steward, Williams Specialty Services' supervision, or Exelon personnel about the alleged incidents or discussions. She was unable to provide any specific dates or times of those alleged occurrences.

4. The petitioner testified that she was working with Morgan Burnett on Elevation 364 which was the main level that everything happened. They were prepping on the strips on the floor, on the fixtures, putting tape down, near an exit door. Morgan Burnett asked her to go up the stairs and get tools that he forgot. She went up the staircase first and got half way, when Morgan said "oh, I forgot this door is locked" and when she came down the stairs, he backed her up against the wall. She testified that he put his hand down her pants and fondled her, and that she couldn't feel anything, couldn't move, and was frozen. She pushed

him away and started screaming at him and he backed off, put his hands up in the air and raced out the door. The petitioner did not to report this incident to either her Union Steward, Exelon or Williams Specialty Services' supervision at the time. She was unable to identify the date that this incident occurred.

5. The petitioner testified that they were apart about a week, not working together, when she had another incident with Mr. Burnett in an elevator. She testified that she got on the elevator, and at some point Mr. Burnett got in. He took two giant steps towards her and had his body up against her and said he "could stop this right now and I could do whatever I want." She asked him if he was afraid to get caught, and he said nothing. Then he took one step before the elevator got ready to open up and smiled at her and raced out. The petitioner was unable to give the date of this incident and shedid not report it to anyone at that time.

6. The petitioner testified that after the December 15, 2007 meeting, she and Mr. Burnett were separated. While working separately, Morgan Burnett came down the elevator and Frank Osgood yelled at him to go back upstairs. That same night or day, Morgan Burnett followed her outside of the workplace. She testified to going to a gas station on the corner and he followed her to that gas station, and said to her he "wanted her to follow him." She was in the gas station store at the time and she saw him get into his vehicle and drive off. She then got into her vehicle. She testified that she followed him into the Exelon parking lot. She testified that she thought that he would be scared off, but he pulled up next to her, she froze and couldn't believe he got in her car and commanded her to kiss him. She testified that Mr. Burnett told her there were no cameras in the area, that he took his cap out of the vehicle, saying "the number 1 rule, don't leave evidence behind, closes the door, and goes to his truck and pulls out a Bears blanket, pointing and said 'this was for you'." She testified that he put it back in his truck and he left.

The petitioner testified that she never advised Mr. Bishop of the problem until December 15 when "she asked to have a meeting with her Union Steward, Jim Madonis, and representatives from Williams Specialty Services. She testified that Mr. Bishop, Mr. Osgood and Jim Madonis, her Union Steward, were present at the meeting. When asked the question on cross examination whether or not at the December 15, 2007 meeting, she gave specifics about what occurred, she testified that she told Jim Madonis prior to the meeting.

Jim Madonis, the Union Stewart, on December 15, 2007, and now the President of the Local, testified that he was working as a Painter at the Exelon facility at the time of the alleged occurrence. He testified that he worked with Maureen Morin and Morgan Burnett and that he saw each of them in the morning meetings, at breaks, at lunch and at the end of the day. He testified to a written statement he prepared dated December 19, 2007 and testified that his first knowledge of the allegations was when his business agent, Glen Fredericks, called him to ask him why he didn't advise him of the sexual harassment. Mr. Madonis denied Maureen Morin ever telling him about the kissing incident, of laughing at her or even knowing that Morgan Burnett was married. He testified that a meeting did occur on December 15, 2007. He testified that he was the Union Stewart at that time. He testified that Maureen Morin said she didn't want to work near Morgan Burnett anymore, she didn't want to be by him. He testified that he took her to Mr. Bishop who was the Job Superintendent and he believed Frank Osgood was brought in. He testified that they discussed the situation and she didn't say why or anything. He testified that she just didn't want to work with him, so there was an agreement that they would put her on another floor because they were doing several floors in different areas.

Ricky Bishop testified as to the December 15, 2007 meeting and confirmed that Mr. Osgood and Jim Madonis were present. He testified that she was making allegations against Mr. Burnett, "just wanting to tell someone."

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He testified that the allegations dealt with something that was going on with them on-and-off the job site. He testified that she didn't want to go into it any further, and that she just wanted to tell someone.

There was a second meeting that occurred December 17, 2007 with Maureen Morin, Frank Osgood, Ricky Bishop, Jim Madonis and Chris Montle. Mr. Montle was a little late to the meeting. Mr. Bishop testified that Maureen made allegations against Morgan and that she was told that they would have to get his side of the story. According to his recollection, she didn't want to get his side. She didn't want it to go any further and she was upset. She started crying and shaking. They were unable to get a statement from her before she left the premises.

Mr. Madonis testified that at the December 17, 2007 meeting, she wanted to confront Morgan Burnett and question him. He testified that he went out and talked to all the painters because of what Maureen Morin told him, to see if anyone had seen anything or known anything and everybody said "no, they hadn't seen anything, they didn't know anything." He testified that he talked to the other trades that were working in the area and nobody saw anything, and no one knew anything. He testified that he did talk to Mr. Burnett and he denied anything happening.

Chris Montle testified to preparing Respondent's Exhibit No. 11. He testified that he was not at the December 15, 2007 meeting, but received a phone call and briefing from Mr. Bishop. He testified that his understanding of the meeting was that she brought up "some allegations but just wanted to clear the air, didn't want to pursue anything further." He testified that the second meeting occurred on Monday, December 17, 2007 and that the meeting was in progress when he got there. He testified that Maureen Morin was stating that there was some thing going on and she wanted to confront Morgan but that was as far as she wanted to go at that point. He testified that at this point in time, she was very upset and wanted to leave. He testified that after she left, they talked to Morgan and he made a statement, denying the allegations.

The petitioner testified that she did not give Ricky Bishop, Jim Madonis and Chris Montle specifics as to what Morgan was doing to her. She testified that she told them that he was talking to her in a bad way, and she said that things were happening. She denied being asked for a statement. She testified that she felt in the first meeting they were trying not to give her the time of day, that she was just wasting their time. She testified that when she was asked what was going on, she said "I can't work with Morgan anymore." That "things were going on, I just can't work with him anymore." When she asked for help, they indicated that they would separate them.

She testified that after the second meeting, she was escorted off the premises and never returned. She testified that she never was asked for a statement. She testified that she left the job, and never returned, indicating that she "was not going back into the plant to give a statement as long as Morgan Burnett was there."

Chris Montle testified that after the December 17, 2007 meeting, he received phone calls from her indicating that she was not coming back. The petitioner testified that she had her business agent pick up her last check. She testified that Jim had asked her, after she left to come in and gave a statement and that she told him she would, if Morgan was not there (Tr. p. 110).

The petitioner testified that the initial conversation that she had with the State's Attorney's office was December 19, 2007. She testified that the State's Attorney's Office was the one who referred her to the Sexual Assault Service Center of Guardian Angel House.

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Pete Piazza, one of the investigators, was subpoenaed to come in and testify on June 10, 2014. At the time of his testimony, he was employed as the Deputy Director of the Illinois Secretary of State Police. At the time of the incident in question, he was working as an Investigator with the Will County Sheriff's Department and was able to authenticate the report from the Domestic Violence Unit concerning the incident in question. That document established that the initial interview with Maureen Morin took place on December 19, 2007. At that time, she could not provide a date of when the sexual assault occurred. She did not know the last name of the suspect. The petitioner told the investigator that on December 4th or 5th, prior to the attack, the suspect allegedly made inappropriate sexual comments to her. The document indicates that the conversation about the suspect's butt occurred after he followed the suspect up a flight of stairs as opposed to what the petitioner testified to of the suspect being on the floor taping when the comments were made. The document from the State's Attorney's Office indicated that the petitioner advised that the sexual assault on December 6, 2007 took place in the stairwell as opposed to the testified tool room. The report indicated that when the petitioner attempted to tell Jim about the incident, she was not specific at the time, as opposed to her testimony being that she told Jim that Morgan was kissing on her. The document from the State's Attorney's Office indicates that the incident occurring on the main floor elevation 364 and the stairway elevation 383 took place on December 6, 2007 as opposed to petitioner's testimony of that occurring days after the December 6, 2008 kissing incident. The report from the State's Attorney's Office indicates that when he put his hand down her pants and fondled her underneath her clothing, he was kissing her. The report indicates that after she pushed him away with both hands, the suspect came back about two to three minutes later and told her to calm down. The report from the State's Attorney's Office indicated that contrary to the petitioner's testimony, it was her at the gas station who requested that Morgan Burnett follow her to the training center as opposed to Morgan Burnett telling her to follow him. The State's Attorney's report does confirm that the petitioner told Mr. Burnett that her truck was not running right. The report indicates that this incident at the gas station occurred on December 14, 2007. The report from the State's Attorney alleges that Mr. Burnett got into the victim's vehicle and before the victim knew how to react, he sexually assaulted her by placing one hand inside her pants underneath her clothes. The petitioner, at the time of hearing, testificd to no fondling occurring in the parking lot.

The report from the State's Attorney's office indicated that they did meet with Jim Madonis, the Union representative, and that he did recall the victim approaching him sometime back in December and making some comments which made him believe that she was having an affair with another painter by the name of Morgan Burnett. Jim Madonis testified that at this meeting, when advised by the investigator about Maureen Morin not being able to identify the suspect, he went to his car to get his badge and showed the investigator same, asking her to look at his badge and advise as to his name. Jim Madonis testified that when the investigator saw the badge, she said "oh well."

The report from Will County Domestic Violence Unit shows that Mr. Piazza was present during the interview of the suspect. Mr. Burnett denied sexually assaulting her. He admitted that he did stick his hand into the victim's vehicle, may have left his fingerprints and/or DNA inside when he reached in and touched her console with his hand. Mr. Burnett denied driving to any location to meet with the victim or of getting into her vehicle. Mr. Burnett believed that the victim made up the story because she invited him to her time-share condo and he turned her down. He agreed to submit to a polygraph.

Mr. Burnett's security ID was pulled for the nuclear plant pending investigation.

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The petitioner, Maureen Morin, admitted that to her knowledge, no charges were brought against Mr. Burnett. She testified that she did not personally bring a civil action against him. Her treating records established that she was aware that the investigation was dropped against Mr. Burnett for lack of evidence.

The petitioner, after the incident, received counseling from: the Sexual Assault Service Center of Guardian Angel Home; by Lorraine Leiser, who diagnosed her with post traumatic stress disorder; by Dr. Barr for a short period of time; and then Dr. Botapoty. Dr. Barr sent the petitioner to Dr. Michael M. Gelbort for a neuropsych evaluation. The petitioner for purposes of litigation, was sent to Dr. Alex J. Spadoni at the request of her attorney, being evaluated on March 11, 2013, and to Dr. Henry Lahmeyer who saw her at the request of the Respondent for purposes of an evaluation on May 2, 2012.

The petitioner testified that she last received treatment in 2013.

The petitioner underwent a vocational assessment by Susan Entenberg at the request of her attorney on July 8, 2011 via video conference. The petitioner's attorney refused access of his client to a vocational specialist of Respondent's choice.

The petitioner testified that after the incident, she had a problem working with or around men. She testified that when she entered a room, she would be counting women, making sure that there were more women in the room than men.

She testified that her first job after leaving Williams Specialty Services was at a Thorton Corner Market Gas Station in Ottawa, Illinois off Etna and Columbus. She testified that it was near I-80 about a half block away, and that people would get off the interstate and get gas at her station. She testified that she worked as a Cashier and had other duties. She testified that in the course of the day, she would have contact with males, unknown number, and that on occasion she would help customers put propane tanks into the trunk of their car. Surveillance films were introduced showing that the petitioner did operate the cash register and she would have interaction with male and female customers. The surveillance films show that the petitioner assisted a male customer with a propane tank. The surveillance film showed her standing, walking, interacting with male and female customers.

The petitioner testified that after working for Thorton Gas Station, she worked at a Fairfield Inn. She testified that her job was back in the breakfast area and that most of the time she was in the kitchen putting food out. She testified that she did deal with male and female customers.

The petitioner testified that she never went back to the Union Hall asking them to place her. She testified that she never went back to Williams Specialty looking for work.

The petitioner testified that she attempted to go back to work as a Painter with her Dad doing small jobs, after Dr. Barr advised her to try it. She testified that when she picked up the brush, she started having flashbacks. She went back to Dr. Barr and advised her of the attempt. She testified that she was paid for the job. When her father, John Berg, was called to testify as to Union scale, he was asked the question "whether Maureen Morin painted after the incident at Williams" and he said "no" and he was asked the question "whether or not she did any side jobs with him" and he said "no."

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It was the petitioner's testimony that she earned $35.40 at the time of incident and through testimony of Mr. Berg and then later Jim Madonis, it was established that if she continued to work as a Journeyman Painter, she would be making $40.75 an hour at the time of hearing.

Morgan Burnett testified pursuant to subpoena. He testified that he became a Union Painter on January 1, 1996 and at the present time, he was working for Kevin Nugent Construction as a Union Painter. He testified that he initially worked for Williams Specialty Services in early 2000, at the LaSalle Nuclear Plant and then went to Bryon and from Bryon to Dresden and from Dresden to Braidwood, back to LaSalle. He testified that in November of 2007, he was working at the Exelon facility for Williams Specialty Services as a Union Painter. He testified to the background check done by Exelon, the training they provided as well as the training provided by Williams Specialty Services. He testified that the training provided include sexual harassment training and that "you were to report all sexual harassment to your supervisor."

Morgan Burnett testified that he knew Maureen Morin as an employee, fellow painter. He testified that he started working with her in early December of 2007. He testified that they were working on the striping crew. He testified that when he worked with Maureen, he layed out everything that was to be done and she was his spotter to make sure that he didn't, "you know, get too close to any sensitive equipment or bump anything." He testified that "in a sense, she was a go-fer." He testified that they did not always work alone. They also worked with other Painters. When asked the question of "how much time of the workday would he spend with Maureen Morin working alone," he testified "that it all depended upon the protocol for the day." He testified that they "worked together four hours, tops, a day."

He testified that at the time, there was about a dozen painters plus supervisors and foremen. He testified that he would see Ricky Bishop on a daily basis and that he would also see Frank Osgood, the General Foreman, and Union Stewarts at the location.

He testified that he was the subject of an investigation by the Will County State's Attorney's Office that dealt with an allegation made by Maureen Morin. He denied engaging in any sexual discussions with her. He denied at any time kissing her or asking her to kiss him. He denied at any time any physical force between himself and Maureen Morin in the way of any touching. He denied putting his hand down her pants and fingering her vagina.

He testified that he was interviewed by two detectives from the Will County State's Attorney's office and that they asked him questions regarding what, if anything, occurred between him and Maureen Morin. He testified that he gave them honest answers and that he was never charged by the State's Attorney's Office or Will County concerning the incident. He testified that he has not been sued by Maureen Morin for the alleged incident. He denied ever asking Maureen Morin to follow his car to a location off of the work site. He denied ever attempting to engage in any sexual activities with Maureen Morin. He denied ever having any sexual activities with Maureen Morin.

He testified that he was brought in by Mr. Bishop and Mr. Osgood as well as Jim Madonis and asked questions about Maureen Morin's allegations. He testified that he provided a Written Statement which was offered into evidence as Respondent's Exhibit No. 4.

He testified that he did have issues with her work in terms of her being competent. He testified that he was going to ask that she be reassigned. He admitted to calling her "slow," criticizing her for her work performance,

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indicating that she needed to "step it up." Jim Madonis, when he testified, testified that Maureen Morin was slow and not a good painter.

Mr. Burnett testified to initially taking a lie detector test on his own which wasn't valid and then at the request of the State's Attorney's Office. He testified that he did not have a receipt from the State's Attorney's Office for that lie detector test.

Mr. Burnett was asked why he was present to testify at this hearing and he testified that he wanted to clear his name. He testified that the allegations against him were false. When asked the question if he cared one way or another whether she gets her workers' compensation benefits, he testified "yes" he did because he didn't believe she deserved them, indicating "maybe Social Security for mental disability, but not workers' compensation."

He testified that painters were male dominant and that women were different in that they weren't as strong, but women were judged by their performance. He pointed out that Kerry was an excellent painter and Maureen Morin wasn't. He testified that his mother was in the trades for 30 years.

MEDICAL TREATMENT

The petitioner, prior to the incident in question, was being seen by Lorraine Leiser and by Dr. Barr and Dr. Sherman. Petitioner's Exhibit No. 2, the records from Central Professional Group, were admitted into evidence. These records established that the petitioner was initially seen on October 18, 2006 and then on November 2, 2006, November 14, 2006, April 3, 2007, April 10, 2007, April 11, 2007, April 29, 2007, May 24, 2007, June 11, 2007, June 21, 2007, and July 17, 2007.

The records show that she was initially seen by Lorraine Leiser on October 18, 2006 with a history of working as a Painter, but she is finding it hard to say "no" to the public, always tired and works overtime. On October 3, 2007, she was questioning whether or not she was bipolar. She was referred to Dr. Sherman. Dr. Sherman saw her on April 11, 2007 and she gave the doctor a history of being stressed and depressed. She had low self esteem, hopelessness, being sad a lot, disorganized, can't focus, worthless, guilty at times, and of being sexually molested as a child. She was found to have average intelligence and she was diagnosed with ADHD, depression, stress of dealing with mother and remembering an unhappy childhood. She was seen on May 24, 2007 concerning marital problems.

TREATMENT AFTER INCIDENT

The petitioner was initially seen by her family physician, Dr. Pillai on December 27, 2007. The indication was she was "here to get an appointment for counseling, states she has several issues at work and is very stressed out, secondary to personal issues at work. She just needs counseling."

Sexual Assault Service Center of Guardian Angel Home

Petitioner's Exhibit No. 1 is the records from Sexual Assault Service Center of Guardian Angel Home. The records show that the petitioner was referred there by the State's Attorney's office and that the initial contact was via hotline on December 18, 2007. The petitioner gave a history of being sexually assaulted last week and ongoing, indicating that the sexual assault took place at her workplace and she was emotional about the

situation. She was initially seen January 2, 2008 with the petitioner sharing symptoms including feeling fearful, decrease in sleep, anger and feeling loss of control.

The petitioner continued to be seen at Sexual Assault Service Center of Guardian Angel Home through May 1, 2008. The last notation was "has made significant progress towards decreasing trauma-related symptoms." There were no off-work slips or any restrictions regarding her returning to work as a Painter contained in their records.

The Central Professional Group – Lorraine Leiser and Dr. Barr

After the alleged incident, the petitioner was seen by Lorraine Leiser on January 17, 2008. The history was of being assaulted by a co-worker in the workplace. She said that she tried to handle it herself out of concern of losing her job.

The petitioner was seen by Dr. Barr on January 28, 2007 and she sent the petitioner for a neuropsych evaluation with Dr. Delbort.

The petitioner continued to follow with Dr. Barr and with Lorraine Leiser, MA LCPC, CADC. There was an off-work note from Dr. Barr dated April 9, 2008 and a report from Lorraine Leiser dated April 24, 2008 diagnosing the petitioner with post traumatic stress disorder, feeling that it would take at least three to six months before she would be able to feel well enough to return to work.

The petitioner continued to see Lorraine Leiser and Dr. Barr with on-going complaints of depression, fatigue, reduced ability to concentrate, and anxiety. On June 9, 2008, there was a note from Dr. Barr indicating that he discussed with the petitioner that "not all our thoughts are always real." On October 28, 2008, Lorraine Lesier noted the petitioner was feeling better and she should return to work. There were discussions thereafter of the petitioner attending college. There are notes from Lorraine Leiser and Dr. Barr going through February 2, 2010 that are difficult to read and written in broken sentences, where there are discussions about working as a Painter, at a gas station, being sent for an exam, being upset about her mother-in-law's death, and what she could get under workers' compensation.

Report of Dr. Michael M. Gelbort

The petitioner was evaluated by Dr. Michael M. Gelbort, Clinical Psychologist, at the request of Dr. Barr on February 20, March 3 and March 4, 2008. She gave the doctor a history of working as a Union Painter and had an issue at work, a guy sexually harassing her and assaulting her. He indicated that she went on to tell a very lengthy story, rather convoluted. The doctor indicated that the long and short of it was that it appears she was involved in a situation where she did not do all that she could or interact/react as quickly as she could to head off a problem. It appeared but could not be ascertained for sure that she had some interest in the man and clearly exercised poor judgment. The indication was whether or not this was due to emotional or cognitive factors were the question which lead, in part, to referral for formal testing. The petitioner indicated to him that she "wanted to be like she was, not feel like she does now," uncomfortable around men and it is a problem. She was able to speak openly with him. The petitioner underwent a battery of tests including the WAIS-III, WMS-III, ephasia screening, category testing, WRAT-III, MMPI-II, productive questions, items from LURIA, sensory perceptual examination, trail making test, lateral dominance test, tapping test and diagnostic interview with mental status testing. The doctor went on to explain what the testing revealed indicating that she was, in many ways, disconnected from her own internal psychological self and function. He found that there was no

significant indication of neuro-cognitive dysfunction and the patient does display neuro-cognitive deficits which are more likely psychogenic rather than organic in nature. He indicated, in addition, her emotional adjustments suggests that she is out of touch with herself and tries to "report things based on what she would like them to be, rather than what actually is occurring inside of her." Dr. Gelbort's report did not establish that the incident actually occurred or that she was disabled from work.

Institute for Personal Development

Records from the Institute for Personal Development were introduced into evidence. The petitioner initially saw Karen Lombardo on September 20, 2010. The petitioner gave a history of being sexually assaulted on her job. She was showing evidence of major depressive disorder. The records show that she was working at times double shifts at the gas station because they were short. The records show that she was last seen in November of 2011. That there was no documentation that she was disabled from work or could not return to work as a painter.

Evaluation by Dr. Alex Spadoni

At the request of her attorney, the petitioner was seen by Dr. Alex J. Spadoni on March 11, 2013. She gave a history of sexual harassment by a co-employee, having had sexual advances in the past but was able to deflect them without difficulty. The history she gave Dr. Spadoni was on two occasions, Mr. Burnett following her from work and of the State's Attorney's office failing to investigate. She gave a history of being very fearful of men, including her husband and son. She gave the doctor a history of experiencing nightmares, avoiding social events, and loss of sexual feelings from her husband, being diagnosed with post traumatic stress disorder. There was no history in this report of her working at Thorton Gas Station with male customers. There was no mention of this doctor reviewing any medical records.

Dr. Spadoni's deposition was taken on July 15, 2013. He diagnosed Petitioner with post traumatic stress disorder, which he related to her alleged sexual assault at work. He testified that the petitioner has occasional nightmares of the incident, is anxious, depressed and requires medication, fearful in an all-male environment. On cross examination, the doctor testified that he spent about an hour and fifteen minutes with the petitioner, admitted that his exam took place almost five years after the incident. He testified that she quit her employment and he is not aware of her making any request for accommodation under the Americans With Disabilities Act from her employer. He admitted that there is less protection for an individual in terms of contact at a gas station than there is in an employment setting. He indicated that there is no indication that she wasn't able to interact with men as well as females at the gas station. He admitted that there is nothing in his examination to establish that what she alleges actually occurred. He indicated that to his knowledge, there have never been any formal charges against Morgan Burnett. He indicated that she has not looked for employment through the Union. He indicated that there were certain psychological testings that can be performed to document or verify the diagnosis of post traumatic stress syndrome. He testified that he did not perform any of those tests. He indicated that she did not give him a history of any prior sexual abuse and that that may be important. He testified that there was nothing that can be done by way of testing to verify what she is subjectively saying.

Evaluation by Dr. Henry Lahmeyer

The petitioner was sent to Dr. Henry Lahmeyer at the request of the Respondent. He testified to his qualifications to include being a Clinical Professor of Psychiatry at the Chicago Medical School, and being

Board Certified in Sleep Medicine and by the American Board of Psychiatry and Neurology. He testified that he evaluated Ms. Morin on May 2, 2012. He testified to reviewing records to include those from Dr. Michael Gelbort, Dr. Barr, Lorraine Leiser, MA, the Guardian Angel records and the records from the State's Attorney's office. He testified to having the petitioner submit to psychological testing. He testified to the history given to him by the petitioner and of conducting a personal interview. He testified that it was difficult for her to tell him in a clear way what actually happened. She could not remember dates very well. He testified to performing mental status tests that displayed no significant anxiety or depression. She did not display any significant anxiety or depression while discussing the encounter with Mr. Burnett. The doctor testified to reviewing the MCMI-III, the Milan Clinical Multi-Phasic Inventory III. He also reviewed the MMPI-II. He testified that she had a chronic personality disorder with avoiding and schizotypal features. He looked at the Grossman Personality test which revealed her inner life was pretty chaotic and conflicting. Based upon his review of records, interview and the review of testing, he formulated a diagnosis of adjustment disorder with mixed anxiety and depressed mood, chronic in remission with medication and learning disorder. Her second axis was personality disorder, not specified and her third axis revealed no medical diagnosis. Axis four was that she was overall functioning 72, which was above average. He testified that she did not have post traumatic stress disorder. He felt that, in his opinion, the incident with Mr. Burnett, more importantly, her reaction to the incident, whatever it was, appeared to be a mutually-consenting incident that got out of control, which did increase her anxiety and depression at least for a few months. He testified, in his opinion, the incident in question was consensual. He felt that based upon all the documents he reviewed and from a psychological standpoint, it appears that it was a mutually-consenting relationship that got out of control. He testified that prior to the incident, there was evidence of depression, axis diagnosis 1. He felt that she could work because her symptoms were only related to this one man, and that he was placed on a different floor. He indicated that she decided not to work on her own. It was noted that Dr. Barr suggested that she return to work in July of 2008, so in his opinion, she could have been returned to work at any setting at that time. He testified that there was no documentation that she tried to get any type of accommodation from her employer, after they were separated and that he put no current restrictions on her. He explained in detail why she did not have post traumatic stress disorder. He testified that by her working around men in the gas station that established that she would be able to work in environments similar to the one as she was working in the past.

Vocational Testing

The petitioner's attorney sent the petitioner to Susan Entenberg who did a video conference with the petitioner after she was already employed at Thorton Gas Station. Susan Entenberg testified that the only restriction the petitioner had was her fear of working around men. She testified that the petitioner did become accustom to working with and around men in the gas station setting. She admitted that there were no specific medical restrictions. She admitted that in reviewing the records, there were no restrictions on her concerning her job. She understood that there were no physical restrictions. She admitted that none of the physicians precluded the petitioner from interaction with men. She didn't know what break if any, there was between the prior counseling and after the incident. She testified that she didn't know what the physical makeup of the petitioner's job was at the time of the incident – male to female. She testified that no physician or psychologist or psychiatrist took her off work prior to her resigning her employment. She admitted that the petitioner told her she was less anxious. She admitted that males and females go to gas stations. She admitted that as a Cashier at Thorton, the petitioner would be exposed to males. She admitted that the petitioner gave her a history of going to grocery stores and shopping and that she would be exposed to males there. She admitted that the petitioner could be assaulted in a gas station environment. She testified that she never contacted the Union to see if the petitioner could return to work as a Painter. She testified she didn't assist the petitioner in preparing a resume,

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that she didn't sit down with petitioner to prepare a vocational rehabilitation plan, that she did no vocational testing.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. This conclusion is based on the lack of credibility on the Petitioner's part. The Arbitrator notes that the Petitioner claims she was assaulted a number of times by her co-worker, Morgan Burnett, but when given the chance to discuss this with her Union Steward, and both Mr. Montle and Bishop, Petitioner chose to walk off the job instead of providing them details of what occurred. While it would be difficult to weigh the credibility of the witnesses if it was simply the word of the Petitioner versus the word of her alleged assailant, this is a case where the Petitioner's own union steward has provided evidence contradicting the Petitioner's testimony. Even more telling is the investigative report from the Will County State's Attorney investigation, in which the events described to them by the Petitioner at the time are in sharp contrast to her testimony at arbitration. In their investigation, the Petitioner provides a history of seeing Mr. Burnett at a gas station and then asking him to follow her to a parking lot. Petitioner's testimony was that she saw Burnett at a gas station and he asked her to follow him to a parking lot. In either situation, it is very difficult for the Arbitrator to believe the Petitioner's claims that she was sexually assaulted by Mr. Burnett at work, and then subsequently saw him outside of work at a gas station at night where she either lead him or followed him to a parking lot in order to catch Mr. Burnett on surveillance cameras. While the decision of the Will County States Attorney's office to not press charges against Mr. Burnett is not binding on the Arbitrator, it is does provide some clarity in terms of the question of credibility – or rather the lack thereof on Petitioner's part. In this case, because of the contradictions between Petitioner's testimony and that of, Mr. Burnett, her Union Steward Jim Madonis and the investigation by the Will County States Attorneys' office, the Arbitrator finds that the Petitioner has failed to prove she sustained an accident on December 6, 2007.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Eric Alvarez,

Petitioner,

15IWCC0443

vs.

NO: 13 WC 20686

Foodliner, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $53,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 10 2015

David L. Gore

DLG/gaf
O: 6/4/15
45

Stephen Mathis

Mario Basurto

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

15IWCC0443

ALVAREZ, ERIC
Employee/Petitioner

Case# **13WC020686**

FOODLINER INC
Employer/Respondent

On 9/29/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LTD
MICHAEL 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)
- [ ] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0443

ERIC ALVAREZ
Employee/Petitioner

v.

FOODLINER, INC.
Employer/Respondent

Case # 13 WC 20686

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **KURT CARLSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JULY 8, 2014 AND SEPTEMBER 11, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

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FINDINGS

On the date of accident, **FEBRUARY 12, 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 **$41,506.40**; the average weekly wage was **$798.20**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$8,046.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,839.12** for other benefits (PPD advances), for a total credit of **$11,885.32**.

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 $532.13/week for 70 and 6/7 weeks, commencing May 4, 2013 through September 11, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent shall pay for the prospective medical treatment recommended by Dr Ellis on June 5, 2013 and April 9, 2014. Specifically, Petitioner is awarded 1) the right wrist MRI and the right to see Dr John Fernandez with respect to the right hand injuries and 2) the right to see Dr John Fernandez with respect to the left hand injuries.

Respondent shall pay to Petitioner penalties of $4,581.98, as provided in Section 16 of the Act; $12,909.91, as provided in Section 19(k) of the Act; and $10,000.00, 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

09-29-14
Date

ICArbDec19(b)

SEP 29 2014

STATE OF ILLINOIS)
)
COUNTY OF COOK)

15IWCC0443

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ERIC ALVAREZ Case # 13 WC 20686
Employee/Petitioner

v.

FOODLINER, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner's Testimony at Hearing

Eric Alvarez ("Petitioner") is claiming an accidental left wrist injury on February 12, 2013, while employed as a Pre-Loader with Foodliner, Inc. ("Respondent"). At the time of the accident, Petitioner was 38 years old. Petitioner is right hand dominant. Tr., p. 8-9. Petitioner testified his driver's license is suspended and that he has not had an active driver's license from the date of employment with Respondent through the September 11, 2014 date of hearing. Tr., p. 37-38.

Petitioner testified that on the day of his accident, he was opening a stuck railcar with a gate bar. When he put extra force on the gate bar, the door gave way and yanked both of his hands forward. He felt an immediate pop and pain in his left wrist. Tr., p. 9-10.

Petitioner sought initial medical treatment at Concentra Medical Centers February 14, 2013, on referral from Respondent. Petitioner was provided with light duty work restrictions from Concentra through his last office visit there on March 18, 2013. The Concentra doctors referred Petitioner to Dr Speziale with Midwest Hand Surgery on

March 18, 2014. Tr., p. 10-11. Dr Speziale examined Petitioner on March 21, 2013 and April 22, 2013. On April 22, 2013, Dr Speziale referred Petitioner to Dr Ramsey Ellis. Petitioner was examined by Dr Ellis on May 1, 2013. Concentra, Dr Speziale and Dr Ellis provided Petitioner with light duty work restrictions and Petitioner worked light duty between February 14, 2013 and May 3, 2013. Tr., p. 10-14.

Petitioner testified that he began having problems with his right hand and wrist while working light duty between February 14, 2013 and May 3, 2013. He was not having any problems with the right hand or wrist before his return to light duty work following the accident. Petitioner testified that while working light duty, he was doing all of his regular job duties, but he was required to perform the duties with his right hand only. He was responsible for loading trucks, driving heavy equipment, carrying tools and cleaning. Tr., p. 24-28.

Petitioner testified that he remained off of work between May 4, 2013, and September 11, 2014 (the date of the second hearing), because Foodliner, Inc., was unable to accommodate the light duty work restrictions. Tr., p. 31-32.

Petitioner was contacted by Dan Varner with Varner Claims Consulting, via a letter sent on May 16, 2013, regarding possible temporary transitional employment with YMCA South Chicago. The initial letter was sent to the wrong address and a letter was re-issued on May 24, 2013. Petitioner was instructed to complete an in-person application by May 28, 2014. RX17. Petitioner completed the application but was not offered the position because it was filled by the time his background check cleared. Tr., p. 39-40 and 51-52.

Petitioner was contacted by Dan Varner via letters sent on June 19, 2013 and June 20, 2013, regarding possible temporary transitional employment with LBD Enterprises/South Suburban Toys for Kids ("South Suburban Toys for Kids"). Tr., p. 41. Petitioner followed up with the contact at South Suburban Toys for Kids and was given information that led him to believe the job was not within the restrictions set forth by Dr Ellis. In addition, Petitioner has a suspended driver's license and requires the use of public

transportation. Public transportation to and from this placement would require over 2 hours of transportation each way. Petitioner considered this an unreasonable amount of travel. Petitioner did not appear for the temporary transitional employment. Tr., p. 52-54.

Petitioner was contacted by Dan Varner via a letter sent on October 22, 2013, regarding possible temporary transitional employment with Villa Guadalupe Senior Services. Tr., p. 44. Petitioner followed up with the contact at Villa Guadalupe and was given information that led him to believe the job was not within the restrictions set forth by Dr Ellis. Petitioner did not appear for the temporary transitional employment. Tr., p. 55 and 60-61.

As of the date of the hearing, with respect to the right wrist and hand, Petitioner testified that he has sharp pains with range of motion. His pain increases with household chores and when caring for his daughter. He wears a brace a few hours each day for pain relief. Tr., p. 29-30.

The right hand and wrist treatment recommended by Dr Ellis has not been authorized. Specifically, Dr Ellis prescribed a MRI of the right wrist. Petitioner wishes to undergo the MRI of the right wrist and wants to see Dr Fernandez for a second opinion. Tr., p. 14, 20-22.

As of the date of the hearing, with respect to the left wrist and hand, Petitioner testified that he is still having a lot of pain in the area where he underwent the surgery. He experiences an increase in pain with activities of daily living like washing dishes or cooking for his daughter. He has constant numbness and weakness and notices a decrease in strength. He gets sharp pains in his wrist and has to wear a brace for pain relief. Tr., p. 22-24.

Petitioner's last office visit with Dr Ellis was on April 9, 2014. Dr Ellis referred Petitioner to Dr John Fernandez for a second opinion. As of the hearing date, the Respondent has not authorized the office visit. Petitioner testified that he wants a second opinion with Dr Fernandez with respect to his left hand and wrist. Tr., p. 20-22.

The Arbitrator had the opportunity to observe Petitioner and review his testimony and finds him to be credible.

Medical Records

Petitioner's initial medical treatment was at Concentra Medical Centers on February 14, 2013. Petitioner was referred to Concentra by Respondent. Petitioner provided a history of the February 12, 2013, work accident to the treating doctor. Petitioner indicated that while he was opening a gate on a railcar, the gate became stuck, requiring Petitioner to put extra pressure on the gate bar. The gate bar gave way causing him to jam his left wrist. He felt a pop in his wrist at the time of the accident but continued working. Petitioner's pain on examination was located on the ulnar aspect of the left wrist. Petitioner was diagnosed with a left wrist sprain and prescribed a course of physical therapy. Petitioner was provided with light duty work restrictions of no lifting, pushing or pulling over 10 pounds. PX1, p. 17-19.

Petitioner attended 11 sessions of physical therapy between February 14, 2013 and March 18, 2013. PX1, p. 24-50.

Petitioner was examined at Concentra on March 18, 2013. On examination there was associated swelling and parethesias of the dorsum of the left thumb. Petitioner continued to have pain on the dorsal aspect of the volar aspect of the left wrist. Petitioner was referred to Midwest Hand Surgery for orthopedic evaluation and provided with light duty work restrictions of no use of the left hand. PX1, p. 5-8.

On March 21, 2013, Petitioner was examined by Dr Nicholas Speziale, an orthopedic surgeon with Midwest Hand Surgery. Petitioner complained of numbness and tingling in the left thumb and sprain in the left wrist and the ulnar aspect of the hand. Dr Speziale prescribed a MRI of the left wrist and an EMG/NCV of the left upper extremity. PX2, p. 31-33.

The MRI of the left wrist was performed on April 5, 2013. The MRI revealed a partial thickness tear along the articular surface of the dorsal radial ulnar ligament, tendinosis of the extensor carpi ulnaris tendon, a mild degree of tenosynovitis of the extensor digitorum and indices tendon sheath, and an extruded ganglion surrounding the pisiform bone. PX2, p. 83-84.

An EMG/NCV of the bilateral upper extremities performed on April 5, 2013 was essentially normal. PX2, p. 85-87.

Petitioner was re-examined by Dr Speziale on April 22, 2013. His physical examination on the left side remained unchanged. He complained of numbness over the dorsum of his left thumb and ulnar sided wrist pain. Petitioner complained of right hand pain which he attributed to working light duty exclusively with the right hand. Petitioner was referred to Dr Ramsey Ellis for further evaluation. PX2, p. 26-27.

On May 1, 2013, Petitioner was examined for the first time by Dr Ellis. Dr Ellis reviewed the left wrist MRI films and found that Petitioner had a TFCC tear along its ulnar attachment. On examination, Petitioner complained of ulnar sided wrist pain on the left hand and central dorsal wrist pain on the right hand which Petitioner attributed to overuse. Dr Ellis recommended Muenster splinting on the left hand and provided Petitioner with sedentary work restrictions with no lifting heavier than 3 pounds with the right hand and no use of left hand. PX2, p. 25.

Petitioner was re-examined by Dr Speziale on May 22, 2013. There was no improvement on the left with the Muenster splint. Dr Speziale prescribed and performed a steroid injection to the ulnar carpal joint of the left wrist. Petitioner was provided with a right wrist cock up splint. PX2, p. 23-24.

On June 5, 2013, Petitioner was re-examined by Dr Ellis. On the left side, Petitioner continued to complain of paresthesias over the dorsal let thumb and pain in the ulnar side

of the wrist. He had tenderness to palpation over the first dorsal extensor compartment and a positive Finkelstein's. He had sensitivity of the radial sensory nerve adjacent to the first dorsal extensor compartment and pain with palpation of the TFCC and pain with pronation and supination of the forearm. Dr Ellis opined that Petitioner had failed left wrist conservative treatment and prescribed arthroscopic surgery with debridement of the TFCC. On the right side, Petitioner complained of pain in the right wrist with clunking. He had pain over the lunar triquetral joint and ulnar carpal joint. Dr Ellis Prescribed a MRI of the right wrist. Petitioner was provided with light duty work restrictions of no lifting more than ½ pound with the right hand, no lifting with the left hand and Petitioner must be able to wear bilateral splints at all times. PX2, 21-22.

On July 18, 2013, Petitioner was examined at Chicago Orthopaedics and Sports Medicine, by Dr William Vitello, a Section 12 Independent Medical Examiner hired by the Respondent. Dr Vitello performed an examination on both the right and left wrists. On right wrist examination, flexion is to 30 degrees, extension is to 40 degrees, supination and pronation is 60 to 70 degrees. He has mild crepitus at the DRUJ with pronation and supination. He is diffusely tender over the dorsum of the wrist at the scapholunate interval. Dr Vitello opined that Petitioner had a right wrist sprain with possible DRUJ injury. He recommended a right radiocarpal joint injection at the level of the DRUJ for both diagnostic and potentially therapeutic reasons. On the left wrist examination, range of motion that could be assessed was flexion at 20 degrees, extension to 30 degrees, supination to 60 degrees, and pronation to 70 degrees with pain and tenderness over the ECU and over the TFC. Dr Vitello diagnosed Petitioner with a left TFCC tear and recommended left wrist arthroscopy. Dr Vitello opined that Petitioner was capable of returning to work with no use of the left wrist and no lifting more than 10 pounds with the right wrist. RX2.

Petitioner underwent left wrist surgery performed by Dr Ellis on August 23, 2013. A left wrist arthroscopy with partial synovectomy and an open repair of the TFCC were performed. During the procedure it was revealed that there was copious dorsal synovitis and a large ulnar dorsal tear. An Arthrex anchor was implanted during surgery. PX2, p. 1-

Petitioner attended a post-surgery office visit with Dr Ellis on September 4, 2013. He was to remain off of work and to follow up in one week for suture removal. PX2, p. 20.

On September 11, 2013, Dr Ellis re-examined Petitioner. Petitioner complained of right sided wrist pain and discomfort at the surgical site on the left wrist. Petitioner is to remain off of work and is not allowed to drive. PX2, p. 18-19.

On September 23, 2013, Petitioner was re-examined by Dr Vitello, a Section 12 Independent Medical Examiner hired by the Respondent. The examination was only of the right wrist, not the left wrist or hand. On physical examination of the right wrist, there was flexion to 40 degrees, extension to 40-50 degrees, supination to 70 degrees and pronation to 70 degrees. He has some mild crepitus along the DRUJ with pronation and supination and he is diffusely tender over the dorsum of the wrist as well as long the ulnar side of the wrist and volar wrist. Petitioner was diagnosed with right wrist synovitis. Dr Vitello recommended a course of physical therapy and a corticosteroid injection to the right wrist. RX3.

Petitioner was examined by Dr Ellis on October 2, 2013. On the left side, Petitioner had minimal swelling but did have mild stiffness at the MP joint. Petitioner was kept off of work and the doctor was waiting on authorization for the recommended treatment on the right wrist. PX2, p. 17, PX4.

Dr Vitello performed a record review in a report dated October 11, 2013. There was no physical examination. Dr Vitello reviewed only the operative report of August 23, 2013 and provided estimated light duty work estimates based on standardized protocols post surgery. Dr Vitello opined that an individual with a TFC repair should go back to sedentary activities including desk work at 6-8 weeks, light duty activity from 8 to 10 weeks, medium activities from 10-12 weeks and expected maximum medical improvement from 12-14 weeks. RX4.

On October 23, 2013, Dr Ellis re-examined Petitioner. Petitioner complained of left wrist stiffness with pronation, supination, flexion and extension. Dr Ellis prescribed physical therapy and provided Petitioner with light duty restrictions of no lifting more than one pound with the left hand, no use of the right hand and Petitioner must wear bilateral splints at all times while working. PX2, p. 16.

Petitioner began a course of physical therapy at Accelerated Rehabilitation Centers on October 31, 2013. RX7.

Petitioner was examined by Dr Ellis on November 6, 2013. Petitioner complained of increased left wrist pain over the ulnar aspect and slow improvement with therapy. He had symptoms consistent with de Quervain's tenosynovitis of the left wrist. A steroid injection was prescribed and performed to the left wrist. Dr Ellis prescribed additional physical therapy and allowed for light duty restrictions of no lifting more than 3 pounds with the left hand. PX2, p. 15.

Petitioner attended 4 physical therapy sessions through December 23, 2013. RX7.

On February 5, 2014, Dr Ellis re-examined the Petitioner. Petitioner continued to have persistent left wrist problems despite not working. Dr Ellis prescribed a MRI of the left wrist and allowed light duty work restrictions of no lifting more than 3 pounds with the left hand. PX2, p. 13-14.

A MRI performed on February 17, 2014, revealed resolution of ECU tendinosis and postoperative changes at the ulnar head. No TFCC tear was appreciated. PX2.

On March 19, 2014, Petitioner was re-examined by Dr Vitello, a Section 12 Independent Medical Examiner hired by the Respondent. The examination was only of the left wrist, not the right wrist or hand. On exam there was no synovitis of the wrist. Flexion was to 50-60 degrees and extension is to 50 degrees, radial deviation of 20 degrees, and ulnar

deviation of 30 degrees. Dr Vitello found Petitioner to be at maximum medical improvement with respect to his left wrist condition. P is at MMI for the left wrist TFC repair. Dr Vitello opined that he cannot state with certainty what Petitioner's exact limitations and work restrictions would be in regard to the left wrist due to the fact that Petitioner's subjective complaints outweigh the clinical objective findings. RX5.

Petitioner was re-examined by Dr Ellis on April 9, 2014. Petitioner continued to have pain in the ulnar side of the wrist, the etiology of which was unclear. Dr Ellis referred Petitioner to Dr John Fernandez for a second opinion and provided Petitioner with light duty work restrictions of no lifting more than 3 pounds with the left hand. PX2, p. 11-12.

Dan Varner's Testimony at Hearing

Dan Varner ("Varner"), Owner of Varner Claims Consulting, LLC ("VCC"), was hired by the Respondent in this case. Tr., p. 64. The Respondent hired Varner to place Petitioner in a temporary transitional employment ("TTE") position. Tr., p. 68. Varner testified that he would not receive a referral from a Respondent unless they were unable to accommodate the light duty work restrictions.

Prior to founding VCC, Varner worked for Farmers Insurance in the Claims Division for 28 years. His business is located in Florida but he provides services nationwide. VCC has been in business for five years. VCC is hired by insurance companies and employers to provide alternate light duty work for injured workers where the Respondent is unable to accommodate the restrictions. Tr., p. 65-68. The alternate light duty work assignments are through non-profit agencies 99% of the time. Tr., p. 114.

VCC places between 25 and 50 people in alternate work assignments in Illinois each year. Tr., p. 65. Prior to this case, VCC placed between 5 and 8 people who worked with Foodliner in alternate light duty work assignments. Tr., p. 76. VCC is paid by the Respondent when the placement is identified and the packet is emailed to the Respondent. Tr., p. 79-80. Varner testified that his company has 100 percent placement

within 48 hours of the referral and 87 percent placement within 24 hours of the referral. Tr., p. 104.

Varner does not know whether the non-profit agencies where he places injured workers receive a tax credit or other state or federal benefit. Tr., p. 80. He does not know whether the Respondent receives a tax credit or other state or federal benefit. He does not know whether the Respondent receives a benefit directly from the non-profit.

Varner does not have a vocational rehabilitation counselor license. No vocational counselor was involved with attempted TTE placements in the current case. Tr., p. 82-83.

Prior to the hearing date, Varner never met Petitioner. Varner never spoke with Petitioner prior to sending the initial placement package. No interview was ever conducted between Varner and the Petitioner. Varner never reviewed Petitioner's personnel file. Tr., p. 83-84.

Varner was provided with work restrictions directly by the Respondent. No HIPPA release signed by the Petitioner authorizing a release of medical documentation to Varner was entered into evidence and to the best of Varner's knowledge no release exists. Varner testified that the individual job placements used in this case were never presented to the treating physicians or the IME doctor to determine whether the jobs were within the current restrictions. Tr., p. 84-85.

Varner testified that TTE is referenced in the Illinois Workers' Compensation Act but he was unable to reference a Section. Varner was unable to cite a study or a statistic that indicated light duty placement benefits the injured worker. No evidence was submitted by Respondent on these issues. Tr., p. 86-91.

Varner testified that he was not aware of a lending/borrowing agreement between Respondent and the prospective non-profits in this case. No evidence was submitted by Respondent on this issue. Tr., p. 95.

Varner is not aware of a contract between Respondent and VCC or Respondent and the non-profits with respect to who covers the liability insurance in the event Petitioner is injured while working at the non-profit. He does not know who would cover the workers' compensation insurance coverage in the event Petitioner suffered a new accident. No evidence was submitted by Respondent on these issues. Tr., p. 96-101.

Varner does not know whether performing work for a non-profit would nullify Petitioner's group insurance benefits, disability benefits, pension benefits or retirement benefits. No evidence was submitted by Respondent on these issues. Tr., p. 101.

Varner testified that the positions filled by injured workers are never paid positions and there is no possibility that they could lead to full time employment. The Petitioner would not be gaining any transferable skills as a result of the TTE. Tr., p. 103.

In this case, Varner attempted three separate TTE placements.

The first placement was attempted at YMCA South Chicago. Varner sent a letter to the Petitioner dated May 16, 2013. The letter was sent to the wrong address and had to be re-issued on May 24, 2013. Petitioner was expected to appear at the YMCA South Chicago by May 28, 2013 to complete an application. Varner's office confirmed with the YMCA that Petitioner did appear on May 28, 2013 and completed an application. Varner testified that Petitioner had to go back to the YMCA the following week to complete additional paperwork related to a background check. Varner confirmed the Petitioner completed the paperwork for the background check. The YMCA placement fell through due to the length of time it took for Petitioner's background check to be completed. Foodliner requested a new placement. Tr., p. 69-70.

The second placement was attempted at South Suburban Toys for Kids. Varner sent a letter to the Petitioner dated June 19, 2013. An amended letter was issued on June 20, 2013. Petitioner was expected to start working at South Suburban Toys for Kids on June

21, 2013. The letters issued to the Petitioner indicate the job required lifting with the right hand between 1 and 2 pounds. Varner testified that he was made aware that the correct restrictions were actually no lifting more than ½ pound with the right hand, no lifting with the left hand and Petitioner must be able to wear bilateral splints at all times. Varner testified that he verified with South Suburban Toys for Kids that the correct restrictions could be accommodated. Varner confirmed that Petitioner never presented for this position.

Varner was made aware of the fact that Petitioner required the use of public transportation after the attempted placement at South Suburban Toys for Kids. He testified that he never did a Google Search to determine how long it would take to get to the job via public transportation. He testified that anything requiring more than one hour of travel would not be considered reasonable. He testified that he learned of the transportation issues after the attempted placement and did not attempt another placement because Respondent told him not to. Varner testified that Respondent considered the placement reasonable. Tr., p. 90-94.

The third placement was attempted at Villa Guadalupe Senior Services. Varner sent a letter to Petitioner dated October 22, 2013. Varner testified that the work restrictions used for this placement were provided to him by Foodliner. The restrictions used were lifting, pushing and pulling up to 20 pounds occasionally, up to 12 pounds frequently and up to 6 pounds constantly. The restrictions set forth by Dr Ellis were not considered. Varner confirmed that Petitioner never presented for this position.

The Arbitrator had the opportunity to observe Varner and review his testimony. The Arbitrator also reviewed Varner's file, entered as Petitioner's Exhibits 6 and 7. The Arbitrator finds Varner to be less than credible.

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 prior to the accident of February 12, 2013, he was not having any problems with his left wrist or right wrist. Immediately after the accident he had pain in his left wrist. His right wrist pain manifested while working light duty following the February 12, 2013 accident.

Petitioner's initial medical treatment was at Concentra Medical Centers on February 14, 2013. Petitioner provided a history of the February 12, 2013, work accident to the treating doctor. Petitioner's pain on examination was located on the ulnar aspect of the left wrist. Petitioner was diagnosed with a left wrist sprain and prescribed a course of physical therapy. Petitioner was provided with light duty work restrictions of no lifting, pushing or pulling over 10 pounds. PX1, p. 17-19.

Petitioner attended 11 sessions of physical therapy between February 14, 2013 and March 18, 2013. PX1, p. 24-50.

Petitioner was examined at Concentra on March 18, 2013. On examination there was associated swelling and parethesias of the dorsum of the left thumb. Petitioner continued to have pain on the dorsal aspect of the volar aspect of the left wrist. Petitioner was referred to Midwest Hand Surgery for orthopedic evaluation and provided with light duty work restrictions of no use of the left hand. PX1, p. 5-8.

On March 21, 2013, Petitioner was examined by Dr Nicholas Speziale, an orthopedic surgeon with Midwest Hand Surgery. Petitioner complained of numbness and tingling in the left thumb and sprain in the left wrist and the ulnar aspect of the hand. Dr Speziale prescribed a MRI of the left wrist and an EMG/NCV of the left upper extremity. Petitioner was allowed a return to work with restrictions of right handed work only. PX2, p. 31-33.

The MRI of the left wrist was performed on April 5, 2013. The MRI revealed a partial

thickness tear along the articular surface of the dorsal radial ulnar ligament, tendinosis of the extensor carpi ulnaris tendon, a mild degree of tenosynovitis of the extensor digitorum and indices tendon sheath, and an extruded ganglion surrounding the pisiform bone. PX2, p. 83-84.

Petitioner was re-examined by Dr Speziale on April 22, 2013. His physical examination on the left side remained unchanged. He complained of numbness over the dorsum of his left thumb and ulnar sided wrist pain. Petitioner complained of right hand pain which he attributed to working light duty exclusively with the right hand. This is the first complaint of right hand or wrist pain in the medical records. Petitioner was referred to Dr Ramsey Ellis for further evaluation. Petitioner was allowed to work with restrictions of right handed work only. PX2, p. 26-27.

On May 1, 2013, Petitioner was examined for the first time by Dr Ellis. Dr Ellis reviewed the left wrist MRI films and found that Petitioner had a TFCC tear along its ulnar attachment. On examination, Petitioner complained of ulnar sided wrist pain on the left hand and central dorsal wrist pain on the right hand which Petitioner attributed to overuse. Dr Ellis recommended Muenster splinting on the left hand and provided Petitioner with sedentary work restrictions with no lifting heavier than 3 pounds with the right hand and no use of left hand. PX2, p. 25.

Petitioner was re-examined by Dr Speziale on May 22, 2013. There was no improvement on the left with the Muenster splint. Dr Speziale prescribed and performed a steroid injection to the ulnar carpal joint of the left wrist. Petitioner was provided with a right wrist cock up splint. PX2, p. 23-24.

On June 5, 2013, Petitioner was re-examined by Dr Ellis. On the left side, Petitioner continued to complain of paresthesias over the dorsal left thumb and pain in the ulnar side of the wrist. He had tenderness to palpation over the first dorsal extensor compartment and a positive Finkelstein's. He had sensitivity of the radial sensory nerve adjacent to the first dorsal extensor compartment and pain with palpation of the TFCC

and pain with pronation and supination of the forearm. Dr Ellis opined that Petitioner had failed left wrist conservative treatment and prescribed arthroscopic surgery with debridement of the TFCC. On the right side, Petitioner complained of pain in the right wrist with clunking. He had pain over the lunar triquetral joint and ulnar carpal joint. Dr Ellis prescribed a MRI of the right wrist. Petitioner was provided with light duty work restrictions of no lifting more than ½ pound with the right hand, no lifting with the left hand and Petitioner must be able to wear bilateral splints at all times. PX2, p. 21-22.

On July 18, 2013, Petitioner was examined at Chicago Orthopaedics and Sports Medicine, by Dr William Vitello, a Section 12 Independent Medical Examiner hired by the Respondent. Dr Vitello performed an examination on the bilateral wrists. RX2.

On the left wrist, range of motion that could be assessed was flexion at 20 degrees, extension to 30 degrees, supination to 60 degrees, and pronation to 70 degrees with pain and tenderness over the ECU and over the TFC. Dr Vitello diagnosed Petitioner with a left TFCC tear and recommended left wrist arthroscopy. Dr Vitello opined that Petitioner was capable of returning to work with no use of the left wrist. Dr Vitello opined that Petitioner's left wrist condition and need for medical treatment was related to his work accident of February 12, 2013. Dr Vitello found that Petitioner had a consistent history of a left wrist injury and his physical presentation coincided with the injury. RX2.

On right wrist examination, flexion is to 30 degrees, extension is to 40 degrees, supination and pronation is 60 to 70 degrees. He had mild crepitus at the DRUJ with pronation and supination. He was diffusely tender over the dorsum of the wrist at the scapholunate interval. Dr Vitello opined that Petitioner was capable of returning to work with no lifting more than 10 pounds with the right wrist. With respect to causal connection, Dr Vitello opined, "This patient has a three-month delay in complaints of the right wrist pain and/or injury from the February 12, 2013 incident. He did not complain of pain in the right wrist according to the medical documentation provided to me to May 22, 2013. Therefore, I cannot definitively say whether this right wrist was involved in the February 12, 2013 accident. He does have finding consistent of right wrist sprain and I

recommend a Corticosteroid injection into the right radiocarpal joint at the level of the DRUJ to determine. This is both diagnostic and potentially therapeutic given his complaints." RX2.

Petitioner testified that he has a prior right hand injury that required surgery when he was a child. Tr., p. 25. He was not having any pain in his right hand or wrist before the accident of February 12, 2013. Tr., p. 24. He began experiencing pain in his right wrist while working light duty. He testified that while working light duty, he essentially was responsible for performing all of his normal job tasks, but he was to perform them right handed. Tr., p. 26-28. The medical records are consistent with this history.

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the Petitioner and finds Petitioner to be credible. The Arbitrator finds a causal connection between Petitioner's present condition of ill-being in the left wrist and the work accident of February 12, 2013. The Arbitrator also finds a causal connection between Petitioner's present condition of ill-being in the right wrist and the work accident of February 12, 2013.

K. Is Petitioner entitled to any prospective medical care?

Petitioner testified that he wishes to undergo the right wrist treatment recommended by Dr Ellis. Specifically, he would like to undergo the second opinion evaluation with Dr John Fernandez recommended by Dr Ellis following the April 9, 2014 examination. Petitioner would also like to undergo the MRI of the right wrist prescribed by Dr Ellis on June 5, 2013. In addition, he would like to have his right wrist examined by Dr John Fernandez. Tr., p. 20-22.

Based on the Arbitrator's findings in Section "F" above, Petitioner is entitled to the additional medical treatment. The Arbitrator finds this treatment to be reasonable, necessary and causally related to the work accident of February 12, 2013. Respondent shall pay for the MRI of the right wrist and the left wrist and right wrist evaluations with

Dr John Fernandez.

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L. What temporary benefits are in dispute? TPD and TTD.

TPD Benefits:

Petitioner claims he is entitled to TPD benefits for the period between February 14, 2013 and May 3, 2013. Respondent claims Petitioner is not entitled to any TPD benefits.

Petitioner worked in a light duty capacity for the Respondent between February 14, 2013 and May 3, 2013. Tr., p. 28. He received his full pay while working light duty. Petitioner is not entitled to any TPD benefits.

TTD Benefits:

Petitioner claims he is entitled to TTD benefits for the period of May 4, 2013 through September 11, 2014 (the date of the hearing). This period represents 70 and 6/7 weeks. Respondent claims Petitioner is entitled to TTD benefits for the periods of May 6, 2013 through June 23, 2013, August 23, 2013 through August 28, 2013, and September 4, 2013 through October 27, 2013.

There is no dispute whether Foodliner could accommodate the light duty work restrictions after May 3, 2013. They could not. If they could have, then they would not have hired Varner. The question is with respect to the attempted TTE placements and whether Respondent can terminate TTD benefits if Petitioner declines the placements.

There is no statutory authority in the State of Illinois for TTE and the Act does not refer to TTE in any Section. Section 8(b) of the Act provides that weekly compensation shall be paid as long as the total temporary incapacity lasts. As stated by our Illinois Appellate Court in *Anders v. Industrial Comm.*, 332 Ill, App.3d 501, 773 N.E. 2d 746 (4th Dist. 2002), a worker has not reached maximum medical improvement on the date he was

returned to work on a light duty basis and he was entitled to continued temporary total disability benefits as the employer refused to provide work within the Petitioner's restrictions.

It is clear that the Petitioner's condition has not stabilized. He is not at maximum medical improvement based upon the Arbitrator's findings in Section "K" above. In addition, no doctor has indicated that Petitioner is able to return to work in a full duty capacity without restrictions. Our Appellate Court has held that where the Petitioner's condition has not stabilized and he was still receiving medical treatment, he had not reached maximum medical improvement, and thus TTD was proper. *Mobile Oil Corp. v. Industrial Comm.*, 327 Ill. App. 3d 778, 764 N.E. 2d 539 (3d Dist. 2002).

The Arbitrator concludes as follows: The Illinois Workers' Compensation Act makes no mention of TTE. The Petitioner is under active medical care. The Respondent cannot accommodate the Petitioner's work restrictions. CBSC, Inc., the Respondent's workers' compensation carrier, has a financial bias in that it stands to gain by reducing its obligation to pay TTD. There are many unresolved issues concerning TTE, including the merit and purpose of volunteering; who is responsible for injuries the Petitioner may suffer while traveling to and from the TTE, or at the site of the TTE while volunteering; does TTE impact Petitioner's pension benefits, disability benefits, retirement benefits, or group insurance benefits; and mileage reimbursement.

The Arbitrator finds that Respondent cannot terminate Petitioner's TTD benefits based on their offering of TTE. A Petitioner has the right to refuse a TTE assignment, regardless of the reason. An injured worker is not required to perform TTE under the Act.

Petitioner is entitled to TTD benefits for 70 and 6/7 weeks, representing the period between May 4, 2013 and September 11, 2014 (the date of the hearing).

Even if TTE was allowed under the Act, in this case Petitioner would be entitled to the TTD benefits for 70 and 6/7 weeks, representing the period between May 4, 2013 and

September 11, 2014 (the date of the hearing). There are too many issues with respect to the June and October TTE placements. The issues are raised in Section "M" below.

M. Should penalties or fees be imposed upon Respondent?

After reviewing the testimony and the evidence submitted by the parties, the Arbitrator finds the Petitioner is entitled to attorney's fees under Section 16 in the amount of $4,581.98 and penalties under Sections 19(k) in the amount of $12,909.91 and 19(l) in the amount of $10,000.00.

In reaching said Decision, the Arbitrator finds that Respondent intentionally failed to pay the TTD benefits. Respondent's conduct was unreasonable, vexatious and in bad faith. Respondent unreasonably delayed the payment of TTD benefits and did not have an honest defense to their delay and non-payment of benefits. In addition, Respondent has no defense for not authorizing the second opinion office visit with Dr Fernandez.

Petitioner worked light duty and received full salary between February 14, 2013 and May 3, 2013. Effective May 4, 2013, Respondent could no longer accommodate the restrictions. This is not in dispute.

Respondent paid TTD benefits May 6, 2013 through June 23, 2013. RX9. Respondent alleges they had a right to terminate benefits because TTE was offered to Petitioner with South Suburban Toys for Kids.

No TTD benefits were paid between June 24, 2013 and August 22, 2013. RX9.

Respondent reinstated TTD benefits effective August 23, 2013, the date of Petitioner's surgery. RX9.

Respondent suspended Petitioner's TTD benefits between August 29, 2013 and September 3, 2013. RX9. Respondent suspended the benefits because Petitioner "refuses

to comply with medical treatment" following the surgery. RX14.

Respondent paid TTD benefits between September 4, 2013 and October 27, 2013. RX9. Respondent alleges they had a right to terminate benefits because TTE was offered to Petitioner effective October 29, 2013, with Villa Guadalupe Senior Services.

No TTD benefits were issued between October 28, 2013 and September 11, 2014 (the date of the hearing). RX9.

June 2013 - Termination of TTD Benefits

Respondent alleges they had a right to terminate benefits because TTE was offered to Petitioner with South Suburban Toys for Kids.

Petitioner was contacted by Dan Varner via letters sent on June 19, 2013 and June 20, 2013, regarding possible temporary transitional employment with South Suburban Toys for Kids. Petitioner was expected to start working at South Suburban Toys for Kids on June 21, 2013. The letters issued to the Petitioner indicate the job required lifting with the right hand between 1 and 2 pounds. RX17.

Petitioner followed up with the contact at South Suburban Toys for Kids and was given information that led him to believe the job was not within the restrictions set forth by Dr Ellis. In addition, Petitioner had concerns regarding the time it would take to get to and from the TTE each day. He testified that he called the RTA (Regional Transportation Authority), an organization similar to the CTA (Chicago Transit Authority), who provides assistance for public transportation route. Petitioner was told that the placement would require over 2 hours of transportation each way. Petitioner considered this an unreasonable amount of travel.

Petitioner testified that he called the insurance adjuster to express his concerns with the restrictions and the travel times required with the position. This phone call is verified in

an email sent by the adjuster with CBSC, Inc., Christopher Neiers, to Varner and Barbara Krieg, a Claims Manager with Foodliner. PX7, p. 70.

Varner testified that he was made aware that the correct restrictions were actually no lifting more than ½ pound with the right hand, no lifting with the left hand and Petitioner must be able to wear bilateral splints at all times. Varner testified that he verified with South Suburban Toys for Kids that the correct restrictions could be accommodated. It is unclear based on the testimony and the evidence presented whether this conversation took place and if it did, when it took place. In addition, Varner did not update the letters to the Petitioner with the corrected restrictions or contact the Petitioner to advise the placement could accommodate the correct restrictions.

Varner testified that he learned of Petitioner's transportation issues after the attempted placement with South Suburban Toys for Kids. He testified that any placement requiring over one hour of travel each way was not reasonable. Varner testified that it is possible a new placement should have been considered based on the transportation issues, but he was told by the Respondent that they considered the placement reasonable and there was no need to attempt another placement.

The Arbitrator finds that the Illinois Workers' Compensation Act makes no mention of TTE and a Petitioner is not required to accept the TTE under the Act. The Respondent's conduct was unreasonable and vexatious and caused an unreasonable delay in the payment of TTD benefits.

Even if TTE was required under the Act, Respondent's conduct in this placement is unreasonable. They were aware of Petitioner's transportation issues and ignored the issues in the placement. Petitioner testified that he contacted RTA and was told the commute to and from work would take over two hours. No evidence was submitted to refute this assertion. The Arbitrator finds Petitioner credible on this issue. Petitioner's testimony is supported by evidence submitted in PX6 and PX7, showing that he called Christopher Neiers to express concerns over the commute required for this placement.

Petitioner even offered to accept placement at the YMCA, a placement sought by Varner in May, 2013. The Respondent ignored Petitioner's pleas and used this placement as a way to terminate TTD benefits. The Respondent acted in bad faith.

August and September 2013 – Termination of TTD Benefits

Petitioner testified that he missed a post-operative visit scheduled on August 28, 2013 because his transportation to the examination fell through. He was unable to re-schedule the examination until September 4, 2013. Petitioner was never issued TTD benefits covering the period between August 29, 2013 and September 3, 2013.

Respondent's Exhibit 14 indicates that TTD benefits were suspended because Petitioner "refuses to comply with medical treatment". The evidence is clear that Petitioner attended the post-operative office visit on September 4, 2013. This was a routine follow up visit where Dr Ellis recommended follow up examination one week later to consider suture removal.

Petitioner's failure to attend the August 28, 2013 office visit did not impact his recovery in any way. Respondent should have issued the TTD benefits due between August 29, 2013 and September 3, 2013 after he attended the office visit on September 4, 2013 and Dr Ellis confirmed the recovery was not delayed as a result of the missed appointment. Instead, Respondent used the missed appointment as a way of terminating benefits for the period. Respondent's conduct was unreasonable, vexatious and made in bad faith.

October 2013 – Termination of TTD Benefits

Petitioner was contacted by Dan Varner via a letter sent on October 22, 2013, regarding possible TTE with Villa Guadalupe Senior Services. Petitioner followed up with the contact at Villa Guadalupe and was given information that led him to believe the job was not within the restrictions set forth by Dr Ellis. Petitioner did not appear for the TTE.

Varner testified that the work restrictions used for this placement were provided to him by Foodliner. The restrictions used were lifting, pushing and pulling up to 20 pounds occasionally, up to 12 pounds frequently and up to 6 pounds constantly. The restrictions set forth by Dr Ellis were not considered.

A review of the evidence shows that Respondent used Dr Vitello's October 11, 2013 report to set the restrictions. In this report, Dr Vitello reviewed the operative report of August 23, 2013, and opined with respect to the "typical postoperative protocol" for this type of injury. Dr Vitello opined that an individual with a TFC repair should go back to sedentary activities including desk work at 6-8 weeks, light duty activity from 8 to 10 weeks, medium activities from 10-12 weeks and expected maximum medical improvement from 12-14 weeks. RX4.

The Arbitrator notes that there was no physical examination in connection with this report. Dr Vitello did not perform an examination on Petitioner's left wrist between July 18, 2013 and March 19, 2014. Petitioner's left wrist surgery was performed on August 23, 2013. Petitioner's right wrist was examined by Dr Vitello on September 23, 2013. No left wrist examination was performed on that date. Other than the operative report, it does not appear Dr Vitello reviewed any other medical documentation before drafting his October 11, 2013 report.

The Arbitrator also notes that the treating surgeon, Dr Ellis, examined Petitioner on October 2, 2013 and kept the Petitioner off of work due to the left wrist injuries. PX2, p. 17. Varner was assigned the placement on October 21, 2013. Varner's placement letter was issued on October 22, 2013. At that time, Dr Ellis had not even allowed Petitioner a light duty work release.

Petitioner was re-examined by Dr Ellis on October 23, 2013. Petitioner complained of left wrist stiffness with pronation, supination, flexion and extension. Dr Ellis prescribed physical therapy and provided Petitioner with light duty restrictions of no lifting more than one pound with the left hand, no use of the right hand and Petitioner must wear

bilateral splints at all times while working. PX2, p. 16. These restrictions were not considered in the TTE placement set up by Varner.

The Arbitrator finds that the Act makes no mention of TTE and a Petitioner is not required to accept the TTE under the Act. The Respondent's conduct was unreasonable and vexatious and caused an unreasonable delay in the payment of TTD benefits.

Even if TTE was required under the Act, Respondent's conduct in this placement is unreasonable. Respondent did not consider the restrictions of the treating doctor. The job description was not sent to the treating doctor for her opinion on whether the job duties were within Petitioner's abilities. Respondent relied upon Dr Vitello's record review and narrative report where he speculated on Petitioner's current restrictions based on a "typical postoperative protocol". If Respondent wanted to rely on Dr Vitello's opinions, they should have had Petitioner re-examined. At the very least, Dr Vitello should have been provided with all of the post-operative medical records. Dr Vitello's opinions are based on speculation and are not credible. The Respondent's conduct was unreasonable and vexatious and caused an unreasonable delay in the payment of TTD benefits.

For the forgoing reasons, the Arbitrator finds Respondent liable for the following penalties and attorney's fees:

Section 19(l):

Section 19(l) provides in pertinent part, as follows:

"In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay."

(Emphasis added.) 820 ILCS 305/19(l) (West 2006).

Penalties under section 19(l) are in the nature of a late fee. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763, 800 N.E.2d 819, 828 (2003). In addition, the assessment of a penalty under section 19(l) is mandatory "if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552 (1998).

The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763, 800 N.E.2d at 829. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9-10, 442 N.E.2d 861, 865 (1982).

Respondent's termination of TTD benefits in June 2013, August 2013, and October 2013 was not reasonable and caused an unjust delay in the payment of benefits. At all of these times, the Petitioner was under active medical care and the Respondent was unable to accommodate the Petitioner's work restrictions. The Arbitrator found in Section "K" above, the Illinois Workers' Compensation Act makes no mention of TTE and a Petitioner is not required to accept the TTE under the Act. In addition, the Respondent's actions in June 2013, August-September 2013 and October 2013 are egregious, unreasonable and vexatious. The Arbitrator has reviewed the emails between Respondent, the insurance carrier and Varner, and finds the actions of Respondent to be reprehensible. PX6 and PX7. It is clear that Respondent was searching for a way to terminate the TTD benefits of an injured worker who was under active medical care and had restrictions that prevented a return to work with them.

The Arbitrator awards $30.00 a day for each day that TTD was underpaid or unpaid. The

period from June 24, 2013 through September 11, 2013 is 445 days. $30.00 per day * 445 days would be $13,350.00. However, the maximum allowed under Section 19(l) is $10,000.00. Therefore, the total amount awarded under Section 19(l) is $10,000.00

Section 19(k):

The standard for awarding penalties under section 19(k) is higher than the standard under 19(l). Section 19(k) of the Act provides, in pertinent part, as follows:

"In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation...then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." (Emphasis added.) 820 ILCS 305/19(k) (West 2006).

An award of penalties pursuant to section 19(k) is "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives." *McMahan v. Industrial Comm'n*, 289 Ill. App. 3d 1090, 1093, 683 N.E.2d 460, 463 (1997), aff'd, 183 Ill. 2d 499, 702 N.E.2d 545 (1998). The standard for awarding penalties and attorney fees under section 19(k) of the Act is higher than the standard for awarding penalties under section 19(l) because section 19(k) requires more than an "unreasonable delay" in payment of an award. *McMahan*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, section 19(k) penalties are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553.

The evidence shows that Respondent withheld TTD payments from other legitimate

motives. The delay was deliberate and is the result of bad faith and improper purpose. There is no such thing as TTE under the Act. Respondent's attempt to place Petitioner in a TTE and the termination of Petitioner's TTD benefits for "non-compliance" raises to the level required to award penalties under Section 19(k).

It is clear from the email chain found on pages 70-72 of Petitioner's Exhibit 7 that there were issues with the placement attempted by Varner. There were issues raised by the Petitioner to the insurance company about both the transportation required and whether the job duties were within his work restrictions. Instead of addressing these concerns, the Respondent ignored them and advised Varner that the placement was reasonable. In addition, concerns about the TTE were raised by the Petitioner's Attorney in an email sent to the insurance adjuster on June 27, 2013. Similar issues were raised by Petitioner's Attorney in a letter sent to Respondent's Attorney on November 1, 2013. These concerns were dismissed by the Respondent, their attorney, their insurance carrier and Varner.

Respondent's actions warrant the award of penalties under Section 19(k).

TTD benefits are due for 70 and 6/7 weeks, representing the period between May 4, 2013 and September 11, 2014. The total amount of TTD benefits due is $37,705.14. Through the date of the hearing, Respondent had paid $11,885.32 in TTD benefits and PPD advances. The total amount outstanding is $25,819.82. Penalties under Section 19(k) are 50% of the unpaid total, or $12,909.91.

Section 16:

Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2006).

Having found the Respondent's actions towards Petitioner to be unreasonable and vexatious, and having found the delay was deliberate and the result of bad faith and improper purpose, the Arbitrator awards attorney's fees under Section 16. The Arbitrator

awards 20% of the total penalties, or $4,581.98 (20% *($12,909.91 + $10,000.00)).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paulina Roque-Almendarez,

Petitioner,

15IWCC0444

vs.

NO: 09 WC 30765

Hauserman's Orchids,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 8, 2013 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.

15IWCC0444

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

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

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

DATED: JUN 1 1 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 6/4/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROQUE-ALMENDAREZ, PAULINA
Employee/Petitioner

Case# **09WC030765**

15IWCC0444

HAUSERMANNS ORCHIDS
Employer/Respondent

On 11/8/2013, 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 0.08% 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:

1042 LAW OFFICE OF OSVALDO RODRIGUEZ PC
1010 LAKE ST
SUITE 424
OAK PARK, IL 60301

0238 WOLF & WOLFE LTD
STEVE WOLF
25 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0444

Paulina Roque-Almendarez
Employee/Petitioner

v.

Hausermann's Orchids
Employer/Respondent

Case # 09 WC 30765

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 **September 16, 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 _____

FINDINGS

On **June 22, 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 $**15,923.44**; the average weekly wage was $**306.22**.

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 $**18,166.29** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**18,166.29**. Respondent has paid $100,601.46 in medical expenses.

ORDER

Respondent shall pay petitioner temporary total disability benefits of $237.67 for 64 weeks.

Petitioner has failed to establish that any medical bills or disability after September 14, 2010 are causally related to the accidental injury at issue.

There is no basis to award penalties or attorney fees.

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

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

Signature of Arbitrator

11-08-13
Date

STATEMENT OF FACTS

The petitioner was employed by the respondent to water and move orchids from place to place. She testified that on the date of the occurrence, she attempted to move a hose out of the way of a customer when she fell and landed on her right side. She did not experience any immediate debilitating pain, however, several hours later, her symptoms increased and she was unable to continue working.

On the date of accident, she went to the emergency room at Glen Oaks Hospital. She testified that she complained of right shoulder pain that emanated into her chest and right knee pain. Records from Glen Oaks Hospital (Petitioner's Exhibit 1) indicate that x-rays demonstrated an AC separation of the right shoulder. No fractures were revealed.

The petitioner was seen at Concentra in Addison, Illinois on June 23, 2009 (See Petitioner's Exhibit 3). At that time, the only complaints she made were related to her right shoulder. She was noted to be in no acute distress. The right shoulder demonstrated no deformity, ecchymosis, erythemia or swelling. There was moderate tenderness to palpation of the anterior and posterior shoulder. There was minimal tenderness to palpation of the AC joint. She was unable to do the "scratch test" secondary to pain. There was no crepitus. There was no ligamentous instability. Deep tendon reflexes were equal bilaterally. Her pulses were normal. Her upper extremity strength and her grip strength were both 5/5. She had normal posture and **no** cervical spine tenderness. She had a **full active** range of motion **without** pain in the cervical spine. She was diagnosed with a shoulder strain. She was advised to have physical therapy three times a week for one to two weeks. Petitioner returned to Concentra on June 24. At that time, x-rays had been reviewed which demonstrated an AC separation.

The petitioner sought follow-up care at Occspecialists (aka Advanced Medical Specialists) (Petitioner's Exhibit 3). She was first seen on June 24, 2009. She was examined by Dr. Charles Mercier, an orthopedic surgeon. At that time, the only complaint she made was to her right shoulder. Dr. Mercier had new x-rays taken and stated that he saw no evidence of AC separation. He ordered an MRI of the shoulder.

Petitioner was seen by Dr. Mercier again at Advanced Medical Specialists on June 29 and July 15. At the June 29 visit, the only complaints petitioner made related to her right shoulder. Petitioner was once again told to get an MRI of the shoulder. On July 15, Dr. Mercier noted that an MRI had been taken of the petitioner's right shoulder. He stated that "it only reveals a small partial-thickness rotator cuff tear versus degenerative changes. Otherwise it is normal."

Petitioner then began treating at Hinsdale Orthopedics (Petitioner's Exhibit 2). Petitioner was seen by Dr. Benjamin Domd on July 23, 2009. At that time, she complained of pain in her right shoulder, right hip and right knee. Petitioner complained of pain in her shoulder that she rated as a "10" on a 1 to 10 scale. She also complained of pain in her right hip in the lateral and anterior parts of the hip. Pain occurred with any motion. Additionally, she complained of knee pain, however, she could not identify one particular area where it hurt. The doctor noted that "…. She was quite hysterical about the pain and has a difficult time localizing her areas of pain". The doctor also noted that "….it was very difficult to tell if she was giving her full effort because she is in a lot of pain".

Dr. Domb ordered a **third** set of x-rays of the shoulder. He noted that AP, lateral and axillary views of the right shoulder demonstrated mild AC joint arthritis and a curved acromion. X-rays were also taken of the bilateral knees which demonstrated no significant abnormalities. He also noted that x-rays of the pelvis and hips demonstrated intact joint spaces bilaterally. She was noted to have a slight acetabular retroversion on the right worse than the left.

Dr. Domb reviewed the MRI of the right shoulder which was taken on June 30, 2009. He agreed that it showed a small partial thickness tear of the supraspinatus. He commented that "…She is quite hysterical about her pain and it is very difficult to tell exactly which joint is hurting her the most and where her pain is coming from". He also stated that "her pain does seem a little bit out of proportion to what would be expected from any of the likely injuries of these joints however".

Dr. Domb referred the petitioner to Dr. Lorenz to evaluate her potential cervical radiculopathy. He also gave her a Cortisone injection in her right subacromial space of the shoulder and ordered additional physical therapy. In addition, he sent the petitioner for an MR arthrogram of the right hip, and an MRI of the right knee and told her to return in six weeks.

The petitioner was next seen by Dr. Michael Zindrick of Hinsdale Orthopedics. (Dr. Zindrick apparently examined the petitioner based upon the referral to Dr. Lorenz in lieu of Dr. Lorenz). Dr. Zindrick saw the petitioner on August 6, 2009. Dr. Zindrick noted that an MRI scan of the cervical spine had been performed which demonstrated no obvious injuries such as a disc herniation or fracture. He noted that the petitioner's major complaint was pain in her right shoulder and peri-deltoid area. X-rays were taken on August 6 which Dr. Zindrick interpreted to demonstrate a straight spine with no disc space narrowing or other abnormalities. The doctor noted that most of the

petitioner's problems were related to her right shoulder. He noted that there were no "hard" neurologic findings seen at that time.

The petitioner next saw Dr. Domb on August 25, 2009. The petitioner continued to complain of pain in her right shoulder, right hip and right knee. She had been undergoing physical therapy since the doctor last saw her. She reported that she had not had any improvement in her pain in any of the identified joints. The doctor noted that the MRI of the right knee that was performed on July 29, 2009 demonstrated no significant findings and no evidence of cartilage damage or a meniscul tear. His assessment at that time was that there was no significant pathology identified in the right knee.

Petitioner continued to complain of right hip pain but an MR arthrogram had not yet been performed. Dr. Domb's diagnosis of the right shoulder was a partial thickness tear of the superspinatus with superimposed adhesive capsulitis which continued to be painful. Her condition had not responded to a subacromial injection followed by physical therapy. He noted that the petitioner had been evaluated by Dr. Zindrick for cervical radiculopathy but Dr. Zindrick felt that her pain was primarily coming from her shoulder.

The doctor had no further recommendations for petitioner's right knee. He continued to recommend an MRI arthrogram for the right hip. As for the shoulder, he recommended an intraarticular Cortisone injection and another six weeks of physical therapy for adhesive capsilitus.

Dr. Domb saw the petitioner again on December 1, 2009. His entire examination was focused on the right shoulder. His diagnosis was adhesive capsulitis and the presence of a partial thickness tear of the superspinatus. He noted that she had not responded to physical therapy or an intraarticular injection of the right shoulder. He recommended another intraarticular injection, continued physical therapy and arthroscopic capsular release with manipulation under anesthesia.

Petitioner went to the Glen Oaks Hospital Emergency Room on January 18, 2010. Her complaints at that time were "right anterior chest" pain. She also complained of pain in her right shoulder which seemed to be getting worse. Her primary work up at the emergency room was for "atypical chest pain". A CT of the head was performed which demonstrated no acute abnormalities. A chest x-ray was taken which was also normal. Her blood tests were normal. An EKG was performed which was normal. A cardiac monitor demonstrated a normal sinus rhythm.

Dr. Domb again saw the petitioner on January 26, 2010. He noted that the petitioner had not had a second intraarticular injection. He also noted that the petitioner stopped therapy since a trigger point injection over a week ago had caused more pain. His assessment was "continued adhesive capsulitis right shoulder". He did not feel that proceeding with surgery at that time was appropriate due to the fact that her shoulder was inflamed.

The petitioner was seen again by Dr. Domb on April 8, 2010. The examination and treatment at that time were limited solely to the petitioner's right shoulder. The doctor noted that the petitioner had reported that she had not had any improvement and continued to complain of substantial pain. The doctor noted that an intraarticular injection was performed in January and that the petitioner had been receiving physical therapy three times a week since that time. The diagnosis was "right shoulder continued adhesive capsulitis, which has now failed to improve with injection and physical therapy". The underlying diagnosis was a partial thickness tear of the rotator cuff. The doctor recommended a right shoulder arthroscopy, capsular release and manipulation under anesthesia.

On April 26, 2010, Dr. Domb performed surgery consisting of the following:

1. Right shoulder arthroscopic capsular release and manipulation under anesthesia.
2. Arthroscopic extensive debridement of the torn labrum and torn infraspinatus.
3. Arthroscopic subacromial decompression.

The petitioner returned to see Dr. Domb on May 11, 2010 for her first post-operative visit. She reported that her shoulder was more painful than it was prior to surgery. She reported experiencing a "syncopal episode" while in physical therapy. She was sent to the emergency room for evaluation of that episode.

Petitioner was seen at Glen Oaks Hospital on May 11, 2010. Contrary to petitioner's testimony at trial, the record indicates that the petitioner was laying down "presumably at home" and could not be aroused for a one to two minute period. Her daughter was present and did not witness any seizure activity. She simply could not arouse the petitioner by shaking and yelling at her. Thus, they thought that the petitioner had a syncopal episode. The note expressly says that the petitioner had a "questionable" syncopal episode.

During the examination in the emergency room, the evaluating physician attempted to measure her strength. He reported that "she does not try squeezing real hard. I do not sense that there is truly right-sided weakness. She is just not trying it seems like to squeeze and push down as much with her right side". The E.R. physician's impression was "syncopal episode, questionable etiology; anemia, suspect gastrointestinal".

Petitioner returned to see Dr. Domb on August 3, 2010. Petitioner continued to report pain in her right shoulder, however, it was getting a little better and her motion was improving. She also reported pain and numbness in the entire right side of her face, her head, her neck, her mid back and her entire right arm. The assessment at that time was "improving range of motion and strength" of the right shoulder following surgery. However, the doctor noted that the petitioner had not followed up as planned. Also, she was diagnosed with numbness of the entire right side of her head, face, back and arm due to a neurological source of **unknown origin**. Dr. Domb referred her to Dr. Bijari regarding petitioner's complaints of numbness.

The petitioner saw Dr. Armita Bijari on August 23, 2010 (Petitioner's Exhibit 6). The doctor noted that the petitioner was complaining of severe right shoulder pain. He also noted that she complained of numbness on the entire right side of her body including her face, head, and back. She complained of not being able to see well out of her right eye. She noted that she did **not** hit her head at the time of the accident at issue. She also had no loss of consciousness. The doctor ordered an MRI of the brain, and MRA of the brain, an MRA of the carotids and an EMG of the right upper extremity and neck.

Petitioner returned to Dr. Domb on September 14, 2010. She continued to have some pain in her right shoulder, however, it had improved and her range of motion had improved as well. She reported to the doctor that her biggest complaint was the pain and the numbness in the entire right side of her face, head, neck and mid back. She reported that she had seen Dr. Bijari who had recommended obtaining MRIs to rule out any neurological deficits.

Dr. Domb's assessment at that time was:

1. She has regained full range of motion. There is no evidence of strength deficits in the shoulder. As far as the shoulder is concerned, she is at full maximum medical improvement.
2. Neurological source of numbness in the entire right side of her head, face, back and arm of an unknown source.

Dr. Bijari wrote a follow-up report dated September 29, 2010. He noted that the MRI of the brain, the MRA of the brain, and the MRA of the carotids were all negative. He then ordered an MRI of the cervical spine and an EMG of the right upper extremity and neck.

The petitioner went to the emergency room at Glen Oaks Hospital on October 29, 2010. The initial emergency room report was prepared by Dr. Robert Kempf. Dr. Kempf noted that Petitioner reported that she had been experiencing right-sided facial weakness since yesterday following an injection by her neurologist, Dr. Kelly. The numbness allegedly involved her whole right side including her forehead and scalp. She also had numbness and decreased strength in her right upper extremity. She had previously experienced numbness in her right upper extremity, however, it had become worse since yesterday. She also complained of blurry vision in the right eye and redness to the right eye. An MRI of the cervical spine was performed. There was no evidence of disc herniation, spinal stenosis or significant foraminal narrowing.

Dr. Domb had already ordered an MRI of the cervical spine which had been performed on July 29, 2009. That cervical MRI demonstrated that there was minor multi-level degenerative disc bulging and no focal disc herniation.

While at the hospital, she was examined by Dr. Kevin McCoyd. Dr. McCoyd appears to be a neurologist. The petitioner reported to Dr. McCoyd that she received an epidural injection a few days earlier. In the "impression" section of Dr. McCoyd's consulting report, (petitioner's exhibit 8) he noted the petitioner had experienced chronic right arm, neck and shoulder pain and weakness which had been "evaluated elsewhere". He noted that these conditions did **not** need to be re-evaulated given the fact that she had ongoing care elsewhere. He did, however, note that there appeared to be some "functional overlay".

Dr. McCoyd was also of the opinion that petitioner's facial symptoms were secondary to an idiopathic peripheral facial or Bells palsy. He did **not** think that the condition was related to the injection she received the other day.

Petitioner was also examined by Dr. Alex Sanchez while at Glen Oaks emergency room on October 29, 2010. After Dr. Sanchez evaluated and treated the petitioner, his "Assessment and Plan" was as follows:

1. Right facial weakness, most likely Bells Palsy. Patient needs to do conservative treatment.
2. Chronic neck pain and right upper extremity numbness. This is a chronic condition after injury. Patient referred no clear etiology for

this problem... I feel that patient does not have any acute condition to remain in the hospital...

Petitioner returned to see Dr. Domb on November 11, 2010. Despite the fact that she had been found to have full range of motion and no evidence of strength deficits in the shoulder on the 9/14 visit, the petitioner reported that her pain had remained "unchanged since her last visit and stated that the pain is still 9/10". Despite her subjective complaints, Dr. Domb once again stated that "she has regained almost full range of motion in her shoulder and there is no evidence of strength deficits of this shoulder. As far as the shoulder is concerned, she is at full maximal medical improvement". He also stated that the neurological source of numbness in the right side of her head, face, back and arm are of an unknown source.

Petitioner returned to see Dr. Domb again on December 23, 2010. Dr. Domb noted that an FCE had been performed. The FCE determined that the petitioner could work at a sedentary level with occasional overhead lifting. He noted that her physical examination was unchanged. He also noted that she had regained "almost full range of motion of the shoulder and no evidence of strength deficits". Thus, it did not appear that her FCE limitations were related to her right shoulder injury. Petitioner continued to complain of numbness in the right side of her head, face, back and arms of an unknown source. The doctor expressly stated that "regarding the shoulder, she is at maximal medical improvement and there is no need for further visits unless there is a new problem". The doctor imposed permanent work restrictions consistent with the FCE. However, these restrictions were inconsistent with the doctor's repeated findings that the petitioner had an almost full range of motion of the shoulder with no evidence of strength deficits.

The petitioner reported to the Central DuPage Emergency Room on September 8, 2011. She complained of pain in her neck and head. She was asked if her conditions were caused by an injury or work related. She responded in the **negative** to both of these questions. She complained of dizziness and a sense of the room spinning. She also complained of right shoulder pain. She was diagnosed with a neck strain. Upon clinical examination, she was noted to have severe tenderness of muscles on both sides of her neck. She was noted to have difficulty with abducting her right shoulder above 90 degrees **secondary to neck pain.**

The petitioner did not return to Hinsdale Orthopedics until September 22, 2011. At that time, she was seen by Physician's Assistant, Julie Morgan. She had **no** complaints of pain in her right shoulder at that time. However, she had complaints of pain in her **left** shoulder and neck. She reported that she had gone to "urgent care" a

week ago due to pain in the right side of her face and the side of her neck. She reported numbness and tingling in her face and down into her hand. There was no reference of any kind to the accident at issue.

Petitioner went to the emergency room at Glen Oaks Hospital on February 1, 2012. She presented with a headache. She also reported that she had a history of a shoulder injury and neck and head pain since 2009 and that she also had right-sided facial weakness and right-sided upper extremity weakness. However, it is clear from a review of the records that the reason she went to the emergency room was for a headache. She reported that the onset was one week ago. The location was in the frontal temporal parietal. It was sharp in nature. The degree of onset was severe. There were no exacerbating factors. There were no preceding symptoms and no associated symptoms.

Her musculoskeletal examination was normal. She had a normal range of motion, normal strength, no tenderness and no swelling. She was noted to have some weakness on the right side of her face. She also had mild weakness of the right upper extremity. She was diagnosed with a headache. A CT scan was performed which was normal.

An EMG and nerve conduction study was performed by Dr. Ranjeet Singh on April 17, 2012. The testing demonstrated **no** evidence for radiculpathy or myopathy. There was evidence for right-sided mild carpal tunnel syndrome.

The petitioner was seen by Dr. Anas Alzoobi on May 3, 2012 (Petitioner's Exhibit 7). She reported that she had been in a **motor vehicle** accident. She was diagnosed with a whiplash injury, neck pain and right shoulder pain. Dr. Alzoobi suggested that the petitioner may be suffering from complex regional pain syndrome to the right side of the face as well as neuralgia and a whiplash injury to the neck.

Dr. Alzoobi again saw the petitioner on May 31, 2012. He noted that the diagnosis of complex region pain syndrome to the right upper extremity was questionable. He indicated that he was "leaning more towards facet joint syndrome and chronic post-operative pain to the right shoulder as well as carpal tunnel syndrome in the right upper extremity. He acknowledged that defining each component of the patient's symptoms would negate the diagnosis of complex regional pain syndrome. The doctor injected the median nerve to treat her carpal tunnel syndrome.

The petitioner again returned to Hinsdale Orthopedics on October 8, 2012. She reported increased pain in her right shoulder along with weakness and limited range of motion. The doctor's assessment at that time was that the petitioner continued to have

pain in her face, neck, trapezious, pec, and basically all around the right side. Her exam did **not** show any persistence of adhesive capsulitis or limitation of range of motion of the shoulder specifically. She was noted to have **pain out of proportion** to her exam with any motion of her right side including the neck or the arm. The doctor noted that he continued to believe that her symptoms seem to be coming from a nerve related cause and was **not** related to the presenting problem of her shoulder.

Petitioner saw Dr. Alzoobi at Health Benefits Pain Management on April 25, 2013. At that time, she complained of severe neck pain, right-sided facial pain, right shoulder pain, low back pain and right lower extremity pain.

The doctor noted that the petitioner had an "inadvertent" complication after her first epidural steroid injection which created significant fear of any type of interventional treatment. As a result, she was refusing any additional intervention treatment at that time. He noted that the petitioner refused to use her **left arm** to perform any resistance type of movement. In the section of his report entitled "History of Present Illness" the doctor indicated that the patient is "probably not a surgical candidate at this point". However, under the section "Treatment Plan" the doctor reported that "the patient will have repeat surgical evaluation as far as shoulders since she is refusing interventional treatment. No further recommendations". His reference to "repeat surgical evaluation" is an apparent reference to the subsequent evaluations at Hinsdale Orthopedics. Thus, Dr. Alzoobi deferred to Hinsdale Orthopedics for further evaluation and care.

The petitioner was next seen by Dr. Domb on May 23, 2013. She again described pain and decreased range of motion in her right shoulder with pain that radiates to her neck and face. Dr. Domb's diagnosis was "unspecified neuralgia neuritis and radiculitis". Again, Dr. Domb noted that this was a neurologic problem and that her shoulder was at maximum medical improvement.

The petitioner was then seen by Dr. Steven Bardfield of Hinsdale Orthopedics on June 12, 2013. She reported right shoulder pain with right-sided neck pain. He noted that petitioner had complained of facial numbness and even weakness on the right side which was diagnosed as Bells Palsy. He noted that an EMG had been recommended but he had not seen the test results. His clinical exam revealed that petitioner's **cervical spine** was significantly limited due to discomfort. His impression was that the petitioner was suffering from right cervical radiculopathy versus right upper extremity neuropathy.

Yet another MRI of the cervical spine was performed on June 22, 2013. The study demonstrated a small central focal posterior disc protrusion at C2-C3 with no significant spinal canal or neural foraminal stenosis. There was also a mild posterior disc bulge at C5-C6 with borderline mild spinal canal stenosis. No one at Hinsdale Orthopedic (or anywhere else) has related the findings in the June 22, 2013 MRI to the accident at issue. No one has offered an opinion that the findings in the June 22, 2013 MRI are the source of any of the petitioner's subjective complaints.

Petitioner was **last** seen at Hinsdale Orthopedics on June 26, 2013 by Dr. Steven Bardfield. His note documents that the petitioner's chief complaint at that time was "neck". Dr. Bardfield performed an EMG and nerve conduction study at that time. The findings suggested "very mild right carpal tunnel syndrome" and **nothing** else. His diagnosis was "myofascial pain syndrome, unspecified neuralgia neuritis and radiculitis". Dr. Bardfield felt that the petitioner was unable to return to work. However, none of his findings were in any way related to the work-related injury at issue.

Petitioner was last seen by Dr. Alzoobi on July 25, 2013. It was noted that she presented with a worsening of her symptoms including facial redness, changes in color of the skin, swelling of the right upper extremity all the way down to the hand, swelling of the skin and slight arythematous, and hypersensitivity to light and touch. Petitioner also reported losing her teeth in both sides of her face, with the right side being more prevalent. The doctor recommended a spinal cord stimulator. He also prescribed a bone scan to evaluate the demineralization process of the bone structure of the face as well as the right upper extremity compared to the left.

The petitioner introduced records from Addison Family Center as Petitioner's Exhibit 19. These records are very revealing. First of all, the records contain a note from April 21, 2009. This record indicates that the petitioner was complaining of pain that she rated as an "8" on a scale of 1 to 10. She identified the pain as chest pain that she had had for the last two weeks. The next note contained in the records is dated November 4, 2010. It is significant to note that this record was more than a year **after** the accident at issue. She was being seen for a "skin problem" in her abdominal area. The notes expressly indicate that the petitioner was **not** experiencing **any** pain.

The next record is dated November 29, 2011. At that time, the petitioner reported that she was having an undescribed level of pain due to headaches. She was noted to have an elevated blood pressure. In addition to headaches, she was complaining of blurred vision. She also mentioned her shoulder surgery. She was told

to begin taking "Coreg" for her headaches/hypertension. She was also given a prescription for Relafen for shoulder capsilitis. She was told to return in three weeks.

Petitioner returned on December 14, 2011. The notes indicate that her headaches had decreased in intensity and her blood pressure had dropped dramatically due to the use of Coreg. There was **no mention of any kind** regarding any symptoms relative to her shoulder.

The petitioner was next seen at Addison Family Health Center on August 30, 2012. It was noted that she had uncontrolled blood pressure readings as of late. She admitted to being non-compliant with her diet. She reported feeling depressed since 2010. The doctor noted that her musculoskeletal exam was positive for myalgias. However, examination of the petitioner's neck revealed that her neck had a normal range of motion and was supple. The assessment at that time was limited to 1; hypertension, 2; dyslipedmia and 3; depression. There was no mention of any kind relating to petitioner's shoulder or neck.

Finally, and perhaps most significantly, the petitioner was examined at Addison Family Health Center on October 3, 2012. The musculoskeletal exam at that time was **negative.** Petitioner's neck was noted to have a normal range of motion and was supple. The report also indicated that petitioner's musculoskeletal exam demonstrated a normal range of motion. The assessment at that time was: 1) depression and 2) flu vaccine needed. There was no mention whatsoever regarding any problems with the petitioner's shoulder or neck.

The petitioner was examined by Dr. Timothy Lubenow at the request of petitioner's attorney on December 20, 2012. The petitioner gave a history to Dr. Lubenow which included experiencing paresthesias in her hand shortly after the occurrence on the day of the occurrence. This is inconsistent with all other medical records.

She also gave a history to Dr. Lubenow of having undergone a cervical epidural steroid injection on October 28, 2010 after which she noted the onset of headaches and right-sided facial numbness. This is consistent with her testimony at trial; however, it is inconsistent with the medical records that indicate that she first began experiencing right-sided facial numbness on August 3, 2010 when she was seen by Dr. Domb at Hinsdale Orthopedics. In addition, she complained of numbness on the entire right side of her head, face, back and arm to Dr. Domb on September 14, 2010.

The petitioner also advised Dr. Lubenow that she had pain between the shoulder blade that radiates into the right shoulder posteriorally and then down the right arm. She also complained of paraesthesias in all of her fingers.

Upon physical exam, Dr. Lubenow identified decreased cervical flexion and extension. The doctor noted that petitioner had decreased grip strength of 3/5 in the right upper extremity. She also had limited abduction of the right upper extremity of 3/5. Forward elevation was limited to 3/5 muscle strength. Hand grasp of the right hand was also limited to 3/5. However, the doctor noted that all of these were limited by pain or self limited by that patient's volition.

Dr. Lubenow opined that the petitioner had chronic right shoulder pain secondary to right rotator cuff syndrome. It was also his opinion the petitioner's current condition of ill being was related to the work injury. However, he qualified his opinion by stating that the basis for the opinion was the "time frame that she offered in her history" as well as the medical record information. What is not specified in his report, however, is the medical records that he reviewed. It is clear that he did not review complete records or he would have known that petitioner's facial numbness began almost three full months earlier than reported by the petitioner.

The doctor concluded that her prognosis was guarded. Again, however, he qualified his opinion by stating that it was based upon her history and her response to medical treatment thus far, as well as her "perception" of their being a complication following the cervical epidural steroid injection.

The petitioner was evaluated by Joseph Belmonte of Vocomative on December 8, 2011. Mr. Belmonte is a Certified Rehabilitation Counselor. His report was introduced into evidence as Respondent's Exhibit 1.

Counsel for petitioner was present during the evaluation. Mr. Belmonte noted that counsel for petitioner reported to Mr. Belmonte that the petitioner received an injection into the spine in which a nerve was injured. Counsel for petitioner reported that the petitioner was hospitalized for 1.5 days at Glen Oaks Hospital following the injection. Counsel for petitioner acknowledged that this was a disputed issue.

Petitioner informed Mr. Belmonte that she had an automobile and a driver's permit. However, she no longer drives because she is in too much pain to do so. Prior to her injury, petitioner was driving a car despite the fact that she did not have a valid driver's license.

The petitioner told Mr. Belmonte that she could not use her right upper extremity for any activity. In conjunction with his vocational evaluation of the petitioner, Mr. Belmonte viewed all available medical records. He noted that the most recent record available was dated December 23, 2010 and consisted of a work status report issued by Dr. Domb of Hinsdale Orthopedics. That document indicated that he petitioner was released to return to work with no lifting greater than 10 lbs, no repetitive activities with the right upper extremity and only occasional overhead work. Mr. Belmonte also noted that Dr. Domb had reported that the petitioner had regained almost full range of motion in her shoulder and there was no evidence of any strength deficit.

Mr. Belmonte also reviewed the functional capacity evaluation that was performed on December 9, 2010. The report indicated that the petitioner was capable of performing sedentary duties for eight hours a day and 40 hours a week. The report also indicated that there was some evidence of low effort or inconsistent behavior during the FCE. Mr. Belmonte also reviewed a consultation report written by Dr. Kevin McCoyd dated November 30, 2010. Mr. Belmonte noted that Dr. MyCoyd had reported that petitioner demonstrated some functional overlay. Mr. Belmonte also relied upon the report of Dr. Kathleen Weber which is dated September 20, 2010. That report identified findings by Dr. Michael Zindrick which indicated that the petitioner did not have any significant neck pathology. Dr. Weber also reported that the petitioner's subjective complaints appear to be out of proportion to the objective findings.

Mr. Belmonte ultimately concluded that the petitioner has residual employment potential. He identified a fast food environment, working in food preparation, select cashier work, limited industrial production activities not requiring repetitive use of the arm and similar occupations. Mr. Belmonte indicated that he has facilitated the placement of other injured workers with profiles similar to that of the petitioner. Mr. Belmonte attached a survey of available jobs that are currently available to his report.

15IWCC0444

In support of the Arbitrator's decision regarding whether the petitioner's current condition of ill-being is causally related to the injury at issue, the Arbitrator finds the following facts:

The medical records introduced into evidence demonstrate that the petitioner has a long and very complicated medical history. She has been seen by numerous medical providers. At times, she has given conflicting medical histories. Multiple medical providers have questioned the veracity of her complaints and have identified "functional overlay" and that her symptoms appear to be out of proportion to any objective findings.

The Arbitrator finds that the petitioner's most reliable record of treatment is contained in the records of Hinsdale Orthopedics. Petitioner was treated at Hinsdale Orthopedics shortly after her accident and consistently returned to Hinsdale Orthopedics for follow-up treatment, despite repeated lengthy gaps in treatment.

The records from Hinsdale Orthopedics clearly establish that the petitioner had a significant problem with the right shoulder that eventually required surgical intervention. Surgery was successful and petitioner regained full or almost full strength in her right arm/shoulder and full range of motion. As of September 14, 2010, Dr. Domb found that the petitioner had regained full range of motion with no evidence of strength deficits in the shoulder. He stated in his record that the petitioner had reached maximum medical improvement in the right shoulder.

On November 11, 2010, Dr. Domb once again stated that petitioner had regained almost full range of motion in her shoulder and there was no evidence of strength deficits in the shoulder. Again, on December 23, 2010, Dr. Domb noted that her physical examination was unchanged and that she had almost full range of motion in the shoulder and no evidence of strength deficits.

Petitioner is also claiming that she suffers from numbness on the entire right side of her head, face, back and arm. She is alleging that this condition is causally related to the accident at issue. Also, the records suggest that petitioner is claiming a cervical condition related to the accident at issue. The records from Hinsdale Orthopedic are unequivocal. Not only do Dr. Domb's notes from August 3, 2010, September 14, 2010, November 11, 2010 and December 23, 2010 make it clear that petitioner's complaints of

pain and numbness in the entire right side of her face, head, neck, back and arm were due to a neurological source of "unknown origin", subsequent records also support this conclusion.

The records from Glen Oaks Hospital from October 29 indicate that the petitioner was suffering from idiopathic peripheral facial or Bells Palsy.

On October 8, 2012, almost a year later, petitioner returned to see Dr. Domb. Dr. Domb stated that he did not see any persistence of adhesive capsilitis or limitation of range of motion in the shoulder. He noted that the petitioner appeared to have pain out of proportion to her examination. The doctor continued to believe that her symptoms were "nerve related" and were not related to the presenting problem of her shoulder.

On May 23, 2013, Dr. Domb again opined that her complaints were **not** related to her shoulder and her shoulder was at maximum medical improvement. His diagnosis was "unspecified neuralgia neuritis and radiculitis".

The petitioner was then examined by Stephen Bardfield of Hinsdale Orthopedics on June 12, 2013. He noted that the complaints of facial numbness and weakness on the right side were due to Bells Palsy. His impression was that the petitioner was suffering from right cervical radiculopathy versus right upper extremity neuropathy.

Petitioner was last seen at Hinsdale Orthopedics on June 26, 2013. Dr. Bardfield performed an EMG and nerve conduction study at that time. The findings suggested very mild right carpal tunnel syndrome and nothing else.

While the medical evidence in this case is complicated and conflicting to some extent, the credible evidence establishes that the petitioner sustained an injury to her right shoulder which ultimately required surgical intervention. Following surgery, the shoulder improved significantly to the point where full range of motion was returned and almost full strength was returned. Petitioner's unrelated problems regarding numbness and pain on the right side of her body are clearly not related to the accident at issue.

In addition, there is no evidence whatsoever that there are any cervical problems that are causing or contributing to petitioner's current symptoms. Also, there is no evidence that any cervical findings on recent MRIs are causally related to the accident at issue. Thus, the Arbitrator finds, based upon the credible medical evidence, that the petitioner's physical ailments of which she complained at the time of the hearing are **not** related to the accident at issue.

15IWCC0444

In support of the Arbitrator's findings regarding whether respondent is responsible for any outstanding medical bills, the Arbitrator finds the following facts:

As stated earlier, the medical evidence is clear: petitioner was at maximum medical improvement for her right shoulder injury as of September 14, 2010. All remaining treatment petitioner received for headaches, neck pain, right-sided numbness and weakness, etc., are unrelated to the accident at issue. Thus, respondent has no responsibility for paying any such bills.

15IWCC0444

In support of the Arbitrator's finding regarding the amount of temporary total disability to which the petitioner is entitled, the Arbitrator finds the following facts:

As discussed earlier, the records from Hinsdale Orthopedics clearly establish that the petitioner was at maximum medical improvement for her shoulder injury on September 14, 2010. The conditions for which she treated subsequent to September 14, 2010 are not causally related to the accident at issue. Thus, TTD is owed from June 23, 2009 to September 14, 2010, for a total of 64 weeks.

15IWCC0444

In support of the Arbitrator's finding regarding whether penalties or attorney fees should be imposed upon respondent, the Arbitrator finds the following facts:

For the reasons discussed earlier in this decision, petitioner has failed to establish that her ongoing medical treatment subsequent to September 14, 2010 was causally related to the accident at issue. Thus, the respondent's refusal to pay for medical benefits or TTD was not unreasonable. Therefore, the petitioner is not entitled to any penalties or attorney fees.

15IWCC0444

In support of the Arbitrator's findings regarding whether the respondent is due any credit, the Arbitrator finds the following facts:

The respondent has paid $18,166.29 in TTD benefits. Based upon Section "K" above, the respondent only owed 64 weeks or $15,210.88. Thus, respondent is entitled to a credit of $2,955.41.

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

Daniel Salinas, Jr.,

Petitioner,

15IWCC0445

vs.

NO: 11 WC 30117

Northwestern University,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical expenses, 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 November 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.

15IWCC0445

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

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

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

DATED: JUN 1 1 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 6/4/15
45

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

15IWCC0445

SALINAS JR, DANIEL
Employee/Petitioner

Case# **11WC030117**

NORTHWESTERN UNIVERSITY
Employer/Respondent

On 11/13/2014, 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 0.06% 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:

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CHICAGO, IL 60603

1109 GAROFALO SCHREIBER & STORM
MATTHEW J NOVAK
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CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0445

Daniel Salinas, Jr.
Employee/Petitioner

v.

Northwestern University
Employer/Respondent

Case # 11 WC 30117

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **August 28, 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 _____

15IWCC0445

FINDINGS

On the date of accident, **12-23-2010**, 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 regarding only the left knee is causally related to the accident.

In the year preceding the injury, Petitioner earned **$73,195.20**; the average weekly wage was **$1,407.60**.

On the date of accident, Petitioner was **54** 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 **$48,260.08** for TTD, $0.00 for TPD, $0.00 for maintenance, and **$65,200.59** for other benefits, for a total credit of **$113,460.67**.

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

ORDER

The Arbitrator finds that Petitioner has not proven, by a preponderance of the evidence that his current condition of ill-being regarding any body part other than the left knee, is causally-related to his accident. Prospective medical treatment is not awarded.

Medical benefits

Respondent shall pay reasonable and necessary medical services incurred from December 23, 2010 until February 13, 2013, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall not be liable for any medical treatment incurred after February 13, 2013, as Petitioner had not proven, by a preponderance of the evidence that his conditions other than that of the left knee, are causally related to his work accident. Respondent shall have credit for all bills it has paid for services incurred prior to February 13, 2013.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $938.40/week for 50 6/7 weeks, commencing 12/24/10 to 1/2/2011 and 3/20/12 to 2/28/13 as provided in Section 8(b) of the Act. Respondent shall be given a credit of $48,260.08 for temporary total disability benefits paid to Petitioner, pursuant to Section 8(b) of the Act and $65,200.59 for other benefits paid. Respondent shall pay Petitioner the temporary total disability benefits that have accrued, and shall pay the remainder of the award, if any, in weekly payments.

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.

15IWCC0445

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) medical bills; 3) temporary total disability; 4) and whether the petitioner is entitled to prospective medical treatment. *See*, AX1.

Daniel Salinas, Jr. ("Petitioner") was employed by Northwestern University, ("Respondent") as a building maintenance engineer, having worked in that position for approximately twenty-one years prior to his date of accident. In his capacity as a building maintenance engineer, he would be required to operate and maintain a multitude of building maintenance equipment, such as air handlers, chillers, pumps and motors. He was required to bend, kneel, crawl, reach, pull and push, as well as lean and twist his body. He was required to cover multiple buildings in his job. The petitioner testified that he could be required to lift up to one hundred pounds in his job, and testified that any lifting above fifty pounds could be done with the assistance of a co-worker. The petitioner testified that co-workers could be made available upon calling the office, though if a co-worker was not timely available to complete a lift; he would simply do it himself, as he liked to get the job done in a timely manner.

On December 23, 2010, the petitioner was climbing a ladder when he missed a step, causing the ladder to fall. He testified that he fell from a height of approximately four feet, though admitted that it could have been approximately eight feet. He further testified that he landed onto a concrete floor on his left side, striking his ankle, hip, knee, and shoulder. After laying on the ground fifteen minutes, he got up, checked his left knee and found a big bulge.

The petitioner presented to Northwestern Memorial Physicians Group Corporate Health Services ("Northwestern") on the date of accident, complaining of falling four feet while getting down from a ladder. The petitioner stated he injured both knees, his back and his shoulder during the fall. He complained of pain in his knees, left greater than right, left ribcage and his back area. He was sent to the emergency room for further evaluation.

The triage notes from the emergency room state the petitioner fell approximately four feet off a ladder onto his left knee. He had a medial left lower extremity abrasion and bruise. He complained of right fourth finger pain and an anterior right lower extremity bump. He also complained of left shoulder and neck pain and left hip pain, radiating down the left lower extremity with sitting. The petitioner denied loss of consciousness, and physical examination revealed abrasions noted to the left back and knee.

The petitioner complained of left knee pain, but stated he walked back to the shop after he fell. Other records state the petitioner complained of right shoulder, back, right knee and left shin pain after a fall off a ladder. The history taken was that the petitioner was four feet off the ground when he fell,

landing on his left side onto concrete. He reported no neck pain, but did complain of some right shoulder pain, right lateral/posterior rib pain, right knee pain, and left tibial pain. The impression was a history of right shoulder, right knee, left tibia/fibula, and right flank pain after a fall off a ladder with contusions and abrasions. X-rays were taken of the chest, left shoulder, the right tibia/fibula, and the left knee, which were all negative for an acute abnormality.

On January 3, 2011, the petitioner followed up at Corporate Health Services with Northwestern. The petitioner stated that he climbed a ladder and reached out with a piece of equipment in his hand, causing him to lose his balance and the ladder slipped out from under him. He fell backwards onto his left side onto a concrete floor. He thought he might have hit the ladder with his legs or knees on the way down. He related that the equipment he was holding did not fall on top of him, but there was another piece of equipment on the floor to his right side when he landed. He states the ladder did not fall on top of him, and he fell from a height of about four to six feet.

He reported that he stayed on the ground for approximately ten minutes due to pain, and then was able to stand up on his own. It is noted that he presented to Corporate Health on the date of accident, where he was sent to the emergency room.

The doctor noted that the petitioner had been using pain medications including Norco and Ibuprofen without GI upset. On his first day back to work, he complained of pain in several areas: medial left knee, left posterior thoracic/rib region, left hip, anterior right leg, lateral distal left leg, left shoulder/trapezius, left ankle and right hand. He stated the right hand did not start to bother him until December 24, 2011. He stated his pain was most severe in the medial left knee and the left posterior rib region. He also reported having multiple scrapes and bruises. He reported occasional numbness to the distal anterior thigh, which occurred intermittently and resolved spontaneously. He reported painless popping in the left knee, which sometimes felt like it was going to give out when walking. He denied tingling, weakness, locking of the knee, fevers, anterior chest pain, shortness of breath, cough, wheeze, neck pain, low back pain, headaches, and other conditions noted in the medical record.

Physical examination revealed tenderness to palpation of the left trapezius and left piriformis areas. He was non-tender to the remainder of his neck and back areas. His left shoulder revealed tenderness to palpation in the left trapezius with limited abduction, but full adduction, full flexion, full and painful extension, full internal rotation and full external rotation. He experienced bony tenderness throughout his left hip and was minimally tender along the left piriformis and the left lateral proximal thigh tissues. The left knee was positive for ecchymosis to the medial aspect of the knee with associated soft tissue edema. The left ankle/foot was tender to palpation along the distal soft tissues of the leg and minimally the ATFL. He had no laxity with inversion/eversion of the foot/ankle. The right leg revealed resolving ecchymosis of the anterior aspect of the leg, which was tender to palpation. He was not tender on the right lower extremity and had full range of motion of the right

knee and ankle. The assessment was that the petitioner suffered strains/sprains and contusion of the various body parts examined. He was to continue with Ibuprofen, use Norco only as needed and was released to return to work, with restrictions.

On January 10, 2011, the petitioner followed-up at Northwestern. At this visit he stated that some areas had improved (left trapezius/shoulder, right hand, right leg and left rib region), which were now minimally painful with certain motions or palpation. He was feeling the same in the left hip, left knee, and left leg/ankle. He was now having some right knee pain and plantar distal left foot pain, which he attributed to, altered gait, as they began to bother him just a few days prior. Overall, his left knee was still the most painful aspect of his injuries. The pain was not constant, but occurred with any attempt at knee motion, especially going up and down stairs. He still complained of a sensation that his left knee was giving out or catching, while walking. He stopped using Norco and was now using Ibuprofen with good relief. He denied having neck pain, low back pain among other conditions. After physical examination, he was advised to apply an Ace wrap to his ankle and wear bilateral knee sleeves. The assessment remained strains/sprains and contusions to the various body parts. Due to the continued severe knee pain on the left and examination findings suggesting a cartilage injury, an MRI was recommended. He was to continue working with restrictions as previously outlined.

On January 18, 2011, the petitioner underwent an MRI of the left knee at Northwestern and the radiologist's impression was no left knee meniscal or cruciate pathology was seen. The posterior, medial joint capsular edema overlying the posterior medial femoral condyle was mildly edematous, possibly representing a low-grade capsular injury. Patellofemoral osteoarthritis with full-thickness central trochlear and medial, patellar, facet cartilage defects, was noted.

On January 20, 2011, the petitioner followed-up at Northwestern. He continued to experience his greatest discomfort in his left knee, left ankle, foot, and right knee. The left hip/buttock area was also still painful, and was only minimally painful in the left trapezius and shoulder, right leg and left rib region. The right hand was no longer painful. He denied any new symptoms and continued to deny having neck or back pain. Examination of the left shoulder and palpation of the left trapezius revealed tenderness but Petitioner was non-tender over the remainder of the shoulder. He had full abduction, adduction, flexion, extension, internal rotation and external rotation. After review of the MRI of the left knee, the petitioner was to continue with his knee sleeves and using an Ace wrap. All of his areas appeared to be stable but he had alot of contusions. He was to continue with over-the-counter pain medications and work restrictions as previously outlined.

When the petitioner presented to Northwestern on February 1, 2011, the three areas that were most painful were the left shoulder, left knee, and left foot. The pain of the left foot was located in the plantar and sometimes the dorsal aspect of the distal foot, without radiation and walking worsened the pain. The pain in the left knee was located in the anterior portion of the knee and worsened with squatting and changing position from sitting to standing. He also noticed pain to the medial and

lateral aspects of the knee when he was twisting/pivoting, and he stated that he sometimes felt like something was "cutting" him in the knee, which occurred at rest and with motion of the knee; lasting only few seconds.

The petitioner subjective complaints were pain in the left shoulder, which had worsened in the last few days, which he attributed to doing repetitive motions with his arms/shoulders at work. He also reported having some pain in the left low back/left buttock area, which was less severe than the three above areas. He states that the left flank/rib, left distal leg/ankle, right hand, right knee, and right leg were all "better". The right knee was only mildly painful if palpated, and when going from squatting to standing. The left ankle was only occasionally painful when walking prolonged periods and only to the lateral portion, without radiation. He states he was working and following restrictions and tolerating this well.

The petitioner advised the treating physicians that he wanted to see his primary care physician for another opinion, which he was advised he could do so. At one point during the examination it was felt that he was experiencing the same symptoms has he was previously, but the physician pointed out that the petitioner had other times indicated he experienced improvement. It was noted that the petitioner's MRI and x-rays showed no acute finding in the left knee, he was obese, his examination was unremarkable, and he had multiple contusions/strains/sprains. It was also noted that he was expected to have a longer-term recovery due to the number of injuries and his body habitus, but they saw no current indication for additional testing/treatment. It was recommended he continue with conservative treatment observation including over-the-counter pain medications. The petitioner's current restrictions were continued and at the end of the visit, he thought he wanted to continue treating with Corporate Health; particularly with Dr. Munoz and his physician's assistant. A follow-up appointment was scheduled for the petitioner.

On February 11, 2011, the petitioner underwent an x-ray of the left foot and ankle. The complaint was persistent pain and an inversion injury to the ankle, with prolonged pain of the distal foot. The impression was soft tissue swelling between the second to fourth proximal phalanges. Osteoarthritis of the first metatarsal phalangeal joint was noted. An x-ray of the left ankle revealed soft tissue swelling of the distal tip of the fibula. The articular surfaces were smooth and regular; and the joint space was normal, as well as the adjacent bones. There was no fracture identified; and an anterior and posterior calcaneal spur formation could be seen. Findings were considered consistent with a lateral ligament injury.

On February 11, 2011, the petitioner also followed-up with Northwestern. The petitioner stated that he was "going in the right direction and it is getting better." He reported that on February 8, 2011 he took a step onto an uneven surface and inverted his left ankle and twisted the left knee. He stumbled but did not fall to the ground or sustain any other injuries during the incident. The incident seemed to aggravate his left ankle and left knee pain for a few days. In terms of pain severity, he ranked his

pain from most severe to least severe in the following order: plantar left foot, left knee, right knee, left shoulder/trapezius, and left ankle. Pains in the other areas seemed to be minimal or resolved. It was noted that the pain in the left low back/left buttock and the right hand had resolved. X-rays of the left foot and ankle were taken on this date. X-rays of the left foot revealed no fracture but some soft tissue swelling between the second to fourth proximal phalanges; and osteoarthritis of the first metatarsal phalangeal joint. X-rays of the left ankle revealed soft tissue swelling over the distal tip of the fibula. It was recommended that the petitioner see Dr. Reed for further evaluation. The diagnosis remained "multiple contusions status post fall, left knee pain, left ankle sprain, left shoulder/trapezius strain, and left foot pain". He was to continue working, with restrictions.

February 16, 2011, the petitioner was evaluated at Northwestern, by Dr. Kerrie Reed. The petitioner continued to complain of left knee and left foot pain. After physical examination, the petitioner the doctor recommended a rocker bottom shoe/boot for Petitioner's left lower extremity; that he perform recommended exercises and have other conservative treatment modalities. He was to continue working with restrictions as previously outlined.

On March 2, 2011, the petitioner followed-up at Northwestern. They reported him using a walking boot for one week and reported significant improvement in his foot pain, though he still rated it at 5/10 (down from an eight). Doctors further noted that Petitioner's left knee pain was improving but still present. Petitioner wanted an evaluation for his upper body symptoms as he was complaining of vague aching pain mostly around the left upper/mid back. He stated that the pain was unchanged since his fall though it was less severe. It was noticeable upon walking, minimal at midday and worsened by the end of the day. It was noted that the petitioner's lower extremity symptoms were much improved, particularly on examination versus subjective reporting. His upper body symptoms appeared to be due to myofascial pain. Conservative treatment measures were again recommended, including continued use the boot and then weaning off to regular shoe wear. He was to continue working with restrictions and conservative treatment measures.

On April 5, 2011, the petitioner followed-up with Northwestern, complaining of right knee pain, which he stated had been bothering him since the original fall and never completely resolved. He states that his right knee pain would be really, bad at times and did not know why. He denied injuring the right knee, which was reportedly related to the work accident. The doctor reviewed the prior notes and saw that the petitioner first mentioned right knee pain on January 10, 2011, which had begun a few days prior to that visit and was attributing to an altered gait from pain on his left side. An MRI of the right knee was recommended, under the circumstances.

On April 15, 2011, the petitioner underwent an MRI of the right knee at Northwestern Memorial Hospital. The impression was patellofemoral osteoarthritis, with full thickness cartilage loss involving the lateral patellar facet and median ridge. There was heterogeneity and irregularity of the

cartilage of the weight bearing surface of the lateral tibial plateau, with mild underlying marrow edema.

The petitioner followed-up with Northwestern on April 18, 2011. He noted he had recently undergone an MRI of the right knee, stating that his right knee felt the same as it did the previous visit, and he still had multiple other complaints including pain of the left knee, left foot, left hip, right knee and left shoulder. He denied any back pain on this visit, but stated that his back occasionally hurt alot. He attributed his increased pain on this date to recent weather changes. It was noted that he had not been wearing his walking boot lately because his left foot had been feeling good. The MRI was reviewed and interpreted as showing no acute findings. Because the petitioner still reported significant pain in several areas, without objective findings of an acute injury, four months after the accident, it was recommended he be evaluated by an orthopaedic specialist, for a second opinion. He was to continue with his home exercise program and continued working with restrictions.

The petitioner was able to return to work performing light duty from January 3, 2011 through April 18, 2011. He testified that during this time, he always had pain in his ankle, left hip, both of his knees, his left shoulder, and in his entire back on both sides.

On May 13, 2011, Dr. Scott Kale examined the petitioner, at the request of the respondent. The history Dr. Kale received from the petitioner was that he was climbing a ladder when he fell approximately six feet, injuring his left shoulder, left upper back, left knee, right knee and left foot. Dr. Kale noted the only significant complaint that kept the petitioner from returning to work in a full duty capacity, was related to the left knee. Physical examination revealed normal motion and cervical spine, moderate tenderness at the apex of the left shoulder in the area of the supraspinatus tendon, normal range of motion of the left shoulder, elbow, wrist and fingers. He could stand from the chair without using his hands, but only could squat fifty percent of normal with mild difficulty, and could not kneel because of pain. His right knee and both of his feet were normal. Examination of the left knee revealed no effusion, mild tenderness in the area of pes anserine bursa and reproducible pain by patellar apprehension test suggesting patellofemoral dysfunction. Dr. Kale suggested the petitioner had sustained injuries at work including myofascial results affecting his left shoulder, upper back, right knee, left foot, and left knee. His left knee, however, did demonstrate evidence of internal derangement, possibly in the form of chondromalacia. Dr. Kale recommended an evaluation by an orthopaedic surgeon with a view towards possible arthroscopic debridement. Dr. Kale opined that the petitioner could return to work, in a full duty capacity, following a definitive procedure to the left knee.

On June 1, 2011, the petitioner followed up-with Northwestern and at this visit, he stated he was not doing well; that he hurt everywhere. He reported pain in his left shoulder, left hip and groin area, left posterior rib region, left foot, left knee and back. Overall, he was experiencing the most pain in his left knee. He states that he told the rheumatologist about all of these pains. In this record, it states that his right knee, right anterior leg, left ankle/distal leg, and the right hand pain had resolved. In this

record it was noted that the petitioner's reports of pain were inconsistent and he reported pains today that he had previously never mentioned, or stated had resolved. He also seemed to be a poor historian, being able to recall when his low back pain started. The petitioner was advised that he was authorized to see an orthopaedic surgeon.

On June 6, 2011 the petitioner was evaluated by Dr. Stephen Gryzlo of the Northwestern Medical Faculty Foundation. He reported falling from a ladder and injuring multiple body parts, but primarily his left knee. The history of the petitioner's treatment and his symptoms was relayed and evaluated. Dr. Gryzlo reviewed the x-rays and the MRI of the left knee, which showed no obvious bony abnormalities, signal change at the medial meniscus but no obvious tear; trace effusion, cartilage loss to the patella and femoral trochlea, and mild marginal osteophytes at the joint lines. The impression was left knee persistent anterior pain following a fall, with no obvious evidence of internal derangement from meniscal or ligament standpoint. There were underlying degenerative changes at the patellofemoral joint that predated the fall, particularly osteoarthritis and cartilage loss. Dr. Gryzlo thought that the fall aggravated the pre-existing condition and that conservative treatment measures should be continued. Dr. Gryzlo did not think he was a surgical candidate but would not perform any more Cortisone injections. He was to perform physical therapy and continue with the same work restrictions.

The petitioner followed-up with Dr. Gryzlo on August 8, 2011 indicating he was slightly better with regards to his left knee. Dr. Gryzlo felt that the petitioner's left knee was improving, though he was not yet capable of returning to work using a ladder. He recommended continued work restrictions that Petitioner discontinue physical therapy, and follow-up in two months time for further evaluation.

The petitioner followed-up with Dr. Gryzlo on October 5, 2011. It was noted he was undergoing physical therapy and that the petitioner had been discharged ten weeks prior. He stated that he knew he could do a better job performing his home exercise program to keep his left leg strong. The petitioner was referred for a Functional Capacity Evaluation ("FCE"), which determined that he was able to perform at the medium physical demand level, but did not demonstrate the physical capabilities and tolerances to meet all of the essential physical demands of his job. His deficit included his inability to negotiate a ladder on a frequent basis. At an October 6, 2011 visit, Dr. Gryzlo noted the petitioner's deficits and stated he would agree with work hardening for two weeks, five days a week.

On October 24, 2011, a Work Conditioning Progress Report was issued by Accelerated Rehabilitation Centers. It states that the petitioner made improvements in various areas, and he was capable of returning to work at the medium physical demand level; he had improved in his ability to climb up and down ladders to a frequent basis. It indicated the petitioner could return to work in a position consistent with the physical capabilities and tolerances and outlined in the report.

On October 27, 2011, the petitioner followed-up with Dr. Gryzlo. At this visit, the petitioner was released to return to work with the only proviso being that he needed to follow the medium duty weight lifting recommendations He was to follow-up on an "as needed" basis.

The petitioner did return to work on October 27, 2011, following his release by Dr. Gryzlo. Petitioner testified that after returning to work, he noticed that he was always in pain while performing his work activities. This included pain in his left ankle, his knees, and sometimes he could not stand up. His left hip was hurting, as well as his left shoulder and both sides of his back. He further testified that while he was trying to do his job, he was in pain all day and taking medication. He ultimately decided to seek additional medical treatment.

On November 29, 2011, the petitioner presented to Elmhurst Memorial Clinic complaining of back pain. He stated that the onset of the back pain was three weeks prior and it occurred persistently. The location of pain was the lower back and the right flank, with no radiation. The petitioner stated that he was doing okay until four weeks ago when he was assigned to work on ladders and then he experienced a gradual onset of low back pain. The assessment was low back pain and the petitioner was to continue with medications, working and doing his home exercise program.

On March 14, 2012, Dr. Ronald Silver evaluated the petitioner for the left knee and he noted that the petitioner injured his left knee as well as multiple other body parts including but not limited to his left shoulder and back, when he fell from a ladder. The petitioner indicated he had persistent pain, swelling, crunching and giving way of the left knee. Prior to the accident, his knee was normal without any treatment or symptoms.

Examination revealed patellofemoral crepitation and mild effusion. There was medial joint line tenderness and a questionable click on McMurray's test. His x-rays were within normal limits. His MRI demonstrated damage to the articular cartilage on the lateral tibial plateau as well as damage to the patellofemoral reticular cartilage. There was also some degenerative changes noted at the patellofemoral joint. Dr. Silver's impression was that the petitioner had suffered damage to the cartilage in his left knee as well as exacerbated and accelerated pre-existing, asymptomatic, degenerative changes in the patellofemoral compartment of the left knee. The damage to the cartilage as well as the exacerbation and acceleration of pre-existing, asymptomatic, degenerative changes resulted in the aforementioned symptoms. Dr. Silver recommended arthroscopic surgery due to the persistence symptoms. Dr. Silver also noted the petitioner was having right knee pain due to overcompensation, and hoped this would resolve once the left knee complaints had been resolved. Dr. Haskell also evaluated Petitioner with regards to his left hip and back. In addition, both doctors examined Petitioner left shoulder, which seemed to demonstrate residuals of a rotator cuff strain, though they would not intervene at this time. The petitioner was released to return to work with restrictions of no climbing/ladders, no crawling, no kneeling, and no squatting.

The petitioner testified that he attempted to return to work with restrictions on March 19, 2012, but the respondent did not accommodate the restrictions and that he was laid off. Under further questioning, the petitioner admitted that the respondent did not lay him off, but that simply he was placed on workers' compensation.

On April 8, 2012, Dr. Steven Levin evaluated the petitioner, at the respondent's request. Dr. Levin reviewed the medical records that were provided to him, including the records of Drs. Gryzlo and Silver. The petitioner complained of pain and grinding in the left knee, locking, catching, popping, pain when he walks up and down stairs. He also noted that his right knee was starting to bother him for compensatory reasons, placing more weight on the right knee. Dr. Levin noted the petitioner had a pre-existing degeneration in his left knee, which was asymptomatic. After the fall, he developed symptoms and based on the MRI findings described above, they were not a result of the fall but were exacerbated by the fall. Dr. Levin thought it was impossible to tell for certain whether the fall caused any significant cartilage damage, but Dr. Levin also noted that the petitioner had mechanical symptoms consistent with a positive McMurray's and possible subtle meniscal tear. Dr. Levin thought the petitioner was a candidate for surgery to his left knee, as he had developed mechanical symptoms.

On April 27, 2012, the petitioner underwent arthroscopic partial medial meniscectomy, abrasion arthroplasty, and removal of loose bodies by Dr. Silver. The postoperative diagnoses were torn medial meniscus, loose bodies, and articular cartilage fragmentation, patellofemoral compartment.

On May 4, 2012, the petitioner followed-up with Dr. Silver one-week post arthroscopic surgery. At this visit, Dr. Silver noted the petitioner had been over compensating with regards to his right leg since his left knee injury. The pain in the right knee had worsened over time to the point where he was now having difficulty walking due to the pain in the right knee. Dr. Silver was concerned about cartilage damage to the right knee, due to over compensation and recommended an MRI scan of the right knee. He was to begin therapy for his left knee and remain temporarily disabled. In addition, his left shoulder continued to trouble him but they concentrated on his right knee.

The petitioner followed-up with Dr. Silver on May 31, 2012. Dr. Silver indicated they are awaiting approval of a right knee MRI. It was noted the petitioner was making progress with his left knee following arthroscopic surgery. With regards to his left shoulder, the petitioner continued to have pain in the region of the trapezius, posteriorly. He recommended a course of physical therapy for the left shoulder and continued therapy for the left knee. Petitioner was released to return to work in a sedentary capacity.

On July 6, 2012, the petitioner underwent an MRI of the right knee at Advanced Medical Imaging. The impression was low-grade chondromalacia of the patella involving the lateral patellar facet. There was a minimal, intrameniscal signal on the posterior horn of the medial meniscus. Otherwise, it was a negative examination of the right knee.

The petitioner followed-up with Dr. Silver on July 12, 2012, who stated the MRI of the right knee demonstrated damage to the articular cartilage of the patella due to overcompensation for his left knee condition. Dr. Silver stated the right knee began to hurt due to overcompensation approximately two to three weeks after his left knee work injury. Petitioner was to be re-evaluated in two to three weeks and could require arthroscopic surgery of the right knee.

Dr. Silver saw the petitioner on July 31, 2012 and indicated he was making progress with his left knee, but his right knee had deteriorated due to overcompensation. Dr. Silver stated that he was temporarily disabled and was to continue physical therapy.

On August 1, 2012, the petitioner returned to Dr. Steven Levin for another examination, at the request of the respondent. At this examination, Dr. Levin was examining the petitioner's left shoulder and right knee. Dr. Levin noted that the petitioner did have left knee surgery performed by Dr. Silver; the petitioner stated that he had some improvement after that surgery. The petitioner related that he developed right knee pain a few weeks after the injury because he was concentrating on multiple other body parts at a time. The petitioner also indicated he was complaining of left shoulder pain, though Dr. Levin noted that Dr. Gryzlo's report from June 11, 2011, stated those injuries had resolved.

Dr. Levin noted the petitioner was complaining of vague left shoulder pain and that he had mild pain with overhead activity. He denied neck pain, radicular pain, numbness, and tingling. He did have spasms of the trapezius muscles and occasional pain at night and pain with reaching. Regarding the right knee, he was complaining of mild pain in the right knee, especially when walking stairs. He denied any locking, catching, giving way or swelling. He denied any prior problems with the right knee and stated that the onset of pain occurred a little time after the accident, and became noticeable within three weeks thereafter.

After physical examination of both the right knee and left shoulder, Dr. Levin felt the petitioner's right knee did not require surgery. He had a benign physical examination with mild patellofemoral syndrome. Dr. Levin could not tell if this was due to the injury, as he stated it would be very difficult to discern if the petitioner had some underlying pre-existing condition, which could have been slightly aggravated due to some compensatory mechanism. He further stated that this condition could typically be worked out with physical therapy. Dr. Levin also noted that the petitioner had, at the most, very mild impingement syndrome of the left shoulder, which would be difficult to relate to the accident. It was possible he could have traumatized the left shoulder, though the symptoms would have been much more prominent at the time of the accident versus almost two years later. Dr. Levin thought that the petitioner's left shoulder condition also could be resolved with physical therapy. Dr. Levin also thought it would be beneficial for the petitioner to undergo a FCE to determine his work abilities.

On August 20, 2012, Dr. Saul Haskell evaluated the petitioner, who was complaining of pain in the left hip along the lateral side. The petitioner stated that he fell off a ladder, falling approximately eight to ten feet. The petitioner stated that prior to this fall, he did not have any knee pain or back symptoms except for mild back pain now and then, but never had formal treatment for back problems. The petitioner stated that at the time of his fall, he had contusions to the left ribs, left hip and back area, with pain radiating to the right lower back. The petitioner reported having an x-ray of the lumbar and thoracic spine, which revealed a possible compression or fracture of T12, osteophytes in the L4-5 and L5-S1 levels, with degenerative disc disease of the L5-S1 level. Dr. Haskell recommended physical therapy for the low back compression of T12.

On August 23, 2012, the petitioner underwent an FCE at ATI Physical Therapy, which was deemed valid and placed the petitioner at the light to medium physical demand level; with occasional lifting up to forty-three pounds from desk to chair, thirty-six pounds above the shoulder, and thirty-two pounds from chair to floor. The therapist stated that the petitioner's job duties were considered at the heavy physical demand level, but he did not have the job specific description for the petitioner. The therapist indicated the petitioner could benefit from participation in a work conditioning or work hardening program.

On August 27, 2012, a Physical Therapy Progress Note issued from ATI states that the petitioner had received forty-five physical therapy sessions and had recently completed a FCE. It was recommended that the petitioner begin a work conditioning program in the near future, when he returns from vacation.

The petitioner followed-up with Dr. Silver on August 28, 2012. Dr Silver again recommended the petitioner undergo a work conditioning program for six weeks, followed by a new FCE, after which time, he would have reached maximum medical improvement ("MMI") with respect to his left knee. Dr. Silver was awaiting approval for arthroscopic surgery to the right knee, which he said demonstrated damage to the articular cartilage in the patella. Dr. Silver opined that Petitioner was unable to work at this time due to the right knee condition.

The petitioner followed-up with Dr. Silver on September 19, 2012, who stated the petitioner still required arthroscopic surgery to the right knee. A work conditioning program was recommended for the next six weeks. Dr. Silver noted that the MRI demonstrated cartilage damage of the patella of the right knee, which was his basis for recommending surgery. The petitioner was to remain off work.

On October 18, 2012, the petitioner followed-up with Dr. Silver. He was in the middle of his work conditioning program, and his right knee pain worsened during the program. He was also experiencing pain in his left knee and left shoulder, left ankle and right elbow during the program, as well as his lower back. He was to continue with work conditioning and remain off work.

A work conditioning progress report prepared on October 31, 2012, by ATI, states that the petitioner had achieved and remains at the medium physical demand level from a functional standpoint. He was capable of doing a chair to floor lift up to fifty pounds and carrying sixty pounds for one hundred consecutive feet. He continued to report bilateral knee pain, left shoulder pain, back and left side pain all with functional activities. He reported that the pain had not increased day to day. He stated that the petitioner was employed as a maintenance engineer for the respondent, which job was considered at the medium physical demand level, according to the provided job description. The petitioner's current capabilities met this level, and the therapist recommended the petitioner be discharged from work-hardening for purposes of returning to work pending doctor's recommendations.

The petitioner followed-up with Dr. Silver on November 15, 2012 who noted that the petitioner completed his work conditioning program and was not able to return to work as a maintenance man, despite the fact that the therapist indicated the petitioner was in fact able to return to such work. In addition, Dr. Silver was awaiting approval for arthroscopic surgery of the right knee. The petitioner was at the maximum medical improvement for his left knee at the light functional level and required further physical therapy for his right knee pending approval of the arthroscopic surgery.

On November 27, 2012, the petitioner returned to Dr. Levin for an IME, at the request of the respondent. At this evaluation, the petitioner was complaining of right knee discomfort. He denied any recent trauma, locking, catching, giving way or buckling. Regarding the left knee, he stated that he would occasionally get popping, but overall, it was much better. In a response to the medical records generated by Dr. Silver, Dr. Levin pointed out that there was no objective evidence, on physical examination or findings on the MRI. That indicated the petitioner needed surgery on his right knee. The MRI did show low-grade chondromalacia, which he noted in his August 1, 2012 IME report.

Dr. Levin also reviewed surveillance footage of the petitioner doing extensive yard work, pulling weeds, lifting garbage cans, stooping, and bending, without favoring either knee, for sixteen minutes. His physical examination, on that date, was unchanged from his prior IME, with respect to Petitioner's left shoulder. Petitioner denied any neck pain, radicular pain, numbness and tingling. He did complain of having mild pain with overhead activity and at night. Concerning the left ankle, the petitioner stated that he might have contused it. He was not certain, and he had vague complaints of pain anteromedially, no pain laterally. He denied any need to limp or use assistance while ambulating. He denied having right elbow pain and denied any intrinsic back pain. He also denied any radicular, lower extremity pain or problems. He did have some mild soreness in the area on the back of the left ankle, which he said was better than when he first hit it, but overall, it was occasionally sore.

Dr. Levin stated that the findings on the MRI of the right knee would be difficult to relate to the work accident. They were very subtle findings, and chondromalacia is a pathological diagnosis and at most,

the petitioner had some mild thinning of the cartilage, which was equal to or appropriate for his age group. The examination of the right knee did not show any obvious objective findings that would suggest a surgical procedure would be of benefit. Dr. Levin recommended finishing work conditioning and obtaining a FCE, to determine Petitioner's work activity level. None of Petitioner's body complaints were evidenced by objective findings on physical examination and the doctor opined that the petitioner could do the work duties listed on the job analysis.

On November 30, 2012, PRIUM generated a utilization review ("UR"), regarding the petitioner's proposed right knee surgery. This review addressed additional right knee physical therapy for four weeks and the right knee arthroscopy. The requested treatment was modified to additional physical therapy for two weeks. The UR report did not certify the surgery and in the judgment of the reviewing physician, the clinical evidence did not establish medical necessity for arthroscopic surgery to the right knee, based upon the official disability guidelines.

The petitioner followed-up with Dr. Haskell on December 3, 2012 for treatment referable to his low back pain. Dr. Haskell noted that in August of 2012, he had recommended authorization for an MRI of the lumbar spine as well as physical therapy, which was not provided. Dr. Haskell recommended an MRI of the lumbar spine and an MRI of the left ankle. He also recommended an MRI of the left shoulder, as examination was said to reveal a first degree AC separation. It should be noted that Dr. Haskell's treatment record from this date does not state he is recommending MRIs of the ankle and the shoulder, but only an MRI of the lumbar spine.

On December 13, 2012, the petitioner followed-up with Dr. Silver, who was still awaiting authorization for surgery to the right knee. The petitioner's left shoulder was also bothering him and he was diagnosed with a rotator cuff strain from the work accident. The doctor recommended physical therapy and various medications for this condition. He also continued physical therapy for Petitioner's right knee, as he had quadriceps atrophy and lack of full flexion.

On December 31, 2012, Dr. Haskell evaluated the petitioner for low back pain. This note states that the petitioner had fallen approximately eight feet from a ladder, landing on the ground. Examination of the petitioner revealed mild acute distress, with pain. The petitioner was prescribed pain medication and restriction of motion of the left shoulder. Motion of both knees was normal with no instability, but motion of the left knee did produce pain and mild crepitation. Low back range of motion was markedly restricted. The petitioner was to continue with a home exercise program and medications and remain off work.

On January 15, 2013, the petitioner underwent an MRI of the lumbar spine at 3T Imaging of Morton Grove. The radiologist's impression was moderate, broad-based disc protrusion at L5-S1 with superimposed slightly left paracentral disc extrusion, as well as a superimposed right, foraminal disc extrusion. These abnormalities caused mild to moderate spinal stenosis as well as severe narrowing of

the right neuroforamen and depression on the right L5 nerve root. Mild peripheral enhancement of an extruded disc was identified. Also noted was moderately severe, facet arthrosis, hypertrophy at the L5-S1 level; and mild disc space narrowing and disc degeneration at the L4-5 and L5- S1 levels.

The petitioner followed-up with Dr. Haskell on January 17, 2013. It was noted that the MRI was performed which, in his opinion, showed disc degeneration at the T12-L1 and L3-4 disc levels. There was also mild facet arthrosis at the L2-3 level. The L4-5 level revealed a small diffuse disc bulge with mild to moderate facet arthrosis. At the L5-S1 level there was disc space narrowing and disc degeneration along with a moderate, broad-based disc protrusion. The extruded fragment measured eight millimeters by six millimeters causing mild to moderate spinal stenosis with compression of the thecal sac. There was also right-sided foraminal disc extrusion resulting in severe compromise of the right neuroforamen.

Dr. Haskell did not have the previous studies to compare with this MRI, to determine when these problems started. According to the petitioner's history, he did not have any evidence of back pain prior to the subject injury. The doctor opined that the petitioner needed more treatment for this condition and the pain he was undergoing was far more likely to be caused by the extruded disc fragment rather than minor arthritic changes. He also opined that the petitioner should continue formal physical therapy and medications. There was a possibility of an epidural steroid injection, if conservative treatment failed and at the present time, there was no indication of surgery for the low back, but it remained a possibility.

Petitioner followed-up with Dr. Silver on January 22, 2013 and he again indicated the need for right knee surgery and kept Petitioner off work.

On January 28, 2013, the petitioner followed-up with Dr. Haskell, continuing to complain of pain in the left shoulder, worse with any activities or lifting. Previous x-rays revealed an acromioclavicular joint separation as evidenced by elevation on the outer end of the clavicle. He also had pain in the low back, radiating to the left hip, which corresponded with the results of the lumbar MRI taken in January 2013. Dr. Haskell again recommended physical therapy for the back injury as well as the left shoulder, low back, and left hip and opined that the petitioner was unable to work at that time.

On February 13, 2013, Dr. Edward Goldberg, at Midwest Orthopaedics at Rush, evaluated the petitioner for an IME, at the request of the respondent. The petitioner stated that he fell ten feet off a ladder on the date of accident and injured his left knee, left ankle, left shoulder, and left lower thoracic spine. He did not report injury or complain of low back pain. He stated he continued to have some mid-thoracic pain, left greater than right. He denied any radicular pain, paresthesias, motor loss, or bowel or bladder dysfunction. He stated he had not had any prior treatment for his lumbar spine and had been under the care of Dr. Haskell. Dr. Goldberg reviewed the medical records from various providers including Dr. Kale. He also reviewed the MRI of the lumbar spine from January 15, 2012,

which showed a central disc herniation at L5-S1. The diagnosis was that the petitioner had a disc herniation of L5-S1, based on the imaging studies. He had no radicular complaints. In addition, the records and the petitioner's subjective complaints of back pain were in the left thoracic spine, which did not correlate with the MRI findings of a disc herniation at L5-S1. Dr. Goldberg opined, with regards to the lumbar spine, the petitioner could return to work without restrictions. Dr. Goldberg also opined that the petitioner did not injure his lumbar spine in the work accident.

The petitioner followed-up with Dr. Haskell on February 21, 2013, complaining of pain in the cervical, thoracic, and lumbar spine, the left shoulder, left hip, and bilateral left flank areas. Physical examination revealed the petitioner walked slowly and deliberately and appeared to be in acute pain. The petitioner had difficulty and pain getting up and down from a chair as well as the examining table. Range of motion of the cervical and lumbar spine was very reduced and accompanied with pain. The petitioner had pain with motion of both knees and the left shoulder. Initially, the petitioner was noted to have weak reflexes and pain with any testing of muscular strength, with decreased muscular strength, on examination.

On February 25, 2013, the petitioner followed-up with Dr. Haskell and the IME with Dr. Goldberg was noted. The petitioner continued to complain of low back pain radiating into his left hip. Based on the recent IME, the petitioner was allowed to return to work, full duty, on a trial basis, effective February 27, 2013.

The petitioner saw Dr. Silver on February 26, 2013, where it was noted he was still awaiting approval for arthroscopic surgery of the right knee. Dr. Silver states the petitioner will have permanent disability lacking arthroscopic surgery. He also states that, because of financial stress, the petitioner was permitted to return to work, full duty, effective February 27, 2013.

The petitioner did testify he attempted to return to work on March 1, 2013. He testified that he performed a full day's work on that date. He was assigned the task of replacing a heating pump seal. This involved dismantling the pump and motor, replacing the seal; then putting it back together. He testified that he was in a bent or kneeling position for probably two hours to take it apart. He then took the part back to the workshop, staying another two hours to remove the seal, replace it, clean it, and then another two hours to put it back in and align it. He was wearing kneepads, a back brace, and safety glasses during this process. Following his return to work, he noticed that he was in alot of pain. He returned to work on March 4, 2014, but concluded that he could not continue to work because he was in so much pain. The petitioner was to return to Dr. Silver on March 4, 2013, at which time, he was taken off work.

On March 25, 2013, the petitioner returned to Dr. Haskell and it was noted that he had returned to work on a trial basis and lasted one day. Petitioner stated that he had a severe recurrence of back pain and pain in other areas. The petitioner continued to have pain in the left hip and left ankle, which he

states all started at the time of the original injury. Examination of the left hip revealed definite loss of internal rotations as compared to the right hip. The pain was constant and worse with weight bearing. X-rays revealed some narrowing of the joint space in the lateral, acetabulum and a bone spur in the same area. Regarding the left ankle, Petitioner continued to complain of pain along the general lateral aspect of the ankle, although his range of motion was good and the ankle was stable. Dr. Haskell recommended MRIs of these areas for further evaluation. The petitioner was to remain off work pending MRIs of the left hip and ankle.

On April 8, 2013, Dr. Goldberg prepared an IME addendum report. He had reviewed a record from Dr. Haskell of February 25, 2013, which the petitioner reported lumbar pain toward the left buttock, with no radicular complaints. Dr. Goldberg opined that if the petitioner had been complaining of lumbar complaints after the prior evaluation, it would be reasonable to have physical therapy, however, he did not think that the petitioner's lumbar condition was related to the work accident.

On April 11, 2013, the petitioner followed-up with Dr. Silver indicating he had tried to return to work but experienced severe pain in his knees, low back, as well as upper back and had to go off work. The petitioner was still being seen pending authorization of the right knee surgery and was to remain off work.

The petitioner saw Dr. Haskell on April 22, 2013 and the note states that he tried to work one day in a full duty capacity, but experienced severely increased pain in his knees, back, and shoulder. Examination revealed the petitioner standing and walking with some discomfort. His gait was very slow and deliberate, but without a definite limp. Range of motion of the lumbar spine was markedly decreased and accompanied with pain in the low back. Dr. Haskell again recommended physical therapy for the lumbar spine. The petitioner was to remain off work at this time.

On June 13, 2013, the petitioner underwent an MRI of the left shoulder. The impression was supraspinatus tendinopathy with no evidence of partial or full thickness tears. There was mild to moderate hypertrophic degenerative changes in the AC joint, causing mild mass effect on the supraspinatus muscular junction. There was joint capsule thickening in the auxiliary recess, consistent with adhesive capsulitis for which clinical correlation was recommended.

On June 14, 2013, an MRI of the left hip was performed. The impression was moderate degenerative changes of the left hip including joint space narrowing and multiple small subchondral cysts in the superior and posterior aspect of the acetabulum. There were questionable findings, possibly representing a labral tear, which could be further evaluated by an MR arthrogram. There was gluteus minimum tendinopathy and a mild strain and mild gluteus medius tendinopathy.

An MRI of the left ankle joint was also performed on June 14, 2013 at 3T Imaging of Morton Grove. The impression was plantar fasciitis and plantar calcaneal spurring.

The petitioner followed-up with Dr. Silver on June 18, 2013, who stated that the left shoulder demonstrated inflammation of the rotator cuff and subacromial bursa, with rotator cuff impingement. The petitioner was given an injection of Cortisone into his left shoulder on this date and they planned a course of physical therapy. He was to remain off work.

The petitioner saw Dr. Haskell on June 24, 2013, who opined that the MRI of the left hip revealed some degenerative osteoarthritis and no evidence of previous fracture. Dr. Haskell thought that the petitioner possibly experienced an aggravation or acceleration of arthritis in the left hip. MRI of the left foot and ankle revealed plantar fasciitis, which in his opinion, could be caused or aggravated by trauma, and there was no way to determine from the MRI itself, an underlying cause. Dr. Haskell recommended physical therapy for both of these conditions, as well as a home exercise program and medications. He opined that the conditions, as they were, were said to be permanent and most likely would progress slowly with time.

On July 23, 2013, the petitioner followed-up with Dr. Silver. It was noted he had received temporary relief from the recent Cortisone injection of the left shoulder, which was indicative of rotator cuff impingement. He opined that petitioner would require arthroscopic surgery of the left shoulder. They were also waiting approval of the arthroscopic surgery of the right knee and in his opinion, the petitioner remained temporarily disabled.

On July 31, 2013, Dr. Steven Levin evaluated the petitioner, at the request of the respondent. Dr. Levin noted his prior IME reports as well as the medical records he reviewed from Drs. Haskell and Silver. He also noted there was a physical examination of the petitioner, which showed he lacked about ten degrees of forward flexion, ten degrees of abduction, about twelve of external rotation and ten of internal rotation. He had mildly positive NEER and Hawkins' impingement signs. These were all of the left shoulder. Regarding the foot, there was some mild anterolateral tenderness in the area of the anterior talofibular ligament. He was non-tender over the calcaneal fibular ligament. He lacked about three degrees of terminal dorsiflexion and he had full plantar flexion. Regarding the left hip, he had full flexion, lacked about five degrees of terminal extension, five degrees of terminal external rotation, and terminal internal rotation.

Dr. Levin felt that the petitioner did not suffer a significant work-related injury to his shoulder, in part based upon his IME examination of November 27, 2012, when he had a full, painless range of motion, very mild positive NEER and Hawkins' impingement signs, but otherwise negative test results. Dr. Levin did not think the petitioner required surgery to the left shoulder. For the left ankle, Dr. Levin noted that the petitioner's MRI showed calcaneal spurs and plantar fasciitis, which are not directly related to the accident, as they are more overuse findings. He thought these conditions could respond to a course of physical therapy and medication. Concerning the left hip, he noted that any arthritic changes noted were not acute or related to the work accident, but were pre-existing in nature. Dr. Levin noted that the accident could have temporarily exacerbated underlying arthritis in the hip,

could have caused some pain in the knee, and could have involved some mild traumatic impingement on the left side however, those conditions should have resolved by this point and the MRI findings suggested that Petitioner had no definitive pathology in the shoulder. Dr. Levin again recommended an FCE be used to determine the petitioner's ability to return to work.

An August 14, 2013, PRIUM prepared a utilization review ("UR") report regarding the petitioner's left shoulder surgery. The UR report recommended denial of left shoulder surgery. The report details the indications for impingement syndrome surgery under the official disability guidelines and finds that the petitioner's condition did not meet the criteria for surgery.

The petitioner followed-up with Dr. Haskell on August 23, 2013 and it was noted the petitioner had recently undergone an IME with Dr. Levin, who had recommended a FCE. Dr. Haskell agreed with this decision, as it sounded like a reasonable conclusion and recommendation. Dr. Haskell also prepared an addendum of the same date, which detailed the petitioner's symptoms and the history of his condition, following his accident. Emphasis was placed on the fact that the petitioner had minimal treatment to his low back prior to the accident. In the interim, the petitioner was to remain off work.

On August 29, 2013, the petitioner followed-up with Dr. Silver, who stated that the petitioner did not have a normal examination of the left shoulder. Dr. Silver also took issue with some of the findings of the recent IME stating that it ignored the fact that the MRI demonstrated inflammation of the supraspinatus tendon/rotator cuff, as well as findings consistent with frozen shoulder. He reiterated that the petitioner did require arthroscopic surgery to the left shoulder and his right knee. He was not ready for a FCE and had not reached maximum medical improvement ("MMI"). The petitioner was to remain off work.

The petitioner followed-up with Dr. Haskell on September 25, 2013 and upon physical examination, the petitioner had difficulty getting up from the chair onto the examining table. He reported difficulty at home getting up from a chair, getting in and out of bed, or getting in and out of a car. He complained of pain in the entire spine; cervical, thoracic and lumbar. The range of motion in the cervical and lumbar spine was markedly restricted with pain and the petitioner exhibited veracious sounds during examination and moving of the spine. The petitioner was to continue a home exercise program, though any movement caused him pain. He was to remain off work at this time.

On December 10, 2013, Dr. Jeffrey Coe examined the petitioner, at the request of his attorney. Dr. Coe's report is primarily a summary of the medical records provided to him. Petitioner's current complaints included left shoulder pain, upper and lower back pain with stiffness, occasional pain radiating to the left hip region, pain and stiffness in both knees and pain in his left ankle. He also complained of left knee post-operative scarring.

In Dr. Coe's opinion, the petitioner suffered sprain and strain injuries from his fall at work. The injuries caused an aggravation of degenerative disc disease and degenerative arthritis of the lumbar spine with a lumbar disc herniation at the L5-S1 level; chest, scapular and shoulder region myofascial pain, internal derangement of the left shoulder and left knee with cartilage damage; and medial meniscal tearing. Dr. Coe states that recovery from the left knee surgery was associated with a strain of the right knee, left foot and ankle, in physical therapies and work hardening with "overcompensation from ongoing left knee symptoms." Dr. Coe felt that the petitioner injured his left shoulder, low back, left knee, right knee, and left ankle, because of his work accident, causing his current symptoms and state of impairment. He stated that the petitioner needed medical treatment, including the right knee and left shoulder surgeries discussed by Dr. Silver and additional medical therapy recommended by Dr. Haskell. Dr. Coe also outlined restrictions including restrictive use of both arms to below shoulder height, limitation of repetitive lifting, bending, pushing or pulling with weight lifting restrictions at the light physical demand level, limitation of kneeling, squatting, and working at heights; and repetitive stair climbing or descending.

The petitioner continued to follow-up with both Drs. Haskell and Silver from the end of 2013 until the date of trial. Both examination findings and treatment recommendations remain unchanged, and the petitioner has been kept off work the entire time.

The petitioner testified that he is still in alot of pain because of his back, both knees, his left shoulder, and left ankle. He testified to having significant difficulty performing activities of daily living, and he tries to take it easy. He limits himself to the activities he performs around the house, as he cannot exert himself as he used to. Whenever he does, he cannot do it for a long period. The petitioner rates his pain at a minimum of six out of ten for his body parts, particularly his back. He noted that the pain in his left knee has never gone away since the date of accident, despite the surgery by Dr. Silver. The significant amount of pain in his entire back, his left ankle, his left hip, his left shoulder, and both of his knees has been constant, since the date of accident. He testified that he was previously prescribed knee sleeves, and that he would use them if he were going to do some physical activity, particularly if he required bending or squatting. He would also wear his ankle brace, if he were going to be active.

Concerning his return to work on March 1, 2013, the petitioner testified that he thought he had to lift at least fifty pounds while performing the job of replacing the pump seal. He noted that the pump part weighed at least fifty pounds, and possibly more.

Respondent's first witness, Keith Barr

The respondent called Keith Barr as a witness. Mr. Barr is a chief maintenance engineer for the respondent, having worked in that position for four years. He previously worked as a shift engineer performing the duties of a maintenance engineer, similar to those duties of petitioner. As chief engineer, he is responsible for over sixteen buildings, the central utility plant, the central chiller plant,

twenty-six engineers, six operators and other issues. His job duties included supervision of the maintenance engineers, including the petitioner.

Mr. Barr testified that he was familiar with the job duties the petitioner would have to perform in the full capacity of his job. Mr. Barr was also familiar with the job the petitioner was assigned to perform on March 1, 2013, i.e., the replacement of the pump seal. Mr. Barr generally described the process of how to replace the pump seal in his testimony. In order the replace the seal, two parts would have to be removed. The first would be the pump guard, which weighed approximately one pound. The second would be the bearing assembly, which is the part that contains the seal. Mr. Barr estimated that the bearing assembly, which the petitioner would be required to lift, weighed approximately fifteen pounds, in his estimation. Mr. Barr also thought that it would take approximately four to five hours to complete the task of replacing a pump seal similar to the one the petitioner worked on.

Finally, Mr. Barr testified that the petitioner would have been able to sit on a bucket and perform the work of replacing a pump seal, as opposed to having to bend over or kneel. Mr. Barr confirmed that the petitioner did not attempt a full duty return to work following Monday, March 4, 2013, as he stated that he was in too much pain. On cross-examination, Mr. Barr testified that it would take four to five hours for a healthy person to complete the task of replacing a pump seal.

Respondent's second and third witnesses, Lewis Stonehouse and Joseph Concepcion
Surveillance reports and videos covering several dates, but focusing on September 22, 2012, May 14, 2014, and May 31, 2014, were also produced. Lewis Stonehouse was called as a witness to testify regarding the surveillance taken on September 22, 2012 and May 14, 2013. Joseph Concepcion was also called as a witness and the investigator regarding the surveillance performed on May 31, 2014.

With respect to the surveillance performed on September 22, 2012, the Arbitrator has read the investigator's report and reviewed the surveillance footage. Of note, on September 22, 2011 at approximately 11:16 a.m. Mr. Stonehouse performed a spot check on the petitioner and observed that his garage door was open. After observing the front of the house for some time, Mr. Stonehouse proceeded to the rear of the house, where the petitioner was observed performing what was described as yard work. The surveillance footage shows the petitioner cutting shrubs and pulling weeds. While performing this activity, the petitioner bent over and squatted for extended periods. This activity continued until approximately 12:06 p.m., at which time the petitioner moved the side of the house.

Mr. Stonehouse also testified to the surveillance he conducted on May 14, 2013. At approximately 11:58 a.m., the video surveillance was started which showed the petitioner cleaning a vehicle. During the process of cleaning the vehicle, the petitioner would alternatively sit in a chair, or stand up and bend over to clean the wheels. While performing much of this work, the petitioner was required to bend at the waist at approximately ninety degrees. In viewing the footage, the petitioner did not

appear to have any difficulty performing these activities. He did not appear to be wearing knee sleeves or an ankle brace.

Mr. Concepcion testified as to the surveillance he conducted on the petitioner on May 31, 2014. However, this witness also testified that although he prepared a report relative to the video surveillance of the petitioner, he had actually used a CRD disc to record Petitioner's activities and that someone, (he did not know who) had prepared the DVD and that it was not the original recording. All parties watched the DVD during the hearing.

CONCLUSIONS OF LAW

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In

addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See generally, *Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

The Arbitrator adopts the above findings of fact in rendering the conclusions of law contained in this section. Based on the foregoing evidence, the Arbitrator finds that the petitioner's current conditions of ill-being, in regards to the petitioner's left hip, ankle and shoulder, right knee and his entire back, are not causally related to his work accident on December 23, 2010 for the reasons outlined below. The Arbitrator further finds the petitioner's condition in his left knee is causally related to the petitioner's work accident.

The emergency room records do show that the petitioner complained of pain to various body parts after falling four feet off a ladder. The follow-up medical records immediately after the accident in January of 2011 also document left-sided body parts, including the left knee, left posterior thoracic/rib region, left hip, left shoulder and left ankle. The Arbitrator notes that on January 10, 2011, the petitioner denied having neck or low back pain. By the time the petitioner was examined by Dr. Kale on May 13, 2011, the only complaint that was preventing him from returning to full duty work was his left knee. As such, Dr. Kale focused on the petitioner's left knee and did recommend further treatment.

The petitioner was seen on June 1, 2011 and reported pain in his left shoulder, left hip and groin area, left posterior rib region, left foot, left knee and back, with most of the pain in his left knee. He stated that the pain in the right knee, right anterior leg, left ankle and the right hand had all resolved. The record notes the petitioner's reports of pain were inconsistent and that he seemed to be a poor historian, being unable to recall when his low back pain started. The Arbitrator notes that the petitioner's description of his accident went from falling from a height of four feet (emergency room records) to a height of ten feet (Dr. Goldberg's IME report). Dr. Gryzlo's treatment records reveal treatment focusing on the petitioner's left knee, and failed to document complaints of pain to the other recited body parts. Dr. Gryzlo eventually returned the petitioner to work, full duty, with the exception of some restrictions regarding amounts of weight to be lifted. He was to follow-up on an "as needed" basis.

Dr. Steven Levin examined the petitioner four times, April 8, 2012, August 1, 2012, November 27, 2012, and July 31, 2013. Dr. Levin's April 8, 2012 examination revealed complaints of pain in the left and right knees. Dr. Levin thought the petitioner may have suffered a meniscal tear in his left knee, and recommended surgery. When the petitioner returned to Dr. Levin on August 1, 2012 for a repeat examination, Dr. Levin focused on the left shoulder and the right knee. After physical examination of the right knee, Dr. Levin felt the petitioner did not need surgery for the right knee. Dr. Levin noted the petitioner had a pre-existing condition in the right knee, and he could not determine whether this condition was truly aggravated considering the lack of objective findings upon examination. With regards to the left shoulder, the petitioner had impingement syndrome, which would also be difficult to relate to the accident. Dr. Levin thought that the symptoms of the left shoulder would be more prominent after the injury, as opposed to two years later. Dr. Levin thought that short courses of physical therapy would be appropriate for both the left shoulder and the right knee, regardless of causal relationship.

Dr. Levin again saw the petitioner at the respondent's request on November 27, 2012, focusing on right knee and left shoulder complaints. Dr. Levin reiterated his opinion that the MRI of the right knee showed a pre-existing condition, in the form of low-grade chondromalacia. Dr. Levin reiterated that the MRI findings of the right knee would be difficult to relate to the work accident, as the chondromalacia was a pathological diagnosis and at most, the petitioner had some mild thinning of the cartilage, which was appropriate for his age group. The examination of the right knee did not show any obvious objective findings that would suggest a surgical procedure would be of benefit. All of the other multiple body parts, which the petitioner complained of, did not show any obvious objective findings on physical examination, that would preclude him from doing his regular work duties. Dr. Levin recommended that Petitioner return to work, with duties consistent with his FCE. The Arbitrator notes the petitioner did undergo a Functional Capacity evaluation at ATI physical therapy on August 23, 2012, which recommended work hardening for the petitioner. The petitioner did complete a course of work hardening, and on October 31, 2012, the physical therapist at ATI stated the petitioner had progressed to work at the medium physical demand level. Since the petitioner's job as a maintenance engineer was deemed at the medium physical demand level, the petitioner met the current capabilities of his job and could return to work in that capacity.

The petitioner again saw Dr. Levin on July 31, 2013, at which time Dr. Levin stated the petitioner did not suffer a significant injury to his left shoulder, as a result of the work accident. Dr. Levin based this opinion upon his examination of November 27, 2012, when the petitioner had full, painless range of motion, very mild McNeer and Hawkins impingement signs, and negative test results otherwise. Dr. Levin did not think the petitioner required surgery of the left shoulder. In regards to the left foot and ankle, all that is noted on the MRI is calcaneal spurs and plantar fasciitis, which were not directly related to the accident, as they were more overuse findings. Dr. Levin again recommended a return to work consistent with a Functional Capacity Evaluation. The Arbitrator also notes that Dr. Haskell in

his August 23, 2013 record, agreed with the decision that the petitioner return to work in accordance with a future FCE, although Dr. Silver did not.

The Arbitrator also notes Dr. Goldberg's IME of February 13, 2013 and his addendum report of April 8, 2013. In particular, Dr. Goldberg's report states the petitioner's low back condition, whatever it may be, would be unrelated to his work accident. Dr. Goldberg noted the initial complaints of pain in the medical records were that of left-sided thoracic pain, upon examination, Petitioner's complaints were of mid-thoracic pain, left greater than right. The notes also state that he was under the care of Dr. Haskell for a lumbar spine condition. Based upon the examination and review of the MRI imaging studies, the petitioner could return to work, full duty, with respect to his spine. Dr. Goldberg's report then addresses the issue of the petitioner's complaints of lumbar spine, which were not present on his initial examination of the petitioner. As such, any lumbar condition would not be related to the petitioner's work accident.

The Arbitrator also places significant weight to the surveillance taken of the petitioner, particularly on September 22, 2012 and again on May 14, 2013. Of note, the surveillance on September 22, 2012 shows the petitioner bending over repeatedly while performing yard work activities. The footage demonstrates an individual that does not appear to have any sort of problem or pain in his lumbar spine, or his entire back. Similarly, the surveillance from May 14, 2013 that showed the petitioner cleaning his vehicle, shows him bending over, or alternatively sitting and standing without any apparent difficulty. The petitioner was able to use both arms freely without evidence of compensation or otherwise being in pain. Finally, while the surveillance of May 31, 2014 does not show the petitioner being quite as active, the Arbitrator notes that a child jumped on his left knee on two occasions, both times the petitioner did not react in any manner. In addition, the petitioner was able to sit for an extended period during the surveillance but during trial, he testified to being unable to do so; and got up and moved around.

In summary, the Arbitrator notes that the petitioner's complaints of pain and his ratings of pain for his various body parts have changed throughout the course of his treatment and he has been an inconsistent historian to all of his treating physicians, particularly inflating the amount of distance he has fallen from four feet to up to ten feet. The medical records, i.e., the objective findings such as imaging studies and physical examination testing, revealed non-acute findings, requiring little if any medical treatment, with the exception of the left knee, which Dr. Levin did detect objective signs of a meniscal tear; which was found during the April 27, 2012 operation. Therefore, the Arbitrator adopts the opinions and reports of Drs. Kale, Levin and Goldberg, as being more persuasive than the opinions of Drs. Coe, Silver and Haskell, as they pertain to the petitioner's current condition of ill being and need for treatment for his left shoulder, left hip, left ankle, low back and right knee. The Arbitrator further finds that, consistent with the IME report of Dr. Levin from November 27, 2012, the petitioner was capable of returning to full duty work, as a maintenance engineer, as outlined in the October 31,

2012 report from ATI. The Arbitrator further finds that the petitioner's current conditions of ill being, with the exception of his left knee, are unrelated to his work accident for reasons set forth herein.

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

Based on the foregoing findings, the Arbitrator finds that the respondent is liable for payment of the petitioner's medical expenses, through February 13, 2013, the date of the examination with Dr. Goldberg. The Arbitrator further finds the respondent is not liable to pay medical expenses for any of the petitioner's conditions after February 13, 2013. The Arbitrator adopts the opinions of both Drs. Goldberg and Levin, in coming to this conclusion. In particular, Dr. Levin stated that the petitioner's right knee, left shoulder, left hip, and left ankle conditions either required no treatment, or required minimal treatment for temporary exacerbations of pre-existing conditions. This medical treatment would include physical therapy, which the records of ATI demonstrate the petitioner had ample physical therapy in 2012. Therefore, the respondent is liable for reasonable and necessary medical treatment up through February 13, 2013. The respondent shall have a credit for any bills that they have previously paid, either through workers' compensation program or through his group health insurance, for treatment awarded herein, pursuant to Section 8(j) of the Act.

K. Is the petitioner entitled to any prospective medical care?

The Arbitrator finds and concludes that the petitioner has not proven, by a preponderance of the evidence, that he is entitled to prospective medical care. With respect to the petitioner's left shoulder surgery recommended by Dr. Silver, the Arbitrator notes that the surgery request was evaluated through utilization review, Respondent's Exhibit 10. The reviewing UR physician was able to speak to Dr. Silver directly regarding his request for left shoulder surgery. Following the official disability guidelines, the reviewing physician stated that the left shoulder surgery was not medically necessary. It does not appear that an appeal of this UR decision was every filed by Dr. Silver's office.

With respect to the right knee surgery, the Arbitrator's notes that this issue was also addressed through utilization review in Respondent's Exhibit #11. The reviewing physician found that the petitioner's knee for right knee surgery did not meet the official disability guidelines, as detailed in the report. Again, it does not appear that this decision was appealed by Dr. Silver's office.

The Arbitrator notes that Dr. Levin's reports also support the finding that the petitioner does not need surgery to either his left shoulder or his right knee. In particular, Dr. Levin found no objective findings on imaging studies or physical examinations that revealed acute or significant pathology, for which surgery would be required. The Arbitrator does place significant weight on this fact, as Dr. Levin was careful to note the positive physical examination findings on the left knee that led to his

recommendation for surgery. The Arbitrator notes Dr. Gryzlo also evaluated the petitioner in 2011 and did not find any indications for surgery for the right knee or the left shoulder. While Dr. Silver states the petitioner's imaging studies show acute findings in the right knee and the left shoulder, the other orthopedic surgeons and radiologists who reviewed the studies, do not corroborate this opinion.

Finally, the Arbitrator notes the above finding that the petitioner's current condition of ill-being with respect to all of the above-cited body parts, is not causally related to his work accident for the reasons outlined above in Section F. Therefore, the Arbitrator denies the petitioner prospective medical care as it pertains to his left shoulder, right knee, his entire back, his left hip, or his left ankle/foot.

L. What temporary benefits are in dispute?

Based on the foregoing information, the Arbitrator awards the petitioner TTD benefits from December 24, 2010 through January 21, 2011, and from March 20, 2012 to February 28, 2013.

The Arbitrator notes that the petitioner was released to return to work as of November 27, 2012, consistent with the FCE of Dr. Levin. The FCE and the work conditioning preformed in October 2012 resulted in the petitioner being discharged with a release to return to his full duty job, effective October 31, 2012. Moreover, the IME of Dr. Goldberg, on February 13, 2013, states the petitioner could return to work, full duty, as it pertains to his back. The petitioner was then coordinated to return to work and did so effective March 1, 2013. The respondent is due any credit it paid for TTD benefits for this period.

15IWCC0445

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11 WC 30117
SIGNATURE PAGE

Signature of Arbitrator

November 12, 2014
Date of Decision

NOV 13 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

Tylon Wilson,
Petitioner,

vs. NO: 10 WC 14456

Southwest Disabilities Service & Support NFB and Illinois State Treasurer and Ex Officio Custodian of the Illinois Injured Workers' Benefit Fund,
Respondent.

15IWCC0446

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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.

15IWCC0446

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $37,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 1 1 2015
O5/19/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSON, TYLON
Employee/Petitioner

Case# **10WC014456**

SOUTHWEST DISABILITIES SERVICE & SUPPORT NFB AND DAN RUTHERFORD ILLINOIS STATE TREASURER AND EX OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0446

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:

1922 SALK, STEVEN B & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

SOUTHWEST DISABILITIES
SERVICES & SUPPORT, NFP
286 E 16TH ST
CHICAGO HEIGHTS, IL 60411

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

15IWCC0446

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

Tylon Wilson
Employee/Petitioner
v.
Southwest Disabilities Service & Support, NFP and Dan Rutherford, Illinois State Treasurer and ex officio Custodian of the Illinois Injured Workers' Benefit Fund
Employer/Respondent

Case # **10** WC **14456**

An *Application for Adjustment 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 **February 18, 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 **Notice of Hearing; Lack of insurance**

FINDINGS

On **January 6, 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 **$34,735.30**; the average weekly wage was **$667.99**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay to the Petitioner reasonable and necessary medical services of **$2,731.05**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$400.79**/week for **86** weeks, because the injuries sustained caused the **40%** loss of the **right leg**, as provided in Section 8(e) of the Act.

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

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

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

Signature of Arbitrator

June 13, 2014
Date

JUN 16 2014

STATEMENT OF FACTS

On January 6, 2009, the Petitioner was employed by Southwest Disabilities Services & Support, NFP as the business manager. He had held that position for approximately three years and still held that job on the hearing date.

Southwest Disabilities Services & Support, NFP, is a not-for-profit corporation in the State of Illinois that provides support services for handicapped individuals. These services include housing, meals and transportation. The meals are prepared and provided by employees of the Respondent who supervise the residents and clean and maintain the housing. The transportation is provided for the residents by motor vehicles operated by the employees of the Respondent.

On January 6, 2009, just before 10:00 a.m. the Petitioner arrived at work and parked his car in the parking lot immediately adjacent to the building occupied by the Respondent.The Respondent controlled and maintained the parking lot for the use of its employees and business invitees. The parking lot was fenced in and the opening led to the sidewalk that led to the entrance of the building (Pet. Ex. Nos. 26, 28, 30 & 35).

After leaving his vehicle, the Petitioner started to walk to the entrance of the building. While still in the parking lot, the Petitioner slipped and fell on some ice. His right leg went back underneath him and he felt a "pop" and immediate pain in that leg. The Petitioner was unable to get up and a co-worker called the Chicago Heights Fire Department.

The Chicago Heights Fire Department transported the Petitioner to St. James Hospital in Chicago Heights for emergency care (Pet. Ex. No. 4). X-rays were negative for a fracture and he was discharged with a diagnosis of right leg flexion pain. He was given pain medication, a knee immobilizer and crutches (Pet. Ex. No. 5).

After his discharge from St. James Hospital, the Petitioner immediately returned to work and had a conversation about the accident with Mr. Reuben Goodwin, his supervisor and Executive Director for the Respondent.

On January 13, 2009, the Petitioner sought treatment with his personal physician Dr. Gottumukkala. Dr. Gottumukkala suspected a right quadriceps tear, and because the Petitioner did not have insurance, referred him to the Cook County Oak Forest Hospital (Pet. Ex. No. 6).

On January 13, 2009, the Petitioner went to the Cook County Oak Forest Hospital emergency room. He gave a history of falling on ice approximately one week earlier (Pet. Ex. No. 7, pg. 1). He was referred to the orthopedic clinic and saw Dr. Schiappa on January 16, 2009. Dr. Schiappa diagnosed the Petitioner as having a ruptured quadriceps and recommended a surgical repair (Pet. Ex. No. 7, pg. 80).

Surgery was performed by Dr. Schiappa, M.D. on January 22, 2009 to repair a torn right quadriceps. An 18 gauge wire was used to secure the quadriceps to the patella (Pet. Ex. No. 7, pg. 23).

Thereafter, the Petitioner received follow-up care from Dr. Schiappa and had physical therapy at the Oak Forest Hospital.

The Petitioner was experiencing increased pain and swelling in his right knee. It was aspirated on July 6, 2009. By September 11, 2009, Dr. Schiappa recommended another surgery to remove a wire suture and revision surgery (Pet. Ex. No. 7, pp 56-60).

On October 22, 2009, the Petitioner returned to see his family physician Dr. Gottumukkala. At that time, the Petitioner still complained of right knee pain and Dr. Gottumukkala referred the Petitioner to Dr. Aribindi (Pet. Ex. No. 6).

The Petitioner saw Dr. Aribindi one time on December 2, 2009. Dr. Aribindi noted swelling in the right knee and a defect in the quadriceps attachment. Dr. Aribindi also recommended a revision surgery with the removal of the wire. Dr. Aribindi recommended a walker and a cane to assist the Petitioner in walking (Pet. Ex. No. 8). Although Dr. Aribindi scheduled a surgery, it was cancelled due to a lack of insurance.

In January 2010, the Petitioner sought treatment at the John Stroger Cook County Hospital. X-rays taken on January 19, 2010 actually revealed that the orthopedic wire was fractured (Pet. Ex. No. 9, pg. 149). The Petitioner attempted conservative care for approximately a year, but ultimately underwent a second surgery on January 5, 2011 at the John Stroger Cook County Hospital (Pet. Ex. No. 9, pp 73-74). That surgery was an open repair of right chronic quadriceps tendon repair and removal of hardware. The revision surgery was performed by Dr. Garapati.

Following the surgery, the Petitioner underwent physical therapy and was discharged from care on August 18, 2011 (Pet. Ex. No. 9, pg. 2). The Petitioner still has a metal fragment in the posterior aspect of the knee that was visualized in an x-ray on February 17, 2011 (Pet. Ex. No. 9, pg. 55).

The Petitioner testified that in the year prior to the accident, he earned $34,735.30 and produced the final pay stub for the year 2008 to substantiate that figure (Pet. Ex. No. 15). He also testified that his date of birth is October 15, 1954 and at the time of the accident he was married and had no children under 18.

The Petitioner submitted into evidence subpoenaed medical bills totaling $2,731.05 after applying the fee schedule (Pet. Ex. Nos. 10, 11, 12, 13 and 14).

The Petitioner also offered into evidence a Certification from the National Council on Compensation Insurance, Inc., that there was no record that the Respondent had workers' compensation insurance on January 6, 2009 (Pet. Ex. No. 1). Notice of the hearing was given to and received by the Respondent by first class and certified mail (Pet. Ex. Nos. 2 and 3).

The Petitioner testified that he had no prior problems with his right knee and leg before the accident of January 6, 2009 and that he has not had any subsequent accidents. His right leg is uncomfortable and painful. It is painful going up and down stairs and when he walks.

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

The Arbitrator finds that the Respondent was operating under and subject to the Illinois Workers' Compensation Act on January 6, 2009.

On that date, Southwest Disabilities Services & Support NFP, was and still is a not-for-profit corporation in the State of Illinois that provides support services for handicapped individuals. These services include housing, meals and transportation. The meals are prepared and provided by employees of the Respondent who supervise the residents and clean and maintain the housing. The transportation is provided for the residents by motor vehicle.

Therefore, the Arbitrator finds that Respondent is subject to the automatic provisions of the Act.

B. Was there an employee - employer relationship?

The Arbitrator finds that on January 6, 2009, there was an employee – employer relationship between the Petitioner and Respondent.

On that date, the Petitioner was employed as the business manager for the Respondent. He had held that position for three years at the time of the accident and still held the position at the time of the hearing. The Petitioner testified and produced a paystub dated December 30, 2008 (Pet. Ex. No. 15) and a W2 form for 2009 (Pet. Ex. No. 16). Both of these forms show wages earned by the Petitioner and taxes withheld by the Respondent for the Petitioner.

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

The Arbitrator finds that on January 6, 2009 an accident occurred that arose out of and in the course of the Petitioner's employment by the Respondent.

On that date just before 10:00 a.m., the Petitioner parked his car in a parking lot that was controlled and maintained by the Respondent for its employees and business invitees. While walking from his car to the entrance of the Respondent's building and while still in the parking lot, the Petitioner slipped and fell on ice suffering a torn or ruptured right quadriceps.

Because the parking lot was controlled and maintained for the use of its employees and business invitees, the lot constitutes an extension of the employer's premises.

Therefore, due to the increased risk on the employer's premises, the Arbitrator finds that the accident arose out of and in the course of the Petitioner's employment by the Respondent.

D. What was the date of the accident?

The Arbitrator finds that the date of the accident was January 6, 2009.

The Arbitrator relies on the Petitioner's testimony and the medical records. ,

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

The Arbitrator finds that timely notice of the accident was given to the Respondent.

On the day of the accident, a co-worker called a Chicago Heights Fire Department ambulance to the scene. After his discharge from the emergency room, the Petitioner returned to work and had a conversation about the accident with Mr. Reuben Goodwin, his supervisor and the executive director for the Respondent.

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

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the injury.

The Petitioner suffered a torn right quadriceps as a result of the accident of January 6, 2009. He had no prior problems with his right leg before the accident and he had to be removed from the scene of the accident by Chicago Heights Fire Department. Subsequently, on January 22, 2009, he underwent a surgery to repair the torn quadriceps with the use of a wire. That wire fractured and on January 5, 2011, the Petitioner underwent a second surgery to remove the broken wire and revise the quadriceps repair. A piece of broken wire is still in the Petitioner's right knee.

The Petitioner denied any subsequent accident or injuries to the right leg.

Therefore, the Arbitrator finds that the accident of January 6, 2009 directly caused a torn right quadriceps muscle that had to be surgically repaired on two occasions and a piece of orthopedic wire remains in the Petitioner's right knee.

G. What were Petitioner's earnings?

The Arbitrator finds that the Petitioner earned $34,735.30 in the year prior to the accident. This finding is based on the Petitioner's testimony and Petitioner's Exhibit 15, which is the pay stub dated December 30, 2008, for the last pay period before the accident of January 6, 2009. This pay stub shows gross earnings of $34,735.30 for 2008. Therefore, the average weekly wage is $677.99 and this yields a TTD rate of $445.33 and a PPD rate of $400.79.

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

The Arbitrator finds that the Petitioner was 54 years old on the accident date of January 6, 2009. This is based on the Petitioner's testimony that his date of birth is October 15, 1954.

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

The Arbitrator finds that on January 6, 2009, the Petitioner was married and had no dependents under the age of 18. This is based on the Petitioner's testimony.

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

The Arbitrator finds that the medical services that were provided to the Petitioner were reasonable and necessary. The Arbitrator further finds that the Respondent employer has not paid any of the charges for reasonable and necessary medical services.

The Petitioner testified and the medical records reveal that he was taken by Chicago Heights Fire Department Ambulance from the accident scene to St. James Hospital. From there, his primary care physician referred him to Oak Forest Hospital where he underwent a surgery with the implantation of a wire to repair the torn right quadriceps on January 22, 2009. He underwent post-operative care and physical therapy until the orthopedic wire used in the surgical repair fractured, requiring a revision surgery. The revision surgery was performed at John Stroger Cook County Hospital on January 5, 2011 after the Petitioner sought a second

opinion from Dr. Aribindi. This treatment was all reasonable and necessary and the Respondent employer paid none of the medical bills.

Therefore, the Arbitrator awards the following bills that were submitted into evidence (these amounts are after the fee schedule is applied):

1.	City of Chicago Heights	$231.80
2.	St. James Hospital	$607.62
3.	Emergency Care and Health Organization, Ltd.	$167.96
4.	Southland Bone & Joint	$449.64
5.	Stroger Cook County Hospital	$1,274.03
	Total per fee schedule	$2,731.05

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

The Arbitrator finds that the accident of January 6, 2009 caused a 40% loss to the Petitioner's right leg as provided in Section 8(e) (12) of the Act.

The Arbitrator previously found that the accident of January 6, 2009 caused a torn right quadriceps that had to be surgically repaired using a wire. The orthopedic wire fractured and a revision surgery was required to remove the wire and revise the quadriceps using fiberwire and vicryl. A piece of broken wire remains in the Petitioner's knee.

The Petitioner complains that he has pain and discomfort in his right leg on a daily basis. He has trouble going up and down stairs due to pain. Pain will be present with walking short distances.

Therefore, the Arbitrator finds that the Petitioner has sustained a 40% loss of use of the right leg.

O. Was notice of the hearing given to the Respondent?

The Arbitrator finds that notice of the hearing was given to the Respondent Southwest Disabilities & Support, NFP.

The Petitioner submitted into evidence Petitioner's Exhibit Nos. 2 and 3 which were copies of the letters sent to Mr. Reuben Goodwin, as the Executive Director of the Respondent and as the Registered Agent of the Respondent. Both letters were dated January 9, 2014 and were sent by certified and first class mail. Both letters notified the Respondent that the hearing was scheduled for February 18, 2014 at 9:00 a.m. at the Illinois Workers' Compensation Commission, 100 West Randolph Street, 8th Floor, Chicago, IL 60601.

Also contained in Petitioner's Exhibits Nos. 2 and 3 were the certified mail receipts (green cards) dated January 13, 2014 and signed by Adrienne Moore.

Therefore, the Respondent had proper notice of the hearing and did not appear.

O. Did the Respondent have Workers' Compensation insurance on the accident date?

The Arbitrator finds that the Respondent, Southwest Disabilities Services & Support NFP did not have workers' compensation insurance as required by the Act.

This finding is based on Petitioner's Exhibit No. 1, which is a certification from the National Council on Compensation Insurance that no workers' compensation insurance information or proof of insurance was filed for Southwest Disabilities Services & Support NFP for the accident date of January 6, 2009.

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

Antonio Gomez,
Petitioner,

vs.

NO: 11 WC 14928

15IWCC0447

Carl Buddig & Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent disability, temporary disability and being advised of the facts and law, by changing January 26, 2011 to September 4, 2013 on the first page of the Decision of the Arbitrator otherwise 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 affirmed and adopted.

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

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

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

DATED: JUN 11 2015
O5/20/15
RWW/rm
046

Ruth W. White

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

GOMEZ, ANTONIO
Employee/Petitioner

Case# **11WC014928**

CARL BUDDING & COMPANY
Employer/Respondent

15IWCC0447

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:

2512 THE ROMAKER LAW FIRM
CHARLES ROMAKER
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

4866 KNELL O'CONNOR & DANIELEWICZ PC
ANDREW M FERNANDEZ
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

15IWCC0447

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

Antonio Gomez
Employee/Petitioner

v.

Carl Buddig & Company
Employer/Respondent

Case # 11 WC 14928

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 26, 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 _____

15IWCC0447

FINDINGS

On **January 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.

In the year preceding the injury, Petitioner earned **$31,408.00**; the average weekly wage was **$604.00**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$10,469.16** for TTD, **$0** for TPD, **$0** for maintenance, and **$10,829.00** for other benefits, for a total credit of **$21,298.16**.

ORDER

THE PETITIONER FAILED TO PROVE A COMPENSABLE INJURY, BENEFITS PURSUANT TO SECTION 8 OF THE ACT ARE DENIED.

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

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

Deborah L. Simpson
Signature of Arbitrator

June 19, 2014
Date

JUN 23 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antonio Gomez,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 14928**
	)	
Carl Buddig & Company,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 26, 2011, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services that were provided to Petitioner reasonable and necessary; Has Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is Petitioner entitled to TTD; and (5) What is the nature and extent of the injury.

STATEMENT OF FACTS

The Petitioner testified that he has been working for the Respondent since August 14, 2000 as a forklift driver. (Tr. p. 16). Petitioner's duties involve moving pallets of meat, and moving "the thing" that is empty or filled with meat. (Tr. p. 16). Petitioner worked the second shift, which was from 2:00 pm until 10:00 p.m.

On April 13, 2004 Petitioner allegedly injured his back while at work. (RX. 9; Tr. p. 16). On that same day, Petitioner presented to Dr. Chandra S. Anand of East Side Medical Center. (RX 4). There Petitioner reported pain in his left leg and thigh. (RX 4). Dr. Anand noted Petitioner suffered from radiculopathy. (RX 4).

On April 23, 2004, an MRI of the lumbar spine revealed Petitioner had a L4-L5 diffuse disc bulge compressing his left nerve root. (RX 4, 5). Over the next two months Petitioner

continued to report left lower extremity pain with symptoms extending to his toes. (RX. 4, 5, 6). On June 21, 2004 Petitioner treated for this injury at the University of Chicago with Dr. Maciej Lesniak, who performed a left L4-L5 lumbar discectomy. (RX. 5; Tr. p. 16).

Due to his injury, on August 17, 2004 Petitioner filed a case against Respondent at the Illinois Workers Compensation Commission. (RX 9). By April 1, 2005 the case was settled. (RX 9).

Initially, Petitioner reported the lumbar discectomy improved his discomfort significantly. (RX 6). However, by May 25, 2006 Petitioner reported that he was again experiencing low back pain radiating down to his foot. (RX. 4). Compounding this, by September 24, 2007 Petitioner endured another work injury, the details of which are unclear. (RX. 10).

Due to Petitioner's second injury, Petitioner's complaints of back pain and radiculopathy continued. (RX. 4). On September 25, 2007 Petitioner underwent an MRI at Preferred Open MRI. (RX. 3; RX 4; RX 7). The MRI revealed hemilaminectomy changes, posterior extension of disc signal centrally and to the left consistent with a disc protrusion, and mild spinal stenosis. (RX 3; RX 4; RX 7).

Further worsening his condition, on April 3, 2008 Petitioner endured a third workplace injury. (RX. 10). On May 8, 2008 while completing a health assessment form for Dr. Luken, Petitioner noted he had very frequent symptoms and a deep ache and pain in his left foot. (RX. 3). The following day, while presenting to Dr. Luken, he explained that he was never quite the same or entirely comfortable after his surgery. (RX 3). Dr. Luken reviewed an MRI of Petitioner's spine taken April 18, 2008 which he opined revealed degenerative desiccation of the L4-5 disc, with what appeared to be postoperative changes on the left at that level, where there also was some combination of enhancing granulation tissues and recurrent or residual herniated disc material. (RX. 3).

On June 16, 2008 Petitioner presented to Dr. Robinson for an epidural steroid injection. (RX. 3). This only made Petitioner's symptoms worse. (RX. 3). On June 26, 2008, Petitioner had another epidural steroid injection. (RX. 3). On June 27, Petitioner still reported pain in his left low back, buttock, posterior thigh, and lower leg extending to the great toe. (RX 3).

Due to the continued pain, on July 21, 2008, Petitioner presented to Open MRI & CT Center. (RX. 3). A CT scan showed osteoarthritis of mild severity and a mild bulging of the intervertebral disc at L4-L5. (RX. 3).

Despite the results of the CT scan, Petitioner never underwent surgery to resolve the symptoms caused by the April 3, 2008 aggravation of his spinal injury. Nevertheless, on June 10, 2009 Petitioner settled his second IWCC case against Respondent for his 2007 and 2008 back injuries. (RX. 10).

At this point, despite no surgical interventions and ineffective epidural steroids, Petitioner claims he was essentially better and required no further back treatment. (Try p. 36). However, as early as April 21, 2010 Petitioner was receiving prescription medications for his complaints of back pain and radiculopathy. (RX. 4). He regularly complained of radiculopathy and treated for it on June 28, 2010, July 28, 2010, and September 8, 2010. (RX. 4).

By September 28, 2010, Petitioner complained that his low back pain reached a level of 8 out of a possible 10. (RX. 4). On November 2, Dr. King of University of Chicago Physicians Group opined that Petitioner suffered recurrent L4-5 HNP and prescribed epidural steroid injections. (RX. 7).

On November 8, 2010 Petitioner reported that his back and leg pain existed since 2004. (RX. 7). Specifically, Petitioner reported numbness and tingling to the lower left extremity. (RX. 7). His pain progressed to an 8-9 out of a possible 10. (RX 7).

Due to Petitioner's pain and radicular symptoms, an MRI was performed on November 12, 2010. The MRI revealed diffuse lumbar spondylosis with associated disc desiccation at L4-L5. Additionally, at L4-L5, there was a mild diffuse generalized no enhancing 2mm disc bulge and mild enhancing granulation/scar tissue within the extradural space surrounding the thecal sac and what appeared to be central canal and neural foraminal stenosis. There were also shallow diffuse disc bulges at L2-L3, L3-L4, and L5-S1 which combined with facet hypertrophy to produce mild bilateral neural foraminal stenosis. (RX. 7).

As a result of the MRI, on December 16, 2010 Petitioner presented to Dr. Uddin at APAC Center for Pain Management for a L5-S1 steroid injection. (RX. 7). The steroid injection only provided temporary relief. (RX 7). On January 7, 2011 Petitioner received another epidural steroid injection. (RX. 7). On January 22, 2011 Petitioner reported that the epidural injection did not relieve his left lateral leg pain. (RX 7).

Petitioner claims he was injured four days later, on January 26, 2011 at around 3:00 in the afternoon. (Tr. p. 18). At trial Petitioner claimed he injured his back when he stepped off a forklift and walked onto a piece of indiscriminate raw meat simply lying on the ground. (Tr. p. 37). Petitioner describes the meat in detail as both small and slippery because it was uncooked. (Tr. p. 37). Moreover, Petitioner claims the meat was in a location where employees washed containers that once had meat in them. (Tr. p. 38). He described the area as a big room with many dirty containers. (Tr. p. 41). However, on April 11, 2011 Petitioner described a very different situation, namely that he slipped while in a meat freezer. (PX. 3). In any event, Petitioner insists he had no pain down his left leg prior to the alleged injury on January 26, despite his January 22 complaint of left lateral leg pain. (Tr. pp. 20, 32). Petitioner testified that he told his supervisor, Juan Vega, about the accident the same day it happened. No report of accident was produced showing that the injury was reported at the time. Petitioner also testified that the pain was very intense strong pain, yet he continued working the remaining seven hours of his shift and did not seek medical treatment for the injury or pain for six weeks.

Subsequent to his alleged injury, Petitioner did not treat until over one month later, namely on March 9, 2011. (RX 4; PX 1). During his treatment, the treating physician, Dr. Anand, made no note of new injury, but instead noted that the visit was a "Pt check up." (RX. 4; PX. 1). It was not until March 17, 2010 that Petitioner reported the alleged back injury to a medical provider. (RX 8). Petitioner treated with physical therapy during March and April (RX. 8)

On April 11, 2011 Petitioner treated with Dr. Zaki Anwar of Chicago Pain and Orthopedic Institute. (PX 4, 6). Dr. Anwar noted that Petitioner experienced pain off and on for the last few years. (PX 4, 6). On April 12, 2011, the Petitioner had an MRI. (PX 4A). The MRI

showed L4-L5 scar tissue but no disc herniation and a L5-S1 disc bulge protrusion that had impingement at that level. (PX 4, 6). Petitioner continued to treat as he had before the alleged injury, specifically he had transforaminal injections on May 2, 2011 and on May 20, 2011. (PX. 4, 6). On May 26, 2011, Dr. Anwar again noted that Petitioner's pain was a progression over a period of years. (PX 4, 6).

On June 16, 2011 Petitioner received a caudal adhesiolysis injection. (PX. 4, 6). Additionally, Dr. Anwar recommended Petitioner undergo a spinal stimulator trial. (PX. 4, 6).

On July 13, 2011, Petitioner presented to Dr. Wajid Kahn for psychological evaluation of mood symptoms. (PX 6, 7). Dr. Kahn opined that Petitioner had Depression Disorder, NOS. (PX. 6, 7). This was later attributed to the injury in a handwritten addendum. (PX. 6, 7). Dr. Kahn further noted that Petitioner endured stressors such as financial issues. (PX. 6, 7). Petitioner was prescribed Zoloft. (PX. 6, 7).

On July 14, 2011, Petitioner presented to Dr. Lorenz at Hinsdale Orthopaedics for an initial exam. (PX. 12). However, Petitioner admits Dr. Lorenz was not even present for his visit. (RX. 1 – Respondent's Dep.Ex. 2). Petitioner's report of injury to Dr. Lorenz, or whoever saw Petitioner in his stead, was only that Petitioner slipped on meat and fell. (PX. 12). Despite this limited history and the limited to nonexistent exposure Dr. Lorenz had to Petitioner, Dr. Lorenz opined Petitioner's condition was work-related and that Petitioner was to remain off work. (PX. 12). While there, Petitioner reported pain 8-9/10 with radiculopathy. (PX. 12). Dr. Lorenz reviewed the April 12, 2011 MRI and opined it showed desiccation of the disk at L4-5 with surgical changes. (PX. 12). He further opined, "this is a disk bulge and acquired foraminal stenosis at L4-5 with some facet arthrosis. There is a report of a tiny 2-3-mm subligamentous posterior disk herniation at L5-S1 central." (PX. 12).

On August 17, 2011 Petitioner underwent surgery with Dr. Anwar, wherein Petitioner received a trial dorsal column stimulator. (PX. 6). On August 24, 2011 Petitioner was taking cymbalta. (PX.6, 7). Petitioner no longer experienced mood symptoms; however, Petitioner was having difficulty sleeping. (PX. 6, 7).

On August 31, 2011 Petitioner presented to Dr. Babak Lami for an independent medical examination. (RX. 1 – Respondent's Dep. Ex. 2). Dr. Lami reviewed Petitioner's medical records, including records regarding Petitioner's 2004 injury and surgery, 2008 injury and treatment, and Petitioner's April 12, 2011 MRI. (RX. 1 – R Dep. Ex. 2). Dr. Lami concluded it was possible the January 26, 2011 accident aggravated a pre-existing condition. (RX. 1 – R Dep. Ex. 2). However, Dr. Lami specifically noted that this opinion heavily relied on the credibility of Mr. Gomez's described history. (RX 1 – R Dep. Ex. 2). Dr. Lami further opined the MRI did not show any new disc herniation or fracture. (RX 1 – R Dep. Ex. 2). He went on to opine that the bilateral injections Petitioner received at the hands of Dr. Anwar were not necessary. (RX 1 – R Dep. Ex. 2). He explained that without any reports of right nerve root injury, only injections on the left were reasonable. He further stated that a third injection was not reasonable because the first two injections failed to perform and provide relief. (RX. 1 – R Dep. Ex. 2). Moreover, Dr. Lami went so far as to opine that Dr. Anwar's treatment was counterproductive. Dr. Lami stated, "In regard to the alleged work injury of January 26, 2011, Mr. Gomez should have reached maximum medical improvement by the time of my examination; however, the path of the

treatment that the second set of treaters chose has diverted him from meaningful rehabilitation and has prolonged his pain and recovery." (RX. 1 – R Dep. Ex. 2).

In regards to further recommendations, Dr. Lami recommended that Petitioner only undergo more physical therapy. (RX. 1 – R Dep.Ex. 2). Dr. Lami completely rejected use of a spinal cord stimulator. Dr. Lami anxiously stated:

"I am also concerned with the aggressive nature of performing the discography, particularly the application of the spinal cord stimulator as it relates to January 26, 2011. Implantation of a spinal cord stimulator in a patient with no stenosis, with minimal findings and after only four weeks of physical therapy is extremely aggressive and excessive and, in my opinion, is not indicated and will eventually do more harm than good to Mr. Gomez." (RX. 1 – R Dep. Ex. 2).

On September 28, 2011, Dr. Babak Lami authored an IME Addendum. (RX. 1 – R Dep. Ex. 4). Dr. Lami stated that Petitioner was able to work from April 11, 2011 to the present date in a light duty capacity. Petitioner was recommended to be restricted to 20 pounds of lifting and no repetitive bending/twisting. (RX. 1 – R Dep. Ex. 4).

On November 9, 2011, Petitioner saw Dr. Lesniak at the University of Chicago Medical Center. (RX. 5) Dr. Lesniak's opinion largely mirrored that of Dr. Lami, stating: "[Petitioner has] a history of herniated lumbar disk. He was well for many years and most recently has had an exacerbation. It seems to me that he has had some unusual procedures including epidural steroid injections, as well as a spinal cord stimulator placed for what I would consider unclear reasons. Objectively, I do not find that he has any neurological deficit and it may be he has a component of pain that should be managed conservatively. In this setting, I have recommended Motrin, as well as physical therapy, but I do not find any indication for any further surgery or interventional procedure." (RX 5).

On December 3, 2011 Petitioner presented to Dr. Tom Dzielawski of MidCity Spine and Ortho rehabilitation. (PX 18). Patient's pain was an 8 out of a possible 10 on this initial visit. (PX 18). Petitioner continued to present to MidCity Spine and Ortho several times a week for the entire month of December. (PX 18). During that time, although Petitioner's pain fluctuated, he noticed improvement from the treatment. (PX 18). Towards the end of the month his pain was lowered to a 4 or 3 out of a possible 10. (PX. 18).

After no treatment in January of 2012, on February 3, 2012, Petitioner resumed treatment. He continued to treat until February 9, 2012, reducing his pain to a 2 out of a possible 10. (PX 18). Then Petitioner has no treatment record until February 29, 2012, when Petitioner's pain was a 5 out of a possible 10. (PX 18). Notably, Petitioner was informed that the frequency of his visits were vital to actually correcting the underlying condition. (PX. 18).

On February 29, 2012 Petitioner was told to return to treatment in a few days. (PX. 18). There is no record provided to indicate that Petitioner ever resumed treatment. (PX 18).

Contrary to Dr. Lami and Dr. Lesniak's recommendations, on February 25, 2013 Petitioner returned to Dr. Anwar regarding the spinal stimulator surgery. (PX. 6). Without taking any further diagnostic films, Dr. Anwar recommended Petitioner visit a psychologist to determine his candidacy for a spinal stimulator implant. (PX 6).

On March 6, 2013 Petitioner visited with Dr. Khan regarding his depressive disorder. (PX. 6, 7). Dr. Khan noted that although Petitioner was medicating, his current psychotropic medications were unknown. (PX. 6, 7). Nevertheless, Dr. Khan prescribed Petitioner mirtazapine. (PX. 6, 7)

Petitioner continued to visit Dr. Khan and Dr. Anwar until August 22, 2013. (PX. 6, 7). Petitioner's subjective reports of pain were low back pain with numbness in the left leg and left toe numbness and tingling. (PX. 6, 7). Petitioner continued to take anti-depressant medications. (PX. 6, 7). Dr. Anwar continued to opine Petitioner should receive a spinal cord stimulator implant. (PX. 6).

On 8/5/13, Petitioner presented to Dr. Lorenz at Hinsdale Orthpaedics. (PX.12). In the History, Dr. Lorenz stated that there were no prior surgeries, and noted that Petitioner does not exercise regularly. (PX.. 12). Dr. Lorenz states that Petitioner's pain "has not really changed over the last couple years" and diagnosed Petitioner with "chronic low back pain, nonspecific type." (PX. 12). Dr. Lorenz recommended that Petitioner see Dr. Bardfield (pain management) for evaluation and rehabilitation program. Petitioner was released to full duty, and was to return p.r.n. (PX. 12).

The Petitioner testified that he returned to work on October 10, 2011, with restrictions recommended by Dr. Lami, specifically a twenty pound lifting limit. He continues to work with that restriction today.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board,* 318 Ill.App.3d 507, 514-15 (1st Dist. 2000).

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course and scope of her employment with Respondent and the date of the accident, the Arbitrator makes the following conclusions of law:

The Arbitrator had the opportunity to observe the Petitioner on this matter when he testified. The Arbitrator has also had the opportunity to examine the extensive medical history on the Petitioner. Based upon the review of the medical records, and the fact that Petitioner's testimony was contradictory to the facts as contained in the medical records, the Arbitrator concludes that the Petitioner is not a credible witness.

The Petitioner testified that he had workplace accidents in 2004 and 2007, both involving his lower back. Petitioner stated that he had surgery to his lower back in 2004, and that he received non-surgical treatment from 2007-2008. (Tr.at 16-17). Petitioner admitted to settling both cases at the Illinois Workers' Compensation Commission. (Tr. at 36). Petitioner stated that after 2008, he was essentially better and did not need any further treatment for his back. (Tr. at 36).

The Petitioner testified that on January 26, 2011, he started his shift at 2:00pm. The Petitioner described that he got down from a forklift, and when he got down, he stepped on a piece of meat that was on the floor and slipped (Tr. at 18-19). The Petitioner stated that he landed "very heavily" on his backside. According to the Petitioner, immediately after his accident, he began experiencing lower back pain. According to the Petitioner, he had "very intense, very strong pain [and] after a few days, it started to go down my leg." (Tr. at 19-20).

The Petitioner stated that prior to January 26, 2011, he did not have any pain radiating down his left leg. (Tr. at 20.) He admitted to having "a little bit of a problem, a slight problem" regarding his lower back, but he stated that he did not have any pain radiating to his leg. (Tr. at 17). According to the Petitioner, since January 26, 2011, he experiences lower back pain, with pain that goes down his left leg and to his big toe. (Tr. at 32).

It is based upon these facts that Petitioner claims that he established that he sustained a compensable accident on January 26, 2011. However, Respondent disputes the Petitioner's claim that a compensable accident ever occurred. Petitioner's testimony at the hearing was contradicted by the medical records that were provided and the statements he made to various doctors regarding the onset of lower back pain, the onset of his left leg radiculopathy, and a significant period of treatment received prior to 2011 for lower back pain and left leg radiculopathy. Petitioner's contradictory testimony regarding his medical history also calls into question whether an at-work accident ever actually occurred on January 26, 2011.

According to the medical records, the Petitioner treated for lower back pain and left leg pain just four days before the alleged work accident. The records introduced into evidence show a consistent pattern of treatment for chronic back pain since 2004, including treatment for left leg radiculopathy. Yet Petitioner denied having such treatment. The facts show that Petitioner treated for the exact same symptoms - low back pain and left leg radiculopathy - before January 26, 2011 and after January 26, 2011. When examining the medical records as a whole, nothing appears to have changed after January 26, 2011.

Additionally, in this case, the timing of Petitioner's treatment and Petitioner's choice of pain management physician do not make sense given the Petitioner's history of his alleged accident. Petitioner alleged that he sustained an accident on January 26, 2011, and that he felt "intense pain" immediately after. (Tr. at 19-20). Yet, the Petitioner did not seek treatment until March 9, 2011 – 6 weeks after he stated that he was hurt at work. The delay in treatment – including the March 9 medical record indicating that Petitioner was there merely for "follow-up" (RX 4), further suggests that on March 9, 2011, Petitioner sought treatment for his pre-existing, chronic back pain and left leg radiculopathy – and not for any specific acute at-work accident.

Moreover, Petitioner did not seek pain management from the physician who had treated Petitioner up until January of 2011. Rather, Petitioner changed physicians and began treating with Dr. Anwar, because of the recommendation of his attorney. (Tr. at 39). The Arbitrator cannot conclude that Petitioner's motivations were genuine in seeking treatment from Dr. Anwar given that the Petitioner had been regularly treating with a different physician for pain management, and the Petitioner lied about having received said prior pain management treatment that is documented in the medical records.

Finally, the facts that the Petitioner's alleged accident on January 26, 2011 was not witnessed or reported near the time of the accident raises further suspicion as to the veracity of Petitioner's allegations, especially given the fact that Petitioner testified it caused extreme pain immediately. (Tr. at 36). This description also is questionable given the 6 week time period between the accident and Petitioner seeking medical treatment.

Considering the totality of the evidence – medical records showing treatment for the same symptoms prior to the accident, an unusual gap in treatment after the alleged accident, treatment and especially the fact that Petitioner lied on the stand, several times, about treatment prior to January 26, 2011, the Arbitrator cannot also believe that the Petitioner is telling the truth about having a workplace accident on January 26, 2011.

Therefore, the Arbitrator finds that the Petitioner did not establish, by a preponderance of the evidence, that he sustained a compensable accident on January 26, 2011 which arose out of and in the course of his employment with Respondent. Rather, the preponderance of the evidence suggests that no accident happened whatsoever on January 26, 2011, and that Petitioner's condition remained unchanged from his baseline. As such, the Petitioner is not entitled to benefits under the Illinois Workers' Compensation Act.

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure?

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

Is Petitioner entitled to TTD?

What is the nature and extent of the injury?

The Petitioner has failed to prove that he suffered an accidental injury on January 26, 2011, that arose out of and in the course of his employment with the Respondent. Having failed to prove a compensable injury, the above listed issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson
Signature of Arbitrator

June 19, 2014
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

Anthony P. Muzik,

Petitioner,

vs.

NO: 13 WC 2602

Village of Wilmette,

15IWCC0448

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

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

DATED: JUN 1 1 2015
O5/20/15
RWW/rm
0469

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(A)

MUZIK, ANTHONY P
Employee/Petitioner

Case# **13WC002602**

VILLAGE OF WILMETTE
Employer/Respondent

15IWCC0448

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE LLC
SCOTT G GOLDSTEIN
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

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

15IWCC0448

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
8(A)

Anthony P. Muzik
Employee/Petitioner

v.

Village of Wilmette
Employer/Respondent

Case # **13** WC **02602**

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 **8/6/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/24/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$65,118.04**; the average weekly wage was **$1,252.27**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$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

Prospective medical

Respondent shall authorize and pay for the surgery and its attendant recommended by Petitioner's treating physician Dr. Palutsis pursuant to Sections 8 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.

Carolyn J. Kelly
Signature of Arbitrator

8/29/14
Date

ICArbDec19(b)

SEP 2 - 2014

FINDINGS OF FACT 15IWCC0448

At trial, the parties stipulated that Petitioner sustained a work related accident on 3/24/11 and that proper and timely notice was provided. ARB EX 1. The issues at trial were causal connection for Petitioner's current condition of ill-being and a request for prospective medical care. ARB EX 1. Petitioner testified that he has worked 13 years for Respondent Village of Wilmette under the job title of maintenance worker 2. His job duties include maintaining underground water systems and winter snow removal.

On 3/24/11, Petitioner was performing underground water main work for Respondent. Petitioner specified that he was repairing a broken valve on an underground water main. Petitioner worked up to 9 feet underground. The repair required Petitioner to break the street surface open with a jack hammer and dig down under the main to complete the repair of the water main. Petitioner used a ladder to climb down into the hole in order to access and repair the valve. Once the valve is located, Petitioner lies on his belly to repair the valve. He remained in this position 45 minutes to 1.5 hours while using a series of wrenches to apply leverage to move the valves. Petitioner testified that he was in an awkward position while lying on his stomach using the wrenches. Petitioner used his right arm and hand to crank the wrenches.

Petitioner testified that after he was finished tightening the bolts and fixing the valve he climbed out of the hole and immediately experienced pain in his right shoulder. Petitioner testified that while at work on 3/17/11, one week before the 3/24/11 accident, he experienced he experienced a twinge in his right shoulder. He testified that he had experienced occasional aches and pain in the right shoulder in the past but that he did not experience any significant right shoulder problems prior to 3/24/11. Petitioner testified that he reported his right shoulder pain on 3/24/11 after coming out of the hole because the shoulder pain was "a lot different and more severe" than any past aches. He reported this right shoulder pain and was sent to the company clinic Omega. At Omega, Petitioner reported working in an awkward position while in a hole on 3/17/11 with shoulder pain and then again on 3/24/11 with a return of shoulder pain. PX 3. An MRI showed evidence of tendinopathy, severe osteoarthritis of the glenohumeral joint with bone spurs, diffuse labral degeneration with focal labral tearing posterior-inferiorly with adjacent paralabral cysts, and no evidence of a rotator cuff tear. PX 3. Petitioner began physical therapy at Omega on 3/29/11.

The accident report at RX 2 is dated 3/28/11. Petitioner indicated that he injured his right shoulder while installing a valve on 3/24/11. He described the injury as "a pain in the right shoulder with a very limited range of motion. Feels like cracking and popping. Seems to get almost locked up at times and I have to force it to move. Pain sometimes goes down my right arm." Petitioner responded "yes" to the question as to whether he had complaints to the same part of the body in the past. RX 2. Petitioner testified that he thought he complained of clicking and popping to Omega and Dr. Palutsis.

Petitioner testified that he was then referred by Omega to Dr. Palutsis at Illinois Bone and Joint. At his first visit on 4/18/11, Petitioner offered a history of minimal and occasional right shoulder stiffness in the past but no significant past shoulder injury. Petitioner stated that his right shoulder became painful on 3/17/11 while underground lying down with his arms extended. He stated that he had increasing shoulder pain since that time. Dr. Palutsis noted "I believe Mr. Muzik is suffering from severe osteoarthritis of the right shoulder. It appears that work an aggravating [sic] cause of pain for him." PX 2. Dr. Palutsis started conservative treatment including an injection for pain in his right shoulder and ordered continued physical therapy. Petitioner was continued on light duty as initially authorized by Omega. He was told to

follow up in 3 weeks. Petitioner was seen next by PA Paison on 4/23/11. Petitioner reported that the injection helped "quite a bit" as did physical therapy. Petitioner was told to continue icing his shoulder, continue physical therapy, use anti-inflammatory medication and follow up .

Petitioner next saw Dr. Palutsis on June 24, 2011. Dr. Palutsis noted that Petitioner was doing well with a "better range of motion and less discomfort in the shoulder." PX 2. He further noted that although Petitioner was on light duty he actually had recently done some heavier work due to storms which required him to lift branches and throw them overhead into dumpsters. Dr. Palutsis noted, "he has gotten a little bit sore with this, but nothing too terrible." Petitioner's physical exam offered "very good range of motion. He lacks just a little bit of internal rotation and horizontal abduction. His strengths are good against my resisted testing today. Overall, he has made progress with our conservative management program." As a plan, Dr. Palutsis wrote that Petitioner was to "... limit as much as he can overhead activities with weight. Secondly, he is going to use his Aleve as necessary up to 4 a day. He will ice regularly and he will continue on a home program of exercise. We will then see him back as needed. We have discussed future cortisone injections if he is symptomatic again." PX 2. At his deposition, Dr. Palutsis testified as to the 6/24/11 office visit stating that he allowed Petitioner to continue working with the restriction of limiting overhead work and limiting his lifting weight. PX 1, p. 15-16. When asked why he allowed Petitioner to continue working Dr. Palutsis answered, "well, because Mr. Muzik wanted to work. I believe his nature, he's a hard worker. Secondly, the work comp criteria would indicate that if he's available for light duty, he should be doing light duty. So we had him available for light duty and they were able to accommodate that." PX 1, p. 16. Dr. Palutsis further testified that when Petitioner left his office on 6/24/11, he was still symptomatic in the right shoulder and that his pain was not fully resolved. PX 1, p. 49.

The Arbitrator notes here that TTD is not at issue as Petitioner was paid all TTD.

At trial, Petitioner testified that at the 6/24/11 visit with Dr. Palutsis he told Dr. Palutsis that he was doing well with some soreness with activity but that he was "overall pretty good." He testified that he did not tell Dr. Palutsis that he was pain free. He further testified that he was told to return as needed. Petitioner testified that Dr. Palutsis released him to full duty work and that he did return to his full duty work as of 6/24/11. Petitioner further testified that he was not pain or symptom free at that time but that he returned to full duty work because he enjoyed his job, does not like to work light duty, and wants to continue working at his job for Respondent. He testified that she simply worked through any continued pain. Petitioner called three co-workers to testify at trial. All three of the witnesses testified that Petitioner is a hard worker with a good reputation. Each testified that Petitioner is not a "complainer." Each testified to witnessing Petitioner having difficulty with tasks at work since the shoulder injury such as digging, reaching for and picking up tools and using a wrench.

Petitioner testified that he worked full duty until his next visit to Dr. Palutsis on 2/17/12. He did not have any treatment for his right shoulder between 6/24/11 and 2/17/12. On 2/17/12 Petitioner again saw a PA in Dr. Palutsis' office who noted that Petitioner "presents to the office today with continued right shoulder pain. He has known severe degenerative joint disease of the shoulder. He has responded well, almost a year ago, to a cortisone injection to this area." Exam revealed "... a very good range of motion of his shoulder. He has good cuff strength to resistive testing. He is limited with his internal rotation, however." PX 2. Petitioner received a cortisone shot and was told to follow up if the injection was not

helping him. It was noted that "at his next appointment , we should obtain x-rays to see if his arthritis has advanced any." PX 2. Petitioner testified that he continued to work full duty.

Petitioner next saw Dr. Palutsis on 9/17/12. He had no treatment between 2/17/12 and 9/17/12 and continued to work full duty. Dr. Palutsis noted, "Mr. Muzik is here with recurrent or persistent pain into his right shoulder. We know that he has underlying osteoarthritis of the shoulder. He recently had an injection on 2/17/12 with mild relief of pain. He now reports increasing pain with the shoulder particularly with heavier activities. He does not report any new injury to the shoulder." On exam, Petitioner showed good range of motion with crepitation. Most of the pain occurred when Petitioner reached from shoulder level and above. Dr. Palutsis advised that Petitioner may need a shoulder replacement at some point and that it would be difficult for him to continue with heavy work activities for a longer period of time. Petitioner received another injection and was told to follow up prn. PX 2. On 10/22/12, Petitioner returned and reported feeling better with the injection but still reported significant weakness into the shoulder despite continued physical therapy. His pain was improved. An MRI was ordered to evaluate the rotator cuff and operative intervention was again mentioned.

On 11/2/12, Dr. Palutsis noted that the MRI did not show evidence of rotator cuff pathology. He discussed the possibility of shoulder hemiathroplasty as a solution for the persistent pain. Given Petitioner's heavy workload, Dr. Palutsis did not recommend a total shoulder arthroplasty. In a letter to Respondent's agent dated 12/10/12, Dr. Palutsis wrote in part that he believed Petitioner's current complaints are related to the underlying osteoarthritis which was made symptomatic by the work injury in that it is "... unclear if and when he would have become symptomatic in regards to his shoulder if there had not been a work related injury." He further stated, "I believe that his present symptoms are a direct result of his injury and there has been unbroken timeline of various degrees of symptoms since the onset of his pain following his work related injury and I believe that his present symptoms are again related to the March, 24, 2011 work injury." PX 2. PX 1, p. 47. Dr. Palutsis again recommended the shoulder hemioarthroplasty as a way of providing enough pain relief for Petitioner to be functional at a high work load level. However, he further cautioned Petitioner that he may need a total shoulder in the future. Dr. Palutsis further noted that Petitioner has had continuous discomfort in the shoulder despite being able to go back to heavy work activities and that he had continuously treated Petitioner for his shoulder problem for over one year. PX 2.

Dr. Brian Cole performed a Section 12 exam on 1/17/13 at Respondent's request. He testified to his opinions via evidence deposition. Dr. Cole opined that Petitioner "arguably" had a temporary aggravation of a preexisting condition which resolved as of 6/24/11. RX 1, p. 12,23. He further opined that the next visit of February 2012 was the "spontaneous presentation of a patient who has severe osteoarthritis and is not related to any single event at work." RX 1, p. 13. He further opined that Petitioner's surgical recommendation is not work related because "...given the profound nature of his underlying osteoarthritis, there is nothing unique to the environment at work that's any different than life itself that would manifest symptoms of osteoarthritic pain and motion loss." RX 1, p. 13. On cross exam, Dr. Cole testified that Petitioner needs surgery but that it is not related to any work injury and that he would perform a total shoulder replacement as more predictive of a good clinical outcome. RX 1, p. 28.

Petitioner received another cortisone injection on 5/10/13 while awaiting surgery. Petitioner testified that the injections and PT have helped but have not completely resolved the pain. He further testified that his shoulder pain since the incident has never resolved and that he now has a headache all the time. Petitioner

testified that he continues to work with fluctuating pain because he understands that "you play hurt." Dr. Palutsis recommended surgery for his shoulder and Petitioner wants the surgery.

CONCLUSIONS OF LAW

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

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

The Arbitrator again notes that the parties stipulated to a work-related accident on 3/24/11. ARB EX 1. With regard to the issue of causal connection for Petitioner's current condition of ill-being in his right shoulder and for the recommended surgery, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his March 24, 2011 work injury. In so finding, the Arbitrator notes that Petitioner's testimony at trial regarding his accident, injury, ongoing complaints and work ability was highly credible. Petitioner was in good health before the work accident in that he only experienced minor ache and stiffness in his right shoulder prior to 3/24/11. Since the accident of that date, Petitioner testified that he has remained symptomatic in varying degrees and that he has continued to work through the pain. Petitioner's credible testimony is buttressed by histories contained in the medical records and by the opinion of treating physician Dr. Palutsis who testified to Petitioner's "... unbroken timeline of various degrees of symptoms since the onset of his pain following his work related injury." The Arbitrator specifically notes that Petitioner performed full duty after 6/24/11 on his own volition while he continued to seek care for right shoulder symptoms as necessary and as directed by Dr. Palutsis at the visit of 6/24/11. Accordingly, the Arbitrator finds that the lack of treatment between 6/24/11 and February 2012 does not constitute a "gap" in treatment sufficient to sever all causal relationship between his continued shoulder problems and the accident which clearly aggravated his previously asymptomatic pre-existing right shoulder osteoarthritis.

Based on the causal relationship between the work injury and Petitioner's right shoulder condition, the Arbitrator further finds that the need for the recommended hemiarthroplasty surgery is also causally related to the work accident and injury of 3/24/11.

(K) IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Based on the foregoing findings on the issue of causal connection, the Arbitrator further finds that the Petitioner is entitled to prospective medical care recommended by Dr. Palutsis in the form of a hemiarthroplasty surgery for his right shoulder work injury. The Arbitrator further finds that Respondent shall authorize and pay for the surgery and its attendant care pursuant to Sections 8 and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian R. Iverson,
Petitioner,

vs.

NO: 12 WC 29132
12 WC 29133

15IWCC0449

Bull's Custom Shop,
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, 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 November 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.

15IWCC0449

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $64,700.00. 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: JUN 1 5 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-06/10/15
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

IVERSON, BRIAN
Employee/Petitioner

Case# **12WC029132**

12WC029133

BULL'S CUSTOM SHOP
Employer/Respondent

15IWCC0449

On 11/17/2014, 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:

0874 FREDERICK & HAGLE
PATRICK J HANLON
129 W MAIN ST
URBANA, IL 61801

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

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

Brian Iverson
Employee/Petitioner

v.

Bull's Custom Shop
Employer/Respondent

Case # 12 WC 29132

Consolidated cases: 12 WC 29133

15IWCC0449

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on September 24, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On May 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 $27,975.00; the average weekly wage was $537.98.

On the date of accident, Petitioner was 48 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $24,746.85 for TTD, $0.00 for TPD, $31,080.03 for maintenance, and $0.00 for other benefits, for a total credit of $55,826.88.

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

ORDER

Petitioner's petition for payment of medical bills subsequent to September 18, 2012, is denied.

Petitioner's petition for maintenance benefits is denied.

Respondent shall pay Petitioner temporary total disability benefits of $358.65 per week for 69 weeks commencing May 24, 2011, through September 18, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $322.79 per week for 200 weeks because the injury sustained caused the 40% loss of use of the body as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from September 19, 2012, through September 24, 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.

William R. Gallagher, Arbitrator

November 12, 2014
Date

NOV 17 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In 12 WC 29132, the Application alleged that on May 13, 2011, "During the course of employment" Petitioner sustained an accident that caused injuries to "Multiple" areas of the body (Arbitrator's Exhibit 2). In 12 WC 29133, the Application alleged that on August 3, 2012, "During the course of employment" Petitioner sustained an accident that caused injury to "Multiple" areas of the body (Arbitrator's Exhibit 3). There was no dispute in regard to either accident and the disputed issues were medical bills, temporary total disability benefits, maintenance and the nature and extent of permanent disability.

Petitioner worked for Respondent as an auto body technician and on May 13, 2011, Petitioner fell off of a creeper seat and, when he did so, he struck his head on a box of metal parts and his back struck the concrete floor. There was no testimony at trial regarding the accident of August 3, 2012; however, Petitioner apparently sustained this accident while he was in therapy and it resulted in a hernia.

Subsequent to the accident of May 13, 2011, Petitioner was seen by Dr. Richard Foellner on May 24, 2011. At that time, Petitioner complained of pain in the upper back and neck with radiation into both arms. Dr. Foellner ordered an x-ray of the cervical spine which revealed post operative changes at C5-C6 with metal hardware. Dr. Foellner authorized Petitioner to be off work and referred him to Dr. William Olivero, a physician with Carle Spine Institute (Petitioner's Exhibit 4; pp 16-19).

Dr. Olivero previously treated Petitioner for a cervical problem in 2006 and 2007. Dr. Olivero performed cervical disc surgery on Petitioner on November 15, 2006, and the procedure consisted of a cervical discectomy and fusion at C5-C6. Dr. Olivero discharged Petitioner from treatment on June 4, 2007 (Petitioner's Exhibit 5; pp 44-45; 130).

At trial Petitioner testified that following the prior neck surgery he was able to return to work without restrictions as an auto body technician in January, 2007. He also stated that he had no further neck or back problems until he sustained the accident in May, 2011.

Dr. Olivero saw Petitioner on June 14, 2011, and he ordered an MRI scan. The MRI scan was performed on June 14, 2011, which revealed spinal stenosis and the prior fusion at C5-C6. Dr. Olivero ordered physical therapy (Petitioner's Exhibit 6; pp 135-138).

Ultimately, Dr. Olivero performed cervical spine surgery on April 4, 2012. The surgical procedure consisted of discectomy and fusion at C3-C4 with a prevail spacer and screws (Petitioner's Exhibit 6; pp 196-198).

Following surgery, Dr. Olivero ordered physical therapy and, on July 10, 2012, a functional capacity evaluation (FCE) was performed at his direction. The FCE indicated that Petitioner could work at medium physical demand level but that he could not do squatting, repetitive

kneeling and pinching. It was also recommended that Petitioner attempt work hardening (Petitioner's Exhibit 9; pp 433-440).

Dr. Olivero saw Petitioner on September 18, 2012, and he noted that Petitioner was not able to complete the work hardening. He opined that Petitioner was at MMI and imposed the permanent restrictions as stated in the FCE (Petitioner's Exhibit 6; p 351).

Petitioner was seen by Dr. Foellner on October 25, 2012. At that time, Petitioner complained of fatigue and muscular weakness as well as numbness in his legs and hands. Petitioner informed Dr. Foellner that he needed a referral to Dr. David Fletcher of SafeWorks (Petitioner's Exhibit 4; p 24).

Petitioner called Dr. Olivero's office on December 13, 2012, and requested a referral to Dr. Fletcher. Dr. Olivero declined to do so noting that it had been four months since he last saw Petitioner and had discharged him from care at that time (Petitioner's Exhibit 6; p 357). Petitioner was then seen by Dr. Foellner on December 13, 2012, and complained of a dull ache "all over." He again requested a referral to Dr. Fletcher (Petitioner's Exhibit 4; p 27).

Petitioner was seen by Dr. Fletcher on July 30, 2013. At that time, Petitioner complained of constant body aches, numbness/tingling in hands/fingers, balance problems, lack of muscular coordination, cervical spine pain, low back pain, elbow/hip joint pain and calf/leg cramps. Dr. Fletcher opined that Petitioner had cervical myelopathy with hyperflexia in the lower extremities. Dr. Fletcher recommended Petitioner have a life care plan and that he be evaluated by a neurologist. He also recommended Petitioner undergo a two day FCE to determine his endurance (Petitioner's Exhibit 10; pp 447-450).

The two day FCE was performed on August 21, and August 22, 2013. The examiner opined that Petitioner did not meet the physical requirements of an auto body technician but that he could work within the medium physical demand level (Petitioner's Exhibit 10; pp 451-456). Dr. Fletcher saw Petitioner on November 8, 2013, and reviewed the FCE. Even though the FCE examiner concluded Petitioner was capable of performing work within the medium demand level, Dr. Fletcher opined that Petitioner was disabled from all gainful employment except sedentary sit down work. He recommended that Petitioner apply for Social Security disability (Petitioner's Exhibit 10; pp 458-461).

Dr. Fletcher was deposed on November 19, 2013, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Fletcher testified that because of the amount of compression and stenosis, the spinal cord was injured and this caused an interruption of the signals going down the spinal cord affecting both the upper and lower extremities. He opined Petitioner was disabled from working as an auto body technician and that the finding of the FCE that Petitioner could work within the medium demand level was just a starting point and that other limitations would need to be analyzed to determine Petitioner's work capacity (Petitioner's Exhibit 1; pp 13-22).

When he was deposed, Dr. Fletcher also opined that Petitioner would have future medical needs. This included modification of his house and that Petitioner might need to be in a wheelchair (Petitioner's Exhibit 1; p 28).

On cross-examination, Dr. Fletcher agreed that the FCE did reveal some submaximal efforts of Petitioner and magnification of Petitioner's fatigue. He agreed that Petitioner was probably capable of more effort than what the FCE revealed (Petitioner's Exhibit 1; pp 37-38).

Dr. Jesse Butler examined Petitioner on January 17, and January 24, 2014. He diagnosed cervical spine stenosis and cervical spondylosis with myelopathy. He consulted with several unnamed orthopedic and neurosurgeons whose treatment suggestions varied from doing nothing at all to further surgery (Petitioner's Exhibit 11; pp 471-473; 495).

At the direction of the Respondent, Petitioner was examined by Dr. Andrew Zelby, a neurosurgeon, on March 10, 2014. In connection with his examination of Petitioner, Dr. Zelby reviewed medical records provided to him by Respondent. Dr. Zelby opined that the accident of May 11, 2011, aggravated the underlying condition of cervical spondylosis and myelopathy. He opined that there had not been any progression of his symptoms and specifically stated that Dr. Fletcher's suggestion that Petitioner was "heading to a wheelchair" was medically inaccurate. He opined Petitioner was at MMI and that no further medical treatment was indicated. He also opined Petitioner was employable, but with lifting restrictions (Respondent's Exhibit 3; Deposition Exhibit 2).

Dr. Zelby was deposed on April 2, 2014, and his deposition testimony was received into evidence at trial. Dr. Zelby's testimony was consistent with his medical report and he reaffirmed his disagreement with Dr. Fletcher's opinion that Petitioner would eventually be in a wheelchair. He opined that Petitioner was subject to work restrictions as stated in the FCE (Respondent's Exhibit 3; pp 18-21).

Counsel for both Petitioner and Respondent sought evaluations from vocational rehabilitation experts. Petitioner's expert was Bob Hammond who met with Petitioner on February 19, 2014. Respondent's expert was Amy Portz who met with Petitioner on June 19, 2014. The narrative reports of both experts were received into evidence at trial (Petitioner's Exhibit 2; Respondent's Exhibit 2). Both Hammond and Portz testified at trial.

Hammond testified that he reviewed Petitioner's medical records and he opined that Petitioner was not employable as an auto body technician and that, at best, Petitioner might be able to work at a minimum wage job. Hammond specifically noted that Petitioner had no computer skills and no customer service experience and suggested working as a telemarketer or security guard might be possibilities.

Portz testified she performed a labor market survey and transferable skills analysis. She opined that there was a stable labor market for Petitioner's medium physical demand level. Her report listed a number of jobs that varied from minimum wage to jobs that paid equal to or in excess of the job Petitioner had at the time of the accident. Portz' report listed a number of potential

employers, but she could not state whether or not Petitioner would be able to secure employment with any of them.

Petitioner testified that he conducted a job search; however, Petitioner's job search was limited to completion of several online job applications between September 8, and September 10, 2014, just shortly before trial. Petitioner did not seek any employment at all from the time Dr. Olivero discharged him from care on September 18, 2012, until approximately two years later. When cross-examined at trial, Petitioner admitted that he had no intention of returning to work.

Petitioner testified that his condition is essentially the same as it was in July, 2012, when Dr. Olivero released him to return to work based on the FCE. Petitioner still complains of weakness in his legs, pain in his neck and upper back and a dull ache all over. Petitioner's daily activities are limited to doing some housework and some light property maintenance.

Conclusions of Law

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner through September 18, 2012, the date of Dr. Olivero's evaluation, was reasonable and necessary and that Respondent has made payment of same.

The Arbitrator further concludes that Respondent is not liable for medical expenses incurred subsequent to September 18, 2012.

In support of these conclusions the Arbitrator notes the following:

Petitioner's treating physician, Dr. Olivero, opined that Petitioner was at MMI and that no further medical treatment was indicated when he examined him on September 18, 2012. Respondent's Section 12 examiner, Dr. Zelby's opinion was consistent with the opinion of Dr. Olivero.

The Arbitrator is not persuaded by the opinion of Dr. Fletcher that Petitioner required or will require future medical treatment.

In regard to disputed issue (K) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner is not entitled to maintenance benefits from September 19, 2012, through September 24, 2014.

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 69 weeks commencing May 24, 2011, through September 18, 2012.

In support of these conclusions the Arbitrator notes the following:

Petitioner's treating physician, Dr. Olivero, opined that Petitioner was at MMI as of September 18, 2012.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kent Schuck,
Petitioner,

vs. NO: 13 WC 12676

Enviro-Safe,Inc.,
Respondent.

15IWCC0450

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24, 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: JUN 15 2015

Joshua D. Luskin

o-06/09/15
jdl/wj
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHUCK, KENT
Employee/Petitioner

Case# **13WC012676**

ENVIRO-SAFE INC
Employer/Respondent

15IWCC0450

On 10/24/2014, 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:

0225 GOLDFINE & BOWLES PC
ATTN; WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61614

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

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

Kent Schuck
Employee/Petitioner

v.

Enviro-Safe, Inc.
Employer/Respondent

Case # **13** WC **12676**

15IWCC0450

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **August 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **March 19, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent children.

ORDER

The Petitioner failed to prove that an employee/employer relationship existed between the Petitioner and the Respondent. The Petitioner's claim for compensation is, therefore, denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

October 20, 2014
Date

OCT 24 2014

FACTS:

The Petitioner testified that he is a licensed heating, ventilation, and air conditioning (HVAC) technician and electrician and that, since 2011, he has been the sole owner of Schuck Heating, Cooling, and Electric Company, which is a licensed HVAC contractor. The Petitioner testified that in the operation of his business, he drove a truck with his company logo painted on it and he owned and used his own tools. He testified that Schuck Heating, Cooling, and Electric Company was not incorporated and had no employees, but it did maintain a liability insurance policy.

The Petitioner testified that sometime in 2011Randy Price, the Respondent's Vice President, hired Schuck Heating, Cooling, and Electric Company to install some furnaces at one of the Respondent's facilities. The Petitioner testified that Schuck Heating, Cooling, and Electric Company did those installations and then did a few other electrical jobs for the Respondent. The Petitioner testified that Mr. Price was happy with the work that was done and proposed that the parties enter into an "exclusive relationship" based upon a $50.00 per hour rate. The Petitioner testified that he agreed and that he and Mr. Price maintained that "exclusive relationship" from January of 2012 through March of 2013. The Petitioner also testified that during the period of his "exclusive relationship" with the Respondent, he put his business "on hold" although he did maintain his business identity and he did do some other jobs for other people.

The Petitioner testified that in January of 2012 he started working at the Respondent's facilities five days per week, eight hours per day doing whatever Randy Price instructed him to do. The Petitioner testified that the Respondent's business was the production of replacement refrigerants and that the Respondent's business utilized four separate buildings and employed 10 to 15 unskilled workers who were paid an hourly wage. The Petitioner testified that the work he did for the Respondent included HVAC work, electrical work, demolition and remodeling work, machine moving, painting, and roof repair, and that he used jack hammers, sledge hammers, and fork trucks. The Petitioner testified that he would provide Mr. Price with an invoice for the work he performed at the end of each week and he would be paid based upon the hours shown in that invoice.

The Petitioner testified that he "brought in" Drew Lusk to help him perform the work at the Respondent's facilities. The Petitioner testified that Mr. Lusk operated his own business, Lusk Construction, and would bill the Petitioner for the time he worked. The Petitioner testified that he did not bill the Respondent separately for Mr. Lusk's time and that Mr. Lusk's services were paid for out of the $50.00 per hour the Petitioner billed the Respondent. The Petitioner testified that Schuck Heating, Cooling, and Electric Company gave Drew Lusk a Form 1099 at the end of 2012 which indicated that Mr. Lusk had been paid about $10,000.00 during that year. The Petitioner testified that, after a while, he also began training and supervising some of the Respondent's hourly employees.

The Petitioner described that he would meet with Randy Price every morning and Mr. Price would explain what he wanted done and how he wanted it done. The Petitioner testified

that Mr. Price would then check on his progress throughout the day and would show him how he wanted certain things done. The Petitioner testified that Randy Price would provide all of the tools and supplies that were needed to complete the various tasks and that he did not use his own tools or provide any supplies. The Petitioner testified that Randy Price always directed the manner in which the work should be done and always showed the Petitioner how he wanted things done.

The Petitioner testified that he received a Form 1099 from the Respondent for the amount he was paid during the period of their relationship. The Petitioner identified Respondent's Exhibit 6 as the invoices that he submitted to the Respondent for his services and Respondent's Exhibit 4 as a copy of the 2012 Form 1099 that he received from the Respondent.

The Petitioner testified that on March 19, 2013 he was assisting a contractor with the installation of a filling machine on the Respondent's premises when he noticed that the gas line that fed the machine needed to be "burped". The Petitioner testified that the gas line had occasionally needed to be "burped" previously, and that Randy Price had showed him how to do it. The Petitioner testified that prior to March 19, 2013 he had always consulted with Mr. Price before the line was "burped" but that on this occasion he did not. The Petitioner testified that as he was burping the line an explosion occurred and he sustained burns to his face and hands.

The Petitioner was taken from the scene by ambulance to OSF St. Francis Medical Center, and then life-flighted to OSF St. Anthony's burn unit in Rockford, Illinois. He came under the care of Dr. Stathis Poulakidas and was hospitalized for nine days receiving treatment deep second degree burns to the dorsal aspect of both of his hands, his ear and his head. At the time of Arbitration, the Petitioner's head and ear burns were resolved with no apparent disfigurement. The Arbitrator observed that the dorsal aspect of the Petitioner's hands were disfigured with raised purplish appearing scar tissue and that the scarring on the Petitioner's left hand was significantly more severe than the scarring on his right hand. There was no scarring or disfigurement noted on the palmar aspect of either hand.

Gino Perez testified that he was employed by the Respondent as a machine operator but he also did demolition and remodeling work as part of his job. Mr. Perez testified the he began his employment with the Respondent in December of 2011 and that he was paid an hourly wage for his work. Mr. Perez testified that was paid $8.50 per hour when he first started and that by the end of his employment with the Respondent he was earning $12.75 per hour. Mr. Perez testified that the Petitioner was present at the Respondent's facilities "every day, all day" and he thought that the Petitioner was Mr. Price's "right hand man". Mr. Perez testified that he considered the Petitioner to be his boss and that the Petitioner supervised his work.

Randy Price testified that he is the Respondent's owner and Vice President and that he has been so for 18 years. Mr. Price testified that the Respondent manufactures refrigerants, sealants and automobile fluids and that in March of 2013 the Respondent maintained five facilities, using its own employees and hiring outside contractors as well. Mr. Price testified

that he met the Petitioner in 2010 or 2011 and that the Petitioner bid on some HVAC work and was hired by the Respondent to do that HVAC work. Mr. Price testified that sometime later, he contacted the Petitioner and asked him if he would do some work cleaning up a hotel property that the Respondent had purchased. Mr. Price testified that the Petitioner agreed to do the work and he agreed to pay the Petitioner's business $50.00 per hour to do the work for the Respondent. Mr. Price testified that the $50.00 per hour was to cover the work of up to two people and that it was agreed that if more than two people were required for the work, additional charges would occur. Mr. Price testified that the Petitioner submitted weekly invoices for the work that was performed and that there were invoices that were submitted for work performed by other people when the Petitioner himself was not present. Mr. Price testified that no taxes were withheld from the money that was paid to the Petitioner.

Mr. Price testified that he did supply all of the materials and some of the equipment but he testified that the Petitioner used his own tools 99% of the time. Mr. Price testified that he supplied materials to all of the contractors that the Respondent hired in order to avoid problems with suppliers filing liens when they weren't paid by the contractors. Mr. Price also testified that he did meet with the Petitioner on a daily basis to let him know what was going on that day and so the Petitioner's work wouldn't interfere with production. Mr. Price testified that he also instructed other contractors as to how he wanted work to be done so as to not have their work interfere with production or safety. Mr. Price testified that he relied on the Petitioner's expertise in his field but that he did instruct him as to where he wanted certain things such as lights and electrical outlets and switches to be located. Mr. Price testified that the Petitioner maintained his own liability insurance and got all of the necessary permits for any work that he performed.

Mr. Price testified that he never asked or instructed the Petitioner to supervise any of the Respondent's employees and that he never told the Petitioner that he could or should "burp" any lines. Mr. Price also testified that, at some point, the Petitioner asked to be made a full-time employee of the Respondent but that he denied the Petitioner's request.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (B.), Was there an employee-employer relationship, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner has the burden of proving each and every element of his claim by a preponderance of the evidence, including the existence of an employee/employer relationship. In determining whether an employee/employer relationship exists, the intention of the parties is not, in itself determinative. Rather, the courts have held that the determination must be based upon consideration of a number of factors including; the right to control the manner in which work is done; the method of payment; the right to discharge; the skills required to perform the work; the ownership of tools, materials, and equipment used; the relationship of the work performed to the business of the alleged

employer; and whether the alleged employer deducted withholding tax. No single factor is determinative but the right to control the manner in which work is done is perhaps the single most important of these factors.

In the instant matter, it is clear that the Petitioner was and is the sole proprietor of his own business which performed heating, ventilation, air conditioning and electrical work and that the Petitioner had special skills which he acquired prior to, and independent of, his relationship with the Respondent. The Petitioner was and is a licensed heating, ventilation, and air conditioning technician and electrician and the sole owner of Schuck Heating, Cooling, and Electric Company, which is a licensed HVAC contractor. The Respondent is in the business of manufacturing refrigerants, sealants and automobile fluids. The work that the Petitioner performed for the Respondent included HVAC and electrical work, as well as demolition and remodeling work.

While it is not a determinative factor, the Arbitrator notes that the evidence in the instant matter demonstrates that the Petitioner did not consider himself to be an employee of the Respondent. While the Petitioner testified that he had an "exclusive arrangement" with the Respondent and put his own business "on hold" during the period of that relationship, the Petitioner continued to maintain his own business identity, driving a truck with his company name and telephone number emblazoned on the side of the truck and continuing to perform work for other entities. The Petitioner submitted itemized invoices for his work on a weekly basis under the name of Schuck Heating & Electric, he was not paid overtime when he worked more than 40 hours in a week, and the number of hours he worked varied from week to week far more than would the hours of a traditional employee. No withholding taxes were deducted from the payments made to the Petitioner and the Petitioner's tax returns for 2012 and 2013 declared his earnings to be business income not wages or salary. The Petitioner's medical records indicate that when he sought treatment after his injury, he did not claim the Respondent as his employer but indicated that his employer was Schuck Heat & Electric. Randy Price testified that, at some point, the Petitioner asked to be made a full-time employee of the Respondent but that he denied the Petitioner's request. The Petitioner did not dispute that testimony on rebuttal.

With regard to the manner of payment, it is undisputed that the Petitioner provided the Respondent with an invoice which detailed the work he performed at the end of each week and he would be paid based upon the hours shown in that invoice. The Petitioner's business name is at the top of each of those invoices. No taxes or other deductions were withheld from the payments made to the Petitioner and the Respondent issued a Form 1099 to the Petitioner's business at the end of the tax year. The Petitioner's tax returns demonstrate that the Petitioner claimed only "business income" for 2012 and 2013 and no wages or salary from any source. The Petitioner's tax returns also demonstrate that he received 1099 forms from two other entities for work he performed during 2012 and that he issued form 1099s to Drew Lusk in 2012 and 2013. The Petitioner acknowledged that he paid Drew Lusk out of the payments he received from the Respondent and he testified that Drew Lusk operated his own business and was not an employee of the Petitioner's business.

With regard to the ownership of the tools, materials, and equipment used, the Petitioner and Randy Price testified that the Respondent provided the Petitioner with all of the materials needed to perform the work. Mr. Price testified, however, that he provided materials to all of the contractors that worked for the Respondent as to avoid the risk of mechanics liens being filed by suppliers who didn't get paid by the contractors. With regard to the tools and equipment used, the Petitioner acknowledged that he did have his own tools, but he testified that Randy Price would provide all of the tools and supplies that were needed to complete the various tasks and that it was "very seldom" that he used his own tools or provided any supplies. Specifically, the Petitioner testified that he used jack hammers, sledge hammers and fork trucks that were provided by the Respondent. Mr. Price testified that he did supply all of the materials and some of the equipment but he testified that the Petitioner used his own tools 99% of the time.

Much of the Petitioner's testimony was directed at the amount of control Randy Price exerted over every aspect of the Respondent's operation. The Petitioner testified that he would meet with Randy Price each morning and that Mr. Price would instruct him as to what he wanted done that day, how he wanted it to be done, and the order that he wanted it done in. The Petitioner testified that nothing got done at the Respondent's business unless it got done "Randy's way" and that there were a number of video surveillance cameras located throughout the Respondent's facilities so that Randy Price could monitor what was happening. The Petitioner testified that if Mr. Price saw something happening that he didn't like, Mr. Price would call the Petitioner and instruct him to rectify the problem. The Petitioner testified that Mr. Price called him three to ten times each day to give him instructions.

Randy Price acknowledged that he met with the Petitioner "most mornings" to let him know what was happening at the Respondent's facilities that day, and to ensure that the Petitioner's work wouldn't interfere with production or safety. Mr. Price testified that he instructed all of the contractors that did work for the Respondent in the same manner. Mr. Price testified that he relied on the Petitioner's expertise in his field but that he did instruct him as to where he wanted certain things such as lights and electrical outlets and switches to be located.

While the evidence demonstrates that Randy Price did exert a great deal of control over what happened at the Respondent's facilities, there is no evidence that he actively controlled the manner in which the Petitioner performed his actual work as a contractor. It is clear that Mr. Price endeavored to ensure that things were done in the order and manner he wanted them to be done so as not to interfere with production or safety. There is, however, no indication that he controlled or directed the manner in which the Petitioner wired circuits, lights, or switches, or installed or repaired compressors, boilers, or motors. There is similarly no evidence that Mr. Price controlled the manner in which the Petitioner performed demolition work or built new walls or put up drywall. There is no evidence that Mr. Price controlled or directed the manner in which the Petitioner did roofing work or put up shelves. While Mr. Price clearly directed the Petitioner as to the work he wanted him to perform, the Arbitrator notes that the "direction" provided by Mr. Price was not much different than what one would expect from any business owner who hired a contractor to perform demolition/remodeling work while

attempting to maintain an ongoing business.

In addition to consideration of the factors enumerated above, the Arbitrator finds it to be compelling that the Petitioner retained other people to work for him in the performance of his work for the Respondent. The Petitioner testified that he "brought on" Drew Lusk to perform some of the work for the Respondent and that he paid Drew Lusk Construction from the amounts that he invoiced to the Respondent. The invoices submitted to the Respondent by the Petitioner do not include any itemization of the hours worked by Drew Lusk but merely the total number of hours for which the Petitioner was seeking payment. The Petitioner testified that Drew Lusk was not an employee but was a separate business that billed the Petitioner for his time and was paid by the Petitioner as Lusk Construction. The Petitioner's tax records demonstrate that he paid Drew Lusk $10,150.00 in 2012 and $7,300.00 in 2013. The Arbitrator notes that the ability to hire and pay subcontractors to assist in the performance of work is more indicative of independent contractor status than it is of an employee/employer relationship.

The Arbitrator also notes that the Petitioner provided the Respondent with his business' Tax ID number and proof that he had Business Insurance. The provision of a business' Tax ID number and the provision of proof of Business Insurance are also more indicative of an independent contractor than an employee.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an employee/employer relationship existed.

Having found that the Petitioner failed to prove that an employee/employer relationship existed, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Willie Vaughn,
Petitioner,

vs.

No: 13 WC 38665

Heath Consultants Inc.,
Respondent.

15IWCC0451

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, prospective medical treatment, and temporary total disability, and being advised of the facts and law, reverses the June 23, 2014 Decision of the Arbitrator, which is attached hereto and made a part hereof.

Arbitrator Jessica Hegarty found that Petitioner proved he sustained an accident that arose out of and in the course of employment on October 15, 2013 and also proved his current condition of ill-being is causally related to that accident. The Arbitrator awarded Petitioner medical expenses and temporary total disability benefits and ordered Respondent to authorize and pay for physical therapy and "subsequent related medical treatment."

After considering the entire record, and for the reasons set forth below, the Commission reverses the June 23, 2014 decision of the Arbitrator. Petitioner failed to credibly prove he sustained an accident that arose out of and in the course of his employment on October 5, 2013. All benefits are denied.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

15IWCC0451

The Commission finds:

1. On October 15, 2013, Petitioner was employed by Respondent as a "leak survey technician." One of his duties was to post notices to customers whose gas was in danger of being terminated. Petitioner was required to complete 50-60 postings per day and utilized a company-provided laptop to keep track of the postings.

2. Petitioner testified that on that date, he was walking toward a residence for the purpose of posting a notice when he tripped on a piece of concrete sidewalk and fell into the customer's gate, injuring his left hand and index finger.

3. Petitioner testified he immediately phoned a co-worker, Charles Zultowski, to tell him what had happened. He then phoned one of the crew leaders, James Merriweather, to report the accident. Petitioner testified that he remained on the phone with Mr. Merriweather for approximately 40 minutes, while the crew leader attempted to dissuade him from reporting the work accident. According to Petitioner's testimony, Mr. Merriweather advised him that reporting an accident would adversely affect Petitioner's career.

4. Petitioner testified that after his phone conversation with Mr. Merriweather ended, he went to Walgreens Pharmacy for ice and tape to treat his injuries. He then continued with his postings. Later that evening, Petitioner sought treatment at the Ingalls Family Care Center Emergency Room, where he reported pain at the level of 1/10.

5. The Emergency Room triage note state "he jambed [sic] his finger while hopping over a fence." The nurse's note states that Petitioner was injured "after tripping against gate striking finger." Petitioner was diagnosed with a fractured left fourth finger and possible tendon injury and advised to follow up with an orthopedist.

6. On October 17, 2013, Dr. Philip Nigro at Bone and Joint Physicians examined Petitioner and recorded the following history of accident:

> [Petitioner] was walking two days ago when he slipped and tried to grab for a gate. His left ring finger caught on the gate and he felt a pop and he had subsequent pain and swelling.

Dr. Nigro diagnosed Petitioner with a left distal phalanx fracture and Jersey finger and referred him to his partner, Dr. John McClelland, for further evaluation and treatment.

7. Dr. McClelland examined Petitioner on October 24, 2013, noting that Petitioner "injured the left ring finger 9 days ago when he slipped and tried to grab onto a gate." The doctor noted that the injury was work-related and recommended surgical intervention. Dr. McClelland ordered Petitioner to remain off work until surgery, which the doctor performed on October 29, 2013. Dr. McClelland continued Petitioner's off work status during physical therapy, which he ordered on January 9, 2014 and again on March 19, 2014. On March 19, 2014, Dr. McClelland noted that Petitioner's insurance was inadequate and that he had not yet reached maximum medical improvement.

8. Petitioner offered the testimony of Charles Zultowski, who confirmed that he received a phone call from Petitioner on October 15, 2013 regarding his alleged work accident. Mr. Zultowski testified that he was employed by Respondent on October 15, 2013, but that he was not so employed at the time of hearing.

9. Respondent countered with testimony from three current employees, one project manager and two crew leaders. Riccardo Moran, Respondent's project manager who oversaw 26 technicians, including Petitioner, and three crew leaders, testified that he handled reporting of accidents involving technicians. If a technician is hurt on a worksite, a crew leader is sent, then the witness would go out to investigate. The crew leader would escort injured workers to medical providers, then return to complete the on-site investigation. Mr. Moran testified that Petitioner was assigned to post notices on front doors of residences on the date of accident and that technicians were instructed not to climb fences or other obstacles if their access to the front door was blocked.

10. Mr. Moran recalled that Petitioner had requested two days off work for medical treatment to his finger, but Petitioner had not reported that the injury was work-related. When he returned to work on October 18, 2013, he attended a breakfast meeting at McDonald's. Mr. Moran testified that he asked Petitioner about his finger, and Petitioner told him he hurt it at home. At breakfast, co-workers asked about the finger and Petitioner again responded that he injured it at home during an argument with his son and wife. Mr. Moran testified that Petitioner then showed a cell phone video of his argument to some of the employees. Although Mr. Moran did not see the video, he heard angry voices on Petitioner's phone.

11. Mr. Moran testified that Petitioner had satisfied his target goal requirements, and that Mr. Moran had written a letter in support of his job performance. However, Mr. Moran noted the claimant had a history of disciplinary problems, and in fact had been suspended at least twice during his tenure with Respondent. In October 2013, shortly before this accident allegedly occurred, Petitioner was reprimanded and suspended for three days for insubordination.

12. Mr. Moran testified that following this alleged incident, Petitioner continued to work for a few days until he was terminated on October 22, 2013, for leaving his assigned area during work hours and for misrepresenting where he was when questioned by management. Although he wore a splint on his finger, he was able to complete his work assignments during the time between his accident and his termination.

13. After he was terminated, sometime in November 2013, Petitioner phoned Mr. Moran and reported that he had hurt his finger at work. Mr. Moran reminded Petitioner that he had previously told Mr. Moran as well as other employees that he had injured his finger at home. Mr. Moran also reminded Petitioner that work-related injuries were to be reported immediately and that he had failed to do so on his alleged date of accident.

14. Crew leader and Petitioner's close personal friend, Steve Fisher, testified for Respondent. Mr. Fisher testified he spoke to Petitioner an average of three times a week about work and non-work related topics. On the date of loss, October 15, 2013, Mr. Fisher spoke with Petitioner at least twice. During the first conversation, Petitioner did not mention an injury. During a later conversation, Petitioner told Mr. Fisher that he had been hurt at home and would need to miss some time related to his injury. Mr. Fisher was present at the McDonald's breakfast meeting when Petitioner told his co-workers that he had injured his finger at home with his wife and son. Petitioner had not mentioned to Mr. Fisher that he hurt his finger on a fence while doing a posting, and he didn't ask Mr. Fisher to complete workers' compensation paperwork for him. Mr. Fisher denied that he had advised Petitioner against reporting a work injury.

15. Crew leader James Merriweather also testified for Respondent, confirming that he first learned of Petitioner's injury at the McDonald's breakfast meeting on the Friday after the alleged accident. According to Mr. Merriweather, Petitioner told him that he had been hurt at home and wore a splint on his finger.

Arbitrator Jessica Hegarty found that Petitioner proved he had suffered an accident on October 15, 2013 that arose out of and in the course of his employment, relying on Petitioner's medical records and "the credible testimony of Petitioner and Charles Zultowski." She awarded Petitioner medical expenses of $28,609.35 and temporary total disability benefits for 25-1/7 weeks, from the date of the accident to the time of hearing. The Arbitrator further ordered Respondent to authorize and pay for additional physical therapy and "subsequent related medical treatment in accordance with the Rules."

The Commission views the evidence differently. Although Petitioner subsequently was consistent in describing his accident to his medical treaters, his initial report to the Ingalls' Hospital triage nurse indicated that he was injured when he hopped over a fence. Petitioner argues that the triage notes are wrong and that he never reported that he hopped or climbed over a fence. He also argues that all of Respondent's witnesses lied about hearing him attribute his injury to an accident or argument that occurred at home. The Commission notes that Respondent's three witnesses, including Petitioner's good friend, Steven Fisher, provided consistent testimony contradicting Petitioner's version of events, and that the Petitioner did not credibly demonstrate a report of a work-related injury to a supervisor until after he had been terminated by Respondent for insubordination.

Petitioner further testified that Respondent pressured its employees to complete a quota of postings during a shift at the risk of losing their jobs. This testimony is impunged, however, by Petitioner's cell phone records, which indicate that he spent an inordinate amount of time on his personal phone during a time when he was supposed to be working. Petitioner admitted on cross-examination at hearing that he made 13 calls on the date of accident before 11:10 AM and that the calls lasted between one and 37 minutes. Riccardo Moran testified that Petitioner was terminated on October 22, 2013 for being outside of his assigned area, where he remained at a pancake house for almost two hours during his shift hours. Petitioner's credibility suffers when his asserted dedication to meeting his job quotas is viewed in comparison with his heavy personal cell phone usage and disregard of company policies.

15IWCC0451

The Commission is likewise skeptical of Dr. McClellan's decision to remove Petitioner from the workforce for the entire period between the date of accident and the date of hearing, given that Petitioner was able to perform his full duties until his termination on October 22, 2013, for insubordination. Moreover, the Commission notes with concern the discrepancies between Dr. McClelland's office notes as submitted to Petitioner and those produced in response to Respondent's subpoena. The Commission notes that both parties requested complete records, yet there are significant dissimilarities in the records produced. Off work slips provided to Petitioner were missing when Dr. McClellan's office records were requested by Respondent, and the doctor's March 19, 2013 office note attributes Petitioner's failure to participate in physical therapy to his inadequate insurance in Petitioner's exhibit, but to family and domestic problems in Respondent's exhibit. No explanation is proffered for these differences.

Respondent timely appealed the Arbitrator's Decision to the Commission. After considering the entire record, the Commission reverses the Arbitrator's findings with respect to accident and therefore vacates the award of medical expenses, temporary total disability benefits, and prospective medical treatment. All benefits are denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the June 23, 2014 Decision of the Arbitrator is reversed. The Commission finds Petitioner failed to prove that he sustained an accident on October 15, 2013 that arose out of and in the course of his employment. All benefits are denied.

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

DATED: JUN 1 5 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/21/15
jdl/dak
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

VAUGHN, WILLIE
Employee/Petitioner

Case# **13WC038665**

HEATH CONSULTANTS INC
Employer/Respondent

15IWCC0451

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:

0290 KARCHMAR & STONE
ADAM KARCHMAR
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
NICOLE WIZA
10 S LASALLE ST SUITE 900
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)

WILLIE VAUGHN
Employee/Petitioner

v.

HEATH CONSULTANTS, INC.
Employer/Respondent

Case # 13 WC 38665

Consolidated cases: _

15IWCC0451

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **April 9, 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 15, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,848.00**; the average weekly wage was **$574.00**.

On the date of accident, Petitioner was **37** 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, $ **Ø** for TPD, $ **Ø** for maintenance, and $ **Ø** for other benefits, for a total credit of $.

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

Respondent is entitled to prospective medical care.

ORDER

The Respondent shall pay the Petitioner Temporary Total Disability benefits in the amount of $9621.42 which represents $382.67 a week for 25 1/7 weeks from October 16, 2013 through April 9, 2014, which is the period of temporary total disability for which compensation is payable.

The Respondent shall pay the further sum of $28,609.35 for necessary medical service as provided in Section 8(a) of the Act. The Respondent shall pay the medical bills incurred on and after October 15, 2013 in accordance with the Act and the medical fee schedule and Respondent shall hold Petitioner harmless for all the medical bills paid by any group health insurance carrier that was related to the accident of October 15, 2013.

That the Respondent is ordered to provide and pay for physical therapy and subsequent related medical treatment in accordance with the Rules.

That in no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, maintenance, 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

6/23/14

ICArbDec19(b)

JUN 23 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIE VAUGHN,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 38665**
	)	
HEATH CONSULTANTS, INC.	)	
	)	
Respondent.	)	**15IWCC0451**

STATEMENT OF FACTS

On October 15, 2013, Petitioner was employed by and working for Respondent as a "leak survey technician". One of Petitioner's duties was to do "postings" which involved providing notice to customers that their gas was in danger of being terminated. Petitioner testified that he was expected to post approximately 60-70 notices per day. Generally, an employee assigned to do postings is given a company laptop computer at the beginning of the workday which contains the list of the addresses that require a posting. After each posting, the employee logs the completed job on the company laptop, and the status is relayed to the supervisor to monitor the employee's progress. If the employee does not keep up with their posting quotas, the supervisor has the authority to send the employee home.

On October 15, 2013, the Petitioner was assigned to do postings. (Tr. at p.7, 9). Petitioner began his work and his route led him to make a posting at the intersection of Lavergne Street and Monroe Street. (Tr. at 15). Around 11:00 a.m., he arrived at the intersection, parked the car, exited the vehicle, and approached the property. A wrought iron gate surrounded the property, and as Petitioner approached the gate he tripped over an uneven piece of concrete, grabbed for the gate with his left hand, fell forward, and injured his left hand and ring finger. (Tr. at p.16).

On October 15, 2013, Rick Moran was a project manager and two of his crew leaders were Steve Fisher and James Merriweather. (Tr. at p.13). Petitioner worked under James Merriweather's supervision on the day of the incident. (Tr. at p.111).

After the accident, Petitioner made two telephone calls to employees of the Respondent, one to his co-worker, Charles Zultowski, and the other to a crew leader, Steve Fisher. (Tr. at p.20). Petitioner testified that he told Mr. Zultowski how the incident occurred and that he injured his left hand and ring finger. (Tr. at. p.26; PX4). Petitioner testified that he also called Steve Fisher and had a 42 minute conversation about the incident. (Tr. at p.25). According to Petitioner, Mr. Fisher attempted to dissuade Petitioner from reporting the accident because a work-related accident would negatively affect the Petitioner's career. (Tr. at p.21-22).

Petitioner testified that after these conversations, he went to a nearby Walgreens and bought ice and tape to treat his injuries and then continued to work. (Tr. at p.23). Later that evening, the pain and swelling increased and Petitioner went to the Ingalls Family Care Center emergency room. (Tr. at p.23).

The emergency room triage records note that Petitioner "states he jambed [sic] his finger while hopping over a fence." (PX1 p. 4) A nursing assessment record notes that Petitioner injured his left hand "after tripping against gate striking finger." (PX1 at p.6) Petitioner was diagnosed with a fractured left 4th finger with a possible tendon injury and ordered to follow up with an orthopedic surgeon to ascertain if the accident damaged tendons in his hand. (PX1 at p.5).

On October 17, 2013, Dr. Philip Nigro at Bone and Joint Physicians noted that Petitioner "was walking two days ago when he slipped and tried to grab for a gate. His left ring finger caught on the gate and he felt a pop and he had subsequent pain and swelling". (PX2 at p.16) Dr. Nigro diagnosed the Petitioner with a left distal phalanx fracture and Jersey finger and referred Petitioner to his partner, Dr. John McClelland. (PX2 at p.16).

On October 24, 2013, Petitioner saw Dr. John McClelland who noted that Petitioner "injured the left ring finger 9 days ago when he slipped and tried to grab onto a gate." Dr. McClelland also noted that Petitioner's evaluation was for "Worker's Compensation". (Px2 at 15) Dr. McClelland examined Petitioner, confirmed Dr. Nigro's diagnosis, and recommended surgery to repair the injured finger and hand. (PX2 at p.13). Dr. McClelland ordered total work restriction pending treatment and rehabilitation. (PX2 at p.15).

On October 29, 2013, Dr. McClelland performed surgery on Petitioner's left ring finger. (PX2 at p.30).

On November 14, 2013, Dr. McClelland reiterated the no-work restriction

pending treatment and rehabilitation. (PX2 at p.10).

On January 9, 2014, Dr. McClelland prescribed physical therapy for Petitioner and maintained the no-work restriction.

On March 19, 2014, Dr. McClelland prescribed physical therapy to be continued for next four weeks and maintained the no-work restriction. (PX at 3) On the same day, Dr. McClelland also noted that Petitioner did not have adequate insurance coverage. The doctor also noted that Petitioner had not achieved maximum medical improvement. (PX at 2)

ARBITRATOR'S DECISION

C. Accident

The Arbitrator finds that Petitioner has established, by a preponderance of evidence, that the accident occurred and that the accident arose out of and in the course of Petitioner's employment by Respondent. In support, the Arbitrator relies on the medical records and the credible testimony of Petitioner and Charles Zultowski.

Whether Petitioner's injuries are a result of a work-related accident arising out of and in the course of his employment is a factual determination. *Gano Electric Contracting v. The Industrial Commission, et. al.,* 260 Ill.App.3d 92, 96, (4th Dist. 1994). This determination can be based on direct or circumstantial evidence and the reasonable inferences drawn from such evidence. *Id.* Under Illinois law, statements made by a patient to a treating physician at the time of treatment are more reliable and carry greater weight in determining the cause of a medical condition because they were made when the events were fresh in [his] mind, and when it was against [his] interest to lie. Shell Oil v. Industrial Commission, 119 N.E.2d 224 (1954).

Petitioner testified that while he was working, he injured his hand when he tripped on an uneven piece of concrete and reached out to grab a gate to help break his fall and injured his hand on the gate. (Tr. at p.15-19). He presented to Ingalls Family Care Center later that evening and the nursing assessment notes that Petitioner injured his left hand by "tripping against a gate striking his finger." (PX1 at p.6).

The Arbitrator does note that the emergency room records also note that

Petitioner "jambed [sic] his finger while hopping over a fence." (PX1 at p.4). According to Petitioner's testimony, this was a mistake, and the record lacks evidence to contradict Petitioner's testimony. (Tr. at p.53). The Arbitrator places weight on the fact that the medical records subsequent to the Ingalls' Family Care Center visit also support Petitioner's causation testimony.

On October 17, 2013, Petitioner continued his treatment with Bone and Joint Physicians and completed a patient questionnaire. (PX2 at p.17). Petitioner listed the day of accident as October 15, 2013, and explained the incident occurred when he "lost his balance and reached for the gate...and as [he] grabbed for the gate...[he] pulled [himself] up stopping his fall and thought [his] finger was jammed." (PX2 at p.17). Petitioner's explanation on October 17, 2013, matches the explanation he gave to Ingalls' staff member on October 15, 2013.

On October 17, 2013, Dr. Nigro noted that Petitioner stated he hurt his left finger when "he slipped and tried to grab for a gate...and he felt a pop and he had subsequent pain and swelling." (PX2 at p.16).

On October 24, 2013, Dr. McClelland noted that Petitioner stated he "injured the finger 9 days ago when he slipped and tried to grab on to a gate." (PX2 at p.11).

The Arbitrator finds that the medical records support Petitioner's testimony as to how the injury occurred. Petitioner's testimony about accident corresponds to the statement he made to the nurse at the emergency room on the same day as the accident.

Petitioner testified that on October 15, 2013, he was required to perform between 55-60 postings. (Tr. at p.9). He began his day at approximately 6:00 a.m. and he planned to do his postings on the west side of Chicago. Between 11:00 a.m. and noon, the incident occurred when he arrived at the corner of Laverne Street and Monroe Street to post a notice on a residence. As he approached the gated residence, he tripped on an uneven piece of concrete, fell forward, grabbed his hand on the gate, and injured his left ring finger. (Tr. at 15-19). Petitioner identified where the incident occurred and circled it on page 3 of Petitioner's Exhibit 5. (PX5 at p.3).

Petitioner testified after the injury, he called his colleague, Charles Zultowski and told him about the incident. (Tr. at 20; PX4). Mr. Zultowski testified that he talked to Petitioner who informed him that he had tripped on some uneven concrete and tried to catch his fall on a fence. (Tr. at p.83-84). Petitioner also produced cellular telephone records from October 15, 2013. Petitioner identified

Mr. Zultowski's phone number on the call log which he highlighted in blue. Mr. Zultowski confirmed that the call log did contain his phone number during his testimony. The Arbitrator notes that the call log contains three conversations between Petitioner and Mr. Zultowski between 11:10 am and 12:03 pm on October 15, 2013. (PX4)

Petitioner testified that he called a crew leader, Steve Fisher, to tell him about the accident. Petitioner testified that Mr. Fisher attempted to dissuade Petitioner from reporting the accident as a work-related injury. (Tr. at p.21). According to Petitioner, Mr. Fisher told Petitioner a work-related accident would adversely affect his career and taint his record. (Tr. at p.21). Petitioner identified Mr. Fisher's telephone number on his cell phone call log and highlighted it in yellow. The Arbitrator notes that Petitioner made a phone call to Mr. Fisher at 11:17 am and the conversation lasted for 42 minutes. (PX4).

Mr. Fisher testified that he was a crew leader on the accident date, that Rick Moran was his superior, and that Petitioner was not on his crew. Mr. Fisher testified that he spoke with Petitioner several times on October 23, 2013, and that Petitioner did not tell him that he had been hurt or involved in a work accident. Mr. Fisher did remember that Petitioner called him later that evening to tell him he was going to the hospital. (Tr. at 144).

Respondent elicited testimony from the following three witnesses in its case-in-chief: Rick Moran, the project manager; Steve Fisher, a crew leader; and James Merriweather, a crew leader.

The credibility of Mr. Moran is diminished in the eyes of the Arbitrator for the following reasons.

Mr. Moran testified that shortly after October 15, 2013, he held a team breakfast at McDonald's. (Tr. at p.103). Petitioner, James Merriweather, and Steve Fisher were present. (Tr. at p.130). Mr. Moran claims he and Petitioner were seated next to each other and at this time, Petitioner told him he hurt his finger at home during an altercation with his wife. (Tr. at p.104). Mr. Moran further testified that Petitioner showed a video that lasted approximately two minutes that showed Petitioner injuring his left hand while arguing with his wife and child. (Tr. at p.104).

On cross-examination, Mr. Moran testified that he did not *see* the video, but heard a lot of screaming and shouting. (Tr. at p.132).

Mr. Merriweather and Mr. Fisher's testimony contradicted Mr. Moran's version of events as to the video:

Mr. Fisher testified:

Q: What did you see on the video?
A: What video?

Q: You don't recall seeing a video that was played when you were at McDonald's for that breakfast meeting?
A: No.

Q: Do you ever recall seeing any kind of video regarding Mr. Vaughn's incident?
A: No.

(Tr. at p.152-153).

Mr. Merriweather's testimony also contradicted Mr. Moran's testimony.

Q: You were at that breakfast at McDonald's?
A: Yes.

Q: What did you see in the video?
A: What video?

Q: You didn't see any video of the incident –
A: No, sir.

(Tr. at p. 164).

Mr. Merriweather and Mr. Fisher testified they have known Petitioner for many years and both testified Petitioner did not tell either of them about the incident. However, Mr. Fisher acknowledged he had a 42 minute telephone conversation with Petitioner shortly after the incident but could not recall the topic of conversation. (Tr. at 154); (PX4). Petitioner testified he and Mr. Fisher discussed the incident during that conversation. (Tr. at p.20-21).

The Arbitrator finds that Petitioner has presented sufficient evidence that the accident of October 15, 2013, arose out of and in the course of his employment by Respondent.

E. Notice

The Arbitrator finds Respondent received timely notice of this accident. The Workers' Compensation Act provides that a defect or inaccuracy of notice of an accident will not be a bar to the maintenance of proceedings on arbitration or otherwise unless Respondent proves he was unduly prejudiced by the defect or inaccuracy. 820 ILCS 305/6(c).

The facts in this case support Petitioner's claim that Respondent received timely notice. Petitioner testified that immediately after the incident, he telephoned Charles Zultowksi, a co-worker, and Steve Fisher, a crew supervisor. (Tr. at p.20, 26). Mr. Zultowski testified Petitioner told him he hurt his hand when he reached for a gate after he lost his balance. (Tr. at p.83). This testimony was unrefuted.

Mr. Fisher, however, could not recall the contents of the 42 minute telephone conversation between him and Petitioner shortly after the incident. Although Petitioner's direct supervisor on the day of incident was James Merriweather, Petitioner gave notice to a different supervisor, Steve Fisher. The Arbitrator notes the testimony Mr. Moran (the project manager who supervises Mr. Fisher and Mr. Merriweather) who testified it is acceptable for an employee to report an accident to any crew leader. (Tr. at p.120-121).

Mr. Moran also testified that Petitioner contacted him sometime before Thanksgiving to tell him about the accident. (Tr. at p.108). The accident occurred on October 15, 2013. In 2013, Thanksgiving fell on November 28. The difference between November 28, 2013, and October 15, 2013, is 44 total days.

The Arbitrator notes that Petitioner did not fill out any workers' compensation paperwork after the incident. (Tr. at p.53). However, oral notice is sufficient under the notice provision of the Workers' Compensation Act. *Westin Hotel v. The Industrial Commission of Illinois,* 372 Ill. App. 3d 527, 541 (1st Dist. 2007). In *Westin Hotel,* the claimant alleged he suffered a knee injury as a result of work-related accident and gave proper notice to his employer, but the employer disputed the notice. The claimant testified that he told his secretary that he injured himself and needed to see a doctor. *Id.* The employer presented no evidence to contradict the claimant's testimony. *Id.* The Court upheld the Commission's decision and found that the employer received proper notice based on the uncontroverted testimony of the claimant. *Id.*

In this case, Petitioner testified he told Mr. Fisher about the incident shortly after

it happened during a 42 minute phone conversation. Mr. Moran admitted he received notice within 45 days. Like the employer in *Westin,* in this case, neither Mr. Fisher nor Mr. Moran offered any evidence to contradict Petitioner's testimony. Therefore, the Arbitrator finds that Respondent received proper notice.

F. Causal Connection

The Arbitrator finds that Petitioner's injury to his left ring finger was caused by the work-related accident that occurred on October 15, 2013. Whether a causal connection exists between Petitioner's condition of ill-being and a work-related accident is a question of fact to be resolved by the Commission. *Westin Hotel v. Industrial Commission of Illinois,* 372 Ill. App. 3d 527, 528 (1st Dist. 2007). It is within the province of the Commission to resolve conflicts in the evidence, especially as they relate to medical opinion evidence. *Id.*

In this case, Petitioner's medical records and his testimony at the arbitration hearing support the finding of a causal connection between the accident and his left ring finger injury. As mentioned above, Petitioner treated for his injury on the same day of the accident and the subsequent medical records from Ingalls and from Dr. McClelland are consistent with Petitioner's testimony. (PX1; PX2). The Respondent does not have medical evidence to contradict Dr. McClelland's finding of a work-related injury and therefore, the Arbitrator finds that the accident of October 15, 2013, caused Petitioner's injuries.

J. Medical Services

The Arbitrator also finds Petitioner's medical treatment was reasonable and necessary. The medical records demonstrate Petitioner treated for his left hand injury the same day of the incident and continued to treat per Dr. McClelland's orders. The medical evidence is unrebutted and the record demonstrates Petitioner treated for a left hand injury which occurred on October 15, 2013, and continues to treat for the same injury. Therefore, in the absence of any other evidence and weighing the evidence in the records, the Arbitrator finds Petitioner's medical treatment to be necessary and reasonable.

Additionally, the Arbitrator finds Respondent has not paid for Petitioner's medical treatment. Petitioner's Exhibit 3 lists the medical bills incurred by Petitioner: $3,285.00 from Bone and Joint Physicians and a total of $25,224.35 from Ingalls Memorial Hospital. The Arbitrator finds Respondent is responsible to pay these bills pursuant to the fee schedule set forth in the Workers'

Compensation Act. 15IWCC0451

K. Prospective Medical Care

The Arbitrator also finds Petitioner is entitled to prospective medical care. Petitioner's Exhibit 2 has numerous notes from Dr. McClelland which order Petitioner to have physical therapy. (PX2 at p.2, 3, 5, 6, 7). Respondent has not offered any medical evidence to contradict Dr. McClelland's opinions and absent any evidence, the Arbitrator rules Petitioner is entitled to prospective medical in the form of the physical therapy and subsequent related medical treatment prescribed by Dr. McClelland.

L. TTD Benefits

The Arbitrator also finds Petitioner is entitled to his TTD benefits from October 15, 2013, through the date of trial, April 9, 2014 for a total of 25 1/7 weeks. The most recent medical note from Dr. McClelland is dated March 19, 2014, ordering Petitioner "unable to return to work." (PX2 at p.3). He gives Petitioner a "total work restriction pending treatment and rehabilitation." (PX2 at p.3). Since this is the only evidence which addresses Petitioner's work status, Petitioner is entitled to his TTD benefits at the rate stipulated to in Arbitrator's Exhibit 1, No. 5. Petitioner's average weekly wage is $574.00 which calculates to TTD benefits of $382.67. Therefore, Petitioner is entitled to $382.67 for 25 1/7 weeks which calculates to $9,621.42.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Denis Mosby,

Petitioner,

15IWCC0452

vs.

NO: 12 WC 38972

Massman Traylor Alberici, aka MTA,

Respondent.

DECISION AND ORDER ON REMAND FROM THE CIRCUIT COURT

This matter had previously been heard and the Decision of Arbitrator Luskin had been filed April 15, 2013. The Arbitrator found that Petitioner's case was not under the jurisdiction of the Illinois Workers' Compensation Act; no benefits were awarded. The matter was presented on Petitioner's Review and the Commission affirmed and adopted the decision of the Arbitrator. Thereafter, Petitioner went before the Circuit Court of Madison County who reversed the decision, finding that Illinois had concurrent jurisdiction and remanded the case back to the Commission for decision on all issues.

- Petitioner is domiciled in Illinois and spends 50% of his time working in Illinois & 50% working in Missouri. Respondent does not have a place of business in Illinois. The Circuit Court reversed and remanded the case to the Commission finding Petitioner has proven Illinois has concurrent jurisdiction because he spent a "substantial" part of his time working for Respondent in Illinois; even though it was stipulated Petitioner was hired and paid by Respondent, a Missouri company, and he was injured on a bridge pier on the Missouri side of the river. Petitioner apparently parked on the Illinois side-(reported to work in Illinois) and then

somehow got to whichever site he was assigned. Pier 11 in Missouri and Pier 12 in Illinois were not yet connected in any way; per stipulation.

- Petitioner argued that it did not matter that the injury occurred on the Missouri side and the bridge was not yet complete as it occurred over the water so concurrent jurisdiction applied. Respondent argued employment is principally located in Missouri as Respondent has no location in Illinois and the bridge was not complete and Petitioner was on the Missouri side so Illinois has no jurisdiction.

- The Circuit Court noted that Petitioner argued jurisdiction on two competing grounds--.
  --That there is jurisdiction at the site of the injury, concurrent jurisdiction in Illinois and Missouri based on the fact it was a construction of a bridge (though not completed). The Circuit Court found as a matter of law the Commission erred in finding no jurisdiction on that basis. The Court believed case law in Illinois is fairly clear there is concurrent jurisdiction over the river and that includes bridges as well as the waterways. The Court cited to People v. Pitt and Schueren v. Querner Truck, Lines in holding that the same applied to Workers' Compensation (WC) cases. The judge stated the legislature knew of concurrent jurisdiction given the facts of life surrounding the Mississippi River since the initial 1818 Constitution. The judge believed, therefore, that concurrent jurisdiction applied under the circumstances here. He noted Respondent's argument that the bridge was not yet complete. The judge stated if the bride is under construction, it is clearly a bridge and that concurrent jurisdiction will apply as a matter of law. The judge stated that he understood this was a case of first impression, but based on the preponderance of the case law presented, he concluded there is concurrent jurisdiction. The judge noted that there was no bright line rule when concurrent jurisdiction applies, but he opined it occurs when the bridge is under construction. The Circuit Court did not find it necessary to reach the alternative argument as to the situs of the employment relationship, but the question, under the Act, was where Petitioner principally worked (Illinois versus Missouri). The Court stated that it found Mahoney v. Industrial Commission, (in which the Union Bridge case was discussed) not to be persuasive as it was decided under another version of the WC Act which was not as broad in defining jurisdiction. The Circuit Court stated that determining a person's employment principal situs in Illinois is plain enough. The Circuit Court stated that per Cowger, a person's employment is principally located in Illinois or another state when the employer has a place of business in this or another state and regularly works at or from such location of business or if that is not applicable, the person is domiciled and spends a substantial part of his working time in service of the employer in this or the other state. The Circuit Court stated that looking at the language of the Act and construing it appropriately in light of Cowger, he believed this was a case where the situs of employment is

not sufficiently clear for the first part of the test to determine that. The Circuit Court stated that Petitioner signed the contract or was hired in Missouri and was paid out of Missouri which would bode in favor of the situs of employment being Missouri, but in this case, Petitioner also reported to work every day in Illinois and at a minimum crossed through Illinois to get to employment. The Application established that Petitioner was domiciled in Illinois and Respondent didn't deny it. However; even if Petitioner did not reside in Illinois he passed through Illinois and reported to work every day in Illinois. The Circuit Court stated it did not know what a substantial amount of time was but that the law does not say a 'majority' of the time and that was not what the law required. The Circuit Court opined that substantial is a lesser standard and 50% being close to a majority of the time Petitioner spent working in Illinois; he found that substantial. He indicated arguably situs of employment many would favor Respondent, however, in applying the Cowger language the Circuit Court stated Petitioner is domiciled in Illinois and it found, as a matter of law, that 50% is substantial time working in Illinois. The Circuit Court stated any decision that Petitioner did not spend a substantial part of his time working in Illinois and is domiciled in Illinois would be against the manifest weight of the evidence.

- In summary, the Circuit Court stated as a matter of law there was concurrent jurisdiction and the Commission erred in finding there was no concurrent jurisdiction. The Circuit Court further stated the Commission's determination that the Cowger test as to employment being in Illinois or principally located in Illinois was not satisfied as against the manifest weight of the evidence, The Court further stated that to the extent it found 50% of Petitioner's time worked in Illinois, the Commission is also incorrect if it did not find that substantial. The Circuit Court therefore reversed the decision of the Commission and found that jurisdiction was appropriate in Illinois under the WC Act.

- From the Illinois Workers' Compensation Act –Jurisdiction

> §1(b) 2. Every person in the service of another under any contract of hire, express or implied, oral or written, including persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made, and including aliens, and minors who, for the purpose of this Act are considered the same and have the same power to contract, receive payments and give quittances therefore, as adult employees.

The Commission notes that there is no question that Respondent is a Missouri company and Petitioner was hired in Missouri, the last act of being hired. Petitioner does reside in Illinois. Petitioner was paid through the Respondent in Missouri and Respondent had no facility in Illinois. Jurisdiction as to the last act of hiring would render no jurisdiction in Illinois. The accident occurred on the Missouri side bridge pier (#11) on October 20, 2012 when Petitioner fell but as he had a safety harness on, he swung and did not fall into the Mississippi River. The piers were not apparently connected at that time in any way as the bridge was not completed. The accident was not otherwise disputed and Respondent agreed to authorize surgery. The I-70 bridge construction was over the river between Illinois and Missouri. The parties stipulated that Petitioner worked 50% on the Missouri side bridge pier (#11) and 50% on the Illinois side bridge pier (#12). Petitioner parked in Illinois every morning and then got to either side to the work site, but it appears clear that the bridge was not complete enough for Petitioner to have walked over to the Missouri side via a footbridge on the bridge they were working on; but somehow he was transported to the work site be it the Missouri side or the Illinois side. The Commission notes that the Circuit Court reasoned concurrent jurisdiction by basically questioning otherwise, when the bridge would be completed enough to be over the river, as in the parties cited motor vehicle accidents and criminal cases on bridges. Also, in this matter, Petitioner did park on the Illinois side so he apparently had some transportation via the river or otherwise to either the Illinois or the Missouri side, depending on where Respondent wanted him to work on a particular day; Petitioner, somehow, was directed on a daily basis, whether Respondent had a location here or not. It is not clear from the information available if Petitioner parked in a Respondent controlled property or even if Respondent had directed Petitioner to park at that location, per se; just that it was where Petitioner parked and then went to work on either side. It would seem most logical to assume Respondent directed Petitioner and any other Illinois workers to park in the same location to then be directed from there to either the Missouri or Illinois bridge pier locations. Again, the parties stipulated that Petitioner worked 50% of the time on the Illinois side and 50% of the time on the Missouri side and Respondent directed Petitioner to where he would be needed on a particular day. As the Circuit Court stated, 50% is a substantial enough amount of time working in Illinois at Respondent's orders to warrant a finding of concurrent jurisdiction. Based on finding that there is a 'substantial' connection to Illinois via working 50% of the time in Illinois for Respondent, the Circuit Court reversed to find jurisdiction in Illinois.

The Commission, therefore, vacates its prior decision, and based on the Circuit Court's remand order finding of concurrent jurisdiction, remands the matter back to the Arbitrator (no longer Arbitrator Luskin at that site) for further hearing on all issues.

IT IS THEREFORE ORDERED BY THE COMMISSION that the matter is remanded back to the Arbitrator for hearing and decision on all issues in accordance with the order of the Circuit Court of Madison County.

15IWCC0452

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

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

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

DATED: JUN 16 2015
d-4/30/15
DLG/jsf
045

David L. Gore

Stephen Mathis

Mario Basurto

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

Jesus Alvarez,
Petitioner,

15IWCC0453

vs.

NO: 10 WC 20995

Atlas Employment Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 16 2015
O5/20/15
RWW/rm
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVAREZ, JESUS
Employee/Petitioner

Case# **10WC020995**

ATLAS EMPLOYMENT SERVICES
Employer/Respondent

15IWCC0453

On 7/25/2013, 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 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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211 W WACKER DR SUITE 1450
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15IWCC0453

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

JESUS ALVAREZ
Employee/Petitioner

v.

ATLAS EMPLOYMENT SERVICES
Employer/Respondent

Case # **10** WC **20995**

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 Mason**, Arbitrator of the Commission, in the city of **Chicago**, 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. [ ] Did an accident occur that arose out of and in the course of 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. [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. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **Number of Dependents**

15IWCC0453

FINDINGS

On **April 30, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current right shoulder condition of ill-being ***is*** causally related to the accident. Petitioner failed to establish causation as to his claimed current lumbar spine and right wrist conditions of ill-being.

In the year preceding the injury, Petitioner earned **$15,390.60**; the average weekly wage was **$301.78**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **3** dependent children.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

Respondent shall be given a credit of **$1,920.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,920.00**.

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

ORDER

Petitioner was temporarily totally disabled from May 24, 2010 through July 12, 2010, a period of 7 1/7 weeks. Having found that Petitioner was married with three dependent children as of his undisputed work accident of April 30, 2010, the Arbitrator awards temporary total disability benefits at the rate of $301.78 per week. Respondent is entitled to credit for the $1,920.00 in temporary total disability benefits it paid prior to hearing. Arb Exh 1.

Based on the foregoing causation-related findings, the Arbitrator finds the treatment provided by Dr. Meisles/Orthopaedic Specialists and Archer Open MRI to be related, reasonable and necessary. RX 9 establishes that Respondent paid $1,505.03 to Archer Open MRI. Respondent is given credit for this payment. Respondent shall pay the following remaining fee schedule balances: 1) Dr. Meisles/Orthopaedic Specialists, S.C., $967.00; and 2) Archer Open MRI, $1,394.72.

Based on the foregoing causation-related findings, the Arbitrator finds that Petitioner established permanency as to the right shoulder equivalent to 5% loss of use of the person as a whole, or 25 weeks of benefits, under Section 8(d)2 of the Act. The Arbitrator awards permanency at the rate of $301.78 per week.

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

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

7/25/13
Date

JUL 25 2013

Jesus Alvarez v. Atlas Employment Services
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Arbitrator's Findings of Fact

The parties agree Petitioner sustained an accident on April 30, 2010 while working for Respondent, a staffing agency. They also agree Petitioner timely notified Respondent of the accident. Arb Exh 1. They disagree as to other issues, with much of the dispute centering on causation and the reasonableness and necessity of the treatment Petitioner underwent on and after October 19, 2010.

Petitioner, who was born on April 10, 1971, testified through a Spanish-speaking interpreter. T. 12. He testified he married Margarita Zavala on April 18, 1998. T. 13. He claimed to have three children under the age of eighteen as of his April 30, 2010 work accident. T. 13-14. He readily identified these children by name, gender and year of birth. He was able to recall his son's exact date of birth, September 9, 1998, but had difficulty recalling the dates on which his daughters were born. He testified his daughter Ashley is eleven years old. He believed she was born in 2001. T. 14. He initially testified his other daughter, Kimberly, was born on April 10, 2003 but then changed the date to May 10, 2003 after recalling she was born on Mother's Day. T. 15.

Petitioner testified that, on May 30, 2010, he worked as a machine operator for Respondent at a factory operated by Pylon Tool Corporation. T. 15-16. As of that date, he had worked for Respondent for two years. T. 16.

Petitioner testified he worked the morning shift, from 6:00 AM to 2:30 PM, on May 30, 2010. He indicated his accident occurred "possibly at 2:00 in the afternoon." T. 20.

Petitioner testified his job required him to open the door of the machine, place a ¾-inch thick piece of metal inside a mold, screw the metal piece into place, close the door, wait for the machine (which was equipped with a blade) to form the metal piece into a plate, open the door of the machine, carefully disengage the formed plate from the mold, using an extractor, and use his right hand to place the part on a table that was about six feet away from the machine. T. 16-19. He would then return to the machine, place another piece inside the machine and return to the table, where he would use a knife to "clean" the part he had just formed. He would then place the cleaned plate in a box.

Petitioner testified each metal part weighed about 25 to 30 pounds. At the point at which he removed the formed plate from the mold, the plate was hot and covered with oil. Oil was used during the fabrication process so that the blade would not break the metal. T. 17. Petitioner testified it was sometimes very difficult to remove the formed plate from the mold because the mold was a "very small space." Due to the mold configuration, he was only able to use one hand to remove the plate. Sometimes he had to use so much force to extricate the plate that, when the plate came loose, it would hit his right forearm. T. 17-18. He had been

instructed to avoid hitting the plates because they were "very delicate" and made of "very expensive material." T. 18.

Petitioner testified his injury occurred while he was in the process of removing a newly formed plate from the machine and transferring the plate to the table. He used his right hand to remove the plate from the mold. The mold was at about shoulder level. Both his hand and the plate were "very wet from the oil." His hand felt "very weak" due to having been repeatedly struck by the plates. As he was lowering the plate from shoulder to waist level, he suddenly felt as if he was losing his grip. His right hand "bent back" while he tried to avoid dropping the plate:

> "So my reaction in a split second so that the boss wouldn't see that [the plate] touched the ground, that it was going to hit the ground, so upon feeling that it was touching the ground, I picked it up rapidly back like this. When I made that movement is when I felt the pain in my shoulder and in my back and in my wrist."

T. 22-23. Petitioner testified he "went down rapidly" and "pulled back rapidly" while trying to avoid having anyone notice that the plate had come into contact with the ground. T. 24-25. He then "put the part on the table rapidly, fast." T. 24.

Petitioner testified he felt pain in his right wrist, right shoulder and lower back after he placed the part on the table. He stopped working and reported the accident to a manager who worked for Pylon. T. 25-27. That manager sent him to an office, where he encountered a supervisor named Lucy Hernandez. Petitioner testified that Hernandez "looked at" him and gave him a note so that he could go to a clinic. T. 27. Petitioner went to Advanced Occupational the same day. T. 27.

Records from Advanced Occupational Medicine Specialists reflect that Petitioner saw Dr. Sandra Bender on April 30, 2010, with Dr. Bender recording the following history in her letter of the same date to Luceli Hernandez of Respondent:

> "[Mr. Alvarez] is a 39-year-old right handed male who presents status-post an acute low back, right shoulder and right forearm injury. Mr. Alvarez states that for the last four and a half days he has been working on a machine, where he removes and replaces a 30-pound piece from a machine with his right arm only. Mr. Alvarez states that he changes this piece approximately 30 times per hour. Mr. Alvarez states that he began to have pain in his right shoulder on Monday, April 26, 2010. Mr. Alvarez states that initially his pain was a 5 to 6 on a maximum 10-point scale. He states that today it is worse. His pain is 6/10 at rest, but

> increases to 8/10 if he uses his right arm. Mr. Alvarez states that he also hit his right forearm on a part of the machine several times on April 29, 2010, causing a 7/10 pain today. Mr. Alvarez states that today at noon he almost dropped one of the 30-pound pieces from his right hand, which caused him to forward flex from his waist as he attempted to catch it, causing pain in his low back. he rates this pain as 7/10. He states that he reported his injury and was sent to my office for an evaluation and treatment."

Dr. Bender noted that Petitioner denied any prior injuries to his back and right shoulder.

On lumbar spine examination, Dr. Bender noted tenderness to palpation over the L2 to S1 spinous processes and over the paraspinous muscles bilaterally. She also noted slight tenderness to palpation of the right SI joint and painful seated straight leg raising.

On right shoulder examination, Dr. Bender noted a limited range of motion in all planes, pain with supraspinatus, impingement and biceps testing, negative crossover testing, equivocal O'Brien's testing, painful lift-off testing and reduced infraspinatus and biceps strength.

On right wrist and forearm examination, Dr. Bender noted three hematomas over the right wrist extensor muscles, tenderness to palpation over the right wrist extensor muscles and pain in the right wrist extensor muscles with resisted wrist flexion and extension.

Dr. Bender obtained lumbar spine X-rays. She interpreted the films as showing degenerative disc disease and osteophytes at multiple levels.

Dr. Bender's impression was: lumbago, right shoulder pain, right biceps tendinitis and right wrist extensor muscle contusion.

Per Respondent's protocol, Dr. Bender performed a urine drug screen and breath alcohol testing. She did not note the results of that testing. She dispensed 48 Ibuprofen tablets to Petitioner and instructed him to apply heat and ice to the affected areas and perform stretches. She released Petitioner to full duty and set up a re-evaluation for May 3, 2010. She indicated she did not anticipate any permanent disability. PX 1.

Petitioner testified he did not return to Advanced Occupational after April 30, 2010. T. 28. Records in RX 3 reflect Petitioner was a "no show" at Advanced Occupational on May 3, 2010. A nurse or other employee of Advanced Occupational noted she was unable to reach Petitioner by telephone on May 4, 2010 and informed "Luceli" of this the same day, with Luceli indicating she would try to reach Petitioner to have him reschedule. Notes in PX 1 and RX 3 reflect that Advanced Occupational closed Petitioner's case on May 12, 2010, "per Luceli Hernandez," because Petitioner allegedly could not be located.

Petitioner testified he saw Dr. Meisles on May 24, 2010. Records in PX 2 reflect that Dr. Meisles is affiliated with Orthopedic Specialists, S.C.

In his initial note of May 24, 2010, Dr. Meisles indicated that Petitioner reported injuring his right wrist, right shoulder and lower back at work on April 30, 2010. Dr. Meisles noted that Petitioner was "apparently working in a machine and lifting a mold when he strained" those three body parts.

A separate two-page history form in PX 2 reflects that Petitioner described himself as married and employed by Respondent. The first page of the form states: "no personal insurance, however WC." The second page reflects a date of injury of April 30, 2010.

On examination, Dr. Meisles noted limited motion of the lumbar spine, no radiating leg pain, negative straight leg raising bilaterally, tenderness to palpation over the biceps tendon but not over the AC joint, a positive impingement sign, no weakness to resisted external rotation and negative crossover testing.

Dr. Meisles obtained right shoulder X-rays which demonstrated normal bone density and no acute abnormalities.

Dr. Meisles diagnosed a lumbar strain and a right shoulder strain. He ordered a right shoulder MR arthrogram to evaluate for a labral tear or rotator cuff injury. He indicated that "no further treatment or evaluation of the wrist should be necessary" since Petitioner described his wrist complaints as having "resolved." He found Petitioner to be "disabled from work in the meantime."

On June 2, 2010, Petitioner filed an Application for Adjustment of Claim alleging he injured his right wrist, right arm, right shoulder and low back while working for Respondent on April 30, 2010. PX 15.

Petitioner underwent the MR arthrogram at Archer Open MRI on June 9, 2010. T. 29. The arthrogram report is not in evidence. The post-arthrogram MRI demonstrated "a small amount of gadolinium within the glenohumeral joint space," a "portion of the gadolinium within the anterior subdeltoid bursa" and "no abnormal extravasation of contrast material through the rotator cuff tendons." The interpreting radiologist, Dr. Goldstein, described the supraspinatus and infraspinatus tendons as intact. He noted thickening of the subscapularis, which he described as "consistent with tendinosis." He described the biceps labral complex and the glenoid labrum as "grossly intact." In his opinion, the fluid extending into the inferior surface of the superior glenoid labrum likely represented a prominent sublabral foramen. He viewed a tear in this location as "less likely." He also noted mild osteoarthritic changes. PX 2, 3.

Following the MR arthrogram, Petitioner returned to Dr. Meisles on June 14, 2010. T. 29. Petitioner described his shoulder as "more tender" since the arthrogram. He complained of some burning and tingling when raising his arm.

Dr. Meisles described the MR arthrogram as demonstrating subscalaris tendinosis and "no evidence of a labral tear." On right shoulder examination, he again noted a positive impingement sign. He described Petitioner as "still somewhat guarded with motion." He injected the shoulder with local anesthetic and cortisone. He prescribed a four-week course of physical therapy and instructed Petitioner to return to him thereafter, at which time he anticipated being able to release Petitioner to full duty. On a separate sheet of paper, he indicated that Petitioner remained under his care and "must remain off work until he is re-evaluated on 7/12/10."

Dr. Meisles' note of June 14, 2010 contains no mention of the lumbar spine or right wrist. PX 2.

Petitioner testified that Dr. Meisles gave him an "off work" note and a therapy prescription slip on June 14, 2010. T. 30-31.

Petitioner testified he went to "the clinic where Dr. Meisles sent [him] for physical therapy" but did not actually undergo therapy because "the insurance didn't authorize it." T. 31. No physical therapy records are in evidence.

Petitioner returned to Dr. Meisles on July 12, 2010. The doctor's note of that date reflects that Petitioner reported four to five days of relief following the shoulder injection. The note also reflects that Petitioner "did not obtain" the therapy the doctor had recommended. The remainder of the note reads as follows:

> "I reassured [Mr. Alvarez] that, given his MRI findings that [were] negative for a tear, that he was not at risk for further injuring his shoulder by working and I released him to return to work without specific restrictions. He informed me that he had been terminated from his job. I suggested that it would be okay for him to find new employment now and I'm releasing him from my care at this time."

PX 2. Petitioner testified that Dr. Meisles "just examined [him] rapidly" on July 12, 2010. He did not return to Dr. Meisles thereafter. T. 31.

A note in RX 3 reflects that Guadalupe of Dallas National contacted Advanced Occupational on August 10, 2010 to "set [Petitioner] back up for re-eval by Coventry," with Guadalupe apparently indicating that "services were auth'd." RX 3. There is no evidence indicating that Petitioner returned to Advanced Occupational on August 10, 2010.

Petitioner testified that, after his last visit to Dr. Meisles on July 12, 2010, he next underwent treatment on October 19, 2010, at which time he saw Dr. Aternino, a chiropractor affiliated with United Medical Associates. Petitioner testified it took him three months to resume care because he could not find a place that would treat him and "because the insurance was not authorizing the places they were sending" him. T. 32-33. Petitioner testified he did not work from April 30, 2010 until May 11, 2011. T. 41.

Dr. Aternino's initial note of October 19, 2010 reflects that Petitioner reported sustaining an injury at work on April 30, 2010. Specifically, Petitioner reported trying to keep a 20- to 35-pound mold from falling and feeling a "pull in his right shoulder down to the wrist and in the back." Petitioner also indicated he was initially sent to Advanced Occupational and later underwent an MRI but "no therapy." Petitioner complained of pain in his right wrist and right shoulder, rated 7/10. He indicated his shoulder pain was aggravated by lifting, sweeping and overhead activities. Petitioner also complained of pain in his lower back and left leg, rated 8/10.

On bilateral wrist examination, Dr. Aternino noted no restrictions in range of motion. On bilateral shoulder examination, the doctor noted moderate restriction on the right in flexion and abduction. On lumbar spine examination, the doctor noted reduction in extension, flexion and flexion. He also noted positive straight leg raising on the left at 50 degrees.

Dr. Aternino recommended a lumbar spine MRI, a referral to an "M.D." for evaluation and pain management and a course of chiropractic adjustments and physical therapy. He opined that the "injuries sustained are causally related to the work accident and the recommended treatment is medically necessary."

Dr. Aternino completed a slip indicating Petitioner required six weeks of physical therapy and would be unable to return to work until re-evaluation on November 30, 2010.

Petitioner underwent a lumbar spine MRI on October 22, 2010. A chiropractic radiologist, John Aikenhead, D.C., interpreted the MRI as showing disc bulging at L1-L2, L2-L3 and L3-L4, a central protrusion effacing the thecal sac at L4-L5 and a central/left central protrusion effacing the thecal sac at L5-S1. He indicated the neural foramina appeared patent at L4-L5 and L5-S1. PX 4, 6.

On November 2, 2010, Dr. Aternino reviewed the MRI and noted that Petitioner complained of left-sided lower back pain radiating to his legs, left worse than right, as well as right wrist and right shoulder pain. Dr. Aternino ordered EMG/NCV testing and referred Petitioner to an orthopedic surgeon.

Dr. Rozman, a physiatrist, reviewed the MRI and performed EMG/NCV testing on November 9, 2010. On examination, Dr. Rozman noted positive straight leg testing, pain to palpation of the lumbar paraspinal muscles and decreased sensation in the distribution of L4-L5

and L5-S1. He interpreted the EMG/NCV testing as demonstrating right lower lumbar radiculopathy, predominantly at L4-L5. PX 4, 8, 10.

On November 10, 2010, Petitioner saw Shingo Yano, M.D., a physician affiliated with the Illinois Pain Institute. Dr. Yango noted that Petitioner complained of low back pain radiating down his right leg. The doctor indicated Petitioner began experiencing this pain while lifting an object at work five months earlier. He noted that Petitioner "has tried physical therapy and bed rest with minimal relief." On examination, the doctor noted positive straight leg raising bilaterally, ipsilateral pain with lumbar spine extension and lateral flexion and pain to palpation over the bilateral sacroiliac joints. He reviewed the MRI and interpreted it as showing a protrusion at L4-L5 and a disc herniation at L5-S1.

Dr. Yano diagnosed herniated lumbar intervertebral discs, lumbar facet syndrome bilaterally, sacroilitis and lumbar radiculitis. He prescribed Tramadol and recommended a transforaminal epidural steroid injection. He instructed Petitioner to remain off work. PX 7.

Petitioner returned to Dr. Yano on December 17, 2010. In his note of that date, the doctor indicated that, with the aid of an interpreter, Petitioner reported his leg symptoms were bilateral but primarily left-sided. After re-examining Petitioner and reviewing the EMG/NCV results, Dr. Yano performed transforaminal epidural steroid injections on the left side at L4-L5 and L5-S1. He dispensed 120 Tramadol tablets to Petitioner. PX 7.

Petitioner continued undergoing care with Dr. Aternino during this period. On November 9, 2010, Dr. Aternino noted that Petitioner's wrist and shoulder were "starting to feel better." On November 16, 2010, Dr. Aternino noted that Petitioner described his wrist as "better," his shoulder as "the same" and his back as "the worst problem." On November 23, 2010, the doctor noted that Petitioner's wrist was "much better" but that his low back and right shoulder "hurt every day." On December 21, 2010, Dr. Aternino noted the following:

> "Had the injections and feels better. The wrist and shoulder have been much better with therapy but, if he works, it hurts again."

On December 28, 2010, the doctor noted an improved range of right shoulder motion. The last note in evidence is dated January 3, 2011. PX 4.

On January 7, 2011, Petitioner returned to Dr. Yano and complained of constant lower back pain, rated 7/10, and occasional radiating left leg pain. Petitioner described his pain as "the same since the last evaluation." The doctor administered additional transforaminal epidural steroid injections on the left side at L4-L5 and L5-S1. He indicated Petitioner might be a candidate for a lumbar facet blockade. He recommended that Petitioner increase his intake of Tramadol from six to eight tablets per day. He issued a note stating: "To whom it may concern: Mr. Alvarez is under my care and will require the same restrictions until the next evaluation scheduled in two weeks." The restrictions are not otherwise described. PX 9.

On January 28, 2011, Dr. Yano performed left lumbar facet blockades at L3-L4, L4-L5 and L5-S1. Only the procedure note of that date is in evidence. PX 7, 9.

Dr. Yano's itemized bill [see last page of PX 7] reflects that Petitioner returned to him on January 31, 2011. The doctor's note of that date is not in evidence.

On February 23, 2011, Petitioner saw Dr. Malek for a neurosurgical consultation. Dr. Malek noted a referral from Dr. Yano.

Dr. Malek noted that Petitioner reported being injured at work on April 30, 2010, after removing a mold from a machine and trying to prevent the mold from falling. The doctor's account of the mechanism of injury is lengthy, detailed and consistent with Petitioner's testimony. He noted complaints referable to the low back, both legs and upper right shoulder. He did not note any complaints referable to the wrist. He indicated Petitioner denied any history of previous similar injuries. He described Petitioner as experiencing a "limited response" to Dr. Yano's treatment.

On lumbar spine examination, Dr. Malek noted positive straight leg raising bilaterally and tenderness in the lower lumbar spine.

Dr. Malek reviewed the EMG/NCV and the lumbar spine MRI. He interpreted the MRI as showing "evidence of Grade 1 spondylolisthesis of L5 on S1, retrolisthesis of L3 on L4, desiccation at L2-L3, L3-L4 and L4-L5." He also noted "evidence of contained disc herniation at L4-L5 and L5-S1." Based on Petitioner's persistent complaints, as well as the EMG/NCV and MRI, Dr. Malek recommended a CT discogram at L4-L5 and L5-S1 with control at L2-L3. He instructed Petitioner to refrain from working and continue his current course of therapy. PX 10.

Dr. Malek performed the discogram at Fullerton Surgery Center on March 11, 2011. He indicated Petitioner was "blinded as to the level injected." Initially, Dr. Malek noted a discordant pain response at L3-L4, "pain of questionable concordance" at L4-L5 and "identical concordant pain" at L5-S1. After administering additional anesthesia and re-pressurizing the discs, he noted no pain response at L2-L3 or L3-L4, a "diminished pain response of questionable concordance" at L4-L5 and an "identical concordant pain response" at L5-S1. He indicated Petitioner displayed "no signs of symptom magnification or malingering." He concluded that Petitioner's "primary pain generator" was at the L5-S1 level "with possible contribution from L4-L5" and "no definite contribution from L2-L3 or L3-L4." A post-discogram CT scan showed Grade 4 tears, without extravasation, at L2-L3, L3-L4, L4-L5 and L5-S1, as well as a bilateral pars interarticularis defect at L5-S1, with Grade 1 anterolisthesis of L5 on S1. PX 10.

On March 23, 2011, Dr. Malek reviewed the CT discogram results with Petitioner and discussed various treatment options. He noted that Petitioner stated he was unable to tolerate his symptoms and wanted to proceed with surgery. Dr. Malek indicated the surgery would consist of a lumbar fusion at L5-S1 and probably at L4-L5.

Petitioner returned to Dr. Malek on May 11, 2011 and again complained of persistent symptoms. Petitioner indicated he was scheduled to undergo an IME on May 19, 2011. Dr. Malek described his examination findings and recommendations as unchanged. He told Petitioner he wanted to obtain the IME report and "go from there." He instructed Petitioner to remain off work. He opined that the work accident caused a previously asymptomatic degenerative condition to become symptomatic, requiring treatment as recommended. He completed a work status report stating that Petitioner was awaiting authorization of surgery and should remain off work "until further notice." PX 10.

Petitioner testified he did not return to Dr. Malek after May 11, 2011. T. 38.

The Arbitrator notes that, even though Dr. Malek recommended surgery and kept Petitioner off work on May 11, 2011, Petitioner did not proceed pursuant to Section 19(b) and is not claiming any temporary total disability benefits after May 11, 2011. Arb Exh 1.

At Respondent's request, Petitioner saw Dr. Andersson for a Section 12 examination on May 19, 2011. Dr. Andersson is affiliated with Midwest Orthopaedics at Rush.

In his report of May 19, 2011, Dr. Andersson indicated that Petitioner reported injuring his lower back, right arm and right shoulder at work on April 30, 2010. Dr. Andersson indicated he reviewed records from Advanced Occupational, Dr. Meisles, Dr. Yano and Dr. Malek, as well as the EMG/NCV report, the MRI report and the CT discogram. Dr. Andersson indicated Petitioner provided him with only one study, i.e., the CT discogram. Dr. Andersson interpreted this study as showing evidence of a "pars defect at L5-S1 and a Grade 1 spondylolisthesis" as well as degenerative changes at L2-L3, L3-L4 and L4-L5.

Dr. Andersson noted that Petitioner complained of pain in his lower back, right shoulder and right forearm. The doctor evaluated only the lumbar spine. On examination, he noted a mildly decreased range of motion, with flexion to 40 degrees, extension to 15 degrees and right and left lateral bending to 15 degrees. Straight leg raising was negative bilaterally. Non-organic physical signs were negative.

Dr. Andersson addressed causation as follows:

> "This patient may certainly have strained his shoulder in late April of 2010. It is also possible that he strained or temporarily aggravated his pre-existing spondylolisthesis which is developmental; in other words, occurred during the patient's childhood or adolescence. It appears that the patient had completely recovered by July 12th and that at that time could have returned to work without any restrictions having reached maximum medical improvement with respect to the accident.

> The patient's spondylolisthesis and degenerative changes preceded the accident. The symptoms had resolved by July 12th. His current symptoms and the possible need for surgery is related to his underlying condition and not to the alleged accident. The argument that the patient had no previous symptoms is only valid for the period between 4/30/10 and 7/12/10, by which time he had fully recovered."

Dr. Andersson further opined that, with respect to the work accident, Petitioner did not require additional care, was capable of full duty and "did not sustain any permanent partial disability with respect to his spine." He characterized Petitioner's chiropractic treatment as "unnecessary and unrelated to the accident of April 30, 2010." RX 4.

Petitioner testified he has difficulty using his right arm and wrist to lift a heavy object. When he attempts to lift something, he experiences shooting pain in his right shoulder. T. 38-39. He experiences lower back pain every day. He has difficulty getting up from a seated position. He sleeps on the floor rather than in a bed. He takes medication to help him sleep and sometimes applies patches to his lower back to control his pain.

Petitioner testified he did not work anywhere between April 30, 2010 and May 11, 2011. T. 41.

Under cross-examination, Petitioner testified he did not have any pills with him but was using a patch. T. 42. The objects he worked with on April 30, 2010 were satellite dishes. T. 43. He believes his son Joshua was born on September 9, 1998 but is not sure. T. 44-46. To his recollection, his daughter Ashley was born in 2001. T. 44. He cannot recall her exact date of birth. T. 44. He was working at Pylon Tool on the day of the accident. He could not recall Pylon Tool's address. He only worked there for three or four weeks. He denied working there only one day. T. 46-48. Dr. Bender did not take X-rays on April 30, 2010. She examined him, gave him pills and told him to perform stretches and apply heat and ice. She instructed him to return to her on May 3, 2010. He did not return to her that day. T. 49. Dr. Bender's and Dr. Meisles' records are not accurate if they do not reflect that he complained of leg pain. T. 50. Dr. Meisles addressed only his shoulder on June 14, 2010 because he was "just on the shoulder." Dr. Meisles was a shoulder specialist. T. 51. Petitioner identified RX 1 as a form he completed on behalf of Dr. Meisles. On the form, he wrote that he was seeing the doctor due to a work injury involving his right shoulder and back. T. 52. When he saw Dr. Meisles a second time, on June 14, 2010, he complained only of his right shoulder. T. 53. When he last saw Dr. Meisles, on July 12, 2010, the doctor released him to full duty. Dr. Bender had previously released him to full duty on April 30, 2010. T. 53-54. Dr. Meisles gave him a slip of paper showing which physical therapy he was to go to. This facility was in Melrose Park but he cannot recall the exact address. T. 54. Dr. Meisles told him that the shoulder MRI did not show a tear. T. 55. When he saw Dr. Aternino, three months after Dr. Meisles released him to full duty, he told Dr. Aternino he had seen Dr. Meisles. Dr. Aternino "looked at [his] reports." T. 56. It is not accurate that he did not tell Dr. Yano and Dr. Malek about the treatment Dr. Meisles rendered.

T. 56-57. He saw Dr. Malek twice. T. 58. After Dr. Meisles released him to full duty, he self-treated with bed rest. T. 59. His complaints increased during the three-month interval between his last visit to Dr. Meisles and his first visit to Dr. Aternino. T. 59. He saw Dr. Andersson at Respondent's request. He did not work for Respondent after April 30, 2010 because his supervisor, Lucy Hernandez, fired him after he failed to return to the clinic on May 3, 2010. Hernandez told him she was "not going to pay anything" if he failed to return to the clinic. T. 60. He did not receive any benefits after May 3, 2010. Respondent did not attempt to find additional employment for him after April 30, 2010. T. 60.

On redirect, Petitioner testified that, at different points in 2011, he received three checks from the insurance company. T. 61.

Under re-cross, Petitioner initially testified he has not worked since April 30, 2010. T. 61. After a brief recess, Petitioner acknowledged performing some light work in a store during the preceding three months. During the month prior to that, however, he did not work. His back "does not allow [him] to work normally." Apart from the work he has performed during the last three months, he has not applied for any other jobs since he last saw Dr. Malek in May of 2011. T. 63.

Julio Chirinos testified on behalf of Respondent. Chirinos testified he has worked as a recruiter for Respondent for eight years. He places employees in temporary jobs, creates job orders and communicates with employees and clients via telephone and E-mail. T. 66.

Chirinos testified he is familiar with Petitioner. Respondent has placed Petitioner in jobs. On April 30, 2010, Petitioner was working for Respondent at Helander Metal, not Pylon Tool. Chirinos indicated he is not familiar with Pylon Tool. Petitioner worked at Helander Metal only one day, April 30, 2010. T. 68.

Chirinos testified that Respondent did not terminate Petitioner. Petitioner came to Respondent's office on April 30, 2010 and indicated he had been laid off. Respondent sent Petitioner to a clinic. T. 69.

Chirinos testified he was only one of several recruiters who worked for Respondent on April 30, 2010. As of that date, Lucy Hernandez was Respondent's office manager. Hernandez also made telephone calls regarding recruiting. T. 70.

Chirinos testified that Respondent tried to find work for Petitioner after April 30, 2010. Petitioner did not contact Respondent after June of 2010. T. 71. Respondent provides its employees with light duty if a client allows the employee to be placed in that capacity. T. 71. Respondent had work available for Petitioner after April 30, 2010. T. 71.

Under cross-examination, Chirinos testified he interviewed Petitioner at some point prior to April 30, 2010. Petitioner "re-applied" to Respondent in December of 2009. T. 72. Chirinos testified he always works in the office. Lucy Hernandez was his manager. Hernandez

no longer works for Respondent. T. 73. Respondent employed Petitioner as of April 30, 2010. He was in Respondent's office on April 30, 2010 when Petitioner came to the office. It was Lucy Hernandez who sent Petitioner to the company clinic that day. T. 75. He was not necessarily a party to every conversation Hernandez had with Petitioner but all Respondent recruiters are required to make notes via computer concerning conversations they have with employees. T. 74. Chirinos reviewed his own notes (RX 2) concerning Petitioner. He did not make a note on April 30, 2010. T. 77. On May 3, 2010, he made three notes, with one indicating that Petitioner was injured at Helander on April 30, 2010, that Petitioner reported this injury to "Sam, Jr.", that this individual sent Petitioner home at 2:00 PM, that Petitioner called Chirinos at 3:45 PM and that Chirinos sent Petitioner to the clinic. T. 78. Chirinos testified he left messages for Petitioner after April 30, 2010 but never spoke with Petitioner after that date. T. 78. On May 3, 2010, he made a note indicating he called Petitioner to offer him a job starting the next day but Petitioner's telephone was disconnected. T. 78-79.

On redirect, Chirinos testified that Fridays tend to be busy at Respondent because the employees get paid on Fridays. On Friday, April 30, 2010, he made sure that Petitioner went to a company clinic. At that time, Respondent directed employees to Concentra. T. 80-81. RX 2 is a document that Respondent keeps in the ordinary course of business. T. 82. Employees rely on the computer notes when conducting business for Respondent. T. 83.

Under re-cross, Chirinos testified that each note logged into the computer has a date and specific time assigned to it. He acknowledged, however, that the second note he made on May 3, 2010, does not reflect the seconds, as the other notes do. The note is merely timed 8:54. The notes are not accurate in that they do not reflect, contemporaneously, what happened on April 30, 2010. The second note he made on May 3, 2010 may also be inaccurate. T. 85. He made a note on April 30, 2010 but the note is not reflected on the computer records. T. 86.

On further redirect, Chirinos testified that, if time allows, he makes a note on a Friday concerning an event that occurred on Friday. If he is too busy, he makes the note the next day. T. 87. The notes dated May 3, 2010 reflect what happened on April 30, 2010. T. 87. It is not possible for him to log a backdated note. T. 88. His May 3, 2010 notes accurately reflect the interaction that took place between Petitioner and Respondent on April 30, 2010. T. 88.

In addition to the exhibits previously discussed, Respondent offered into evidence utilization reports dated December 13, 2012 authored by Dr. Rabin, a chiropractor. Petitioner objected to these reports on the basis that a chiropractor is not qualified to render opinions concerning the reasonableness or necessity of MRI scans or EMG studies. The Arbitrator overruled this objection. T. 115-116. Respondent also offered into evidence a print-out of the medical payments it made (RX 9) and a separate copy of PX 14 marked to reflect the medical bills that Respondent paid prior to the hearing (RX 8).

15IWCC0453

Arbitrator's Credibility Assessment

As indicated earlier, Petitioner had difficulty recalling the exact birth dates of his two daughters. He attributed this difficulty to nervousness. Under cross-examination, he restated his son's birth date but acknowledged he was not positive about the date. T. 15.

Petitioner's testimony concerning the mechanism of his April 30, 2010 injury was detailed, credible and corroborated by Dr. Bender's lengthy history of the same date. PX 1. Dr. Bender is a physician of Respondent's selection.

The Arbitrator finds credible Petitioner's testimony that Lucy Hernandez told him he would not be paid based on his failure to return to Advanced Occupational on May 3, 2010. Also credible is Petitioner's testimony that he presented himself to a facility in Melrose Park in order to undergo shoulder therapy per Dr. Meisles, only to be told the therapy was not authorized. A therapy prescription in RX 10 reflects that Dr. Meisles directed Petitioner to Midwest Physical Therapy, with that business having various locations, including one in Melrose Park.

The Arbitrator finds credible Petitioner's testimony that he told Dr. Aternino about Dr. Meisles' recommendation of therapy. Petitioner testified Dr. Meisles gave him a "little paper" concerning the prescribed therapy. That "little paper," i.e., Dr. Meisles' handwritten physical therapy prescription of June 14, 2010, is among Dr. Aternino's certified medical records, as is Dr. Meisles' MR arthrogram prescription of May 26, 2010. PX 4. There is only one explanation for the presence of these prescription slips in Dr. Aternino's chart: Petitioner had the slips in his possession, having received them from Dr. Meisles, and gave them to Dr. Aternino.

Less believable is Petitioner's statement that Dr. Meisles did not record his low back or wrist complaints on June 14, 2010 because the doctor was "just on the shoulder" since he was a "shoulder specialist." T. 51. There is no indication that Dr. Meisles saw Petitioner only for his shoulder. When the doctor first saw Petitioner, on May 24, 2010, he noted injuries to the right shoulder, lower back and wrist, examined the lumbar spine as well as the right arm and shoulder and indicated Petitioner no longer had wrist complaints. PX 4.

The Arbitrator also has some difficulty believing Petitioner's testimony that he did not work at all between the accident and May 11, 2011. T. 41. Dr. Meisles' last note, dated July 12, 2010, strongly suggests that Petitioner inquired of the doctor as to whether it was safe for him to resume working, given that he had "not obtained" the recommended shoulder therapy, with the doctor giving the go-ahead based on the arthrogram results. PX 2.

Arbitrator's Conclusions of Law

Did Petitioner establish he was 39 years old and married with three dependent children as of his undisputed work accident?

Petitioner testified he was born on April 10, 1971. T. 12. This is the date of birth reflected in the Advanced Occupational (PX 1) and other treatment records. Petitioner also testified he was married as of his April 30, 2010 work accident. He was able to identify his three children by name, gender and year of birth. He testified as to his son's birth date but had some difficulty recalling the exact dates on which his daughters were born. Under cross-examination, he reiterated his son's exact birth date but then acknowledged he was not positive about the date. He did not offer a marriage certificate or birth certificates into evidence.

The Arbitrator finds that Petitioner established he was 39 years old, married and had three minor dependent children as of his undisputed work accident of April 30, 2010. When asked about his children, Petitioner started with his son. He readily identified his son's current age as thirteen. T. 14. He then worked his way down. He had some difficulty recalling the months and days on which his two daughters were born but, by their years of birth, identified them as younger than his son. It is the pattern of his thinking, in terms of moving from the oldest to the youngest, that prompts the Arbitrator to find that all three children were minors and thus dependent as of the accident.

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established causation as his current right shoulder condition of ill-being.

In so finding, the Arbitrator relies on the following: 1) Petitioner's description of the machine and the mechanism of injury, with Petitioner indicating he wrenched his dominant right arm while attempting to retrieve and then safely transfer a metal plate; 2) the corroborating history set forth in Dr. Bender's records; 3) the lack of evidence of any pre-accident right shoulder problems or treatment; 4) the post-arthrogram MRI report; 5) Dr. Meisles' last note of July 12, 2010, which reflects that Petitioner reported only transient improvement of his right shoulder pain following the June 14, 2010 injection; 6) Petitioner's credible testimony that he was unable to undergo the shoulder therapy Dr. Meisles recommended due to lack of authorization; 7) the history Petitioner provided to Dr. Aternino on October 19, 2010; 9) Dr. Aternino's shoulder-related findings of October 19, 2010; 10) Dr. Andersson's opinion that Petitioner "may certainly have strained his shoulder in late April of 2010"; and 12) Petitioner's credible testimony as to his ongoing right shoulder complaints.

The Arbitrator finds that Petitioner failed to establish causation as to his claimed current lumbar spine condition of ill-being. In so finding, the Arbitrator relies primarily on Dr. Meisles'

records. PX 2. When Dr. Meisles first saw Petitioner, on May 24, 2010, he noted a complaint of lower back pain and limited lumbar spine motion but no complaints relative to the legs. He described straight leg raising as negative bilaterally. He diagnosed a lumbar strain but did not recommend any back-related treatment. In his subsequent notes of June 14, 2010 and July 12, 2010, he did not document any back-related complaints. He released Petitioner to full duty on July 12, 2010. PX 2.

Petitioner next sought treatment on October 19, 2010. The complaints Petitioner voiced to Dr. Aternino that day were markedly different than those recorded by Dr. Meisles five months earlier. Dr. Aternino indicated that Petitioner complained of severe, 8/10 left-sided lower back pain radiating into his left leg. On examination, Dr. Aternino noted positive straight leg raising on the left side. PX 4. Dr. Aternino recommended back-related treatment. That treatment ultimately resulted in a recommendation of surgery although Petitioner did not seek that surgery at the hearing. As of the June 27, 2013 hearing, Petitioner had not seen a doctor for his back for almost two years.

The evidence does not support a finding of causation as to Petitioner's claimed current lumbar spine condition of ill-being.

With respect to the lumbar spine, the Arbitrator finds that the undisputed work accident of April 30, 2010 resulted in a strain, as diagnosed by Dr. Meisles, with that strain essentially resolving as of May 24, 2010.

With respect to the right wrist, the Arbitrator notes that, per Dr. Meisles, Petitioner described his right wrist pain as having resolved as of May 24, 2010. PX 2. Petitioner did undergo additional right wrist care after that date but, in the Arbitrator's view, failed to establish causation as to that care. Petitioner testified to some difficulty using his right arm to lift, implicating both his shoulder and his wrist, but the Arbitrator finds that Petitioner failed to prove causation as to any claimed current right wrist condition of ill-being.

Is Petitioner entitled to temporary total disability benefits?

At the hearing, Petitioner claimed he was temporarily totally disabled from April 30, 2010 through May 11, 2011. Arb Exh 1. In his proposed decision, Petitioner claimed temporary total disability from May 24, 2010 through July 12, 2010 and from October 19, 2010 through May 11, 2011.

The Arbitrator finds that Petitioner was temporarily totally disabled from May 24, 2010, the date on which Dr. Meisles recommended an MR arthrogram and took Petitioner off work, through July 12, 2010, the date on which Dr. Meisles released Petitioner from care and to work, after expressing awareness that Petitioner "did not obtain" the shoulder therapy he had previously recommended. The interval in question comprises 7 1/7 weeks. The Arbitrator has previously found that Petitioner was married with three dependent children as of the accident.

Based on that finding and the stipulated average weekly wage of $301.78, the Arbitrator awards temporary total disability benefits at the rate of $301.78 per week. The Arbitrator's award of 7 1/7 weeks of benefits is equivalent to $2155.57, with Respondent receiving credit for the $1,920.00 in benefits it paid prior to trial, per the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to medical expenses?

At the hearing, Petitioner claimed fee schedule charges of various providers totaling $54,963.83. Respondent offered into evidence a print-out showing it made payments to some of these providers. RX 9. The print-out does not reflect any payments to Dr. Meisles/Orthopaedics Specialists, S.C.

Based on the foregoing causation-related findings, and Dr. Meisles' records, the Arbitrator finds that the medical services provided by Dr. Meisles and Archer Open MRI were related, reasonable and necessary. RX 9 establishes that Respondent paid $1,505.03 to Archer Open MRI. Respondent is given credit for this payment. Respondent is responsible for the remaining fee schedule balances: 1) Dr. Meisles/Orthopaedics Specialists, S.C., $967.00; and 2) Archer Open MRI, $1,394.72. PX 2-3; RX 8.

Despite having found that Petitioner established causation as to his current right shoulder condition of ill-being, the Arbitrator declines to award the fee schedule charges associated with the shoulder-related care Petitioner underwent with Dr. Aternino. When Dr. Meisles last saw Petitioner on July 12, 2010, he learned that Petitioner "did not obtain" the shoulder therapy he had prescribed on June 14, 2010. He did not recommend that Petitioner pursue this therapy. Nor did he recommend any other shoulder-related care. Instead, he released Petitioner from treatment and to work, based on the MR arthrogram. The Arbitrator notes that Dr. Meisles was a physician of Petitioner's selection.

Is Petitioner entitled to permanent partial disability benefits?

The Arbitrator has found that Petitioner established causation as to his current right shoulder condition of ill-being. Based on the MR arthrogram results, Dr. Meisles' last note of July 12, 2010, showing that Petitioner received only transient relief from a right shoulder injection, and Petitioner's credible testimony as to his lingering right shoulder problems, the Arbitrator awards permanency equivalent to 5% loss of use of the person as a whole under Section 8(d)2, or 25 weeks of compensation, at a rate of $301.78 per week. The Arbitrator awards permanency under Section 8(d)2 rather than 8(e) based on Will County Forest Preserve District v. IWCC, 2012 Ill.App.LEXIS 109.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Baker,
Petitioner,

15IWCC0454

vs.

NO: 10 WC 41471

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 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: JUN 16 2015
O6/10/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0454

BAKER, DAVID
Employee/Petitioner

Case# **10WC041471**

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 10/20/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

OCT 20 2014

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

15IWCC0454

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Baker
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # **10** WC **41471**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **August 6, 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 _____

FINDINGS

On **October 11, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$54,973.00**; the average weekly wage was **$1,057.17**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

Petitioner failed to prove he sustained an accident on October 11, 2010 that arose out of and in the course of his employment or that his current condition of ill-being is causally related to said accident. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

10/11/14
Date

OCT 20 2014

David Baker v. State of Illinois/Pinckneyville Correctional Center, 10 WC 41471

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. Petitioner alleged that he sustained injuries to his bilateral hands and bilateral arms/elbows as a result of repetitive duties while working for Pinckneyville Correctional Center. Petitioner has alleged the date of accident as October 11, 2010. This is a repetitive trauma claim and the issues in dispute are notice, accident, causation, medical bills, and nature and extent.

Petitioner was 40 years old on October 11, 2010 which is his alleged manifestation date for his repetitive trauma claim. Petitioner testified that he worked as a Correctional Officer at Pinckneyville Correctional Center from November 17, 2003 until July 2011. Petitioner testified that his last day at Pinckneyville would have been December 3, 2010.

On October 11, 2010, Petitioner presented to Dr. David Brown, an orthopedic surgeon at The Orthopedic Center of St. Louis, for evaluation and treatment for both his upper extremities. He was referred by his attorney, Tom Rich. On the New Patient Questionnaire, Petitioner reported that his hobbies included gardening, hunting, and building model vehicles. Also on the New Patient Questionnare, Petitioner noted that he smoked one pack of cigarettes per day. Petitioner reported to Dr. Brown that he had worked at Pinckneyville Correctional Center since November of 2003. He worked 7.5 hours a day, forty to sixty hours a week. He stated his job entails operating a computer continuously for seven and a half hours a day. He also wrote entries in log books and reports. Petitioner also stated that six months prior to the visit he would turn keys ten to twenty times per hour. Petitioner reported a six to ninth month history of gradual progressive numbness and tingling in both his hands. Dr. Brown's physical examination of Petitioner revealed a positive Tinel's sign over the ulnar nerve at the right and left cubital tunnels. Direct compression test/elbow flexion test was positive bilaterally. He had no specific point tenderness over the flexor pronator tendon origin bilaterally. He had a negative Tinel's over the right and left carpal tunnels. Direct compression test induced some discomfort. Phalen's test was negative bilaterally. Dr. Brown opined that Petitioner's symptoms and findings on examination were consistent with bilateral cubital tunnel syndrome, and possibly carpal tunnel syndrome. He recommended a nerve conduction study of both upper extremities.

Petitioner underwent the recommended nerve conduction study on October 11, 2010, with Dr. Daniel Phillips, a neurologist at Neurological & Electrodiagnostic Institute, Inc. The study revealed mild to moderate demyelinative bilateral ulnar neuropathies across the elbow. The study was not impressive for carpal tunnel.

Dr. Brown was able to review the nerve conduction study the same day, and in an addendum to his notes of October 11, 2010, he diagnosed Petitioner with bilateral cubital tunnel syndrome. He prescribed Petitioner pads to wear on his elbows and a nonsteroidal anti-inflammatory medication.

Petitioner followed up with Dr. Brown on November 22, 2010. Petitioner reported no improvement in his symptoms, and that they had actually increased. Dr. Brown recommended surgical intervention in the form of an ulnar nerve transposition.

Petitioner's treatment then was transferred to Dr. Brown's partner, Dr. George Paletta. Petitioner first presented to Dr. Paletta on October 5, 2011. Dr. Paletta noted that the recommended surgery was not performed as there was a dispute between Dr. Brown's office and the State. Petitioner advised Dr. Paletta that he had been fired from his job, so he had not been working, but was having continued symptoms. Upon physical examination, Petitioner had a positive Tinel's sign at the cubital tunnel bilaterally. Ulnar nerve compression test was positive bilaterally. Elbow flexion test was positive bilaterally. He had full flexion and extension from 0 to 140 degrees. He had full forearm pronation and supination. He had no pain or laxity on valgus stress testing. The milking maneuver and moving valgus stress test were negative. There was normal wrist flexion and forearm pronation strength. Based on the physical evaluation, and review of the nerve conduction study from October 11, 2010, Dr. Paletta recommended a subcutaneous ulnar nerve transposition.

Petitioner underwent a right elbow subcutaneous type ulnar nerve transposition, with Dr. Paletta, on October 18, 2011, and a left elbow subcutaneous type ulnar nerve transposition on November 22, 2011.

Petitioner presented to Dr. Luke Choi, Dr. Paletta's partner, on October 31, 2011, for his first post-operative visit, at which time phase I of Dr. Paletta's postoperative protocol for unlar nerve transposition was started. Petitioner followed up with Dr. Paletta on December 5, 2011. Dr. Paletta noted that overall Petitioner was doing quite well. All of his pre-op symptoms had been relieved. Dr. Paletta recommended physical therapy. Petitioner next saw Dr. Paletta on January 25, 2012. Petitioner advised that his elbows felt absolutely "great," and that he had complete resolution of all his symptoms. Dr. Paletta noted he had an excellent outcome with complete resolution of his symptoms. He had a normal range of motion, normal strength, and normal flexion. He was placed at MMI and released from care.

Dr. George Paletta testified via evidence deposition on February 1, 2013. (PX8) Dr. Paletta testified that the first time he saw Petitioner for his hand and arm complaints was October 5, 2011. Dr. Paletta testified that on that date Petitioner was complaining of bilateral elbow pain and numbness and tingling down the borders of the arm, forearm into the fourth and fifth fingers. Dr. Paletta testified that by the time Petitioner presented to him Petitioner's symtpoms had been ongoing for about 18 to 24 months. Dr. Paletta agreed that Petitioner did not have carpal tunnel syndrome.

Dr. Paletta testified that it was his understanding that Petitioner worked at Pinckneyville CC as a correctional officer. Dr. Paletta testified that Petitioner had given him a history of operating a computer for seven to eight hours a day in early 2010, but prior to that Dr. Paletta

understood that Petitioner "did the more normal activities typical of my understanding of a prison guard".

Dr. Paletta testified that he reviewed the demands of the job form prepared by the State of Illinois and the records review from Dr. Williams. Dr. Paletta agreed that the activities of forcefull pulling to check the integrity of heavy steel doors, and the activity of inserting a key and forcefully turning it with the elbow in a flexed position could contribute to the development of cubital tunnel syndrome. Dr. Paletta also testified that frequent lifting of 10 – 25 lbs a day up to 5.5 hours a day could contribute to the development of cubital tunnel syndrome. Dr. Paletta further testified that cuffing/uncuffing inmates could contribute to the development of cubital tunnel syndrome if it was done frequently enough. Dr. Paletta testified that in his opinion Petitioner's job activities were a causative or contributing factor to his elbow condition. However, on cross-examination Dr. Paletta testified that any change in the information available would potentially change his opinion.

Dr. Paletta testified on cross-examination that Petitioner did not even indicate to him that he lifted heavy objects at work, nor did he correlate his symptoms to those activities. Dr. Paletta also admitted that Petitioner did not indicate to him that he pulled on steel doors. Dr. Paletta further testified that Petitioner did not enumerate to him the frequency of how often he turned keys, and he admitted that he did not know how many times Petitioner turned keys as a correctional officer. Dr. Paletta testified that he did not know what job post Petitioner was working when he developed symptoms, nor did he know any of the job posts Petitioner had held in the two years prior to presenting to him.

Dr. Paletta testified on cross that he did not know how long Petitioner had been a correctional officer at Pinckneyville, but what was important to him was whether there was a clear correlation between at-risk activities and the onset or worsening of symptoms. Dr. Paletta testified that Petitioner did not relate to him that he was experiencing symptoms during non-work related activities. However, Dr. Paletta admitted that Petitioner stated that his symptoms were aggravated by two non-work related activities, sleeping and driving, on Dr. Phillips patient intake questionnaire. Dr. Paletta also testified that Petitioner had non-work related risk factors for the development of cubital tunnel syndrome, specifically his increased body mass index and his history as a smoker.

Dr. Paletta admitted on cross that there was no medical literature indicating a relationship between typing and key turning with the development of cubital tunnel syndrome.

Dr. Paletta testified that he had never been to any Illinois Department of Corrections facilities. Dr. Paletta also testified that he had never held a Folger Adams key, cuffed/uncuffed another individual using facility cuffs, or lifted a property box. Dr. Paletta agreed that it would be fair to state that someone who had performed those activities would have a better understanding of those activities than him.

Dr. James Williams testified via evidence deposition on March 6, 2014. (RX14) Dr. Williams testified that he is a board certified orthopedic surgeon with a Certificate of Added Qualification in the hand and upper extremity surgery. Dr. Williams testified that he reviewed medical records from Dr. Paletta, a nerve conduction study, a staff assignment history for Petitioner, job analysis reports from Corvel, and a key estimation study performed by Lt. Jason Thompson. Dr. Williams testified that he had toured Pinckneyville Correctional Center. Dr. Williams testified during that tour he has performed job duties that a correctional officer performs, specifically the activities of key turning, he opened a chuckhole with a Folger Admas key, opened a cell door with a smaller key, handled and manipulated property boxes, handled trays in dietary, and operated handcuffs.

Dr. Williams testified that Petitioner's body mass index and history as a smoker could predispose him to the development of cubital tunnel syndrome. Dr. Williams testified that he did not understand Petitioner's job duties to be repetitive based upon how many times he said that he had turned keys, which was ten to twenty times per hour. Dr. Williams testified that would indicate he was turning a key about every six minutes and he did not feel that was significantly repetitive in nature. Dr. Williams testified that from what he could tell Petitioner's job duties were not vibratory in nature. Dr. Williams testified that he did not feel there was significant force involved in the activity of key turning when he personally performed the activity at Pinckneyville.

Dr. Williams testified that based upon Petitioner's description of his activities to his providers, the job description of a correctional officer, Dr. Williams tour of the facility, the two videos from Corvel, and the key turning study he did not believe within a reasonable degree of medical certainty that Petitioner's job activities as a correctional officer at Pinckneyville would cause or aggravate cubital tunnel syndrome.

Petitioner testified on direct-examination that he is 6 ft tall and weighs 250 lbs. Petitioner testified that with regard to hobbies he hunted infrequently, fished a little bit, and gardened. Petitioner testified he hunted a couple times a year and gardened a couple times a week. Petitioner testified on cross that he hunts deer and squirrel and uses a shotgun to do so. Petitioner testified that he has been hunting since his surgery. Petitioner testified that the hours he spent gardening differed per season, but that it was a maximum of 10 hours per week. Petitioner testified that his garden was 1,000 square feet. Petitioner testified that he used a tiller on his garden and that it was vibratory.

Petitioner testified on direct that as a correctional officer at Pinckneyville he changed and rotated jobs. Petitioner testified that he was constantly a relief officer, although Petitioner estimated that he spent 70 – 80% of his time as a wing officer.

Petitioner testified that as a wing officer he pulled doors every 30 minutes during a wing tour. Petitioner testified that he used a Folger Admas to open and close chuckholes as a wing

officer. Petitioner testified that a chuckhole is a slot that's in the steel cell door that opens and closes to pass feed, mail, laundry, and other things without opening the entire door. Petitioner testified that most of the chuckholes were dirty when he worked at Pinckneyville and the hinges were still and rusty. Petitioner testified that he used both hands to open the chuckhole. To open the chuckhole he would grab the lift, like a handle on the door, insert the Folger Adams key, turn it and pull the door down. Petitioner testified that the locks did not always work smoothly, but that some did.

Petitioner testified on cross-examination that he did not recall what shift he worked the most as a wing officer, but that he would have worked all shifts. Petitioner agreed that the amount of work he would do as a wing officer varied depending on the shift he was on. Petitioner was asked about the key estimation study performed by Lt. Jason Thompson, Respondent's Exhibit 11. Petitioner agreed that under the best circumstances he would use 55 large keys and 50 small keys as a general population wing officer on the day shift and evening shift.

Petitioner testified on cross-examination that during a wing check he would walk down each row of doors and shake the doors to make sure they were secure. Petitioner testified that when shaking the door "it's not a tough shake" he further described it as "a medium – a physical shaking of the door". Petitioner testified if the wing check was done properly it would take 5 – 10 minutes to complete.

Petitioner testified on cross that as a wing officer he would use Folger Adams keys for the chuckhole, but stated inmate services were given through the chuckhole in general population "mostly just during lockdown" but he would use a Folger Adams key every day as a wing officer. Petitioner testified that sometimes you would just open the door to put laundry in a cell, but sometimes you had to deliver laundry through the chuckhole. However, "generally on lockdown would be the majority of the use of the Folger Adams key".

Petitioner testified on cross that unless the facility was on lockdown all the feeds were done through chow lanes, therefore in general population feeds were done through lines via mass movement. Petitioner testified that mass movement was done through the control pod on a touch screen computer.

Petitioner testified on cross-examination that he did not remember what shift he was on from 2008 – 2010, but he did remember that he was on day shift when he reported his injury. Petitioner agreed that the Staff Assignment history, Respondent's Exhibit 7, appeared to be an accurate summary of the places and shifts he worked from April 2009 – June 2011.

Petitioner agreed on cross that from April 2009 – January 2010 he would have been on midnight shift. Petitioner testified that although the Staff Assignment history showed he worked the Tower 6 position, it was only a half a shift assignment. Petitioner testified that he would have spent the other half of the shift on walk in a patrol. Petitioner testified that the tower

assignment was a "pretty slow assignment", that there was not a lot going on and he would observe the facility from the tower. Petitioner testified that when he was in the tower he was not required to use Folger Adams keys or cuff/uncuff inmates. Petitioner testified that the job duties for the post of walk on midnight shift depended on whether you did walk on the first half of the shift or the last half of the shift. If Petitioner had the post on the first half of the shift he would distribute paperwork and go around to different cell houses and pick up the count. Petitioner testified if he was scheduled to work the last half of the shift then he would escort inmates to and from dietary for breakfast. Petitioner testified that while on walk he would not use Folger Adams keys and, unless the facility was on lockdown or he was escorting a segregation inmate, he would not be cuffing/uncuffing inmates.

Petitioner testified on cross that the post of inner core officer, which was listed on his Staff Assignment history, was the same as the activity of walk.

Petitioner testified on cross that the post of health care officer, which was listed on his Staff Assignment history, ensured the security of the health care unit. Petitioner testified that he would be observing three rooms that held four inmates in each room and three iso segregation rooms, for a total of six cells, in the health care unit. Petitioner testified that they were not always fully occupied. Petitioner agreed that the only time he would use a Folger Adams key in the health care unit would be if there were inmates in the isolation cells, which could be as many as three inmates or as few as zero.

Petitioner testified on cross that the post of sally port officer, which was listed on his Staff Assignment history, was a half a shift post where you worked in the sally port where trucks would come in. Petitioner testified that this post involved observing, paperwork, searching vehicles, and searching inmates.

Petitioner testified on direct that as a correctional officer he would open cell doors. Petitioner testified that the doors were very heavy. Petitioner testified that there were 52 to 56 cells on a wing.

Petitioner agreed on cross-examination that Pinckneyville opened in 1998 and was a state of the art facility at that time. Petitioner testified that the cell doors were on a hinge and, for the most part, the hinges were pretty well oiled and opened fairly easily.

Petitioner testified that he did not remember where he spent most of his time from 2008 – 2010. Petitioner testified that he spent quite a bit of time in the control room in 2010. Petitioner testified that the control room officer works in a room in the center of the housing unit that has computers that run the wings.

Petitioner agreed on cross that when he presented to Dr. Brown he had advised him that he had switched to control six months prior. Petitioner testified that the job post of control

required him to maintain records, operate a computer, open and close doors with a mouse or touch screen computer, issue keys, and issue handcuffs.

Petitioner testified that he worked in the segregation unit, but did not remember how much time he spent there. Petitioner testified that in the segregation all inmate movement is escorted and all inmates have to be handcuffed.

Petitioner testified on cross that he was not assigned to R5 segregation as a regular assignment from 2008 – 2010, that he might have been sent there as a relief officer.

Petitioner testified on cross that in R5 segregation property boxes were kept outside the cells, and that the inmates were only allowed correspondence boxes inside their cells. Petitioner agreed that correspondence boxes were 1/3 the size of a property box. Petitioner testified if the correspondence box was full it could weigh up to 20 – 25 lbs, but it could also weigh less.

Petitioner testified on cross-examination that bar rapping was only done in receiving segregation at Pinckneyville on the two shower cells located in receiving segregation. Petitioner testified that he had been assigned to receiving segregation, but estimated he spent very little time there in 2008 and 2010. Petitioner agreed that receiving segregation was different than R5 segregation, and that there are not bars in R5 segregation.

Petitioner testified that he performed shakedowns. Petitioner testified that a shakedown is where you go into an inmate's cell and go through their property and look for contraband. Petitioner testified that during a shakedown he would lift mattresses, open vents, and lift property boxes. Petitioner testified that some property boxes weighed up to 50 lbs., but some were not that heavy, it depended on how much property the inmate had.

Petitioner testified on cross that he was required to shakedown two cells per shift if he was assigned to one wing. Petitioner testified that if there wasn't very much property the process would take 10 – 15 minutes.

Petitioner testified that there was a locksmith on duty at Pinckneyville. Petitioner testified that during his tenure at Pinckneyville he did fill out reports for broken or disabled locks, but that it was not very many. Petitioner testified that he would only fill out a report if the lock was totally inoperable. Petitioner testified it the lock took time to open he would just wiggle the key and pull harder. Petitioner testified on cross that he would estimate 20% of the locks were sticky or inoperable.

Petitioner testified that lockdown is where all movement ceases and no inmates are out of their cells unless they are escorted and restrained. Petitioner did not recall how much the facility was on lockdown in 2008 or 2009, but he remembered it being frequently. Petitioner testified that he duties of a correctional officer increased when the facility was on lockdown because the inmates can't get out of their cells to do anything for themselves, so if they get anything, like

food, mail, laundry, or ice, it is delivered to them through the chuckhole of their cell by the correctional officer.

Petitioner agreed on cross that there were different levels of lockdown. Petitioner testified that on a level 4 lockdown inmate porters could still be used. Petitioner also agreed that certain areas of the facility could be on lockdown while others were not. Petitioner agreed this meant that part of the facility could be on lockdown but he might not have been affected depending on his job post. Petitioner also agreed that lockdown would not affect his job duties if he was assigned to R5 segregation.

Petitioner testified that he would have no reason to dispute that the facility was on lockdown in 2010 from: January 1, 2010 – January 3, 2010 (Level 1), January 4, 2010 – January 12, 2010 (Level 4), February 19, 2010 – February 21, 2010 (Level 1) per Respondent's Exhibit 8.

Petitioner testified that he cuffed and uncuffed inmates, and that sometimes the inmates resist. Petitioner testified on cross that inmates were only cuffed through the chuckhole during lockdown or in R5 segregation. Petitioner admitted on cross he only had a couple of inmates resist cuffing during the course of his career.

Petitioner testified that during the course of performing his job duties he began developing symptoms in his elbows and hands. Petitioner described his symptoms as numbness in his pinky, ring fingers, and on the outside palms of his hands. Petitioner testified that his attorney sent him to a physician for those problems. Petitioner testified that he underwent a nerve conduction study and that day was the first time he realized he had a work related condition. Petitioner testified that he had never treated with anyone before for any type of problem related to numbness and tingling in his hands or arms.

Petitioner agreed on cross that on Dr. Brown's patient intake questionnaire he advised he was being seen for a work related injury and was represented by an attorney. Petitioner testified that prior to seeing a doctor he assumed his symptoms were work related. Petitioner testified that he was told his condition could be cubital tunnel syndrome by the people he worked with.

Petitioner testified that he underwent surgery on his elbows, and that surgery improved his condition. Petitioner testified that he still has some problems despite surgery. Petitioner testified that he has some tenderness in the local area of the elbows where the incision was made and a little soreness at times depending on what he does. Petitioner testified that the activities of work, lifting, carrying, and pulling bother him. Petitioner testified that rest helps these symptoms and he takes Ibuprofen occasionally.

Petitioner testified that he currently works for Gateway FS as an LP fuel truck driver. Petitioner testified that he drives a large truck, an International 4300. Petitioner testified that he does not notice any symptoms of vibration or numbness and tingling, that has resolved.

Lt. Jason Thompson was called in Petitioner's case in chief. Lt. Thompson testified that he is employed by the Illinois Department of Corrections. Lt. Thompson testified he began working for DOC on May 13, 1996 and that he transferred to Pinckneyville in 1998. Respondent called Lt. Thompson in their case in chief. Lt. Thompson was asked to describe wing checks. Lt. Thompson stated that after a mass line movement officers would go and "flick the doors" to see if they come open. He testified that after a mass line movement if a cell door was showing that it was open on the computer screen in the pod that's when you would do the total pull but "even in that circumstance, it's fairly light because you can hear the metal hitting up inside the locking mechanism". Lt. Thompson testified that if an officer didn't hear the metal hit, and the door wasn't open, then the door was either jimmied or tight and an officer would tug it a little bit harder.

Lt. Thompson was asked if he agreed with Petitioner's testimony that up to 20% of the chuckholes in the facility were sticky or inoperable. Lt. Thompson testified that probably only 1 – 2% of the locking mechanisms were really hard to twist. Lt. Thompson testified that in some houses the percentage of chuckholes that were sticky, as in wouldn't slide down, might be that high but in most houses it probably wasn't.

Therefore, the Arbitrator concludes:

1. The Petitioner failed to prove he sustained an accident on October 11, 2010, that arose out of his employment with Respondent. Petitioner failed to prove that his condition of ill-being in his bilateral elbows is causally related to his alleged accident of October 11, 2011. Petitioner's testimony as to the job duties he performed was varied.

   Petitioner testified that he had worked every shift and held numerous posts at Pinckneyville Correctional Center, and further testified to the different job duties required in each post that he had held. Dr. Paletta, Petitioner's treating physician, did not have a clear and accurate understanding of Petitioner's job duties for each post he held. At most, his opinion is based solely on Petitioner's representations to him without any type of objective analysis or understanding of his complete job duties. Dr. Paletta testified on cross-examination that Petitioner did not even indicate to him that he lifted heavy objects at work, nor did he correlate his symptoms to those activities. Dr. Paletta also admitted that Petitioner did not indicate to him that he pulled on steel doors. Dr. Paletta further testified that Petitioner did not enumerate to him the frequency of how often he turned keys, and he admitted that he did not know how many times Petitioner turned keys as a correctional officer. Dr. Paletta testified that he did not know what job post Petitioner was working when he developed symptoms, nor did he know any of the job posts Petitioner had held in the two years prior to presenting to him.

"The Commission has determined that a claimant fails to prove causation from repetitive trauma when the treating physician testified repetitive motions causes the injuries but failed to detail what repetitive motions the petitioner engaged in and the frequency of the motions." *Phillips v Pinckneyville Correctional Center*, 10 WC 23567, citing *Gambrel v. Mulay Plastics*, 97 IIC 238.

Dr. James Williams performed a records review on behalf of Respondent and testified via evidence deposition. Dr. Williams testified that he reviewed Petitioner's medical records, the Corvel Job Analysis reports and DVDs, key estimation study by Lt. Jason Thompson, and job and post descriptions.

Based upon the testimony of Jason Thompson, P Ex 17, the Petitioner's testimony, and R Ex 7-12, the Arbitrator finds the work activities of the Petitioner to be varied. Coupled with Dr. William's testimony, R Ex 14 the Arbitrator concludes the Petitioner's work was not sufficiently repetitive and forceful to cause cubital tunnel pathology or aggravate it as was indicated by the fact the Petitioner's condition did not improve after leaving his employment. (P 23-24).

2. Therefore, the Petitioner's claim for compensation is denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHARON MONTGOMERY,

Petitioner,

vs.

NO: 12 WC 30084

ST. JOSEPH HOSPITAL /
RESURRECTION HEALTH CARE,

15IWCC0455

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

The Commission finds that Petitioner has not reached maximum medical improvement (MMI) and is entitled to medical expenses and temporary total disability benefits through the date of hearing along with the prospective surgery as recommended by Dr. Kolavo.

We agree with the Arbitrator's finding that the causation opinion of Respondent's Section 12 physician, Dr. Lieber, is not persuasive. However, we find that the opinion of Petitioner's treating physician, Dr. Kolavo, is persuasive. Although Dr. Kolavo did not review the surveillance videos, we find that those videos don't depict Petitioner doing anything outside of her restrictions or that would indicate that she had reached MMI. For example, they show her walking (most of the time guardedly), carrying some grocery bags, and getting into a car. None of these activities would support a finding of symptom magnification or malingering. Petitioner never told her doctors that she couldn't walk or carry grocery bags, etc. and she, in fact, testified that she was able to do those things. Therefore, we find that the limited video surveillance is not sufficient to conclude that Petitioner was not credible with her complaints.

The Arbitrator found that Dr. Kolavo was "unaware of significant symptom magnification." However, this appears to be a reference to some of the early physical therapy records indicating Petitioner's significant pain complaints and statements that she felt unable to return to work. It is true that, for example, the July 18, 2012 therapy note indicates 9/10 pain that is "inconsistent with the diagnosis." However, the diagnosis at that time was simply a lumbar strain while Petitioner's later treating records indicate degenerative disc disease, lumbar radiculitis, etc. Even Respondent's Dr. Lieber opined on September 25, 2012 that Petitioner's pre-existing degenerative disc diseases was temporarily aggravated by her work injury. Therefore, this "evidence of symptom magnification" was determined by a physical therapist early in the course of treatment and was based on an inaccurate diagnosis. None of the physicians involved had found Petitioner to be magnifying her symptoms or malingering.

Although Dr. Heller's examination note on February 12, 2013, does indicate that Petitioner moved with "fair ease from sit to stand" and that her lumbar range of motion was "fairly normal," Dr. Heller also recommended a surgical consult with Dr. Kolavo because Petitioner was still symptomatic after three lumbar epidural steroid injections. Petitioner reported that she still had left leg pain but her right leg had improved. Pending the surgical consult, Dr. Heller released Petitioner to light duty of 10 pound lifting and sitting 50% of the time, adding, "under these restrictions, I don't believe she would be dong more than she currently is doing daily at her home." Therefore, it is clear that Petitioner had not reached MMI as of that date.

The Arbitrator noted the gap in treatment between February 12, 2013 and July 10, 2013, when Petitioner first saw Dr. Kolavo. However, we find Petitioner's testimony credible that the referral to Dr. Kolavo was initially denied but she eventually saw him under her group health insurance. Furthermore, there is no evidence that Petitioner was engaging in any activities during this period that indicate that she had reached MMI or that she suffered any intervening accident.

Dr. Kolavo testified that had Petitioner had discogenic low back pain and radicular pain from the narrowing of her foramen and that her work injury was an "aggravating factor that triggered her symptoms that led to her condition at the time I saw her." He recommended surgery involving facetectomy, foraminotomy, and fusion at L4-5 and L5-S1, for which Petitioner is still waiting.

We find the opinion of Dr. Kolavo to be persuasive and consistent with the medical records and Petitioner's credible complaints that have persisted since her injury despite conservative treatment. We therefore award Petitioner's medical expenses submitted into evidence, pursuant to the provisions of Section 8.2 of the Act. On the issue of temporary total disability, we find that Petitioner has not reached maximum medical improvement. The restrictions she was given by Dr. Heller on February 12, 2013 were not permanent. To the contrary, they were temporary pending her surgical evaluation with Dr. Kolavo who took Petitioner off work entirely as of July 10, 2013. Therefore, Petitioner is entitled to temporary total disability for 100-5/7 weeks from June 29, 2012 through the date of hearing on June 3, 2014.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $762.67 per week for a period of 100-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

15IWCC0455

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses in evidence under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective surgery as recommended by Dr. Kolavo.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $55,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 17 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 4/21/15
49

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

MONTGOMERY, SHARON
Employee/Petitioner

Case# **12WC030084**

ST JOSEPH HOSPITAL/ RESURRECTION HEALTH CARE
Employer/Respondent

15IWCC0455

On 6/30/2014, 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:

0062 TEPLITZ & BELL
JOEL BELL
221 N LASALLE ST SUITE 1900
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
NATHAN S BERNARD
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0455

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)

Sharon Montgomery
Employee/Petitioner

v.

St. Joseph Hospital/Resurrection Health Care
Employer/Respondent

Case # 12 WC 30084

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 **June 3, 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 [x] 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, **6/28/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident; however, Petitioner has reached maximum medical improvement.

In the year preceding the injury, Petitioner earned **$59,485.00**; the average weekly wage was **$1,144.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$23,206.96** for TTD, and **$10,301.48** for the medical bills.

Respondent is entitled to a further credit of **$10,578.74** under Section 8(j) of the Act, provided Respondent holds Petitioner harmless from any claims by the group insurance carrier.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$762.67**/week for **32 5/7** weeks, commencing **June 29, 2012**, through **February 12, 2013**, as provided in Section 8(b) of the Act.

Further, Respondent shall pay Petitioner temporary total disability or maintenance benefits of **$762.67**/week for **21 1/7** weeks, commencing **February 13, 2013**, through **July 10, 2013**, as provided in Sections 8(a) and 8(b) of the Act.

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

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

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

Signature of Arbitrator

6/27/2014
Date

ICArbDec19(b)

JUN 30 2014

15IWCC0455

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified that she worked for Respondent as a respiratory therapist. Her job duties included bending, stooping, lifting patients and lifting and pushing equipment. She denied prior back problems. On June 28, 2012, Petitioner slipped on wet floor at a patient's bedside and fell, striking the nightstand and landing on the floor. Petitioner felt pain in the buttocks and left shoulder. She received emergency treatment at Respondent's hospital and follow-up care at DuPage Medical Group.

The medical records from DuPage Medical Group show preexisting problems with the right knee, but no treatment for low back problems. On June 29, 2012, Petitioner sought treatment for back pain with radiation to the left buttock and hamstring, giving a history consistent with her testimony. She saw Physician's Assistant Erin Kopeny, who prescribed medication. On July 6, 2012, Petitioner followed up with Physician's Assistant Kopeny, complaining of low back pain with radiation to the buttocks and mid hamstrings, worse on the left. Physician's Assistant Kopeny prescribed physical therapy and took Petitioner off work. On July 18, 2012, Petitioner presented for initial physical therapy evaluation, exhibiting significant disability and rating her pain a 9/10. The physical therapist was unable to complete the evaluation due to Petitioner's pain behaviors, including "crying through out [*sic*] the evaluation." On July 19, 2012, Petitioner saw Dr. King, who made only a cursory note of the visit. On July 24, 2012, Petitioner presented for physical therapy, complaining of nausea and vomiting from the pain medication and reporting no improvement in her pain. She did not meaningfully participate in physical therapy, explaining she could not do much because of the pain. Petitioner continued to exhibit significant pain behaviors and disability during subsequent physical therapy visits on August 1, 2012, August 6, 2012, August 8, 2012, and August 15, 2012. On August 29, 2012, Petitioner saw Dr. King, complaining of persistent back pain and requesting more time off work. Dr. King referred Petitioner to Dr. Heller, a physiatrist.

On September 4, 2012, Petitioner consulted Dr. Heller, complaining of extreme low back pain with bilateral radiation to the buttocks and thighs. X-rays showed degenerative changes at L4-L5 and L5-S1. On physical examination, Petitioner had a restricted lumbar range of motion due to pain complaints. Dr. Heller diagnosed persistent mechanical low back pain, prescribed additional physical therapy, and kept Petitioner off work.

On September 24, 2012, Dr. Lieber, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner complained of persistent posterior back and bilateral posterior thigh pain, with some numbness. She gave a history consistent with her testimony. On physical examination, Petitioner had a restricted range of motion. Straight leg raise test was negative. Dr. Lieber reviewed an X-ray report and a note from Dr. Heller and diagnosed "[d]egenerative low back disease with associated lumbar strain and contusion." Dr. Lieber opined:

> "The petitioner shows evidence of pre-existing degenerative lumbar disc disease that appears to have been temporarily aggravated by her work injury of June 28, 2012. The petitioner would benefit via treatment with a Medrol Dosepak versus a two-to-three week course of prednisone, and continued physical therapy for approximately three weeks. If the petitioner showed no improvement in

symptomatology with continued posterior thigh pain, she would be indicated for an MRI to rule out any underlying acute abnormalities within the lumbar spine.

***

The petitioner shows no evidence of any permanent disability as a result of the June 28, 2012 work injury. Further treatment as indicated is in direct relationship to the June 28, 2012 work injury."

Dr. Lieber recommended that Petitioner work on sedentary duty while she underwent treatment.

On September 30, 2012, Petitioner followed up with Dr. Heller, reporting no improvement and exhibiting "tremendous" pain on physical examination, which prevented Dr. Heller from completing the examination. Dr. Heller noted, "[She] [d]oes continue to have normal strength, sensation and reflexes both Les with negative seated SLR. Gait normal." Dr. Heller ordered an MRI, prescribed prednisone, and kept Petitioner off work. The MRI, performed October 23, 2012, showed mild bilateral foraminal stenosis at L4-L5, moderate right foraminal stenosis at L5-S1, and moderately severe left foraminal stenosis at L5-S1. Also on October 23, 2012, Petitioner followed up with Dr. Heller, reporting improvement with physical therapy and rating her pain a 5-6/10. Seated straight leg raise test was again negative. Dr. Heller recommended continuing physical therapy, switched Petitioner to non-narcotic pain medications, and kept her off work. On November 12, 2012, Petitioner reported no improvement. Dr. Heller noted that the physical therapist reported "having a very hard time progressing patient." Dr. Heller recommended an epidural steroid injection and continuing physical therapy, and kept Petitioner off work.

On December 5, 2012, Dr. Heller performed an interlaminar epidural steroid injection at left L5. On December 11, 2012, Petitioner followed up with Dr. Heller, reporting "pain so significant that she absolutely cannot RTW." Dr. Heller recommended another injection. On December 19, 2012, Dr. Heller performed bilateral transforaminal epidural steroid injections at L5. On January 8, 2013, Petitioner followed up, reporting improvement on the right side. Dr. Heller recommended a third injection.

On January 21, 2013, Dr. Lieber reexamined Petitioner. Petitioner reported some relief in her right thigh pain, and complained of persistent pain in her low back, buttocks and legs, the left worse than the right. On physical examination, Petitioner had a restricted range of motion. Straight leg raise test was positive at 60 degrees. Dr. Lieber reviewed the MRI report and medical records from Dr. Heller and agreed with the recommendation for a third epidural steroid injection. Dr. Lieber further recommended a two week course of physical therapy after the injection. In the meantime, Petitioner should be off work. Dr. Lieber opined that upon completion of the two weeks of physical therapy, Petitioner should be able to return to work full duty. Lastly, Dr. Lieber stated:

"There is no evidence of any permanent disability as a result of the June 28, 2012 work injury. The petitioner shows evidence of significant pre-existing

abnormalities and no evidence of any permanent abnormality that could be related to the June 28, 2012 work injury."

On January 30, 2013, Dr. Heller performed a transforaminal epidural steroid injection at left L5. On February 12, 2013, Petitioner followed up, complaining of persistent pain in the left leg and stating she could not work. Physical examination findings were as follows: "Pt morbidly obese/about 300#. Moves with fair ease from sit to stand. Lumbar spine ROM fairly normal. Motor intact. Gait fairly normal." Dr. Heller referred Petitioner to a spine surgeon and released her to return to work on light duty, with the restrictions of sitting 50 percent of the time and lifting no more than 10 pounds.

Petitioner testified that Respondent terminated her employment in December of 2012, when she was still off work per Dr. Heller. Petitioner explained that after the accident, she attempted to return to work on one occasion, but Respondent told her to go home when she complained she was in a lot of pain. In February of 2013, Respondent stopped paying temporary total disability benefits. Petitioner has unsuccessfully looked for work, applying for jobs as a receptionist or respiratory therapist.

From January through May of 2013, Respondent conducted video surveillance of Petitioner. The surveillance videos in evidence show Petitioner: lift and carry shopping bags from a car to a house; lift bags of groceries and put them in a car; lift the groceries out of the car and carry them inside a house; walk across a parking lot carrying a carry-on size bag; ride in a car as a passenger; and walk in a waddling, guarded manner while running errands. Petitioner's condition appeared unchanged throughout the surveillance period.

Petitioner testified that in July of 2013 she consulted Dr. Kolavo, an orthopedic surgeon. The medical records from Dr. Kolavo show Petitioner was referred by Dr. Heller. Petitioner first saw Dr. Kolavo on July 10, 2013. She complained of pain in the back, buttocks, left thigh and left foot, and described the work accident consistently with her testimony. Dr. Kolavo noted the pain was in the L5 dermatomal distribution and found it "obvious *** based on [the] history, radiographic finding and clinical presentation that her condition was aggravated by her injury of record." Dr. Kolavo ordered a repeat MRI, a discogram and post-discogram CT scan, and took Petitioner off work.

On July 15, 2013, Dr. Lieber reexamined Petitioner. Petitioner complained of persistent low back pain with radiation down the left leg, reporting no improvement in her symptoms since January of 2013. On physical examination, she had a severely restricted range of motion secondary to pain. Straight leg raise test was positive at 60 degrees. Dr. Lieber also noted abnormal gait. Dr. Lieber reviewed the surveillance videos, noting that Petitioner climbed in and out of a car and lifted bags of groceries without any sign of distress or abnormal gait. Dr. Lieber opined:

"[T]he petitioner shows no evidence of any functional impairment of the lumbar spine that could be related to the isolated injury during her employment on June 28, 2012. The petitioner has reached maximum medical improvement in association with that injury and requires no further treatment at this time or in the

future. The petitioner is able to return to full employment with no restrictions in association with the June 28, 2012 event. *** The petitioner does not require a referral to an orthopedic specialist at this time or in the future in association with the June 28, 2012 work injury. There is no evidence of any permanent functional disability or impairment in association with the June 28, 2012 event. The petitioner's present complaints are related to significant pre-existing degenerative abnormalities that were neither aggravated, related, and/or accelerated by the isolated injury of June 28, 2012."

The repeat MRI, performed July 16, 2013, showed a left-sided annular tear at L3-L4, a bulge and annular tear at L4-L5 without nerve root displacement, mild lateral recess stenosis at L5-S1 with probable encroachment on the left S1 nerve root, and moderate to severe narrowing of the left neural foramen with probable encroachment on the left L5 dorsal root ganglion. The discogram, performed August 5, 2013, showed severe concordant pain at L4-L5, with a left-sided radicular component. The post-discogram CT scan showed mild disc bulging at L3-L4, diffuse bulging and significant disc degeneration at L4-L5, and disc bulging with multiple annular tears at L5-S1 with moderate bilateral foraminal narrowing and mild central stenosis. On August 13, 2013, Dr. Kolavo recommended decompression and fusion surgery at L4-L5 and L5-S1. Petitioner testified she was still covered by Respondent's group health insurance in July and August of 2013, as she had elected to continue the coverage under COBRA. She put the treatment with Dr. Kolavo through the group health insurance plan.

Dr. Kolavo testified via evidence deposition on February 4, 2014, that he thought Petitioner suffered from a combination of radicular pain and pain due to disc degeneration and facet arthritis. Dr. Kolavo opined the work accident triggered Petitioner's symptoms, and fusion surgery was a reasonable option to alleviate the symptoms.

Petitioner testified she stopped looking for work when Dr. Kolavo took her off work. She continues to suffer from pain in her back and buttocks, which radiates to the thighs and legs. Her gait is slower than it used to be and a little wobbly. She takes prescription and over-the-counter pain medication and wishes to proceed with the surgery recommended by Dr. Kolavo. She has not seen a doctor for her back condition since August of 2013. Petitioner further testified that she stopped driving because of the pain and did not renew her driver's license. However, she admitted on cross-examination she can ride in a car for an approximately hour.

Daniel Minnich, a certified vocational rehabilitation counselor, testified that in February of 2014 he performed a vocational assessment at Respondent's request, based on Petitioner's medical records and the reports from Dr. Lieber. Mr. Minnich concluded Petitioner was employable in a number of occupations and did not require vocational training. The parties agree vocational rehabilitation is not at issue. Rather, Mr. Minnich's opinion is relevant to the issue of temporary disability or maintenance benefits.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds Dr. Lieber's opinions internally inconsistent. In his report dated September 25, 2012, Dr. Lieber opined the work injury "temporarily aggravated" Petitioner's preexisting degenerative disc disease and Petitioner "shows no evidence of any permanent disability as a result of the June 28, 2012 work injury." Yet Dr. Lieber recommended further treatment and an MRI if Petitioner failed to improve, connecting the need for treatment to the work accident. Dr. Lieber further recommended that Petitioner work on sedentary duty while she underwent the treatment. Likewise, in his report dated January 22, 2013, Dr. Lieber recommended further treatment related to the work accident, while at the same time stating: "There is no evidence of any permanent disability as a result of the June 28, 2012 work injury. The petitioner shows evidence of significant pre-existing abnormalities and no evidence of any permanent abnormality that could be related to the June 28, 2012 work injury." Clearly, Dr. Lieber's opinions regarding any residual disability were premature at that point. Subsequently, in a report dated July 17, 2013, Dr. Lieber opined that Petitioner had reached maximum medical improvement. Not surprisingly, Dr. Lieber found "There is no evidence of any permanent functional disability or impairment in association with the June 28, 2012 event." The Arbitrator notes Dr. Lieber's final opinion of no permanent functional impairment appears conclusory and preordained. For these reasons, the Arbitrator does not find Dr. Lieber's opinions credible.

Turning to Dr. Kolavo's opinions, the Arbitrator notes they are based on the chain of events. However, Dr. Kolavo did not review the physical therapy records, the medical records from Dr. Heller, or the surveillance videos. Thus Dr. Kolavo was unaware of significant symptom magnification. Furthermore, Dr. Kolavo was unaware that Petitioner's physical examination on February 12, 2013, was grossly normal, and the surveillance videos showed no change in her condition through May of 2013. The Arbitrator therefore cannot give much weight to the opinions of Dr. Kolavo.

The Arbitrator relies on Dr. Heller's physical examination findings on February 12, 2013, the surveillance videos and the gap in treatment between February and July of 2013 to find Petitioner reached maximum medical improvement from the work injuries by the time she consulted Dr. Kolavo on July 10, 2013. The Arbitrator notes that Petitioner testified she was covered under group health insurance through COBRA during the gap in treatment. Thus, Petitioner cannot claim she went without treatment because Respondent did not authorize it. The Arbitrator again notes evidence of symptom magnification. Having carefully considered all of the foregoing, the Arbitrator finds Petitioner failed to prove she was suffering from an unstable condition of ill-being related to the work accident when she first consulted Dr. Kolavo.

In support of the Arbitrator's decision regarding (J), were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner claims medical bills for the visits to Dr. Kolavo and the diagnostic studies she underwent at his recommendation. Having found that Petitioner reached maximum medical improvement from her work injuries before July 10, 2013, the Arbitrator denies the medical bills.

In support of the Arbitrator's decision regarding (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Dr. Kolavo recommended surgery to address preexisting degenerative changes and alleviate the symptoms triggered by the work accident. The surgery would be causally connected to the work accident only if Petitioner continued to suffer from debilitating symptoms caused by the work accident. Having found that Petitioner lacks credibility and failed to prove an unstable condition of ill-being related to the work accident, the Arbitrator awards no prospective medical care.

In support of the Arbitrator's decision regarding (L), what temporary benefits are in dispute, the Arbitrator finds as follows:

Having carefully considered the entire record, the Arbitrator finds Petitioner met her burden of proving she was temporarily totally disabled or only capable of light duty work during the time period from June 29, 2012, through February 12, 2013. On February 12, 2013, Dr. Heller released Petitioner to return to work on sedentary duty. Petitioner testified that in February of 2013 Respondent stopped paying temporary total disability benefits. Petitioner looked for work between February of 2013 and July 10, 2013, when Dr. Kolavo took her off work.

The Arbitrator finds Petitioner is entitled to temporary total disability benefits from June 29, 2012, through February 12, 2013. Regarding Petitioner's brief unsuccessful attempt to return to work, there is no evidence in the record as to what job duties Respondent asked her to perform. Accordingly, Respondent failed to make a showing that it offered Petitioner a job within the restrictions recommended by Dr. Lieber, which Petitioner declined. Furthermore, Petitioner was off work per Dr. Heller at the time. Regarding Petitioner's entitlement to temporary benefits after February 12, 2013, the Arbitrator notes it is difficult to pinpoint the date of maximum medical improvement. In any event, the surveillance videos cast doubt on Petitioner's ability to perform the physically demanding job duties of a respiratory therapist. Accordingly, the Arbitrator finds Petitioner is entitled to temporary total disability or maintenance benefits from February 13, 2013, through July 10, 2013, since she actively looked for work during that time period.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WOJCIECH CUDZICH,

Petitioner,

15IWCC0456

vs.

NO: 09 WC 34493

KOWALKOWSKI CONSTRUCTION CO.,
D/B/A KOWALKSOWSKI CONSTRUCTION
GROUP, INC, AND
ILLINOIS STATE TREASURER AS EX-OFICIO
CUSTODIAN OF THE INJURED WORKERS'
BENEFIT FUND

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, benefit/wage rate, 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.

Although we agree that Petitioner failed to prove that his work on Saturdays and Sundays was regular and mandatory, he testified that he worked between 10 and 12 hours each day, Monday through Friday and earned $10 per hour. We find that, under the facts of this case, Petitioner's average weekly wage should be based on 12 hours per day, 5 days a week for a total of $600.00 per week (60 hours x $10 per hour). Petitioner's permanent partial disability benefits are adjusted accordingly.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360.00 per week for a period of 16.2 weeks, as provided in §8(e) of the

15IWCC0456

Act, for the reason that the injuries sustained caused the 10% loss of use of the right eye.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses submitted into evidence under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for 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: JUN 17 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 5/20/15
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CUDZICH, WOJCIECH
Employee/Petitioner

Case# **09WC034493**

KOWALKOWSKI CONSTRUCTION COMPANY D/B/A KOWALKOWSKI CONSTRUCTION GROUP INC AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0456

On 4/11/2014, 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:

1938 BELCHER LAW OFFICE
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

KOWALKOWSKI CONSTRUCTION CO
REG AGENT MARK KOWALKOWSKI
15655 S 116TH AVE
ORLAND PARK, IL 60467

5048 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

WOJCIECH CUDZICH
Employee/Petitioner

Case #09 WC 34493

v.

KOWALKOWSKI CONSTRUCTION COMPANY
D/B/A KOWALKOWSKI CONSTRUCTION GROUP, INC. AND
ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on March 19, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☒ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☒ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- This claim was on file for more than three years when it appeared on the March 4, 2014, status call and received a trial date of March 19, 2014. Respondent Kowalkowski Construction Company failed to appear by its officers or a representative at the status call on March 18, 2014. The petitioner presented evidence of service of a notice on January 2, 2014, of the hearing date for March 19, 2014, time and location to respondent Kowalkowski Construction Company to their last known address via regular and certified U.S. Mail and moved to proceed *ex parte* against them.

- Evidence of an online proof of coverage inquiry by the petitioner failed to establish workers' compensation insurance coverage for August 19, 2008, for respondent Kowalkowski Construction Company.

- The respondent Injured Workers' Benefit Fund Illinois through the State Treasurer, the *ex-officio* custodian of the Injured Workers' Benefit Fund, was represented by the Illinois Attorney General's office.

- Respondent Kowalkowski Construction Company did not appear or request a continuance and a hearing was conducted *ex parte* with regard to them.

- At the time of injury, the petitioner was 21 years of age, single with one child under 18.

ORDER:

- The respondent Kowalkowski Construction Company shall pay the petitioner the sum of $300.00/week for a further period of 16.2 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 10% loss of use of his right eye.

- The respondent Kowalkowski Construction Company shall pay the petitioner compensation that has accrued from August 19, 2008, through March 19, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner was reasonable and necessary. The respondent Kowalkowski Construction Company shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall hold the petitioner harmless for any payments by its health insurance carrier.

- This award is hereby entered against the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of respondent Kowalkowski Construction Company to pay the benefits due and owing the petitioner. The respondent Kowalkowski Construction Company shall reimburse the Injured Workers' Benefit Fund for any of their compensation obligations paid to the petitioner from the Injured Workers' Benefit Fund.

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

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

Robert E. Williams

Signature of Arbitrator

April 11, 2014

Date

APR 11 2014

FINDINGS OF FACTS:

On August 19, 2008, the petitioner received emergency care at Mercy Medical Center for a right eye injury. It was noted that a tire on a wheelbarrow blew up in his face while being inflated. The petitioner was transported by an emergency medical service to the University Of Iowa Hospital, where foreign bodies were removed from his right eye..

FINDING REGARDING WHETHER RESPONDENT KOWALKOWSKI CONSTRUCTION COMPANY WAS OPERATING UNDER AND SUBJECT TO THE WORKERS' COMPENSATION ACT:

Based upon the evidence presented, the respondent Kowalkowski Construction Company was operating under and subject to the provision of Section 3, paragraph 1 of the Workers' Compensation Act. The petitioner was hired in Illinois and taken by respondent Kowalkowski Construction Company to Iowa to do construction work.

FINDING REGARDING WHETHER THERE WAS AN EMPLOYER/EMPLOYEE RELATIONSHIP BETWEEN THE PETITIONER AND RESPONDENT KOWALKOWSKI CONSTRUCTION COMPANY:

Based upon the evidence presented, the petitioner established that an employer/employee relationship existed between him and the respondent Kowalkowski Construction Company on August 19, 2008. The petitioner was transported to the Iowa job site by Kowalkowski and housed in a trailer provided by Kowalkowski. Kowalkowski took the petitioner to the job site and assigned his work duties. The petitioner performed construction duties for respondent Kowalkowski Construction Company two to three months before his injury.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT KOWALKOWSKI CONSTRUCTION COMPANY:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on August 19, 2008, arising out of and in the course of his employment with the respondent Kowalkowski Construction Company. The petitioner was performing an activity related to his work duties when the tire on a wheelbarrow burst while being inflated sending debris into his right eye.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT KOWALKOWSKI CONSTRUCTION COMPANY:

The respondent Kowalkowski Construction Company received timely notice of the petitioner's injury. Kowalkowski was present when the petitioner was injured and accompanied him to Mercy Medical Center.

FINDING REGARDING THE AMOUNT OF WAGES:

In the year preceding the injury, the petitioner's average weekly wage from respondent Kowalkowski Construction Company was $500.00. The petitioner's testimony is that he consistently worked ten hours up to twelve hours a day at $10 per hour. His work hours on Saturdays were not consistent and are not included in the determination of his average weekly wage. The petitioner worked 50 consistent work hours per week at $10 per hour.

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

The medical care rendered the petitioner was reasonable and necessary. The respondent Kowalkowski Construction Company shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent Kowalkowski Construction Company shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any

adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right eye is causally related to the work injury on August 19, 2008.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of morning headaches and problems with bright lights. He has difficulty working and needs pain medication when he is in bright lights. The respondent Kowalkowski Construction Company shall pay the petitioner the sum of $300.00/week for a further period of 16.2 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 10% loss of use of his right eye.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Murphy,
Petitioner,
vs.

NO: 13WC 30500

Southern Wine & Spirits,
Respondent,

15IWCC0457

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 October 29, 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 $13,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 17 2015
d060915
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MURPHY, KEVIN
Employee/Petitioner

Case# **13WC030500**

SOUTHERN WINE & SPIRITS
Employer/Respondent

15IWCC0457

On 10/29/2014, 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:

0355 WINTERS BREWSTER CROSBY ET AL
THOMAS CROSBY
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MARION, IL 62959

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

15IWCC0457

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Kevin Murphy
Employee/Petitioner

v.

Southern Wine & Spirits
Employer/Respondent

Case # **13** WC **30500**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 5, 2014**. By stipulation, the parties agree:

On the date of accident, **7/24/13**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**38,526.54**, and the average weekly wage was $**740.94**.

At the time of injury, Petitioner was **54** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**8,467.37** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**8,467.37**.

Respondent may not have paid all appropriate charges for all reasonable and necessary medical services. Respondent shall be liable for the medical bills contained in Petitioner's Exhibit 1 subject to the Medical Fee Schedule and with Respondent receiving a credit for any and all bills paid by it or its group medical plan as allowed pursuant to Section 8(j) of the Act.

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 **$444.56**/week for a further period of **48.375** weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **22.5%** loss of use of the right leg.

Respondent shall pay Petitioner compensation that has accrued from **7/24/13** through **9/5/14**, 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.

Nancy Lindsay

Signature of Arbitrator

October 26, 2014

Date

ICArbDecN&E p.2

OCT 29 2014

Kevin Murphy v. Southern Wine & Spirits,
13 WC 30500

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner, at the time of his undisputed accident, had been employed by Respondent for five years as a Merchandiser. Petitioner's job required him to deliver wine and spirits from Respondent to various customers. The job required Petitioner to remove the product from the pallet as it arrives from the truck, transport it on an L-cart and place it on the shelves. He testified at time he would also have to make displays. Petitioner testified that at the time of injury, he had about 18 accounts. He testified that he would have to handle during the off-season probably 160 to 300 cases a day, and during the holiday season, he would have to handle 400 cases a day. He testified that the cases contained anywhere from 12 to 15 bottles. He testified that when making displays, it was typical of what one sees in a liquor store, maybe 60, 80, 100 cases of product stacked, with the box cut open to display the merchandise.

Petitioner testified that on July 24, 2013 he was working at the Walmart store located in Anna, Illinois, handling a delivery. Petitioner testified that while lifting a case of wine from the L-cart, he rotated around to place the wine on the shelf and heard a pop and snapping sound in his right knee. He testified that it felt like a "twinge, not a lot of pain at that point, but did feel a twinge, and that's when the accident occurred." He testified that he finished the work day.

Petitioner initially sought treatment on August 5, 2013 at Logan Primary Care. Petitioner was taken off from work until he could see Dr. Davis, his doctor of choice. On August 6, 2013, Petitioner saw Dr. Davis. Dr. Davis kept Petitioner off work and ordered x-rays. X-rays were taken at Herrin Hospital on August 6, 2013 and the history was of right knee pain, injury, osteoarthritis. X-rays showed that there was no fracture or joint effusion.

An MRI was performed at Herrin Hospital on August 14, 2013. The MRI showed multiple findings including complex tear of the medial meniscus with flap formation. (PX 3, pp. 34-36; PX 2, pp. 18-20) Petitioner returned to Dr. Davis on August 21, 2013. Dr. Davis diagnosed him with a complex medial meniscal tear. Dr. Davis advised him to see an orthopedic surgeon.

Petitioner testified that through the coordination of his employer's insurance carrier, he saw a Dr. Schlafly at Woods Mill Orthopedics in St. Louis. Petitioner was initially seen on September 3, 2013 by Dr. Schlafly at Woods Mill Orthopedics in St. Louis. The records show that he was complaining of pain, persistent, medially, checked it out with x-rays which were negative, reviewed by me on a disk today, and an MRI scan which was also reviewed and showed torn medial meniscus and subtle degenerative changes. It was noted that he had

previous left knee arthroscopic years ago, denied any previous right knee problems. At the time of the examination, Petitioner was ambulating without aid, discrete limp. He had good neck and back motion. The diagnosis was a torn meniscus. The recommended treatment was arthroscopy and probable partial medial meniscectomy. On October 24, 2013 Dr. Schlafly performed a right knee arthroscopy and a "generous" partial posterior third meniscectomy. Dr. Schlafly's surgical findings included an extensive tear of the posterior third of the medial meniscus. (PX 4, pp. 46, 48, 51)

After the surgery, Petitioner continued to follow with Dr. Schlafly. Petitioner was seen for a follow-up visit by Dr. Schlafly on November 8, 2013 and Petitioner indicated that his knee felt a lot better already. There was minimal effusion and nicely-healing incisions. There was mild limitation in motion, good strength and good stability. It was noted that he had a physical job, moving many boxes of beverages throughout the day. The plan was to work on continued motion and strength, giving it more time to heal, and to get on a bicycle. Petitioner was to do physical therapy, home exercises and return to work, without restrictions, on December 2, 2013. (PX 4)

Petitioner underwent physical therapy for his injury from November 14, 2013 through November 26, 2013. The therapist described Petitioner's job for Respondent as "heavy." At the conclusion of his therapy, Petitioner had met all goals. He could perform squats at frequent frequency, although he reported "deep squats" caused discomfort. According to the "Functional Progress Note" of the same date Petitioner demonstrated the ability to perform one hundred percent of the physical demands of his job for Respondent. It further noted under "Client/Occupation Physical Demand Level" Petitioner demonstrated the ability to perform within the medium physical demand level based on the definitions developed by the US Department of Labor. The therapist noted Petitioner's job as a representative is classified within the heavy physical demand level. (PX 5)

Petitioner testified that he returned to unrestricted work on December 2, 2013.

Petitioner testified that for a few weeks, he was making pretty good progress, but as the load increased during their busy season his knee started swelling and he noted pain and difficulty sleeping.

Petitioner returned to see Dr. Schlafly on January 27, 2014. Dr. Schlafly's records show that Petitioner advised him at this time that he was doing "fine." Petitioner reported an occasional limp and that getting out of his wife's car caused some pain medially; however, his truck presented no problems. Once a week, he would wake up with pain, but most nights without a problem. The bottom line was that his knee was feeling "good" but, at times, still bothered him. Petitioner indicated that his job was physically demanding and that he was able to get it done more or less without too much difficulty. Physical examination revealed healed incisions, excellent motion, good strength and good stability, no joint effusion, a little posteromedial joint line tenderness, good sensation and circulation. Noting that Petitioner's medial tear was quite large and that he had been

moderately aggressive with the excision, Dr. Schlafly was hopeful that things would "quiet down" and that additional resection would not be necessary. He indicated that there were mild degenerative changes in the medial compartment though he doubted Petitioner's symptoms related to that. Dr. Schlafly did not feel Petitioner needed any additional surgery and he was told he could continue with his activities, as tolerated, with no restrictions. Petitioner was advised to continue with the home exercise programs and was advised to give the doctor a call if he had any problems or questions. No follow-up appointment was scheduled. (PX 4)

Since being released or discharged from Dr. Schlafly's care, Petitioner has not returned to Dr. Schlafly or Dr. Davis.

Petitioner underwent an AMA evaluation by Dr. David Fletcher on June 2, 2014. The report of Dr. Fletcher was introduced into evidence. Dr. Fletcher concluded Petitioner had a 3% loss of use right lower extremity under the AMA Guidelines. Dr. Fletcher's report makes note of Petitioner's Pain Disability Questionnaire and a Quick Dash "upper extremity" functional history; however, those are not a part of his report. Dr. Fletcher's report also indicates that while the doctor reviewed some of Petitioner's treating medical records the doctor did not review Petitioner's operative report or any post-surgical records of Dr. Schlafly. Dr. Fletcher's report documents that Petitioner had a slight limp, crepitus, and limited range of motion of his right knee at the time of the examination. However, no evidence of instability or need for assistive devices was noted. (RX 2)

Petitioner testified that after returning to work, there was a direct correlation between the load and his swelling and knee pain as his swelling and knee pain increased when the load was heavier. He testified that squatting in his job causes him some problems and he actually sits on his butt to stock shelves, rather than crawl. He testified that being on a hard floor all day causes problems. He testified that he still limps.

Petitioner testified that he would continue to follow the RICE protocol and would continue to elevate his legs and take Ibuprofen at home. He complained of considerable popping and cracking.

Petitioner also testified that prior to working for Respondent he worked at the Herrin prisons and retired as an Associate Warden in 2008. He testified that his job there entailed physical fitness, wellness and extreme athletic activities. He testified that he was a very active member of the Marion Special Operations and Response Team. He testified that he did weight lifting and he did keep up with his activities when he started to work for Respondent. He testified that cycling is a big part of his life, bicycle riding, and especially ultra-marathons. He testified that he does continue to ride mountain bikes but not "off trail" any longer due to his injury. Petitioner testified that he continues to weight lift but to a limited degree.

Petitioner testified that on the day of his examination with Dr. Fletcher his right knee was swollen and his kneecap was not visible. Dr. Fletcher documented the swelling with photographs; but he did not address the swelling in his report or include the photographs.

Petitioner testified that at the time of trial, he was still working for Respondent but had turned in his resignation effective October 4, 2014.

Petitioner admitted that Dr. Schlafly knew what his job was prior to the injury, advising him to return if he had any additional problems, and he did not return to Dr. Schlafly. He admitted that he lost no time from work since returning from his injury. He admitted that no physician has told him that he needs to retire or resign as a result of his injury.

Petitioner admitted that after the injury in question, he received a raise, earning more money now than he did before the injury.

With regard to Issue (L) - What is the nature and extent of the injury, the Arbitrator concludes:

The Arbitrator notes that for injuries occurring after September 1, 2011, as here, 820 ILCS 305/8.1b – governs determinations of permanent partial disability. In particular, the Arbitrator is to consider the following factors:

(i) the reported level of impairment pursuant to the AMA evaluation under the Sixth Edition;
(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 the treating medical records.

With regard to the case herein and each of the foregoing factors, the Arbitrator notes the following:

(i). The reported level of impairment pursuant to an AMA evaluation - Petitioner submitted to an AMA evaluation by Dr. David Fletcher and he was found to have a 3% impairment of the right lower extremity. The AMA evaluation was not challenged by way of deposition or a conflicting AMA evaluation. As Dr. Fletcher's report did not include the Quick Dash or PPQ limiting the Arbitrator's knowledge as to what information Petitioner may have provided to Dr. Fletcher. Additionally, Dr. Fletcher's report notes reference to a Quick Dash "upper extremity" functional history. Petitioner's injury herein is to the lower extremity.

(ii). The occupation of the injured employee. Prior to going to work for Respondent Petitioner had four years of military experience and twenty-five years experience with the Federal Bureau of Prisons. He began his career with the Federal Bureau of Prisons as a correctional officer and retired as an Associate Warden in 2008.

Petitioner has worked for Respondent as a merchandiser for the last five years or so. Petitioner's job requires him to be on his legs carrying and setting up product and displays. Petitioner testified that, as a result of his injury, he has had to modify how he performs some aspects of his job duties. Nevertheless, he currently works full duty and has received a raise since returning to work. The Arbitrator gives some weight to this factor.
(iii). Petitioner's age at the time of his injury. Petitioner was 54 at the time of his injury. No evidence was presented as to how Petitioner's age impacts/affects any disability.
(iv.) Petitioner's future earning capacity. While Petitioner has tendered his resignation to Respondent out of "concerns" for aggravation of his right knee, there was no direct evidence presented that Petitioner's injury has impacted his earning capacity now or in the future. Petitioner has actually earned more since his injury thus leading to the reasonable inference that, as of the date of arbitration, Petitioner's injury has had no impact on his earning capacity.
(v). Evidence of disability as corroborated by the treating medical records. The records from Dr. Schlafly show that Petitioner was released to return to his job without restrictions with the evaluation on the last day he was seen by Dr. Schlafly indicated Petitioner had healed incisions, excellent motion, good strength, good stability, and no joint effusion. The only finding of any residual was a little "posteromedial tenderness."

In considering all of the foregoing factors, the Arbitrator gives limited weight to the impairment report and rating noting it was incomplete and referenced an upper extremity Quick Dash report and not a lower extremity Quick Dash report. The Arbitrator notes Petitioner's occupational history and that he is retired from his primary career and returned to work for Respondent in his pre-injury capacity. No doctor has told him he should not work as a merchandiser. The Arbitrator gives additional weight to how Petitioner's injury has affected his ability to perform his job, noting his complaints post-surgery have been consistent and corroborated by the medical records of Dr. Schlafly and the physical therapist. With regard to the physical therapist's notes, the Arbitrator notes that there appeared to be some inconsistencies in how Petitioner's physical abilities were ultimately labeled. Petitioner's job for Respondent was described as "heavy." At the end of Petitioner's therapy, the therapist indicated Petitioner could engage in "medium" activity and, yet, the therapist also indicated that Petitioner met all job goals for that of a merchandiser albeit with the difficulties associated with squatting. Petitioner's complaints of his inability to squat, use Kettle bell weights, painful kneeling and crawling, inability to run, jog or mountain bike without experiencing pain and swelling are consistent with Dr. Schlafly's explanation to Respondent that the knee pain symptoms are most likely related to the "aggressive" surgical approach which resulted in removal of a large amount of meniscal tissue to address the large tear. Having considered all of the factors as required by statute, the Arbitrator concludes that Petitioner has been permanently partially disabled to the extent of 22.5% loss of use of the right leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nathaniel Hill,

Petitioner,

vs. NO: 14WC 7262

15IWCC0458

Tradesmen International,

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, causation, medical, 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 October 15, 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: JUN 17 2015
o060915
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

HILL, NATHANIEL
Employee/Petitioner

Case# **14WC007262**

TRADESMAN INTERNATIONAL
Employer/Respondent

15IWCC0458

15IWCC0458

On 10/15/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0438 BROWN & CROUPPEN
KERRY O'SULLIVAN
211 N BROADWAY 16TH FLOOR
ST LOUIS, MO 63102

0445 RODDY LAW LTD
RICHARD S ZENZ
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

15IWCC0458

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nathaniel Hill
Employee/Petitioner

v.

Tradesmen International
Employer/Respondent

Case # 14 WC 7262

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 **Mt. Vernon**, on **August 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 31, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

On the date of accident, Petitioner was **22** 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 **$0.00** 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** 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 JANUARY 31, 2014 THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT OR THAT HIS CURRENT CONDITION OF ILL-BEING IN HIS HANDS AND WRISTS IS CAUSALLY RELATED TO THE ACCIDENT. PETITIONER'S CLAIM FOR COMPENSATION IS DENIED AND NO BENEFITS ARE AWARDED.

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

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

Signature of Arbitrator

October 9, 2014
Date

ICArbDec19(b)

OCT 15 2014

Nathaniel Hill v. Tradesman International, 14 WC 7262 (19(b))

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner began working for Respondent as an electrician laborer in April of 2013.

On February 3, 2014 Petitioner went to see Dr. Veena Gupta at Care First Medical Center. According to the history contained in the doctor's office note Petitioner had musculoskeletal symptoms and pain in both wrists of six months duration but recently worsening. Petitioner described the pain as an "8-9" at its worse and a "6" when not working. Petitioner's complaints included numbness of the left thumb and numbness in all fingers of the right hand. Petitioner's past medical history included a notation of "Physical Trauma: Overuse injury." Phalen's and Tinel's signs were negative. Dr. Gupta's assessment was overuse syndrome of both wrists and she wished to rule out carpal tunnel syndrome. Petitioner was advised to rest his wrists and was sent for nerve conduction studies. Petitioner was also given a script for Naprosyn. The notes state "Check with W/C carrier about the test." Petitioner was given light duty restrictions from January 31, 2014 through February 26, 2014 which included avoiding repetitive movements with both wrists and no twisting or turning with the wrists. (PX 3)

Petitioner signed his Application for Adjustment of Claim on February 18, 2014. (AX 2)

The EMG was completed on February 27, 2014 at St. Mary's Good Samaritan Hospital and the report states that the EMG and nerve conduction studies were within normal limits. At the time of the test Petitioner's complaints included paresthesia in both upper extremities. (PX 2; PX 3)

When Petitioner returned to Dr. Gupta on March 3, 2014, Dr. Gupta noted Petitioner's bilateral pain had not improved. Dr. Gupta also noted Petitioner wasn't working. The doctor's assessment was arthralgia in multiple sights and referred him to a rheumatologist; however, Petitioner's light duty restrictions were continued from March 5, 2014 through April 18, 2014. Thereafter restrictions were to be determined by the rheumatologist. (PX 3)

Respondent sent Petitioner to Dr. David Brown for a Section 12 examination on May 6, 2014. Dr. Brown took a history from Petitioner as well as a description of Petitioner's job duties with Respondent. Petitioner advised the doctor that he was an electrician's helper and that his job entailed taking two ten foot pieces of pipe and twisting them together and then placing them onto a bracket and tightening a U-bolt and using a ratchet, approximately ten to fifteen turns to tighten the bolt. Petitioner repeated the process and put together approximately seven or eight pipes per hour or fifty to sixty pipes in a ten hour period. According to Petitioner, 80% of his job involved putting the pipes together. The other twenty percent of his job day was spent pulling wires through a pipe. The wires (which resembled speaker wires) were pulled through the pipe by hand and then hooked to a machine using a ratchet and screwdrivers. He would then strip the ends of the wires and place them on a terminal, twist, and then tighten them using a screwdriver. (RX 2, p. 1)

Petitioner told the doctor he first noticed symptoms in November of 2013 and saw a doctor in January of 2014 who placed him on light duty. Petitioner had not returned to work since then. However, "he states he was eventually released to return back to work but he's been told there is no work and he is unsure whether or not he is still employed [with Respondent]." (RX 1, p. 2) Dr. Brown noted in his report that he had reviewed Petitioner's treatment records and he discussed them therein. Petitioner told the doctor he had not experienced any improvement in his symptoms despite his lack of work since January. Petitioner also reported that any type of work with his hands causes them to hurt, cramp and go numb. (RX1) Petitioner's physical examination was essentially normal. (RX 1)

Dr. Brown opined that Petitioner's exam was negative for peripheral compression neuropathy or a specific tendonitis or upper extremity diagnosis. Dr. Brown opined that he saw no evidence of any work-related condition. He saw no objective reason Petitioner could not return to work. He felt Dr. Gupta's recommendation of a rheumatologist was a reasonable one. Dr. Brown also commented that Petitioner's lack of exposure to the alleged work activities for over three months with no improvement in his condition was inconsistent with a work-related problem. (RX 1)

After being examined by Dr. Brown, Petitioner was referred to Dr. Bruce Schlafly by his attorney. The exam occurred on May 30, 2014 and a written report issued thereafter. Dr. Schlafly took a detailed history regarding Petitioner's work duties. Petitioner told the doctor his wrist problems began while working at a plant designed for processing and cleaning coal. Petitioner had worked for Respondent approximately one year having stopped on January 30, 2014. Since then, he had been unemployed. According to the report Petitioner related that some of his symptoms had improved "a bit" since he stopped working. While working for Respondent Petitioner noted his hands would wake him up at night with numbness. While the numbness had stopped Petitioner still had bilateral wrist pain complaints, the right worse than the left. Petitioner denied any problems with his hands or wrists before going to work for Respondent.

With regard to his job duties for Respondent, Petitioner told the doctor that he installed pipes used for carrying electrical wires. The pipes were ten feet long and ranged in diameter from 3/4 of an inch to 3 inches. Petitioner's job was to connect the pipes by "screw[ing] them together, with use of an intermittent coupling device between each segment of pipe." (PX 1, p. 2) Petitioner would place the pipes into walls and ceilings and he often worked on a scaffold. He usually handled the pipes by himself and would assemble a length of pipe ranging from sixty to two hundred feet by screwing the pipes together. Petitioner also pulled wires through the pipes which required "considerable force, because there was a lot of resistance, to the bundles of wires used in the larger pipes." Petitioner used a tape or rope to pull the wires. According to Petitioner all of that work required forceful and repetitive use of both hands and wrists and Petitioner considered his work more difficult (in terms of physical forces) that what he had previously done as a car mechanic. (PX 2)

Dr. Schlafly's report states that after developing problems with his hands and wrists Petitioner advised his employer and "his employer told him to go see a physician." Petitioner initially went to Dr. Gupta and underwent nerve conduction studies. Dr. Schlafly also reviewed the EMG nerve conduction study and opined, that on his review of the data, the peak latency for the median nerve at the right wrist was abnormally high, exceeding the normal upper limit and the measurement for the left wrist was exactly at the normal upper limit of 3.5 milliseconds. Dr. Schlafly opined that, in his experience, when that measurement is abnormally high, it indicates a diagnosis of carpal tunnel

syndrome. However, he also noted that he spoke with Dr. Nemani (who had performed the test) and the doctor told him that Petitioner's electrical abnormalities were insufficient to qualify for a diagnoses of carpal tunnel syndrome since all other measurements were normal. Dr. Nemani recommended repeat testing in six months. Dr. Schlafly also noted Petitioner's last visit with Dr. Gupta and the referral to a rheumatologist. Dr. Schlafly was also provided with Dr. Brown's report of May 6, 2014. (PX 1)

On examination Petitioner had good circulation to his fingers and normal range of motion for all digits. Strength was good. Grip strength in the right hand was less than in the left hand. Phalen's tests were negative although Petitioner reported some right wrist pain. Considerable pain was noted with Tinel's testing on the right wrist and mild pain on the left wrist. Petitioner had slightly decreased sensation to the pinwheel in the right index finger but not the left index finger. Pressure over the median nerve of each wrist did not produce any tingling. Petitioner had limited "excursion of the superficialis flexor tendons of the long and ring fingers" bilaterally. (PX 1)

Dr. Schlafly diagnosed work-related carpal tunnel syndrome and flexor tenosynovitis of the wrists with temporary improvement in his carpal tunnel symptoms due to rest and night splints but with a poor prognosis. He did not feel Petitioner was currently experiencing any median nerve symptoms but the doctor felt his history strongly suggested he had been experiencing them and that they often follow the development of flexor tenosynovitis of the wrists. Dr. Schlafly recommended surgery for bilateral carpal tunnel or cortisone injections at the carpal tunnels followed by a trial of return to work. Dr. Schlafly felt that, without treatment, Petitioner needed the same light duty restrictions Dr. Gupta ordered with no twisting or repetitive use of the hands and wrists. (PX 1)

At the arbitration hearing Petitioner testified that at the time of his alleged accident Petitioner was 22 years old and had been employed by Respondent as an electrician laborer for approximately one year. Petitioner worked ten hour days, four days per week.

Petitioner testified that when he started working for Respondent he spent ten hours per day putting together pipe. Petitioner explained that this required him to grab pipe with his left hand and put/push it into another piece using glue to attach the two pieces. Petitioner did not twist or screw the pipes together; rather, he pushed the ends together and then turned them to let the air out.

Petitioner further testified that when he first started with Respondent he also pulled wire and built brackets.

Petitioner testified that he also spent a couple of hours each day building brackets. He would take three pieces of angle iron and drill holes in them and then bolt them together. Petitioner would use a grinder or band saw to cut and drill the pieces. When gluing pipes together Petitioner would push to pieces of pipe together and turn the pipes to remove air.

Petitioner also testified that he spent 3/4 of his work day hooking up conduit which required him to grab "it" with his left hand and twist "it" together with both hands and then put "it" up on the brackets.

Finally, Petitioner testified that he pulled wire through conduit using a rope as part of his job.

Petitioner testified that he began having problems with both of his hands in November of 2013. He noted symptoms in the form of numbness and tingling. He also experienced pain. Petitioner, however, continued working. On January 31, 2014, Petitioner reported to his supervisor that he could not work anymore and he needed to go to the doctor. He was sent to complete an accident report, which was admitted into evidence as Respondent's Exhibit 3. Petitioner testified that on page one of the report, the date of the occurrence is listed as November 20, 2013 and that was written by Dominique Vitari, a human resources representative with Respondent. On page two of the accident report, Petitioner listed November 20, 2013 as the date of injury because Dominique told him to do so.

On cross-examination Petitioner acknowledged that when he "hooked" the conduit (made of fiberglass) together it was like inserting a pipe into a sleeve and one would turn and twist "a little bit" for the adhesive to catch. Petitioner also acknowledged using drills, grinders, power saws, band saws, screwdrivers and wire cutters. He agreed that there was no twisting motion involved in pulling wire nor did his job require him to assemble small parts. Petitioner also testified that he did not hook conduit the entire work day as he performed different activities throughout the day.

On re-direct examination Petitioner explained that there was a lot of force required to pull wire through the pipe.

Petitioner testified that since he stopped working in January, he has noticed less numbness, but he has not had complete resolution of his symptoms. He still has problems holding onto things, with pain in his wrists and into his thumbs and fingers.

The Arbitrator concludes:

Issues (C), (D), and (F) -Accident, Date of Accident, and Causal Connection.

Petitioner has failed to prove he sustained an accident on January 31, 2014 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his wrists is causally related to his accident or his employment duties for Respondent.

Petitioner's testimony regarding how often he performed his four primary job duties (hooking conduit, pulling wires, building brackets, and putting together pipes) was somewhat confusing. He testified he worked ten hour days. He also testified that he started out putting together pipe ten hours a day thus suggesting that was all he was initially doing during his work day. However, Petitioner then went on to state he pulled wire and built brackets when he first started working for Respondent. He provided no testimony as to when he stopped putting together pipe all day long and began doing these other activities. Thus, it is unclear during precisely what time period Petitioner was engaged in what activities. In any event, he acknowledged varying job duties throughout the work day and the use of numerous tools.

Most significantly, none of the doctors (and most notably Dr. Schlafly upon whom Petitioner relies) were made aware of Petitioner's complete job duties. It is axiomatic that in order to establish liability for a repetitive trauma injury expert testimony is required. In this instance each party has submitted the written report of an examining physician. An examining physician's causation opinion is only as good as the information upon which it is based. In this instance, Dr. Schlafly was not provided

with a full and complete understanding and description of Petitioner's job duties for Respondent. Petitioner clearly identified four components to his job with Respondent. Petitioner did not provide this information to Dr. Schlafly. Indeed, much of the description as to Petitioner's job found in Dr. Schlafly's report was not corroborated by Petitioner's testimony. Thus, Dr. Schlafly's opinion is not persuasive and Petitioner has failed to meet his burden of proof on the issues of accident and causal connection. The Arbitrator further notes that Petitioner made no mention of a perceived work-related problem with his hands and wrists when seen by Dr. Nemani for nerve conduction studies. Additionally, the Arbitrator has carefully considered the records of Dr. Gupta. While the doctor's records note under "Encounter" - "WI New Patient" and "WI" might imply a "work injury," the only reference to Petitioner's work is that his wrist complaints were not as bad as when he was working. While Dr. Gupta's assessment of Petitioner's condition was an "overuse syndrome to both wrists," the doctor provided no causal connection opinion nor is there any indication in the office notes that Petitioner provided Dr. Gupta with information pertaining to his job. Ultimately, Dr. Gupta referred Petitioner to a rheumatologist; yet, Petitioner has never followed up on that recommendation.

Petitioner's claim for compensation is denied and no benefits are awarded. All other issues herein are rendered moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

☒ 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

Kyle Stanczak,
Petitioner,
vs.

NO: 12WC 6285
12WC 6721

Town of Normal,
Respondent,

15IWCC0459

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 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: JUN 17 2015
o060915
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STANCZAK, KYLE
Employee/Petitioner

Case# **12WC006285**

12WC006721

TOWN OF NORMAL
Employer/Respondent

15IWCC0459

On 10/20/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0863 ANCEL GLINK
BRITT ISALY
140 S DEARBORN ST SUITE 600
CHICAGO, IL 60603

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

Kyle Stanczak
Employee/Petitioner

v.

Town of Normal
Employer/Respondent

15IWCC0459

Case # **12** WC **006285**

Consolidated cases: **12 WC 006721**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **August 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 15IWCC0459

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$14,866.39**; the average weekly wage was **$479.54**.

On the date of accident, Petitioner was **24** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $316.49/week for 20-6/7weeks, commencing November 7, 2012 through April 1, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $24,345.00 to Orthopedic & Sports Enhancement Center, $30,464.00 to The Center for Orthopedic Medicine and $1,570.00 to Empire Anesthesia, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for all bills paid.

Respondent shall pay Petitioner permanent partial disability benefits of $287.72/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.

Signature of Arbitrator

10/17/14
Date

OCT 20 2014

STATEMENT OF FACTS:

On or about October 3, 2011, Petitioner worked for the Town of Normal. He had worked three months in 2010 between September of 2010 and December of 2010. He then worked from April 2011 through April 2012 when he was terminated. Petitioner worked as a trash collector. He worked five days a week for total of 40 hours per week. Petitioner testified that his job was to empty trash cans. He made approximately 500 stops per shift. At each stop he would lift trash bags and throw them into the truck. He testified that the bags weighed between 20 and 150 pounds. He described that he would lift the trash at least chest level or above and further described it as similar to throwing a chair.

Petitioner provided that in August of 2011 his job duties changed somewhat. At that point, his duties were modified in that the process of trash pick-up became automated. He used a joy-stick on the truck to throw the trash; however, half of his work included the landscape waste, which required him to dump out yard waste bags, 90 degrees from his body at chest level and shake out the bag into the compactor. Petitioner stated that his hand position was "like holding a towel out and folding." Petitioner indicated the yard waste bags weights were considerably heavier than trash. The bags of landscape waste, if filled with mulch or grass, would weigh upwards to between 175 – 200 lbs. and typically weighed between 75 – 80 lbs. Petitioner stated that each house did not have yard waste, estimating he made at least 75-80 stops per day while doing these job duties. As he performed these job duties, he noticed pain in his shoulders.

Petitioner testified that on October 3, 2011, he noticed pain in his shoulders after performing his work. As a result he went to see Dr. J. Anthony Dustman. Petitioner presented with a history of increasing right shoulder pain located specifically of the AC joint. Dr. Dustman recorded that Petitioner had been doing a lot of throwing garbage cans over the years for Respondent and that the process had recently gone automated. The doctor also recorded that Petitioner had done a lot of weight lifting. An examination of the right shoulder demonstrated tenderness in the AC joint and a little prominence on the right side AC joint. Yergason's, Sulcus, lift off, Speed maneuver and O'Briens signs were all within normal limits. Anti-inflammatories were started. (PX 3)

On November 30, 2011, Petitioner was seen by Dr. Dustman's physician assistant, Brad Cole. Petitioner continued with pain. It was noted the pain was deep in the shoulder, more glenohumeral in nature. Also noted was that Petitioner described it very specifically with activities involving overhead lifting, all with his arms out straight in front. He related his discomfort to his work activities involving emptying garbage cans and compost cans into a garbage truck. Petitioner also complained of left shoulder pain but not as severe. An examination revealed mild pain with cross arm on the left. There was pain with Speed's and O'Brien's test bilaterally. There was tenderness to the bicipital groove on the left shoulder. It was noted that Petitioner was an avid weightlifter and coupled with occupational activities, he may be developing impingement or some labral pathology. A MRI was recommended. (PX 4)

Petitioner underwent the prescribed MRI on January 20, 2012. The result demonstrated supraspinatus tendinosis with no demonstrated rotator cuff tear. There was a SLAP tear of the superlabrum and biceps anchor with posterior extension. Also noted was edema at the acromioclavicular ligament, small amount of fluid in the acromiovicular joint space, and mild erythema in the adjacent distal clavicle and acromion, possibly due to a Type I separation injury of inflammation. Laterally down sloping Type II acromion process. (PX 5)

Petitioner returned to Dr. Dustman on February 6, 2012. Dr. Dustman noted Petitioner's pain was in two areas that being 1.) the right glenohumeral joint aggravated by certain activities, especially overhead and throwing and 2.) the AC joint which is aggravated by compression. After reviewing the MRI, the doctor recommended surgery. (PX 7)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Stephen F. Weiss on March 6, 2012. In his report dated March 13, 2012, Dr. Weiss noted that the history portion of the report was dictated in Petitioner's presence. Dr. Weiss recorded that Petitioner provided that he was an avid weightlifter, but stopped weightlifting in April 2011 when he began working for Respondent. Dr. Weiss recorded that Petitioner sought treatment for his right shoulder pain on October 3, 2011. According to Dr. Weiss, Petitioner indicated that he was not being seen at that time for an injury, but to prevent an injury from occurring. Dr. Weiss wrote that Petitioner indicated that on November 28, 2011, he was laying in bed and reached overhead to grab something when he felt a sudden, sharp pain in the posterior aspect to the right shoulder. Petitioner also informed the doctor that initially, his job required repetitive lifting of garbage cans. However, in August 2011, this part of the job became automated. Petitioner conveyed that since then he frequently had to handle landscape waste to about head height in order to dump them into a hopper of the disposal truck. (RX 1, Dep #2)

Dr. Weiss performed an examination and reviewed Petitioner's medical records. The doctor rendered the following diagnoses: 1.) SLAP tear – right shoulder; 2.) impingement syndrome and rotator cuff tendinosis; and 3.) acromioclavicular degeneration. In response to a causal connection query, Dr. Weiss wrote, "[Petitioner] reports a specific traumatic incident occurring at home on November 28, 2011. He was very specific in this regard in this stating that as he reached over his girlfriend to grab an object from the headboard on his bed he felt a sudden, sharp pain in the posterior aspect of his shoulder. In my opinion, his current need for treatment is related to the November 28, 2011 incident." Dr. Weiss added that being an avid weightlifter can cause the shoulder injury stating avid weightlifters are commonly seen for shoulder pathology. The doctor also added that he could not determine if the SLAP tear was acute or chronic indicating the surgical findings could shed light on the issue. (RX 1. Dep #2)

Petitioner continued treating with Dr. Dustman. On April 13, 2012, Dr. Dustman noted Dr. Weiss' opinion that Petitioner's shoulder condition was more related to weightlifting and not work related. Dr. Dustman wrote that "[c]ertainly it has been known as weightlifter shoulder but throwing garbage bags is also a form of weightlifting." (PX 7) Thereafter, Dr. Dustman authored a report stating that "from a clinical standpoint on both shoulders demonstrates that there is some osteolysis in the distal clavicle. This is a particular entity that occurs from repetitive overhead activities. This is specifically true with weightlifting. However, in his job as a garbage collector he was throwing the trash over his head a lot and that would be a form of weightlifting. Therefore whether his job or the weightlifting caused this entity in this gentleman would be of debate. However, certainly the throwing overhead trash bins into the truck would be an aggravating factor." Dr. Dustman added, "[t]he second problem that he presents to is with the right shoulder. He has a very specific pain in the glenohumeral joint. This is secondary to a SLAP lesion. That occurs very specifically from a throwing activity. I feel that it is directly related to his job description as a trash collector." (PX 2, PX 7)

On November 7, 2012 Dr. Dustman performed a surgical procedure. Dr. Dustman performed an arthroscopy with arthroscopy repair of SLAP lesion, arthroscopic subacromial decompression, arthroscopic resection of the distal clavicle and release of the CA ligament. The post-operative diagnosis was SLAP lesion, impingement with AC joint changes. (PX6)

Records submitted show Petitioner continued with Dr. Dustman through April 1, 2013. At that time, the doctor noted Petitioner was doing very well. He had good range of motion and he didn't complain of a lot of

AC joint pain. There was a little bit of feeling of instability on occasion. Dr. Dustman felt Petitioner needed to work on a scapular strengthening program. (PX 7) Records submitted show Petitioner attended therapy sessions at Sports Enhancement through May 2, 2013. (PX 7)

Petitioner testified that he was off work from November 7, 2012 through and including April 1, 2013. Petitioner testified that the Director of Public Works for the Town of Normal later terminated his employment. Petitioner testified that he tried to get back to work in 2013, including working a landscape job in Carlock, Illinois where he mowed grass and lifted blocks weighing between 40 – 50 lbs., moving them around 20 feet. He moved to Littleton, Colorado. Between the dates of September, 2013 – January, 2014, he worked for Erosion Controls of Colorado in the title of Driver. His job duties included shoveling, carrying heavy bales of hay, taking down fence posts and rope lines 80 – 90 times a day. In January, 2014, he started working for Alpine Waste in Commerce City, Colorado, where his job duties included emptying dumpsters. Around March, 2014, he was employed by Westin Enterprises with a job title of driver. His job duties at Westin Enterprises included using a Grapple Truck to pick up construction waste and that his job duties included running an arm on the grapple truck to pick up this waste. He has also worked since March, 2014 as a bicycle courier for Jimmy Johns Restaurant.

Petitioner testified that before working for Respondent he had no problems with his right shoulder. Currently, he feels that his right shoulder grinds, he cannot throw anything with force and he sleeps on his side. He has limited range of motion. Petitioner testified that his left shoulder is doing well and although he has some popping problems, it is not as significant as his right shoulder problems.

Dr. Stephen Weiss, Respondent's Section 12 physician, testified via deposition in this matter. The doctor testified that while recording Petitioner's accident history, Petitioner told him that on November 28, 2011, he was in bed with his girlfriend and reached across his body and towards the head of the bed to grab something and he felt a sudden very sharp pain in the posterior aspect of his right shoulder. (RX 1, pg. 10) Dr. Weiss testified that the posterior aspect of the right shoulder did not correspond with the AC joint that he was complaining of in October, 2011. (RX 1, pgs 11, 13)

Dr. Weiss testified that he felt Petitioner had a SLAP tear of the right shoulder; an impingement syndrome and rotator cuff tendinosis possibly secondary to the SLAP tear. The doctor also felt Petitioner had acromioclavicular degeneration due to weightlifting. (RX 1, pg 15) Dr. Weiss reviewed the operative report of Dr. Dustman during the deposition. The doctor stated that same did not show evidence of a rotator cuff tear and that any rotator cuff atrophy was secondary to the SLAP tear. He felt this implied that the SLAP tear had been around for awhile, and would not just have happened with that amount of atrophy. He indicated that it was more likely than not that the SLAP tear was pre-existing. He stated that Petitioner clearly had a problem and "I guess I would have to say permanently aggravated and caused the need for treatment on November 28 when he was in bed and he went to grab something overhead and had this acute onset of his new complaints of shoulder pain which led to the need for surgery. So I think he probably had a partial SLAP tear which was essentially completed in this activity at home." (RX 1, pg. 18) Dr. Weiss went on to state Petitioner probably had a pre-existing degenerative SLAP tear or SLAP tear from an unremembered injury during weight lifting which was permanently aggravated and made symptomatic and completed in the bed-reaching incident that he specifically described. The doctor stated that in the absence of a specific traumatic injury or fall, there was no evidence that work played a part in causing the need for Petitioner's right shoulder surgery. Dr. Weiss further stated that there was no evidence of repetitive trauma to the right shoulder based on Petitioner's history. He indicated that if there were any repetitive trauma it was much more likely it was from bench pressing, military press, and those kinds of weight lifting activities more so than dumping garbage cans. (RX 1, pgs. 19-20)

On cross-examination, Dr. Weiss testified that his diagnosis was a SLAP tear. He indicated that once you have a SLAP tear, once the labral is damaged, you could have some impingement. (RX 1, pg 23) Dr. Weiss stated that he could not say with medical certainty that Petitioner didn't have a SLAP tear on October 3, 2011. He provided that if Petitioner's history was correct, simply reaching overhead on November 28th would not cause a tear in a normal labrum. (RX 1, pg. 26) Dr. Weiss testified that during his examination, he found Petitioner had a slight limitation extension from the right shoulder to the left. He had a slight deficit and external rotation. He also had infraspinatus atrophy. Dr. Weiss provided that the atrophy might be secondary to the labral tear. (RX 1, pgs. 31-33) Dr. Weiss also indicated that if somebody was doing repetitive lifting overhead and already has a labral tear that could put stress on the shoulder and could contribute to some problems. (RX 1, pg. 37)

Dr. Dustman testified via deposition. Dr. Dustman testified that he first saw Petitioner on October 3, 2011. At that time, Petitioner presented with specific pain in the AC joint. Petitioner informed the doctor that he had been throwing garbage cans overhead for a number of years and that he had done some weightlifting in his career. Conservative care was recommended. (PX 1, pg. 8) Dr. Dustman testified that Petitioner was next seen by his nurse practitioner, Brad Cole, on November 30, 2011. Petitioner again provided a history of overhead activities. It was noted that Petitioner's work activities involved emptying garbage cans and compost cans into a garbage truck. An examination revealed pain with Speed's and O'Briens testing bilaterally. Dr. Dustman discussed the difference in his examination in October 2011 which showed a negative Speed's and O'Brien's test versus the November 2011 examination by Brad Cole showing positive Speed's and O'Brien's tests. The doctor indicated that these are very subtle tests that are not always positive and not always positive. This is the reason why a MRI was prescribed which will show the labrum. The MRI when performed showed two pathologies, i.e., inflammation and irritation in the AC joint and a tear of the labrum. (PX 1, pgs. 10-12)

Dr. Dustman testified that the glenohumeral joint can be aggravated by certain activities, especially overhead and throwing. The AC joint is aggravated by compression. The doctor explained that the slap lesion is more in the overhead throwing motion and the AC joint has been referred to as weightlifters' shoulder. He stated that a SLAP lesion can be caused or affected by the overhead motion such as emptying garbage cans. (PX 1, pg. 13) In response to his opinion regarding Dr. Weiss' indication that Petitioner's condition was more related to weightlifting than his job duties, Dr. Dustman responded, "[w]ell, I'm not sure how you look at it. But to me, taking a garbage can, throwing it into a truck is weightlifting." (PX 1, pgs. 14-15)

Dr. Dustman testified that Petitioner's diagnoses were 1.) inflammation in the AC joint that was causing pain in the anterior aspect of his shoulder and; 2.) SLAP lesion in the glenohumeral joint. Dr. Dustman felt that Petitioner's job activities could cause or certainly aggravate Petitioner's condition (PX 1 pgs. 19-20)

On cross-examination, Dr. Dustman testified that the activity of throwing garbage is essentially weightlifting and the AC joint could also be affected by that. The doctor indicated there is no way to pin down whether it's the result of weightlifting or throwing garbage. He however added that it could be the combination of both. (PX 1, pg. 26)

Dr. Dustman was queried as to whether Petitioner told the doctor that on November 28, 2011, he was laying in bed at home and reached overhead to grab something when he felt a sudden sharp pain in the posterior aspect of his right shoulder, Dr. Dustman replied "No. That actually makes sense. That would come from the SLAP lesion. Remember what we said: one of the purposes of the labrum was to stabilize the ball and socket joint, the glenohumeral joint. And that can only come forward with a Type 2 SLAP lesion, which is what he had, with an abducted externally rotated shoulder, which is reaching up and out. And then it wants to come forward because that labrum's not holding. So that makes sense to me." (PX 1, pg. 31) When asked if such a

maneuver cause the SLAP lesion, Dr. Dustman replied, "...[t]he cause of a SLAP lesion can be twofold...One is repetitive use...And then the other is trauma...it's usually an acute episode to cause this. It's usually a pretty violent act. The repetitive use, which can also cause it, is usually just that overhead use repetitively." (PX 1, pg 32) Dr. Dustman added that he didn't believe the November 28th act of Petitioner reaching up over his head could have been "the straw that broke the camel's back." The doctor stated that the act has to be more violent to have an acute cause of the tear. Dr. Dustman felt that it was more of the repetitive use that caused this to finally go. He added "...throwing garbage cans is weightlifting. That's a fairly significant heavy object, and you're doing it repetitively. Even if it doesn't cause it, it certainly aggravated this condition." (PX 1, pg33)

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; and (F.) Is Petitioner's current condition of ill-being causally related to the injury the Arbitrator finds as follows:

Petitioner's unrebutted testimony was that he had no prior shoulder problems before working for Respondent. He required no surgery, physical therapy, MRI or doctor's visit with regard to his shoulder.

On October 3, 2011, Petitioner worked as a trash collector for the Town of Normal. He had worked three months in 2010 between September of 2010 and December of 2010. He then worked from April 2011 through April 2012 when he was terminated. He worked five days for 40 hours per week. Petitioner's job was to empty trash cans. He made approximately 500 stops per shift. At each stop he would lift trash bags and throw them into the truck. He testified that the bags weighed between 20 and 150 pounds. He described that he would lift the trash at least chest level or above and further described it as similar to throwing a chair.

In August of 2011 his job duties changed somewhat. At that point, his duties were modified in that the process of trash pick-up became automated; however, half of his work included the landscape waste, which required him to dump out yard waste bags, 90 degrees from his body at chest level and shake out the bag into the compactor. The yard waste bags were considerably heavier than trash. The bags of landscape waste could weigh upwards to between 175 – 200 lbs. but typically weighed between 75 – 80 lbs. Petitioner stated that each house did not have yard waste, estimating he made at least 75-80 stops per day while doing these job duties. As he performed these job duties, he noticed pain in his shoulders.

Petitioner sought treatment with Dr. Dustman on October 11, 2011. He related a history of throwing garbage cans for many years. Dr. Dustman noted that Petitioner demonstrated tenderness in the AC joint and prominence on the right side AC joint. He suggested conservative treatment. On November 30, 2011, Dr. Dustman's physician assistant, Brad Cole, saw Petitioner. Petitioner reported that he suffering from bilateral shoulder pain. He had deep pain in the shoulder glenohumeral in nature. During the exam there was mild pain with cross arm on the left. There was pain with Speed's and O'Brien's test bilaterally. There was tenderness to the bicipital groove on the left shoulder. Brad Cole recommended an MRI which when completed on January 20, 2012 showed a SLAP tear of the superior labrum and biceps anchor with posterior extension. Thereafter, Dr. Dustman recommended surgery. The doctor noted that Petitioner's pain was in two areas that being 1.) the right glenohumeral joint aggravated by certain activities, especially overhead and throwing and 2.) the AC joint which is aggravated by compression.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Stephen F. Weiss on March 6, 2012. Dr. Weiss recorded that Petitioner indicated that on November 28, 2011, he was laying in bed and reached overhead to grab something when he felt a sudden, sharp pain in the posterior aspect to the right shoulder. Petitioner also informed the doctor that initially his job required repetitive lifting of garbage cans and

that in August 2011, this part of the job became automated. Petitioner conveyed that since then he frequently had to handle landscape waste to about head height in order to dump them into a hopper of the disposal truck. Dr. Weiss diagnosed Petitioner with 1.) SLAP tear – right shoulder; 2.) impingement syndrome and rotator cuff tendinosis; and 3.) acromioclavicular degeneration. In response to a causal connection query, Dr. Weiss wrote, "[Petitioner] reports a specific traumatic incident occurring at home on November 28, 2011. He was very specific in this regard in this stating that as he reached over his girlfriend to grab an object from the headboard on his bed he felt a sudden, sharp pain in the posterior aspect of his shoulder. In my opinion, his current need for treatment is related to the November 28, 2011 incident." Dr. Weiss added that being an avid weightlifter can cause the shoulder injury stating avid weightlifters are commonly seen for shoulder pathology.

Dr. Dustman noted Dr. Weiss' opinion that Petitioner's shoulder condition was more related to weightlifting and not work related. Thereafter, Dr. Dustman authored a report stating that "from a clinical standpoint on both shoulders demonstrates that there is some osteolysis in the distal clavicle. This is a particular entity that occurs from repetitive overhead activities. This is specifically true with weightlifting. However, in his job as a garbage collector he was throwing the trash over his head a lot and that would be a form of weightlifting. Therefore whether his job or the weightlifting caused this entity in this gentleman would be of debate. However, certainly the throwing overhead trash bins into the truck would be an aggravating factor." Dr. Dustman added, "[t]he second problem that he presents to is with the right shoulder. He has a very specific pain in the glenohumeral joint. This is secondary to a SLAP lesion. That occurs very specifically from a throwing activity. I feel that it is directly related to his job description as a trash collector."

Dr. Dustman ultimately performed an arthroscopy with arthroscopy repair of SLAP lesion, arthroscopic subacromial decompression, arthroscopic resection of the distal clavicle and release of the CA ligament. The diagnosis was SLAP lesion, impingement with AC joint changes.

Dr. Dustman testified by evidence deposition. He is board certified. Dr. Dustman reiterated that a causal relationship exists between Petitioner's job duties and his condition of ill-being. Conversely, Dr. Weiss testified that a causal relationship does not exist between Petitioner's job duties and the condition on ill-being. As noted above, Dr. Weiss was of the opinion that Petitioner's need for treatment was related to the November 28, 2011 reaching incident and/or the fact that Petitioner was an avid weightlifter. Dr. Dustman testified that "…[t]he cause of a SLAP lesion can be twofold…One is repetitive use…And then the other is trauma…it's usually an acute episode to cause this. It's usually a pretty violent act. The repetitive use, which can also cause it, is usually just that overhead use repetitively." Dr. Dustman added that he didn't believe the November 28th act of Petitioner reaching up over his head could have been "the straw that broke the camel's back." The doctor stated that the act has to be more violent to have an acute cause of the tear. Dr. Dustman felt that it was more of the repetitive use that caused this to finally go. He added "…throwing garbage cans is weightlifting. That's a fairly significant heavy object, and you're doing it repetitively. Even if it doesn't cause it, it certainly aggravated this condition." The Arbitrator is persuaded by the opinions of Dr. Dustman.

Based on the above the Arbitrator finds that Petitioner sustained a repetitive trauma injury to his right shoulder which manifested itself on October 3, 2011. The Arbitrator further finds the Petitioner's condition of ill-being related to his right shoulder is causally related to his job duties while working for Respondent.

With respect to (K.) What temporary benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner was temporarily and totally disabled from work for the period of November 7, 2012 through April 1, 2013. Petitioner had a surgical procedure on November 7, 2012. Dr. Dustman testified that Petitioner would have been unable to work as of November 7, 2012 and that he was

unable to work on December 6, 2012, February 7, 2013 and return him to work without restrictions on April 1, 2013.

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

The Arbitrator incorporates by reference the findings made above. Based on the above, the Arbitrator finds that Respondent is liable for the medical charges listed in Petitioner's Exhibit Number 8.

Respondent shall pay, pursuant to the Fee Schedule, $24,345.00 to Orthopedic & Sports Enhancement Center, $30,464.00 to The Center for Orthopedic Medicine and $1,570.00 to Empire Anesthesia. Respondent is shall receive a credit for all bills paid.

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

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. In this case, neither party submitted an AMA impairment rating.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner testified that since April 1, 2013, when he was released to return to work, he has worked several heavy jobs, including a driver of a grapple truck: a landscape job in Carlock, Illinois where he mowed grass and moved 40 – 50 lb. blocks about 20 feet; that he has worked for Alpine Waste, a commercial dumpster company in Commerce City, Colorado and Erosion Control of Colorado, where he was required to shovel and carry heavy bales of hay. The Arbitrator finds that although Petitioner has permanent injuries, he has been engaged in physical employment since April 1, 2013, which has required regular use of his right shoulder.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner was only 24 years old at the time of his injuries. The Arbitrator considers Petitioner to be a younger individual and concludes that Petitioner will likely have to live and work for a longer period of time than an older individual with the same injuries.

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.

With regards to paragraph (v) of Section 8.1(b) of the Act:

v. Petitioner sustained a repetitive trauma injury to his right shoulder which manifested itself on October 3, 2011. Petitioner's treating physician, Dr. Dustman, ultimately performed an arthroscopy with arthroscopy repair of SLAP lesion, arthroscopic subacromial decompression, arthroscopic resection of the distal clavicle and release of the CA ligament. The diagnosis was SLAP lesion, impingement with AC joint changes. Post operatively Dr. Dustman described it as Petitioner having tolerable pain on December 6, 2012. Abduction and external rotation was slightly limited. There was expected weakness. On February 7, 2013, Petitioner still had pain. He had discomfort in the shoulders. During the exam there was 4 out of 5 strength. Dr. Dustman suggested he work on strengthening. (PX7) On April 1, 2013 Dr. Dustman noted Petitioner was doing very well. He had good range of motion and he didn't complain of a lot of AC joint pain. There was a little bit of feeling of instability on occasion. Dr. Dustman felt Petitioner needed to work on a scapular strengthening program. (PX 7) Petitioner attended therapy sessions at Sports Enhancement through May 2, 2013. Physical therapy notes show that the therapist notes soreness due to working in May of 2013. Petitioner would fatigue quickly. (PX7) Petitioner credibly testified that he continues to experience discomfort in his shoulder.

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, the Arbitrator finds Petitioner is permanently disabled to the extent of 10% under Section 8(d)2 of the Act.

15IWCC0459

STATE OF ILLINOIS)
) SS.
COUNTY OF COLES)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EVA EPPERSON,

Petitioner,

vs.

NO: 11 WC 16986

HERFF JONES, INC.,

15IWCC0460

Respondent,

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court of Douglas County, which found in a Letter Ruling, dated August 30, 2013, that:

> In this court's opinion, the Commission relied too heavily on parking lot cases where there is language about "dangerous conditions." The line of cases that should be applied are lunch breaks and other normal breaks during the regular hours when a person remains on the property of the employer for their personal comfort.
>
> For all of these reasons, the court feels the Illinois Workers' Compensation Commission finding that "the fall did not arise of the Petitioner's employment" is against the manifest weight of the evidence.

(Id. at 4).

Respondent appealed the circuit court's decision but this appeal was dismissed by the appellate court on September 24, 2014. Although we note that the circuit court order remanded this case to the Commission "for hearing on award of damages," we find that a new hearing is unnecessary because all of the remaining issues, including causal connection, medical expenses, temporary total disability, and nature and extent, were tried at that the first hearing. The original Arbitrator's decision did not make findings about the other issues because he found that Petitioner did not sustain a compensable accident, but the evidence related to those other issues is

already in the record. Therefore, for the sake of efficiency and in order to issue a final decision as quickly as possible, we interpret the court's order as instructing the Commission to issue a decision on the remaining issues without the need to remand it for a new hearing before the Arbitrator.

Based on the circuit court's finding that Petitioner sustained an accident arising out of and in the course of employment on April 13, 2011, the Commission finds that her right wrist fracture was causally related to her fall at work. However, Petitioner also argues that "[t]he injury caused by the fall was a displaced comminuted radial styloid fracture and widened scapholunate interval of the right arm." (Petitioner's brief at 12). Although it is true that the initial x-rays did mention a widening of the scapholunate joint consistent with scapholunate ligament tear, Petitioner's treating physician, Dr. Johnson, determined that the ligament tear was chronic and degenerative. His operative report states:

> The scapholunate interval was examined. There was found to be a completely torn scapholunate ligament. **The ligament had the appearance of a chronic degenerative tear. There was absolutely no evidence of an acute tear of the scapholunate ligament**. ... Decision was made to carry out ligament debridement and no attempt at repair.

(Emphasis added.) Therefore, we find that the ligament tear was not causally related to the fall at work.

The evidence shows that Petitioner was off work from April 14, 2011 through May 10, 2011 when she was given restrictions of left hand work only per Dr. Johnson. Px3. Petitioner returned to work while she was in occupational therapy. Therefore, the Commission awards 3-6/7 weeks of temporary total disability benefits.

Petitioner submitted into evidence medical bills totaling $27,391.87, which we find are causally related to her work injury and are hereby awarded pursuant to the fee schedule in Section 8.2 of the Act. Petitioner also requests mileage reimbursement from her home in Ashmore, IL to Champaign, IL for visits to Dr. Johnson. However, the evidence to support this mileage is weak with Petitioner only testifying that it is "probably about" 90 miles round trip and when asked how many trips she made she responded, "Oh, I think total maybe 5 or 6." T.25. Petitioner did not introduce any mileage logs that would indicate the date of her visits and the actual mileage driven or any other evidence of the distance between her home and Dr. Johnson. Therefore, we find it would be speculative to base a mileage award on this evidence.

Regarding permanency, Dr. Johnson performed a right wrist arthroscopy with scapholunate ligament debridement plus arthroscopic reduction and internal fixation of right radial styloid fracture with wires and screws. At hearing, Petitioner testified regarding her current right hand and wrist condition and how she is limited to how much weight she can pick up. She doesn't have the flexibility that she had before for simple things like curling her hair. She has to pick up heavy items with her left hand because her right hand won't support it. If the item is too heavy for one hand, she has to have somebody else lift it. She can move her hand but it is achy and very tender in the top part of the wrist because of the surgery. Petitioner testified that she is a "lot more clumsy" with her right hand. She will "run the sweeper" for a while with the right hand but then has to switch to the left. Petitioner is right-hand dominant. When chopping vegetables, she has to stop after "so long" to rest her wrist and readjust the position of the knife. The same thing happens when she is ironing due to the weight of the iron. Repetitious

things will make it start to ache and her wrist will swell from time to time. She no longer has the strength to open a package of chips or cookies and has to use a knife or scissors. Petitioner testified that she doesn't have the strength she used to have and, when she moves her wrist, it will "pop, crack." She takes over-the-counter Aleve. T.26 – 28. Petitioner's most recent medical records include:

7/5/11 Occupational Therapy Progress Note:

Patient has no complaints of pain at rest and would like to know limitations at this time. [P] would like to return to playing golf and engage in all functional tasks.
O = No tenderness to palpation over radial styloid and throughout right wrist.
Discomfort at end range flexion/extension with AAROM.
[P] seen in conjunction with Dr. Johnson who instructed [P] to return to all activities as tolerated including return to playing golf. No restrictions at this time per MD.
...
A = All goals have been met. [P] has reached maximum benefit from therapy at this time. [P] has achieved all goals, has no pain with functional tasks and can return to activities as tolerated per MD.

7/5/11 Occupational Therapy Discharge:

0/10 pain at rest; Rt wrist flexion 50 degrees; "unable to effectively write using right UE"; functional limitations = heavy lifting and return to playing golf
Work status = full duty
No restrictions

Based on the above, the Commission finds that Petitioner has sustained a 35% loss of use of the right hand.

The parties stipulated that Petitioner's average weekly wage in the year preceding her injury was $618.30.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $412.20 per week for a period of 3-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $370.98 per week for a period of 71.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 35% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $27,391.87 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

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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 $55,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 17 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 5/20/15
49

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Steimel,
Petitioner,
vs.

NO: 13WC 38925

Scheels All Sports,
Respondent,

15IWCC0461

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 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 $3,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 17 2015
o061015
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEIMEL, SCOTT
Employee/Petitioner

Case# **13WC038925**

13WC038926

SCHEELS ALL SPORTS
Employer/Respondent

15IWCC0461

On 10/17/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

2250 LAW OFFICE OF STEPHEN H LARSON
BRUCE J MAGNUSON
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

15IWCC0461

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Scott Steimel
Employee/Petitioner

v.

Scheels All Sports
Employer/Respondent

Case # 13 WC 38925

Consolidated cases: 13 WC 38926

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on August 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On September 9, 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, in part, causally related to the accident.

In the year preceding the injury, the parties stipulated that Petitioner earned $17,450.16; the parties further stipulated that the average weekly wage was $335.58.

On the date of accident, Petitioner was 23 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $440.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $440.00.

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

ORDER

Respondent shall pay reasonable and necessary medical services from September 10, 2013, through October 18, 2013, as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $223.72 per week for two weeks commencing September 11, 2013, through September 26, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00 per week for 16.125 weeks because the injuries sustained caused the seven and one-half percent (7 1/2%) loss of use of the left leg, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

October 10, 2014
Date

OCT 17 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged that he sustained accidental injuries to his left knee arising out of and in the course of his employment for Respondent. In 13 WC 38925 the Application alleged that Petitioner sustained a left knee injury while delivering exercise equipment (Arbitrator's Exhibit 2). In 13 WC 38926 the Application alleged that Petitioner sustained a left knee injury while reaching for hangers (Arbitrator's Exhibit 4). In both cases, Respondent agreed that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship.

Petitioner became employed by Respondent in April, 2011, and worked as a service shop technician. Petitioner's job duties included sharpening skates, assembling bikes, moving exercise machines and making deliveries of workout equipment to Respondent's customers.

Petitioner testified that he graduated from high school in 2008 and that he played hockey and indoor soccer while he was in high school and thereafter. Between July, 2006, and July, 2009, Petitioner had four separate surgical procedures performed on his left knee. All of these surgeries were because of injuries Petitioner sustained as a result of either hockey or soccer.

The first surgery performed on Petitioner's left knee was in July, 2006, for a left knee lateral meniscus tear which occurred as a result of a soccer injury. The second surgery on Petitioner's left knee was in March, 2007, and it again involved the left lateral meniscus and this was also the result of a soccer injury. The third surgery on Petitioner's left knee was in October, 2008, and was a left knee arthroscopy following a hockey injury. The medical records of these three surgeries were not tendered into evidence at trial; however, Respondent's Section 12 examining physician, Dr. John Kefalas referenced them in his report of November 6, 2013 (Respondent's Exhibit 2).

Petitioner had the fourth surgical procedure on his left knee performed in July, 2009, and that surgical report was not tendered into evidence either; however, in a post-operative office visit of August 27, 2009, Dr. Rodney Herrin noted that Petitioner had just undergone an arthroscopic re-repair of a lateral meniscal tear (Petitioner's Exhibit 1).

On August 21, 2012, Petitioner was seen by Dr. Daniel Adair, an orthopedic surgeon. At that time, Petitioner complained of sharp pain and his left knee giving out since November, 2011. Dr. Adair's record of that date noted that Petitioner had undergone four surgical procedures on his left knee which involved partial removal of the lateral meniscus. On clinical examination, the range of motion of the left knee was excellent and there was no instability; however, Dr. Adair noted some atrophy of the left leg musculature. He suggested the possibility of a lateral meniscus transplant but before proceeding further, he ordered an MRI scan (Petitioner's Exhibit 1).

An MRI scan was performed on September 6, 2012. The radiologist noted that there was a pical blunting of the body of the lateral meniscus which may have been related to a prior meniscal tear as well as mild irregularity suggestive of mild chondromalacia. Petitioner was subsequently seen by Dr. Adair on September 18, 2012, and, at that time, Petitioner was doing very well and not having any significant symptoms. Dr. Adair discussed treatment options with Petitioner which

included either viscosupplementation or a lateral meniscus transplant (Petitioner's Exhibit 1). Petitioner testified that he decided against undergoing either of these procedures because he stated that he did not believe that he needed them.

On September 9, 2013, Petitioner and another employee were in the process of transporting a home gym in a box to one of Respondent's customers. Petitioner estimated the weight of the box to be 300 to 350 pounds. Petitioner was in a squatting position and was pulling on the box while the other employee was pushing it. While Petitioner was performing this task, he felt some discomfort in his left knee. After Petitioner and his co-worker finished moving the box, they returned to the truck and, when Petitioner sat down he felt a sharp pain in his left knee.

Petitioner testified that from the time he started working for Respondent in April, 2011, and the accident of September 9, 2013, he had no problems with his left knee and was able to perform all of his job duties. Petitioner also stated that he continued to play hockey and soccer as well as working out in a gym. Petitioner described a vigorous exercise regimen that involved his whole body including the lower extremities. Further, Petitioner had a concurrent job at Snap Fitness where he was an exercise instructor. While working as an instructor, Petitioner participated in the exercises because he wanted to lead the class by example. Following the accident of September 9, 2013, Petitioner instructed the classes from a seated position and did not participate.

Petitioner sought medical treatment from Dr. Adair who saw him on September 10, 2013. Dr. Adair's record of that date contained a history of the work-related accident. He again noted that Petitioner had four prior surgeries on the left knee and that he previously discussed Petitioner having a meniscal transplant about a year prior. He noted that the Petitioner had experienced intermittent trouble with the knee but that it was now a little bit worse. On clinical examination, the range of motion was normal, the knee was stable but there was some swelling. Dr. Adair ordered an MRI scan (Petitioner's Exhibit 1).

An MRI scan was performed on September 18, 2013, and the radiologist was able to compare it to the MRI scan that was previously performed on September 7, 2012 (they were both performed at Memorial Medical Center) and noted that the scan of September 18, 2013, revealed a small stable tears within the lateral meniscus unchanged (Petitioner's Exhibit 1).

On September 19, 2013, Petitioner was seen by Dr. Adair who reviewed the MRI scan which he opined revealed a posterior tear of the lateral meniscus which he thought was repairable but noted that there had been two prior attempts to repair it. At Dr. Adair's direction, Petitioner was seen by Dr. Brett Wolters, an orthopedic surgeon, that same day. Dr. Wolters examined Petitioner and reviewed the diagnostic studies. He opined that Petitioner had a vertical tear of the posterior horn of the lateral meniscus. He opined that this was an aggravation of a pre-existing condition and recommended a left knee arthroscopy, revision of the lateral meniscal tear and repair with platelet rich plasma injection (Petitioner's Exhibit 1).

Dr. Adair imposed work/activity restrictions on Petitioner at the time of the initial post-accident visit and Petitioner was unable to work from September 11, 2013, through September 26, 2013, as was stipulated to by Respondent.

On October 15, 2013, Petitioner was working as a cashier and was sitting on a stool. While Petitioner was attempting to get some hangers for another employee, he turned his stool and his left foot got stuck which caused him to twist his left knee. Petitioner testified that this was the same area of his left knee that he injured on September 9, 2013.

Petitioner was seen by Dr. Adair on October 18, 2013, and Petitioner informed him that he had re-injured his left knee at work. Dr. Adair's opinion regarding Petitioner's left knee condition remained the same and he renewed his recommendation that Petitioner undergo arthroscopic surgery and possible meniscus transplant (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. John Kefalas, an orthopedic surgeon, on November 6, 2013. In connection with his examination of Petitioner, Dr. Kefalas reviewed medical records following the September, 2013, accident, Petitioner's job description and the MRIs from both September, 2012, and September, 2013. Dr. Kefalas opined that Petitioner had a left knee sprain and possible lateral meniscal tear. In regard to causality, Dr. Kefalas opined that Petitioner's left knee sprain exacerbated pre-existing left knee symptoms; however, he opined that the left knee pain had been present since September, 2012, and that it was not related to the work-related accident of September 9, 2013. In arriving at this opinion, Dr. Kefalas specifically noted that the MRI scans performed in September, 2012, and September, 2013, showed no changes in the appearance of the lateral meniscus (Respondent's Exhibit 2).

Petitioner had arthroscopic surgery performed on his left knee on December 4, 2013, by both Dr. Adair and Dr. Wolters. The surgical procedure consisted of a revision/repair of the left lateral meniscus and platelet rich plasma injection (Petitioner's Exhibit 3).

Dr. Adair saw Petitioner following the surgery on December 10, 2013, and noted that Petitioner was doing very well, that there was no significant tenderness and that the range of motion of the left knee was excellent. Dr. Adair saw Petitioner on January 21, 2014, and noted continued improvement. He ordered physical therapy and indicated he wanted to see Petitioner in one month (Petitioner's Exhibit 1).

Petitioner received physical therapy from January 28, 2014, through February 20, 2014 (Petitioner's Exhibit 4). Petitioner did not see Dr. Adair subsequent to January 21, 2014, and testified that he was not aware that he was to be seen by him again.

Dr. Kefalas was deposed on March 26, 2014, and his deposition testimony was received into evidence at trial. Dr. Kefalas' testimony was consistent with his narrative medical report and he reaffirmed his opinion that Petitioner sustained a strain of his left knee that exacerbated a prior left meniscus injury. In regard to the accident of September 9, 2013, Dr. Kefalas opined that it caused a left knee sprain but that the left knee lateral meniscal symptoms were not causally related to the accident. Dr. Kefalas explained that the basis of his opinion was the fact that Petitioner had four prior left knee arthroscopic surgeries and that when compared, the MRI scans of September, 2012, and September, 2013, were the same in appearance (Respondent's Exhibit 1; pp 15-17).

Dr. Adair was deposed on May 19, 2014, and his deposition testimony was received into evidence at trial. Dr. Adair testified that he initially saw Petitioner on August 21, 2012, and that after having an MRI scan performed on September 6, 2012, he suggested either a lateral meniscus transplant or possible viscosupplementation. He next saw Petitioner on September 10, 2013, following his work-related accident and recommended another MRI scan (Petitioner's Exhibit 2; pp 7-10).

When Dr. Adair reviewed the MRI scan of September, 2013, he noted that it "...showed just some lateral meniscus things. Everything else looked okay." He also stated that Petitioner had some small stable tears and a good posterior cleft which indicated an unstable lateral meniscus. When asked if those clefts were present in the prior MRI (September, 2012) he stated that he thought so but did not remember them being "...quite that distinct." When asked if there appeared to be something different on the second MRI scan, Dr. Adair stated "Maybe a little bit, yeah." (Petitioner's Exhibit 2; pp 12-13).

Dr. Adair opined the accident of September 9, 2013 was an aggravation of the pre-existing condition in the left knee and that the twisting of the knee contributed to Petitioner's pain symptoms. He performed surgery to relieve Petitioner's pain symptoms (Petitioner's Exhibit 2, p 18).

Petitioner did not return to work for Respondent but obtained a job at Complete Nutrition where he started on May 1, 2014. Petitioner helps individuals meet their health goals and his job does not require any manual labor. Petitioner testified that he still experiences a little bit of pain in his left knee but he has resumed his fitness routine and recently began jogging again. He stated that he jogs one and one-half miles, three to four times per week. He also stated that he plans to resume playing hockey in the fall of 2014. Petitioner has not sought any medical treatment since last time he was seen by Dr. Adair on January 21, 2014.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being is, in part, causally related to the accident of September 9, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner had a long history of left knee injuries prior to the accident of September 9, 2013, including four arthroscopic surgeries at least three of which involved pathology to the left lateral meniscus.

Petitioner's primary treating physician, Dr. Adair, saw Petitioner in September, 2012, approximately one year prior to the accident, and had an MRI scan performed. At that time, Dr. Adair recommended either a lateral meniscus transplant or viscosupplementation.

Following the accident of September 9, 2013, Petitioner was again seen by Dr. Adair who ordered another MRI scan. The radiologist to read both MRI scans opined that they were "Unchanged since comparison." Further, Respondent's Section 12 examiner, Dr. Kefalas reviewed both scans and opined that they revealed no changes in the appearance of the left lateral meniscus.

When he was deposed, Dr. Adair testified that there may have been a little bit of difference between the two MRI scans but he was not more specific than that. Dr. Adair opined that there was an aggravation of a pre-existing condition which increased Petitioner's symptoms of pain.

Dr. Kefalas testified that the accident of September 9, 2013, was a strain of the left knee which exacerbated Petitioner's left knee symptoms but that the left lateral meniscal pathology was present both before and after the accident of September 9, 2013, as revealed by comparison of the MRI scans.

The Arbitrator finds the opinion of Dr. Kefalas to be more persuasive.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical services provided to Petitioner through October 18, 2013, were reasonable and necessary and that Respondent is liable for the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6 for services provided to Petitioner from September 10, 2013, through October 18, 2013, but not thereafter, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

In support of this conclusion the Arbitrator notes following:

As noted in the Arbitrator's conclusion of law in disputed issue (F) Petitioner sustained a left knee strain as a result of the accident of September 9, 2013. Respondent is not responsible for the treatment pertaining to the surgery performed on Petitioner on December 4, 2013.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of two weeks commencing September 11, 2013, through September 26, 2013.

In support of this conclusion the Arbitrator notes the following:

Other than the aforestated period of time, Petitioner continued to work until he had the left knee surgery performed on December 4, 2013.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of seven and one-half percent (7 1/2%) loss to use of the left leg as a result of the accident of September 9, 2013.

In support of this conclusion the Arbitrator notes the following:

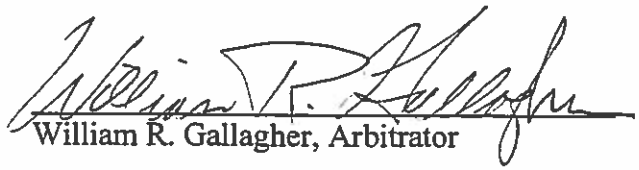
Neither the Petitioner nor Respondent tendered into evidence an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner returned to work at Complete Nutrition and is apparently working without any physical restrictions, but his job requires no manual labor. The Arbitrator gives this factor a moderate amount of weight.

At the time of the accident Petitioner was 23 years of age and was, and continues to be, a very athletic young man. Petitioner has resumed his exercise regimen and is intent upon playing hockey again notwithstanding the left knee symptoms that he has, both work and non-work related. The Arbitrator gives this factor significant weight.

There was no evidence that this injury will have any effect on Petitioner's future earning capacity. The Arbitrator gives this factor moderate weight.

The medical treatment records indicated that Petitioner sustained a left knee sprain with no additional pathology in regard to the left lateral meniscus. The Arbitrator gives this factor significant weight.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Steimel,
Petitioner,
vs.

NO: 13WC 38926

Scheels All Sports,
Respondent,

15IWCC0462

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 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: JUN 17 2015
o061015
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEIMEL, SCOTT
Employee/Petitioner

Case# **13WC038926**
13WC038925

SCHEELS ALL SPORTS
Employer/Respondent

15IWCC0462

On 10/17/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

2250 LAW OFFICE OF STEPHEN H LARSON
BRUCE J MAGNUSON
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

15IWCC0462

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Scott Steimel
Employee/Petitioner

v.

Scheels All Sports
Employer/Respondent

Case # 13 WC 38926

Consolidated cases: 13 WC 38925

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on August 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On September 9, 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, the parties stipulated that Petitioner earned $17,450.16; the parties further stipulated that the average weekly wage was $335.58.

On the date of accident, Petitioner was 23 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

October 10, 2014
Date

OCT 17 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged that he sustained accidental injuries to his left knee arising out of and in the course of his employment for Respondent. In 13 WC 38925 the Application alleged that Petitioner sustained a left knee injury while delivering exercise equipment (Arbitrator's Exhibit 2). In 13 WC 38926 the Application alleged that Petitioner sustained a left knee injury while reaching for hangers (Arbitrator's Exhibit 4). In both cases, Respondent agreed that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship.

Petitioner became employed by Respondent in April, 2011, and worked as a service shop technician. Petitioner's job duties included sharpening skates, assembling bikes, moving exercise machines and making deliveries of workout equipment to Respondent's customers.

Petitioner testified that he graduated from high school in 2008 and that he played hockey and indoor soccer while he was in high school and thereafter. Between July, 2006, and July, 2009, Petitioner had four separate surgical procedures performed on his left knee. All of these surgeries were because of injuries Petitioner sustained as a result of either hockey or soccer.

The first surgery performed on Petitioner's left knee was in July, 2006, for a left knee lateral meniscus tear which occurred as a result of a soccer injury. The second surgery on Petitioner's left knee was in March, 2007, and it again involved the left lateral meniscus and this was also the result of a soccer injury. The third surgery on Petitioner's left knee was in October, 2008, and was a left knee arthroscopy following a hockey injury. The medical records of these three surgeries were not tendered into evidence at trial; however, Respondent's Section 12 examining physician, Dr. John Kefalas referenced them in his report of November 6, 2013 (Respondent's Exhibit 2).

Petitioner had the fourth surgical procedure on his left knee performed in July, 2009, and that surgical report was not tendered into evidence either; however, in a post-operative office visit of August 27, 2009, Dr. Rodney Herrin noted that Petitioner had just undergone an arthroscopic re-repair of a lateral meniscal tear (Petitioner's Exhibit 1).

On August 21, 2012, Petitioner was seen by Dr. Daniel Adair, an orthopedic surgeon. At that time, Petitioner complained of sharp pain and his left knee giving out since November, 2011. Dr. Adair's record of that date noted that Petitioner had undergone four surgical procedures on his left knee which involved partial removal of the lateral meniscus. On clinical examination, the range of motion of the left knee was excellent and there was no instability; however, Dr. Adair noted some atrophy of the left leg musculature. He suggested the possibility of a lateral meniscus transplant but before proceeding further, he ordered an MRI scan (Petitioner's Exhibit 1).

An MRI scan was performed on September 6, 2012. The radiologist noted that there was a pical blunting of the body of the lateral meniscus which may have been related to a prior meniscal tear as well as mild irregularity suggestive of mild chondromalacia. Petitioner was subsequently seen by Dr. Adair on September 18, 2012, and, at that time, Petitioner was doing very well and not having any significant symptoms. Dr. Adair discussed treatment options with Petitioner which

included either viscosupplementation or a lateral meniscus transplant (Petitioner's Exhibit 1). Petitioner testified that he decided against undergoing either of these procedures because he stated that he did not believe that he needed them.

On September 9, 2013, Petitioner and another employee were in the process of transporting a home gym in a box to one of Respondent's customers. Petitioner estimated the weight of the box to be 300 to 350 pounds. Petitioner was in a squatting position and was pulling on the box while the other employee was pushing it. While Petitioner was performing this task, he felt some discomfort in his left knee. After Petitioner and his co-worker finished moving the box, they returned to the truck and, when Petitioner sat down he felt a sharp pain in his left knee.

Petitioner testified that from the time he started working for Respondent in April, 2011, and the accident of September 9, 2013, he had no problems with his left knee and was able to perform all of his job duties. Petitioner also stated that he continued to play hockey and soccer as well as working out in a gym. Petitioner described a vigorous exercise regimen that involved his whole body including the lower extremities. Further, Petitioner had a concurrent job at Snap Fitness where he was an exercise instructor. While working as an instructor, Petitioner participated in the exercises because he wanted to lead the class by example. Following the accident of September 9, 2013, Petitioner instructed the classes from a seated position and did not participate.

Petitioner sought medical treatment from Dr. Adair who saw him on September 10, 2013. Dr. Adair's record of that date contained a history of the work-related accident. He again noted that Petitioner had four prior surgeries on the left knee and that he previously discussed Petitioner having a meniscal transplant about a year prior. He noted that the Petitioner had experienced intermittent trouble with the knee but that it was now a little bit worse. On clinical examination, the range of motion was normal, the knee was stable but there was some swelling. Dr. Adair ordered an MRI scan (Petitioner's Exhibit 1).

An MRI scan was performed on September 18, 2013, and the radiologist was able to compare it to the MRI scan that was previously performed on September 7, 2012 (they were both performed at Memorial Medical Center) and noted that the scan of September 18, 2013, revealed a small stable tears within the lateral meniscus unchanged (Petitioner's Exhibit 1).

On September 19, 2013, Petitioner was seen by Dr. Adair who reviewed the MRI scan which he opined revealed a posterior tear of the lateral meniscus which he thought was repairable but noted that there had been two prior attempts to repair it. At Dr. Adair's direction, Petitioner was seen by Dr. Brett Wolters, an orthopedic surgeon, that same day. Dr. Wolters examined Petitioner and reviewed the diagnostic studies. He opined that Petitioner had a vertical tear of the posterior horn of the lateral meniscus. He opined that this was an aggravation of a pre-existing condition and recommended a left knee arthroscopy, revision of the lateral meniscal tear and repair with platelet rich plasma injection (Petitioner's Exhibit 1).

Dr. Adair imposed work/activity restrictions on Petitioner at the time of the initial post-accident visit and Petitioner was unable to work from September 11, 2013, through September 26, 2013, as was stipulated to by Respondent.

On October 15, 2013, Petitioner was working as a cashier and was sitting on a stool. While Petitioner was attempting to get some hangers for another employee, he turned his stool and his left foot got stuck which caused him to twist his left knee. Petitioner testified that this was the same area of his left knee that he injured on September 9, 2013.

Petitioner was seen by Dr. Adair on October 18, 2013, and Petitioner informed him that he had re-injured his left knee at work. Dr. Adair's opinion regarding Petitioner's left knee condition remained the same and he renewed his recommendation that Petitioner undergo arthroscopic surgery and possible meniscus transplant (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. John Kefalas, an orthopedic surgeon, on November 6, 2013. In connection with his examination of Petitioner, Dr. Kefalas reviewed medical records following the September, 2013, accident, Petitioner's job description and the MRIs from both September, 2012, and September, 2013. Dr. Kefalas opined that Petitioner had a left knee sprain and possible lateral meniscal tear. In regard to causality, Dr. Kefalas opined that Petitioner's left knee sprain exacerbated pre-existing left knee symptoms; however, he opined that the left knee pain had been present since September, 2012, and that it was not related to the work-related accident of September 9, 2013. In arriving at this opinion, Dr. Kefalas specifically noted that the MRI scans performed in September, 2012, and September, 2013, showed no changes in the appearance of the lateral meniscus (Respondent's Exhibit 2).

Petitioner had arthroscopic surgery performed on his left knee on December 4, 2013, by both Dr. Adair and Dr. Wolters. The surgical procedure consisted of a revision/repair of the left lateral meniscus and platelet rich plasma injection (Petitioner's Exhibit 3).

Dr. Adair saw Petitioner following the surgery on December 10, 2013, and noted that Petitioner was doing very well, that there was no significant tenderness and that the range of motion of the left knee was excellent. Dr. Adair saw Petitioner on January 21, 2014, and noted continued improvement. He ordered physical therapy and indicated he wanted to see Petitioner in one month (Petitioner's Exhibit 1).

Petitioner received physical therapy from January 28, 2014, through February 20, 2014 (Petitioner's Exhibit 4). Petitioner did not see Dr. Adair subsequent to January 21, 2014, and testified that he was not aware that he was to be seen by him again.

Dr. Kefalas was deposed on March 26, 2014, and his deposition testimony was received into evidence at trial. Dr. Kefalas' testimony was consistent with his narrative medical report and he reaffirmed his opinion that Petitioner sustained a strain of his left knee that exacerbated a prior left meniscus injury. In regard to the accident of September 9, 2013, Dr. Kefalas opined that it caused a left knee sprain but that the left knee lateral meniscal symptoms were not causally related to the accident. Dr. Kefalas explained that the basis of his opinion was the fact that Petitioner had four prior left knee arthroscopic surgeries and that when compared, the MRI scans of September, 2012, and September, 2013, were the same in appearance (Respondent's Exhibit 1; pp 15-17).

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law because these issues are rendered moot.

William R. Gallagher, Arbitrator

15IWCC0462

Dr. Adair was deposed on May 19, 2014, and his deposition testimony was received into evidence at trial. Dr. Adair testified that he initially saw Petitioner on August 21, 2012, and that after having an MRI scan performed on September 6, 2012, he suggested either a lateral meniscus transplant or possible viscosupplementation. He next saw Petitioner on September 10, 2013, following his work-related accident and recommended another MRI scan (Petitioner's Exhibit 2; pp 7-10).

When Dr. Adair reviewed the MRI scan of September, 2013, he noted that it "...showed just some lateral meniscus things. Everything else looked okay." He also stated that Petitioner had some small stable tears and a good posterior cleft which indicated an unstable lateral meniscus. When asked if those clefts were present in the prior MRI (September, 2012) he stated that he thought so but did not remember them being "...quite that distinct." When asked if there appeared to be something different on the second MRI scan, Dr. Adair stated "Maybe a little bit, yeah." (Petitioner's Exhibit 2; pp 12-13).

Dr. Adair opined the accident of September 9, 2013 was an aggravation of the pre-existing condition in the left knee and that the twisting of the knee contributed to Petitioner's pain symptoms. He performed surgery to relieve Petitioner's pain symptoms (Petitioner's Exhibit 2, p 18).

Petitioner did not return to work for Respondent but obtained a job at Complete Nutrition where he started on May 1, 2014. Petitioner helps individuals meet their health goals and his job does not require any manual labor. Petitioner testified that he still experiences a little bit of pain in his left knee but he has resumed his fitness routine and recently began jogging again. He stated that he jogs one and one-half miles, three to four times per week. He also stated that he plans to resume playing hockey in the fall of 2014. Petitioner has not sought any medical treatment since last time he was seen by Dr. Adair on January 21, 2014.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to the accident of October 15, 2013.

In support of this conclusion the Arbitrator notes the following:

In 13 WC 38925, the Arbitrator concluded that Petitioner's current condition of ill-being was, in part, related to the accident of September 9, 2013, and that Petitioner sustained a left knee strain.

At the time Petitioner sustained the accident of October 15, 2013, his left knee was symptomatic as a result of the accident of September 9, 2013, and his act of reaching for hangers was nothing more than an exacerbation of the strain that he sustained as result of the accident of September 9, 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)
☒ Modify down	☐ PTD/Fatal denied
	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Hadaway,
Petitioner,

vs. No: 07 WC 14800

State of Illinois,
Department of Transportation,
Respondent.

15IWCC0463

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, being advised of the facts and law, modifies the Arbitrator's award of medical expenses and temporary total disability and otherwise affirms and adopts the June 5, 2014 Decision of Arbitrator Falcioni, which is attached hereto and made a part hereof.

Petitioner, a 54 year old highway maintainer, sustained injury to his right leg and low back on February 15, 2007 when he was struck by a 55 gallon drum filled with debris and ice. A hearing under Section 19(b) of the Act was held on April 21, 2008. The Arbitrator issued a decision dated July 31, 2008, finding that Petitioner's condition of ill-being with regard to the low back and right knee was causally related to the accident and finding that Petitioner was still undergoing medical treatment for the low back and right knee conditions at the time of hearing. The Commission affirmed the Decision on March 6, 2009.

After the Section 19(b) hearing, Petitioner remained off work and underwent a total right knee replacement as well as two lumbar spine surgeries. On June 11, 2013, Dr. Templin released Petitioner at maximum medical improvement pursuant to a functional capacity evaluation that found him able to work medium demand up to four hours per day lifting 28 pounds occasionally and 23 pounds overhead. Petitioner also received restrictions on his ability to carry, push, pull, climb, kneel, crawl, bend, squat, and reach. Respondent offered no rehabilitation services or work within Petitioner's restrictions. Petitioner underwent a self-guided job search through the date of hearing and submitted job search logs into evidence for a period from January through November 2013. Petitioner testified he received no offers of employment but did go on several interviews. Petitioner's highest level of education was high school, and his prior work experience was limited to heavy duty work. The Arbitrator found Petitioner had demonstrated

15IWCC0463

permanent total disability based on the "odd-lot" theory effective June 12, 2013, and the Commission affirms the Arbitrator's finding in that regard.

The Arbitrator found Respondent had paid all appropriate charges for reasonable and necessary medical services and ordered Respondent to pay reasonable and necessary medical services of $80,467.32 pursuant to Section 8.2 and 8(a) of the Act, if the bills had not been paid already. No additional finding of fact regarding medical expenses is contained in the Arbitration Decision, and the Record is void of any stipulations regarding medical expenses as the Arbitrator's Exhibit 1, Request for Hearing, was lost prior to preparation of the official transcript. The parties stipulated on the record there was no dispute as to liability for the medical expenses contained in the record but it is unclear which, if any, of the bills remain outstanding. After review of the medical expenses contained in Petitioner's Exhibits 7 through 10, the Commission modifies the Arbitrator's award of medical expenses to conform to the evidence as contained in the Record. The Commission finds Respondent has not paid all appropriate charges for reasonable and necessary medical services and further finds Respondent shall pay to Petitioner reasonable and necessary medical expenses contained in Petitioner's Exhibits 7 through 10, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for expenses paid to date.

The Arbitrator ordered Respondent pay to Petitioner temporary total disability benefits of $507.43/week for 324-1/7 weeks, commencing March 27, 2007 through June 11, 2013, as provided in Section 8(b) of the Act with Respondent to be given a credit for all amounts previously paid. The Commission notes the July 31, 2008 Section 19(b) Decision awarded temporary total disability benefits through the date of hearing, April 21, 2008, and the Decision was affirmed by the Commission. The Commission modifies the Arbitrator's award of temporary total disability benefits to encompass only the period after the Section 19(b) hearing. The Commission orders Respondent pay to Petitioner temporary total disability benefits of $507.43/week for 268 1/7 weeks, commencing April 22, 2008 through June 11, 2013, as provided in Section 8(b) of the Act. Respondent is to receive credit for all sums previously paid.

After considering the entire record, and for the reasons set forth above, the Commission finds that Petitioner's current condition of ill-being with regard to the low back and right leg is causally related to his February 15, 2007 accident. The Commission affirms the Arbitrator's award of permanent total disability and modifies the award of medical expenses and temporary total disability benefits to conform to the evidence contained in the Record.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the June 5, 2014 Decision of the Arbitrator is modified with regard to the issues of medical expenses and temporary disability benefits, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $507.43/week for a period of 268 1/7 weeks, commencing April 22, 2008 through June 11, 2013, that being the period of temporary total disability from work under Section 8(b) of the Act. Respondent to receive credit for benefits heretofore paid.

15IWCC0463

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical expenses contained in Petitioner's Exhibits 7 through 10, as provided in Sections 8(a) and 8.2 of the Act. Respondent to receive credit for expenses paid to date.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent and total disability benefits of $507.43/week for life, commencing June 12, 2013, as provided in Section 8(f) of the Act. Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in section 8(g) 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 injuries.

Pursuant to Section 19(f)(1) of the Act, in this case, where the Respondent is the State of Illinois, the decision of the Commission shall not be subject to judicial review.

DATED: JUN 18 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/21/15
jdl/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HADAWAY, DANIEL
Employee/Petitioner

Case# **07WC014800**

SOI DEPT OF TRANSPORTATION
Employer/Respondent

15IWCC0463

On 6/5/2014, 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:

0320 LANNON LANNON & BARR LTD
PATRICIA LANNON KUS
180 N LASALLE ST SUITE 3050
CHICAGO, IL 60601

4127 ASSISTANT ATTORNEY GENERAL
GANSMANN, GREGG
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
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 - 5 2014

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

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

- [ ] 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

Daniel Hadaway
Employee/Petitioner

v.

State of Illinois/Department of Transportation
Employer/Respondent

Case # **07** WC **14800**

Consolidated cases: _____

15IWCC0463

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **11/13/13**. 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. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What 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 **2/15/07**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,579.80**; the average weekly wage was **$761.15**.

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

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

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

Respondent shall be given a credit for all amounts of temporary total disability benefits paid.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$507.43**/week for **324-1/7** weeks, commencing **3/27/07** through **6/11/13**, as provided in Section 8(b) of the Act. Respondent to receive credit for all sums previously paid hereunder.

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$80,467.32**, as provided in Sections 8(a) and 8.2 of the Act, if those bills have not as yet been paid. All bills to be paid pursuant to the fee schedule.

Permanent Total Disability

Respondent shall pay Petitioner permanent and total disability benefits of **$507.43**/week for life, commencing **6/12/13**, 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.

Signature of Arbitrator

12/5/14
Date

JUN 5 - 2014

STATE OF ILLINOIS)
)
COUNTY OF Will)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Daniel Hadaway
Employee/Petitioner

Case # 07 WC 14800

v.

15IWCC0463

State of Illinois/
Department of Transportation
Employer/Respondent

FINDINGS OF FACT

The Petitioner was employed as a highway maintainer on February 15, 2007. The Petitioner injured his low back and right knee when a co-employee dropped a 55 gallon drum which struck the Petitioner's leg causing him to twist.

The Petitioner sought immediate treatment and eventually came under the care of Hinsdale Orthopedic Group. The State disputed the relationship of the Petitioner's back and knee injury and the case proceeded to a hearing pursuant to §19(b) of the Act. The Arbitrator rendered a decision on July 30, 2008 awarding temporary total disability benefits through the date of the hearing and finding that the Petitioner's condition of ill-being regarding his back and right leg was causally related to the work injury. The Respondent filed an appeal of the decision and the Commission affirmed the decision on March 6, 2009. The findings of fact in the original decision are hereby incorporated in this subsequent hearing.

Following the Arbitration hearing, the Petitioner continued under the care of Hinsdale Orthopedic Group. Dr. Templin was treating the Petitioner for his low back condition and referred him to Dr. Patel at the Pain & Spine Institute for injections. Dr. Patel performed a lumbar diagnostic medial nerve branch block in April 2008, followed by an SI joint injection for the Petitioner's right hip pain. He subsequently performed a radiofrequency ablation on April 11, 2008 (Px.#1).

The Petitioner also continued treating with Dr. Durkin regarding his knee condition. The Petitioner's condition was not improving. Dr. Durkin recommended synvisc injections to the Petitioner's knee. The Petitioner underwent a series of those injections (Px.#5).

Dr. Templin recommended further diagnostic studies and referred the Petitioner to Dr. Fronczak for a second opinion. Dr. Fronczak examined the Petitioner and diagnosed probable lumbar radiculopathy secondary to spinal stenosis and status post knee surgery for internal knee derangement. Dr. Fronczak felt the Petitioner was still symptomatic for the right knee and felt that an additional work up for the back should be performed. The doctor felt the knee problem needed to be addressed first (Px.#2).

The Petitioner returned to Dr. Durkin and he recommended a total knee arthroplasty (Px.#3). The Petitioner subsequently underwent the surgery at St. Joseph Hospital on December 1, 2009. Following the surgery, the Petitioner continued to see Dr. Durkin and started physical therapy. He was also on various medications.

The Petitioner also returned to Dr. Templin as the Petitioner continued to have ongoing back problems. Dr. Templin felt that a discogram should be performed. The Petitioner underwent the discogram at Pain & Spine Institute on August 19, 2010. The test was positive at

L4-L5. When the Petitioner returned to Dr. Templin following the test, the doctor recommended a fusion (Px.#5).

The Petitioner underwent surgery with Dr. Templin at Provena St. Joseph Medical Center on December 27, 2010. The doctor performed a lateral interbody fusion with a caged device at L4-5 and an allograft bone perfusion at L4-L5, along with screw instrumentation at that level (Px.#3).

Following the back surgery, the Petitioner started physical therapy at Champion Fitness Physical Therapy. The Petitioner continued to have ongoing issues with his back. He also returned to Dr. Durkin regarding his right knee.

On June 21, 2011, Dr. Durkin noted that the Petitioner was still walking with a limp and wearing a knee brace. The doctor stated that the Petitioner would be unable to return to work as a heavy laborer (Px.#5).

The Petitioner continued to see Dr. Templin. He kept the Petitioner off work and sent him for further testing.

On January 12, 2012, the Petitioner underwent a CT Scan at St. Joseph Hospital. The impression was that the fusion across the endplate at L4-L5 was not reached and there were multi-level lateral recesses and foraminal stenosis which appeared to be worse at L3-L4 due to a far lateral disc protrusion superimposed on a broad based disc bulge (Px.#3).

The Petitioner continued to complain of back problems and Dr. Templin eventually recommended a second surgery due to the lack of definitive fusion. The doctor performed a re-exploration of the fusion and removed the posterior hardware on July 11, 2012, at St. Joseph Medical Center. The anterior cage was left in place. The post-op diagnosis was L4-L5 fusion with retained instrumentation (Px.#3).

The Petitioner resumed physical therapy at Champion Fitness Physical Therapy. At the time of the last appointment on October 22, 2012, the therapist felt that rehabilitation potential was only fair and only limited progress had been made towards his goals. She felt that the Petitioner had reached MMI with therapy (Px.#5).

The Petitioner returned to Dr. Templin who recommended an FCE. The FCE, also performed at Champion Fitness, stated that the Petitioner participated at less than full effort. The therapist concluded that the Petitioner would not be able to function on a full time basis since his low back and knee became worse as the FCE progressed. The therapist recommended various guidelines for a possible return to work (Px.#4).

Following the FCE, the Petitioner returned to Dr. Templin. He noted that the FCE was not valid but felt the Petitioner could only work at a medium demand level 4 hours per day. He noted that the Petitioner was still complaining of low back pain and knee pain in the range of 6 to 7 out of 10 (Px.#5).

The Petitioner returned to Dr. Templin on June 11, 2013. The doctor stated that he was status post removal of instrumentation and a return to work per the FCE. Dr. Templin further noted the Petitioner walked with an antalgic gait on the left. He took new x-rays which showed a solid fusion with no migration and unchanged instrumentation. He felt the Petitioner had reached MMI status post fusion and only needed to follow up as needed. He continued to prescribe medication for the Petitioner (Px.#5).

The Petitioner testified that he began a job search following the results of the FCE. He testified that he has been unable to find a job although he has contacted a substantial number of employers. He attended some interviews, but no one has hired him. The Petitioner further testified that the State did not provide any type of rehabilitation services to him.

Conclusions of Law

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

The case was initially litigated pursuant to §19(b) of the Act and the Commission awarded temporary total disability benefits to the Petitioner from March 27, 2007 through April 21, 2008, for a period of 56 weeks. That decision became final.

Following the initial 19(b) hearing, the Petitioner remained off work. He continued to see both Dr. Templin and Dr. Durkin. The Petitioner underwent a total knee replacement and two back surgeries after the initial hearing.

The records of Hinsdale Orthopedics support the Petitioner's testimony that he was unable to work while under their medical care. Dr. Templin eventually released the Petitioner to return to restricted work on December 11, 2012. At that time, Dr. Templin reviewed the FCE and released the Petitioner to a medium demand work level at 4 hours per day. The doctor also advised the Petitioner to return in 6 months for a new x-ray and to follow up regarding his restrictions (Px.#5).

The Petitioner testified that he then began a job search. The Petitioner submitted into evidence copies of job search logs beginning January 7, 2013 through November 1, 2013 (Px.#6). The logs outline the places where the Petitioner looked for work. The Petitioner consistently continued to look for work through the date of the hearing.

The Petitioner returned to Dr. Templin on June 11, 2013. At that time, Dr. Templin noted that the Petitioner had reached maximum medical improvement and only needed to return as needed. He felt the Petitioner could return to work per the FCE restrictions.

The Petitioner was employed as a highway maintainer for the State of Illinois when he was injured. The job consisted of maintaining the roads, removing ice and snow. When there was no snow to remove, the Petitioner would repair potholes and empty debris. The job involved heavy work.

The Petitioner's past work experience consisted of truck driving, laboring work and cabinet work. He testified that this work involved heavy lifting, shoveling, twisting, and climbing activities which he can no longer perform due to the back and knee surgeries.

The Petitioner further testified that he was only a high school graduate and had no other educational background. The Petitioner is currently 60 years of age. He has no clerical experience, no computer skills, and no retail or sales experience. He has no transferable skills in order to find employment. The Petitioner did produce evidence of a valid job search. He went on several interviews, approximately 20-25, and had no offers of employment.

The Petitioner's current restrictions are substantial. He can only work part time at a medium work level. The FCE stated that the Petitioner could only lift 28 pounds occasionally from floor to waist, 28 pounds from waist to shoulder and 23 pounds occasionally with overhead lifting. He would only be allowed to carry 32 pounds occasionally, push 34.1 pounds occasionally and pull 36.6 pounds occasionally. There were also restrictions on climbing, kneeling, crawling, bending, squatting and reaching (Px.#4).

The Petitioner testified that the State did not provide any type of rehabilitation services to him. The State did not assist him in seeking employment. The Arbitrator concludes that Petitioner has made a prima facie case for an "odd lot" permanent total.

In *Economy Packing Co. vs. Illinois Workers' Compensation Commission*, 387 Ill. App. 3d 283 (2009), the Court held that a claimant can satisfy the requirement that he falls in an odd lot category by showing a diligent but unsuccessful job search or by demonstrating that because of his age, training, education, experience and conditions, he is unable to engage in stable and continuous employment. At that point, the burden shifts to the employer to show that suitable work is regularly and continuously available to the claimant.

The Respondent in the present case, chose not to provide vocational counseling or rehabilitation. The Respondent did not prepare an assessment for a plan to include vocational evaluation pursuant to the rules of the Illinois Workers' Compensation Commission, §7110.10.

The Arbitrator finds that based on the Petitioner's job search, his current medical restrictions, his age, training and experience, there is no stable labor market for the Petitioner. Based on this finding, Arbitrator finds that the Petitioner became permanently and totally disabled as of June 12, 2013.

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

Gene Eubanks,

Petitioner,

vs.

NO: 09 WC 26290

15IWCC0464

Con-Way, Inc., Con-Way Transportation Services, Con-Way Freight, Inc., Con-Way Freight-Central,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 30, 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.

15IWCC0464

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

DATED: JUN 19 2015
TJT:yl
o 6/16/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EUBANKS, GENE
Employee/Petitioner

Case# **09WC026290**

10WC038648

12WC033476

CON-WAY: CON-WAY TRANSPORTATION SERVICES: CON-WAY FREIGHT INC AND CON-WAY FREIGHT-CENTRAL
Employer/Respondent

15IWCC0464

On 12/30/2013, 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 0.09% 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:

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

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0464

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

GENE EUBANKS
Employee/Petitioner

v.

CON-WAY; CON-WAY TRANSPORTATION SERVICES; CON-WAY FREIGHT, INC., and CON-WAY FREIGHT - CENTRAL.
Employer/Respondent

Case # **09** WC **26290**

Consolidated cases: **10 WC 38648**
12 WC 33476

An *Application for Adjustment 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/CHICAGO**, on **10/15/13 and 11/12/13**. 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. [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 **2/14/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **58,446.96** the average weekly wage was $ **1,123.98**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $ **54,593.32** for TTD, $ **209.11** for TPD, $ **-0-** for maintenance, and $ **-0-** for other benefits, for a total credit of $ **54,802.43.**

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW ARE ATTACHED.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$619.97/week** for 37.5 weeks, because the injuries sustained to the left shoulder caused a 7.5% loss of a person as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$619.97/week** for **75** weeks, because the injuries sustained to the back caused a **15%** loss of a person as a whole as provided in Section 8(d)(2) of the Act.

Respondent shall pay Petitioner the reasonable and necessary medical services admitted into evidence, pursuant to the Medical Fee Schedule, as provided in Sections 8 and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$749.32/week** for **73** weeks for the period of **October 23, 2007** through **March 16, 2009.**

Respondent shall pay Petitioner compensation that has accrued from **February 14, 2007**, 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

12/28/13
Date

DEC 30 2013

FINDINGS OF FACT 15IWCC0464

Three consolidated matters were tried together. ARB EX 1,2,3. At trial, Petitioner testified that he works as a truck driver for Respondent driving tractor trailers. Petitioner testified that he manually loads and handles his own freight as part of his duties. Accident is not at issue in any of the three matters. The first accident took place on 2/14/07. Petitioner testified that he got out of his truck at a warehouse, climbed over a snow bank to get to a sidewalk and then slipped on a thin layer of ice and snow on the sidewalk. He fell striking his left shoulder and left hip. He immediately felt pain in the left shoulder and notified the dispatcher. Respondent does not contest the left shoulder injury on 2/14/07.

Petitioner went to the company clinic and received x-rays to the left shoulder and a prescription for left shoulder pain. RX 2. There is no mention in the clinic records of injury to Petitioner's low back or legs. Petitioner worked light duty from 2/15/07 through 2/17/07. He was returned to full duty on 2/19/07. RX 2. Petitioner continued to work full duty through the spring of 2007. Petitioner testified that his legs and low back started to hurt during the second week of March 2007. Petitioner saw his family physician, Dr. Webb, on 4/3/07 complaining of a sinus problem. Although Petitioner testified that he mentioned his low back pain to Dr. Webb at that visit, no mention of left shoulder or low back/hip pain was documented at that visit. RX 3. Petitioner testified that he continued to work and his back and leg pain worsened.

Petitioner saw Dr. Webb again on 6/5/07 and the visit records document complaints of right-sided hip pain and left shoulder pain. RX 3. Dr. Webb noted "C/o R sided hip pain going down leg x 1 month c/o L shoulder pain post fall 4 mo ago." RX 3. Dr. Webb ordered an MRI of the left shoulder which suggested a partial tear of the supraspinatus tendon. RX 3. At the visit of 6/12/07, Dr. Webb referred Petitioner to Dr. Hudoba for medical treatment of the left shoulder and the lumbosacral radiculopathy. RX 3.

Petitioner saw Dr. Hudoba on June 21, 2007, complaining of lower back and right lower extremity pain, as well as left shoulder discomfort. PX 2. Petitioner reports "experiencing right lower extremity and lower back pain for approximately the last 6 weeks. Initially, he mostly felt lower back and gluteal discomfort, later also radiating pain into the right leg and toes. The radiating pain occurs occasionally mainly with longer standing or bending. ... symptoms worsen especially upon sitting or driving, also with longer standing. He says it is difficult to stand up after driving because of lower back stiffness and lower extremity pain. Patient reports that he fell while walking on the sidewalk in the middle of February 2007 after which he also developed left shoulder pain..." PX 2. Dr. Hudoba recommended an MRI of the lumbar spine, lumbar injections and a left upper extremity EMG and MRI of the cervical spine to clarify his symptoms. Petitioner testified that he continued to work full duty as a driver despite Dr. Hudoba taking him off work through 6/21/07. PX 2.

The lumbar MRI showed degenerative disc disease at L4-5 and L5-S1, small central L5-S1 disc extrusion minimally indents the thecal sac with no definite nerve root compression, and mild narrowing of the bilateral L5-S1 neural foramina. PX 2. Petitioner testified that the injections to his low back under a diagnosis of lumbar radiculopathy and protruding disc, did not provide relief. Petitioner underwent an EMG for the lower extremities in September 2007 which showed chronic right and left L5 and right S1 radiculopathy. PX 2. Petitioner received an additional lumbar injection. PX 2. Thereafter, Petitioner still had pain in his shoulder and low back so Dr. Webb referred Petitioner to Dr. Montella.

Petitioner saw Dr. Montella on 10/22/07. PX 4. Petitioner completed a patient assessment form indicating that he had "right side leg and butt pain- lower back" and left shoulder pain. Petitioner reported the onset of the problems in "Feb" and that the problem occurred when he "fell at work." PX 4. In his history, Dr. Montella noted "He had a fall at work in February 2007 and injured his left shoulder. Shortly thereafter, he developed the onset of back and radiating buttock posterior thigh and calf pain. His difficulties seem to directly resulting [sic] from this work related fall. He has been attempting to work through it full duty, full time but is having increasing severe and debilitating difficulties over the course of the day." Petitioner reported burning pain down the leg and pain with any shoulder motion overhead or behind his back. PX 4. In his assessment, Dr. Montella noted that Petitioner was "injured at work in February 2007. He injured both his shoulder and his back. His presentation is consistent with rotator cuff tear and lumbar disc herniation." Dr. Montella took Petitioner off work and sent him to physical therapy for his left shoulder and low back which he attended through April 2008. Dr. Montella took Petitioner off work from 10/23/07 through 3/16/09. During this period, Petitioner was paid TTD and followed up with Dr. Montella monthly for his left shoulder and low back. Injections to Petitioner's shoulder provided only minimal relief in April 2008.

In May 2008, Dr. Montella performed a laser disc decompression on Petitioner's low back based on the failure of conservative care. PX 4. Petitioner testified that the surgery provided him with relief of his low back pain as well as the bilateral leg pain. A tens unit was prescribed for low back pain after the surgery. Petitioner testified that the back pain went from a 9/10 to a 1.5/10 after the surgery. Petitioner continued to see Dr. Montella and on 9/8/08, Dr. Montella performed left shoulder arthroscopic surgery. The post-op diagnosis was left shoulder impingement rotator cuff injury. PX 4. Petitioner attended post op physical therapy and was off work through March 2009 when he was returned to work full duty at his own request. PX 4. Petitioner testified that he was examined at the company clinic as well and received a full release to return to driving activities. On 3/16/09, Petitioner returned to the same job and duties as a truck driver for Respondent.

Respondent sent Petitioner for an examination with Dr. Mash on 1/14/08. Dr. Mash noted the history Petitioner provided of falling at work in February 2007 and developing immediate left shoulder pain and then low back pain one week later. RX 4, p. 8. Upon exam, Dr. Mash diagnosed rotator cuff syndrome left shoulder and right sciatica. He agreed further treatment was necessary. The second exam was on 2/25/09, following Petitioner's left shoulder and low back surgeries. Petitioner reported his low back radiculopathy was gone and that he still had problems reaching over head with his left shoulder. He thought Petitioner would benefit from an FCE and work hardening. RX 4, p. 13. Subsequent to his exams of Petitioner, in August 2010, Dr. Mash reviewed records from Emery Medical Center where Petitioner was initially treated after the 2/14/07 accident, Dr. Webb and Dr. Montella. Noting the contents of these records as summarized above, and noting the differing history offered by Petitioner to Dr. Mash at the initial IME, Dr. Mash opined that Petitioner's low back problems were not casually related to the accident of 2/14/07. Specifically, Dr. Mash opined that Petitioner's low back problems treated by Dr. Montella are "...in no way related to the injuries alleged. The medical record does not support documentation of symptomatology related to the low back until June 2007, at least four months after the onset of difficulty about the patient's left shoulder. ... The history, which the patient would provide as to the onset of low back discomfort at the time of the injury, is not supported by the documentation in the medical record, in any way." RX 5, RX 4, pp. 16-17. He further opined that Petitioner's condition was not necessarily caused by trauma but could also be caused by a combination of genetic background

superimposed upon the progression of activities of daily living associated with the further chronology of aging." RX , p. 19.

Petitioner's second date of accident is May 5, 2010. Petitioner had been back at work for 13 months after his release for the first accident. On 5/5/10, Petitioner was climbing a ladder and unloading a trailer when he felt a burning sensation under his left arm. PX 8. Petitioner testified that he could not lift his arm up in the air. Accident is not at issue in this matter.

Petitioner saw Dr. Khanna for the left shoulder pain and following an MRI of the left shoulder, Dr. Khanna recommended surgery. PX 8. Dr. Khanna sent Petitioner to Dr. Giannulias but Petitioner testified that due to the long wait for an appointment, he saw Dr. Neal. Dr. Neal sent Petitioner to physical therapy between May and June 2010. His left shoulder did not improve and he was unable to lift on his own power. The MRI of 5/12/10 revealed an acute supraspinatus full-thickness tear and tendinosis and a possible labral tear. Dr. Neal noted that the prior left shoulder surgery was done arthroscopically and the rotator cuff was not addressed or repaired. Dr. Neal noted that Petitioner suffered an acute tear to the left shoulder rotator cuff at work on 5/5/10 and that his shoulder had not been the same since that accident. Dr Neal performed a second shoulder surgery on 6/29/10 with and open repair of his left rotator cuff. The post op diagnosis was left shoulder full thickness 2.5 cm rotator cuff tendon repair. PX 9. Petitioner was off work from June 2010 to September 2010 when he returned to light duty. PX 9. Petitioner testified that he was able to work light duty and complete the assigned office duty using one hand.

Petitioner also attended physical therapy while seeing Dr. Neal between September 2010 and November 2010. On 11/18/10, Dr. Neal took Petitioner off work again until such time he could return to full duty unrestricted work. Petitioner was returned to full duty work on 1/3/11. PX 9.
Petitioner testified that he returned to full duty work driving the truck and making deliveries without further treatment to his left shoulder after his release from care in March 2011.

Petitioner's third uncontested accident occurred one year later on 1/13/12. On that day, Petitioner twisted his left knee while adjusting a cord between the tractor and the trailer. Petitioner testified that he went to a clinic near his home over the weekend due to knee pain. Petitioner called work on Sunday and was told to come in on Monday and to return to Dr. Khanna at the company clinic. Dr. Khanna took Petitioner off work and ordered a left knee MRI. The MRI revealed a left knee posterior medial meniscus complex tear. Dr. Khanna referred Petitioner to Dr. Giannoulias who performed a left knee partial medial meniscectomy and left knee arthroscopic extensive two compartment synovectomy on 2/17/12. The post op diagnosis was left knee partial medical meniscus tear and left knee extensive synovitis. Petitioner was kept of work and attended physical therapy after surgery. Petitioner testified that he had a good result from his left knee surgery. Petitioner returned to light duty work on 3/13/12 again doing office work. Petitioner also attended work conditioning for 10 sessions. Dr. Giannoulias returned Petitioner to full duty work on 5/1/12. PX 12.

Petitioner attended a Section 12 exam with Dr. Patari with regard to his left knee injury on 9/13/12. RX 6. Dr. Patari diagnosed a left medial meniscus tear which had resolved after surgery and determined that Petitioner was at MMI at the time of the exam. Dr. Patari was asked and did provide an AMA impairment rating of 4% of the lower left leg translated to 2% of a person as a whole. RX 6, p. 5. Dr. Patari arrived at the impairment of 4% based on a 1% assignment to the medial meniscus tear and 3% for

the saphenous nerve impairment around Petitioner's incision sites. RX 6, p. 5. Using the 6th Edition Guides to the Evaluation of Permanent Impairment, Dr. Patari applied and subtracted modifiers including minimal findings on exam to arrive at 1% of the leg. RX 6, p. 6. He did not apply a modifier to the saphenous nerve injury. RX 6, p. 6.

Petitioner again returned to fully duty driving and delivery work. He has had no additional treatment for his left knee, left shoulder or low back since his releases. Currently, Petitioner's left shoulder get weak after working an 11 to 12 hour day at work. Petitioner testified to occasional throbbing in the left shoulder and problems with overhead type activities at work. Petitioner testified that he has this pain at work from 2 to 3 times per week depending on his activities. He takes Tylenol for pain. Petitioner testified that he has the same pain at home with his left shoulder. He is unable to reach up to high shelves and favors the left shoulder during activities of daily living. Petitioner has problems with reaching and extension of the left arm and is unable to lift more than 20 pounds with his arm extended. He no longer bowls or plays baseball due to problems with his left shoulder.

With regard to his low back, Petitioner testified he has problems at work sitting in the trailer and driving his truck. He has pain down his left buttock and leg in the back of the upper left thigh. Petitioner testified that this pain stars after about 15 minutes of driving and will go away when he gets up to walk. Petitioner testified that his longest driving distance is about 30 to 35 minutes and he drives short routes with 2 to 4 stops per route. Petitioner testified that he is able to lift and handle freight by hand as well as with a two wheeled dolly but normally he moves the freight by hand without problem as long as he does not have to lift "up high." Petitioner also testified that he avoids twisting in the middle of his back while at home doing home activities. He gets low back soreness with everyday activities and takes Tylenol to work through the pain.

With regard to his left knee, Petitioner testified that he favors and avoids use of the left knee. Petitioner is still able to climb ladders but tries to avoid that activity. He is not as active as he was before the accident and does not put pressure on the left knee. Petitioner is back at work fully duty and has not been back for more medical care.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law. Each of these consolidated matters is addressed in a separate Decision.

Case 09 WC 26290 – DOA 2/14/07

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

Based on the foregoing, the Arbitrator finds that Petitioner's left shoulder injury is causally connected to the uncontested accident of 2/14/07. Petitioner immediately reported a left shoulder injury. He returned to work full duty and continued to experience left shoulder pain. Petitioner sought care from his family doctor, Dr. Webb, on June 5, 2007 complaining of left shoulder pain. Petitioner also complained of left shoulder pain to Dr. Hudoba on 6/21/07 and commenced an immediate course of care under a diagnosis of suggested partial tear of the supraspinatus tendon following an MRI of the left shoulder. Petitioner's left shoulder care was eventually provided by Dr. Montella and culminated in arthroscopic shoulder surgery.

The post-op diagnosis was left shoulder impingement rotator cuff injury. PX 4. Respondent offered no evidence to the contrary. The Arbitrator notes that Petitioner did not have left shoulder symptoms or problems prior to the accident of 2/14/07 and that his care was continuous thereafter.

On the issue of causal connection for Petitioner's low back condition, the Arbitrator finds that Petitioner has met his burden to show by a preponderance of the evidence that his low back condition is causally connected to the fall at work on 2/14/07. In finding causal connection for Petitioner's low back condition, the Arbitrator is mindful of the lack of initial documentation on Petitioner's low back complaints. The Arbitrator also notes that the lack of reported back complaints in the initial records is the primary basis for Dr. Mash's opinion. However, the Arbitrator does not find a lack of initial documentation alone to be a sufficient basis to deny causal connection. In addition, the Arbitrator does not find a delay in seeking treatment for low back complaints (approximately 4 months) sufficient to sever causal connection given the fact that Petitioner continued to work full duty after his fall and credibly testified that his low back and left shoulder complaints continued to worsen such that he sought care in June 2007 for both conditions. Finally, the Arbitrator notes that while documenting the history of Petitioner's low back complaints Dr. Hudoba noted that Petitioner fell in February 2007 *after which he also* developed left shoulder pain...". The Arbitrator's finding of causal connection for Petitioner's low back injury is therefore based on Petitioner's credible testimony regarding symptom development a few weeks after the fall, the treating records of Drs. Webb and Hudoba, and the lack of any symptom, complaint or treatment to Petitioner's low back prior to the accident of 2/14/07.

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

Based on the Arbitrator's findings of causal connection between the February 14, 2007 fall at work and Petitioner's left shoulder and low back injury the Arbitrator finds that Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in the care and treatment of his left shoulder and low back injuries pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

K. What temporary benefits are in dispute? TTD

Based on the Arbitrator's findings of causal connection between the February 14, 2007 fall at work and Petitioner's left shoulder and low back injury the Arbitrator further finds that Respondent shall pay Petitioner $749.32 per week for 73 weeks in that Petitioner was temporarily and totally disabled for that period commencing 10/23/07 through 3/16/09 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

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

As a result of the accident on 2/14/07, Petitioner suffered a lumbar disc herniation for which he underwent a laser disc decompression surgery. Petitioner also underwent a Petitioner underwent arthroscopic left shoulder surgery which revealed left shoulder impingement rotator cuff injury. PX 4. Petitioner attended post op physical therapy and was off work through March 2009 when he was returned to work full duty at his own request. PX 4. Petitioner testified that he was examined at the company clinic as well and received a full release to return to driving activities. On 3/16/09, Petitioner returned to the same job and duties as a truck driver for Respondent.

The surgeries improved Petitioner's pain levels to the point where he returned to full duty work as a truck driver. Petitioner testified that he has continued pain in the left shoulder and low back but that the radiating leg pain was alleviated by the surgery. He takes Tylenol for pain caused by work and activities of daily living. Petitioner has not had any medical care for his back injury since his release in 2009.

Based on the foregoing, with regard to Petitioner's low back, the Arbitrator finds that Petitioner sustained 15% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act. The Arbitrator further finds that Petitioner sustained an additional 7.5% loss of use of the person as a whole under Section 8(d)(2) of the Act for his left shoulder impingement injury and surgery.

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

Gene Eubanks,

Petitioner,

vs.

NO: 10 WC 38648

Con-Way, Inc., Con-Way Transportation Services, Con-Way Freight, Inc., Con-Way Freight-Central,

15IWCC0465

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 30. 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.

15IWCC0465

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 19 2015
TJT:yl
o 6/16/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EUBANKS, GENE
Employee/Petitioner

Case# **10WC038648**

09WC026290
12WC033476

CON-WAY: CON-WAY TRANSPORTATION SERVICES; CON-WAY FREIGHT INC CON-WAY FREIGHT-CENTRAL
Employer/Respondent

15IWCC0465

On 12/30/2013, 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 0.09% 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:

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

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0465

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

GENE EUBANKS
Employee/Petitioner

v.

CON-WAY; CON-WAY TRANSPORTATION SERVICES; CON-WAY FREIGHT, INC., and CON-WAY FREIGHT - CENTRAL.
Employer/Respondent

Case # **10** WC **38648**

Consolidated cases: **09 WC 26290**
12 WC 33476

An *Application for Adjustment 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/CHICAGO**, on **10/15/13 and 11/12/13**. 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 15IWCC0465

On **5/5/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **59,875.92** the average weekly wage was $ **1,151.46**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $ **14,365.78** for TTD, $ **-0-** for TPD, $ **-0-** for maintenance, and $ **-0-** for other benefits, for a total credit of $ **14,365.78.**

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW ARE ATTACHED.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$767.64/week** for **18-5/7** weeks for the periods **June 29, 2010 through September 10, 2010** and **November 13, 2010 through January 2, 2011** as provided in Section 8(b) of the Act and as stipulated by the parties. ARB EX 2.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72**/week for 62.5 weeks, because the injuries sustained caused a 12.5% loss of a person as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **May 5, 2010**, 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.

Carolyn Doherty
Signature of Arbitrator

12/28/13
Date

DEC 30 2013

FINDINGS OF FACT

Three consolidated matters were tried together. ARB EX 1,2,3. At trial, Petitioner testified that he works as a truck driver for Respondent driving tractor trailers. Petitioner testified that he manually loads and handles his own freight as part of his duties. Accident is not at issue in any of the three matters. The first accident took place on 2/14/07. Petitioner testified that he got out of his truck at a warehouse, climbed over a snow bank to get to a sidewalk and then slipped on a thin layer of ice and snow on the sidewalk. He fell striking his left shoulder and left hip. He immediately felt pain in the left shoulder and notified the dispatcher. Respondent does not contest the left shoulder injury on 2/14/07.

Petitioner went to the company clinic and received x-rays to the left shoulder and a prescription for left shoulder pain. RX 2. There is no mention in the clinic records of injury to Petitioner's low back or legs. Petitioner worked light duty from 2/15/07 through 2/17/07. He was returned to full duty on 2/19/07. RX 2. Petitioner continued to work full duty through the spring of 2007. Petitioner testified that his legs and low back started to hurt during the second week of March 2007. Petitioner saw his family physician, Dr. Webb, on 4/3/07 complaining of a sinus problem. Although Petitioner testified that he mentioned his low back pain to Dr. Webb at that visit, no mention of left shoulder or low back/hip pain was documented at that visit. RX 3. Petitioner testified that he continued to work and his back and leg pain worsened.

Petitioner saw Dr. Webb again on 6/5/07 and the visit records document complaints of right-sided hip pain and left shoulder pain. RX 3. Dr. Webb noted "C/o R sided hip pain going down leg x 1 month c/o L shoulder pain post fall 4 mo ago." RX 3. Dr. Webb ordered an MRI of the left shoulder which suggested a partial tear of the supraspinatus tendon. RX 3. At the visit of 6/12/07, Dr. Webb referred Petitioner to Dr. Hudoba for medical treatment of the left shoulder and the lumbosacral radiculopathy. RX 3.

Petitioner saw Dr. Hudoba on June 21, 2007, complaining of lower back and right lower extremity pain, as well as left shoulder discomfort. PX 2. Petitioner reports "experiencing right lower extremity and lower back pain for approximately the last 6 weeks. Initially, he mostly felt lower back and gluteal discomfort, later also radiating pain into the right leg and toes. The radiating pain occurs occasionally mainly with longer standing or bending. ... symptoms worsen especially upon sitting or driving, also with longer standing. He says it is difficult to stand up after driving because of lower back stiffness and lower extremity pain. Patient reports that he fell while walking on the sidewalk in the middle of February 2007 after which he also developed left shoulder pain..." PX 2. Dr. Hudoba recommended an MRI of the lumbar spine, lumbar injections and a left upper extremity EMG and MRI of the cervical spine to clarify his symptoms. Petitioner testified that he continued to work full duty as a driver despite Dr. Hudoba taking him off work through 6/21/07. PX 2.

The lumbar MRI showed degenerative disc disease at L4-5 and L5-S1, small central L5-S1 disc extrusion minimally indents the thecal sac with no definite nerve root compression, and mild narrowing of the bilateral L5-S1 neural foramina. PX 2. Petitioner testified that the injections to his low back under a diagnosis of lumbar radiculopathy and protruding disc, did not provide relief. Petitioner underwent an EMG for the lower extremities in September 2007 which showed

chronic right and left L5 and right S1 radiculopathy. PX 2. Petitioner received an additional lumbar injection. PX 2. Thereafter, Petitioner still had pain in his shoulder and low back so Dr. Webb referred Petitioner to Dr. Montella.

Petitioner saw Dr. Montella on 10/22/07. PX 4. Petitioner completed a patient assessment form indicating that he had "right side leg and butt pain- lower back" and left shoulder pain. Petitioner reported the onset of the problems in "Feb" and that the problem occurred when he "fell at work." PX 4. In his history, Dr. Montella noted "He had a fall at work in February 2007 and injured his left shoulder. Shortly thereafter, he developed the onset of back and radiating buttock posterior thigh and calf pain. His difficulties seem to directly resulting [sic] from this work related fall. He has been attempting to work through it full duty, full time but is having increasing severe and debilitating difficulties over the course of the day." Petitioner reported burning pain down the leg and pain with any shoulder motion overhead or behind his back. PX 4. In his assessment, Dr. Montella noted that Petitioner was "injured at work in February 2007. He injured both his shoulder and his back. His presentation is consistent with rotator cuff tear and lumbar disc herniation." Dr. Montella took Petitioner off work and sent him to physical therapy for his left shoulder and low back which he attended through April 2008. Dr. Montella took Petitioner off work from 10/23/07 through 3/16/09. During this period, Petitioner was paid TTD and followed up with Dr. Montella monthly for his left shoulder and low back. Injections to Petitioner's shoulder provided only minimal relief in April 2008.

In May 2008, Dr. Montella performed a laser disc decompression on Petitioner's low back based on the failure of conservative care. PX 4. Petitioner testified that the surgery provided him with relief of his low back pain as well as the bilateral leg pain. A tens unit was prescribed for low back pain after the surgery. Petitioner testified that the back pain went from a 9/10 to a 1.5/10 after the surgery. Petitioner continued to see Dr. Montella and on 9/8/08, Dr. Montella performed left shoulder arthroscopic surgery. The post-op diagnosis was left shoulder impingement rotator cuff injury. PX 4. Petitioner attended post op physical therapy and was off work through March 2009 when he was returned to work full duty at his own request. PX 4. Petitioner testified that he was examined at the company clinic as well and received a full release to return to driving activities. On 3/16/09, Petitioner returned to the same job and duties as a truck driver for Respondent.

Respondent sent Petitioner for an examination with Dr. Mash on 1/14/08. Dr. Mash noted the history Petitioner provided of falling at work in February 2007 and developing immediate left shoulder pain and then low back pain one week later. RX 4, p. 8. Upon exam, Dr. Mash diagnosed rotator cuff syndrome left shoulder and right sciatica. He agreed further treatment was necessary. The second exam was on 2/25/09, following Petitioner's left shoulder and low back surgeries. Petitioner reported his low back radiculopathy was gone and that he still had problems reaching over head with his left shoulder. He thought Petitioner would benefit from an FCE and work hardening. RX 4, p. 13. Subsequent to his exams of Petitioner, in August 2010, Dr. Mash reviewed records from Emery Medical Center where Petitioner was initially treated after the 2/14/07 accident, Dr. Webb and Dr. Montella. Noting the contents of these records as summarized above, and noting the differing history offered by Petitioner to Dr. Mash at the initial IME, Dr. Mash opined that Petitioner's low back problems were not casually related to the accident of 2/14/07. Specifically, Dr. Mash opined that Petitioner's low back problems treated

by Dr. Montella are "...in no way related to the injuries alleged. The medical record does not support documentation of symptomatology related to the low back until June 2007, at least four months after the onset of difficulty about the patient's left shoulder. ... The history, which the patient would provide as to the onset of low back discomfort at the time of the injury, is not supported by the documentation in the medical record, in any way." RX 5, RX 4, pp. 16-17. He further opined that Petitioner's condition was not necessarily caused by trauma but could also be caused by a combination of genetic background superimposed upon the progression of activities of daily living associated with the further chronology of aging." RX , p. 19.

Petitioner's second date of accident is May 5, 2010. Petitioner had been back at work for 13 months after his release for the first accident. On 5/5/10, Petitioner was climbing a ladder and unloading a trailer when he felt a burning sensation under his left arm. PX 8. Petitioner testified that he could not lift his arm up in the air. Accident is not at issue in this matter.

Petitioner saw Dr. Khanna for the left shoulder pain and following an MRI of the left shoulder, Dr. Khanna recommended surgery. PX 8. Dr. Khanna sent Petitioner to Dr. Giannulias but Petitioner testified that due to the long wait for an appointment, he saw Dr. Neal. Dr. Neal sent Petitioner to physical therapy between May and June 2010. His left shoulder did not improve and he was unable to lift on his own power. The MRI of 5/12/10 revealed an acute supraspinatus full-thickness tear and tendinosis and a possible labral tear. Dr. Neal noted that the prior left shoulder surgery was done arthroscopically and the rotator cuff was not addressed or repaired. Dr. Neal noted that Petitioner suffered an acute tear to the left shoulder rotator cuff at work on 5/5/10 and that his shoulder had not been the same since that accident. Dr Neal performed a second shoulder surgery on 6/29/10 with and open repair of his left rotator cuff. The post op diagnosis was left shoulder full thickness 2.5 cm rotator cuff tendon repair. PX 9. Petitioner was off work from June 2010 to September 2010 when he returned to light duty. PX 9. Petitioner testified that he was able to work light duty and complete the assigned office duty using one hand.

Petitioner also attended physical therapy while seeing Dr. Neal between September 2010 and November 2010. On 11/18/10, Dr. Neal took Petitioner off work again until such time he could return to full duty unrestricted work. Petitioner was returned to full duty work on 1/3/11. PX 9. Petitioner testified that he returned to full duty work driving the truck and making deliveries without further treatment to his left shoulder after his release from care in March 2011.

Petitioner's third uncontested accident occurred one year later on 1/13/12. On that day, Petitioner twisted his left knee while adjusting a cord between the tractor and the trailer. Petitioner testified that he went to a clinic near his home over the weekend due to knee pain. Petitioner called work on Sunday and was told to come in on Monday and to return to Dr. Khanna at the company clinic. Dr. Khanna took Petitioner off work and ordered a left knee MRI. The MRI revealed a left knee posterior medial meniscus complex tear. Dr. Khanna referred Petitioner to Dr. Giannoulias who performed a left knee partial medial meniscectomy and left knee arthroscopic extensive two compartment synovectomy on 2/17/12. The post op diagnosis was left knee partial medical meniscus tear and left knee extensive synovitis. Petitioner was kept of work and attended physical therapy after surgery. Petitioner testified that he had a good result from his left knee surgery. Petitioner returned to light duty work on 3/13/12

again doing office work. Petitioner also attended work conditioning for 10 sessions. Dr. Giannoulias returned Petitioner to full duty work on 5/1/12. PX 12.

Petitioner attended a Section 12 exam with Dr. Patari with regard to his left knee injury on 9/13/12. RX 6. Dr. Patari diagnosed a left medial meniscus tear which had resolved after surgery and determined that Petitioner was at MMI at the time of the exam. Dr. Patari was asked and did provide an AMA impairment rating of 4% of the lower left leg translated to 2% of a person as a whole. RX 6, p. 5. Dr. Patari arrived at the impairment of 4% based on a 1% assignment to the medial meniscus tear and 3% for the saphenous nerve impairment around Petitioner's incision sites. RX 6, p. 5. Using the 6th Edition Guides to the Evaluation of Permanent Impairment, Dr. Patari applied and subtracted modifiers including minimal findings on exam to arrive at 1% of the leg. RX 6, p. 6. He did not apply a modifier to the saphenous nerve injury. RX 6, p. 6.

Petitioner again returned to fully duty driving and delivery work. He has had no additional treatment for his left knee, left shoulder or low back since his releases. Currently, Petitioner's left shoulder get weak after working an 11 to 12 hour day at work. Petitioner testified to occasional throbbing in the left shoulder and problems with overhead type activities at work. Petitioner testified that he has this pain at work from 2 to 3 times per week depending on his activities. He takes Tylenol for pain. Petitioner testified that he has the same pain at home with his left shoulder. He is unable to reach up to high shelves and favors the left shoulder during activities of daily living. Petitioner has problems with reaching and extension of the left arm and is unable to lift more than 20 pounds with his arm extended. He no longer bowls or plays baseball due to problems with his left shoulder.

With regard to his low back, Petitioner testified he has problems at work sitting in the trailer and driving his truck. He has pain down his left buttock and leg in the back of the upper left thigh. Petitioner testified that this pain stars after about 15 minutes of driving and will go away when he gets up to walk. Petitioner testified that his longest driving distance is about 30 to 35 minutes and he drives short routes with 2 to 4 stops per route. Petitioner testified that he is able to lift and handle freight by hand as well as with a two wheeled dolly but normally he moves the freight by hand without problem as long as he does not have to lift "up high." Petitioner also testified that he avoids twisting in the middle of his back while at home doing home activities. He gets low back soreness with everyday activities and takes Tylenol to work through the pain.

With regard to his left knee, Petitioner testified that he favors and avoids use of the left knee. Petitioner is still able to climb ladders but tries to avoid that activity. He is not as active as he was before the accident and does not put pressure on the left knee. Petitioner is back at work fully duty and has not been back for more medical care.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law. Each of these consolidated matters is addressed in a separate Decision.

Case 10 WC 38648- DOA 5/5/10

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

The Arbitrator finds that Petitioner sustained a new and acute left shoulder injury on 5/5/10 as a result of his uncontested work related accident on that date. The Arbitrator acknowledges that Petitioner sustained a prior left shoulder injury on 2/14/07 in the form of a rotator cuff impingement. However, the left shoulder MRI taken on 5/12/10 revealed an acute supraspinatus full-thickness tear and tendinosis and a possible labral tear. Dr. Neal noted that the prior left shoulder surgery was done arthroscopically and the rotator cuff was not addressed or repaired. Dr. Neal noted that Petitioner suffered an acute tear to the left shoulder rotator cuff at work on 5/5/10 and that his shoulder had not been the same since that accident. Dr Neal performed a second shoulder surgery on 6/29/10 with an open repair of his left rotator cuff. The post op diagnosis was left shoulder full thickness 2.5 cm rotator cuff tendon repair. PX 9.

Based on the record as a whole, the Arbitrator finds that Petitioner's left shoulder rotator cuff tear is causally connected to the uncontested accident at work on 5/5/10. No evidence to the contrary was presented.

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

Petitioner underwent open surgical repair of his torn left rotator cuff. He attended lengthy post surgical physical therapy prior to returning to full duty work 1/3/11. Petitioner testified that he returned to full duty work driving the truck and making deliveries without further treatment to his left shoulder after his release from care in March 2011. Currently, Petitioner's left shoulder gets weak after working an 11 to 12 hour day at work. Petitioner testified to occasional throbbing in the left shoulder and problems with overhead type activities at work. Petitioner testified that he has this pain at work from 2 to 3 times per week depending on his activities. He takes Tylenol for pain. Petitioner testified that he has the same pain at home with his left shoulder. He is unable to reach up to high shelves and favors the left shoulder during activities of daily living. Petitioner has problems with reaching and extension of the left arm and is unable to lift more than 20 pounds with his arm extended. He no longer bowls or plays baseball due to problems with his left shoulder.

Accordingly, the Arbitrator finds that Petitioner sustained 12.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act for the left rotator cuff injury sustained on 5/5/10.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elsa Rios,

Petitioner,

vs. NO: 13 WC 01210

Union Health Service,

15IWCC0466

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability, permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Commission finds that Petitioner failed to prove that her accident arose out of her employment with the Respondent.

Petitioner was a nursing clerk for the Respondent on October 16, 2012. On that date, she was going to the bathroom on the Respondent's property. She testified that she was leaving the stall and fixing herself when she slipped and fell. She did not touch the floor. The left hand grabbed the handicap railing and her low back struck the toilet. There was water on the floor. Her right hand hit the floor and that was what stopped her from hitting the floor. (Transcript Pgs. 14-17)

She further testified that when she pulled herself up she had pain in her lower back and right wrist. She told another nurse when she got back to her station. She then went to the Respondent's security guard, Jimmy Sanchez, and advised him. She told Sanchez that she slipped and fell in the bathroom and that there was water around the toilet. Jimmy then called maintenance and they both walked over to the bathroom where there was a bathroom closed sign

already put up. They stepped over the sign and she showed Jimmy where she fell. There was no water in front of the toilet and she testified the water had been removed. (Transcript Pgs. 18-27)

Jimmy Sanchez was called to testify and his testimony disputes that of the Petitioner. He testified that the station reported to him of the fall and he came to investigate with Petitioner at the scene of the fall. When they got to the restroom, Sanchez testified that he closed the restroom and that Petitioner was with him when it was closed. It was when he got to the scene that he called the maintenance department. He was informed by the Petitioner that she had fallen in the smaller stall. He did not find any water or leak in the smaller stall. None of the plumbing fixtures were leaking. He observed the back of Petitioner's clothing and did not notice anything. (Transcript Pgs. 93-100)

Sanchez testified that he was the one who closed the restroom. He then called maintenance on the radio and they arrived shortly after he closed the restroom. (Transcript Pgs. 105-112)

The Commission finds that the Petitioner's testimony was not credible. The Petitioner's complaints of pain following the alleged accident are inconsistent along with the histories given to the various doctors. Petitioner testified that her head did not strike anything but it just "jerked back." She had pain in her lower back and pain in her right wrist immediately following this accident. However when she saw Union Health Service on October 16, 2012, she complained that she hit her back on the edge of the toilet but did not complain of right wrist pain. (Petitioner Exhibit 1) She saw a chiropractor, Dr. Jiminez, on October 18, 2012 and advised him that she struck her back on the toilet and was experiencing low back pain and numbness down both legs. Once again, nothing was mentioned regarding her right wrist. (Petitioner Exhibit 2) On October 23, 2012, she saw Dr. O'Keefe who diagnosed her with right hand dysthesia, back pain with left sciatica and headaches. She gave O'Keefe a history of coming out of the bathroom stall and water was leaking from the toilet. She slipped back; hit the edge of the toilet, landing on her buttocks. Petitioner testified that she did not fall down and nothing was mentioned in her testimony regarding falling on her buttocks. This is the first time any physician mention's the right hand and wrist, headaches and her neck. (Petitioner Exhibit 2)

Dr. Wehner performed an Independent Medical Examination on behalf of the Respondent on February 27, 2013.The Petitioner presented herself to the doctor leaning heavily on the left side of a cane, shaking, and moaning. She told the Doctor she cannot walk on her heel and toes. Although her range of motion of the neck was full, she moaned, grimaced, and closed her eyes during the range of motion tests. The Doctor reviewed the X-rays and found no evidence of a fractured rib and her review of the records revealed that her right wrist and neck were not initially documented. The Doctor concluded that Petitioner's neck complaints and right wrist complaints had nothing to do with the alleged accident at work. (Respondent Exhibit 6)

The Commission also finds that Petitioner's testimony regarding the actual accident is not credible. Mr. Sanchez credibly testified that when Petitioner told him she had fallen in the bathroom they immediately returned to the bathroom and Mr. Sanchez put up a sign advising the bathroom was closed. He then inspected the scene and found no water near the toilet where Petitioner fell and noticed no water on the back of her clothes. He then called maintenance by

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radio. The Petitioner was not credible when she testified that when she and Sanchez went to the bathroom the water was removed and the bathroom sign was already set up.

The Commission finds that the Petitioner failed to prove her accident arose out of her employment with the Respondent. Petitioner fell when she went to the bathroom and was getting up from the toilet and "fixing" her pants. This activity was not in furtherance of her job for the Respondent and had nothing to do with the maintenance of the property.

Compensation is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION the Arbitrator's decision is reversed and that the Petitioner failed to prove that her accident arose out of the course and scope of her employment.

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

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

DATED: JUN 19 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 4/21/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIOS, ELSA
Employee/Petitioner

Case# **13WC001210**

UNION HEALTH SERVICE
Employer/Respondent

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On 3/14/2014, 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 0.08% 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:

4239 THE LAW OFFICES OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

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STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ELSA RIOS
Employee/Petitioner

v.

Union Health Services
Employer/Respondent

Case # 13 WC 1210

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 30, 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 _____

FINDINGS

On **October 16, 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 **$19,500.00**; the average weekly wage was **$375.00**.

On the date of accident, Petitioner was **19** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$220.00** week for **20 3/7** weeks, commencing **October 18,2012** through **March 13, 2014**, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for treatment related to the back injury, including the radicular pain, numbness and tingling in her legs only, as provided in Sections 8(a) and 8.2 of the Act. Respondent is not responsible for costs of treatment related to the neck or wrist and the headaches.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of **$220.00** /week for**35** weeks, because the injuries sustained caused the **7%** 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.

Deborah L. Simpson
Signature of Arbitrator

March 13, 2014
Date

MAR 14 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elsa Rios,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 1210**
	)	
Union Health Service,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 16, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $19,500.00, and that her average weekly wage was $375.00.

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) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services provided to the Petitioner reasonable and necessary medical services; and (4) What is the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner Elsa Rios testified that as of October 16, 2012, she had been employed with Respondent Union Health Service as a nursing clerk since May 7, 2012. Respondent is a medical clinic that serves union employees in regard to work-related injuries.

Petitioner testified that at approximately 10:00 a.m. on October 16, 2012, she went to use the bathroom. In the bathroom, there are two stalls – one small stall and one larger handicapped-accessible stall. Petitioner was using the smaller stall. After using the facilities, Petitioner stood up and fixed her shirt. She then stepped forward to open the stall door. As she stepped, her foot slipped in water, and she fell backwards. She testified that as she fell, she grabbed the handrail on her left side with her left hand, but was unable to prevent her body from falling. Her mid-back struck the toilet bowl, and she fell to her

right side, putting out her right hand to break her fall. After the fall, she ended up with her body propped against the toilet bowl. She pulled herself upright and noticed that there was water on the floor in front of the toilet.

Petitioner felt immediate pain to her lower back. Petitioner testified that she also had pain in her right wrist, but that it was not as bad as her lower back. She testified that after she composed herself for a few minutes, she left the bathroom and returned to her work area. She reported her injury to two nurses and a clerk on duty at her station. She later identified one of the nurses as Lucille McMurtry. McMurtry told her to report the injury to security and then report to the nurses' station for triage and treatment.

Petitioner testified that she then walked to the security station, which was by the front door; this was about 15 minutes after the accident. The security guard on duty was Jimmy Sanchez. Petitioner testified that she told Sanchez what had happened, and Sanchez immediately used his radio to call maintenance to close off the bathroom. Sanchez then asked Petitioner to accompany him to the bathroom and show him what happened.

Petitioner testified that by the time they got to the bathroom, it was already closed off with floor stands indicating caution and wet floor. Petitioner showed Sanchez where she fell, but there was no longer any water in front of the toilet.

Petitioner then reported to the triage station. According to the records (RX4), Petitioner arrived at 10:27 a.m., and reported that she fell on a slippery floor in the bathroom and hit her upper thoracic area on the toilet seat. She reported a pain intensity of 7/10. Petitioner was later examined by Dr. Adamji. She reported the pain as increasing over time and radiating into her tailbone. Examination revealed a patch of hyperemic tender skin in Petitioner's mid-back. Dr. Adamji prescribed medication and kept Petitioner off work until October 19, 2012.

Before the next visit, Petitioner saw Miguel Jiminez, a chiropractor, at Central Medical Specialists on October 18, 2012. She gave essentially the same history. (PX2). Dr. Jiminez prescribed physical therapy three times a week, recommended that she continue to take her medications, and kept her off work for one week. (PX2). Petitioner also had an x-ray of her thoracic and lumbar spine on the same day at Union Health Service, which was normal. (RX4).

Petitioner returned to Union Health Service on October 19, 2012. (RX4). Petitioner complained of pain and swelling in her mid-back, with associated numbness and tingling. On examination, she has tenderness and muscle spasm in her mid-back. After a review of the x-rays, by the orthopedic consultant Dr. Jachimowicz, she was diagnosed with a severe sprain, advised to continue with medications and released to return to work as of October 29, 2012. (RX4).

Petitioner next saw Dr. James O'Keefe, the orthopedic specialist at Central Medical Specialists on October 23, 2012. (PX2). Petitioner was complaining of radiating symptoms, right greater than left. At this time she also complained of pain in her right hand and headaches. After an examination, Dr. O'Keefe recommended that Petitioner remain off work, continue with medications and physical therapy.

Petitioner was sent for a lumbar MRI at Advantage MRI, which was performed on November 5, 2012. It was normal. She was never sent for a thoracic MRI.

Petitioner returned to Dr. O'Keefe on November 11, 2012. (PX2). She was complaining of ongoing back pain, and worsening right hand symptoms. Dr. O'Keefe recommended she start strengthening exercises as part of her therapy, and added a TENS unit and a back brace. He kept Petitioner off work. (PX2). According to petitioner, the TENS unit did not provide any relief. (PX3)

Around this time, Petitioner discovered that she was pregnant. Her treatment was suspended. Petitioner testified that her lower back and right wrist pain remained. She saw Dr. O'Keefe on December 5th, 2012, and her course of treatment was altered to reflect her new condition.

Petitioner testified that she had a miscarriage on December 24, 2012. She was then released by her gynecologist at Union Health Service to return to physical therapy on January 3, 2013. She then returned to Dr. O'Keefe on January 8, 2013. The records reflect that Petitioner started to complain of some neck pain, radiating into both arms, right greater than left. Dr. O'Keefe took some x-rays of her cervical spine, which were negative. An MRI could not be ordered because Petitioner wears braces. Dr. O'Keefe altered Petitioner's medications, and also ordered an H-Wave machine for home use. She was kept off work.

Petitioner returned to Dr. O'Keefe on February 7, 2013, still complaining of low back pain radiating into her lower extremities and neck pain. He ordered an EMG. The EMG was performed on February 13, 2013, and showed mild L5-S1 radiculopathy. (PX2). Petitioner continued to follow up with Dr. O'Keefe, who recommended continued medication, physical therapy and use of the H-Wave unit.

Petitioner testified that the treatment helped with her hand, neck and lower back conditions, and she improved to the point where she could return to work on March 11, 2013. Petitioner testified that she did in fact return to her pre-accident job on March 11. 2013. She testified that for the first few weeks, she took it easy, and did not attempt to perform activities that were too strenuous. She was thereafter able to return to her previous level of function at her job.

Petitioner testified that her hand and neck symptoms have essentially resolved, but she continues to get pain and radiating symptoms in her lower back on a regular basis. However, her symptoms do not rise to the level that she is unable to perform her job duties or that she requires additional medical care. When she begins to feel numbness or tingling after sitting for too long she just gets up and moves around.

Respondent called Mr. Sanchez as a witness. Sanchez testified that as of the day of the accident, he had been employed by Respondent for 15 years as a security guard. Part of his job duties involves investigating accidents.

Sanchez testified that on the day of the accident, he was at the security stand, which is by the front doors to Respondent's building. He testified that he received a call on his radio that the Petitioner was injured by a fall in water in the bathroom. He went to the bathroom to meet Petitioner to investigate at about 10:45 am. He also testified that he called maintenance to come to the bathroom to address any dangerous condition.

Sanchez testified that he met Petitioner at the door of the bathroom and that he "closed the bathroom off". He then went into the bathroom with Petitioner. Petitioner pointed out where she fell, in the smaller of the two bathroom stalls. Sanchez testified that he inspected the area around the toilet and

found no water. He also testified that he did not see that Petitioner's clothing was wet. He then escorted Petitioner to triage for medical treatment.

On cross-examination, Sanchez testified that he investigated the bathroom closer to 15 minutes after the accident, and that maintenance had not arrived by the time he met Petitioner. He testified that both maintenance and he have caution and wet floor signs. Sanchez testified that he kept his by the security stand and on the day of the accident, brought them with him to the bathroom. He used these signs to close off the bathroom himself. Maintenance arrived sometime after he and Petitioner investigated the scene.

Sanchez admitted that he was testifying from memory, approximately a year after the accident, and that he reviewed the incident report he prepared in preparation for his testimony. He further testified that he prepared the report right after his investigation on the day of the accident.

Respondent offered Sanchez' report into evidence. (RX3). In the report, Sanchez identified the time of the accident as 10:15 am. He indicates that Petitioner reported slipping on some water, where she hit her back on the toilet. He indicated that he immediately close[d] (sic) the restroom and ask[ed] (sic) her to show me where she fell. There was no evidence of any water on the floor of the small stall next to the handicap stall and that Petitioner's clothes were dry. Petitioner was not asked to review or sign the report.

Respondent also sent Petitioner for a Section 12 examination with Dr. Julie Wehner on February 27, 2013. (RX6). Dr. Wehner opined that Petitioner suffered a back contusion as a result of a fall at work. Dr. Wehner also opined that her neck and right had symptoms were not causally related to her accident. Further, Dr. Wehner opined that the only reasonable treatment was a back x-ray, anti-inflammatory medications and decreased activity for 2-4 weeks, and that all other treatment received by Petitioner was not reasonable. Dr. Wehner opined that Petitioner could return to work full duty, but did not give any opinion regarding Petitioner's work capacity prior to the examination. Dr. Wehner reviewed the MRI report and film of 11/5/12, but did not review the EMG.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course and scope of her employment with Respondent and the date of the accident, the Arbitrator makes the following conclusions of law:

Petitioner claims that she fell at work as a result of a condition that caused a greater risk to her than members of the general public, i.e., that water in the bathroom exposed her to a greater risk and she

fell. Respondent claims that there was no water where Petitioner fell, and therefore her injury is not work-related by operation of law.

Petitioner testified that she fell as a result of water in front of the toilet. Most of her testimony is supported by all of the medical records, as well as partially supported by the incident report prepared by Sanchez.

In contrast, Respondent offered the testimony and report of Sanchez, where he wrote in his report and testified that he investigated the area where Petitioner fell immediately after the accident and did not find water.

Petitioner agrees that there was no water when she went with Sanchez to investigate the area where the accident occurred. However, Petitioner claims that by the time they arrived, the bathroom had already been closed off by maintenance, called in by Sanchez to close off the bathroom. Sanchez claims that he went immediately to the bathroom after he was informed of the accident, that he met Petitioner there, and that the bathroom had not yet been closed off and that he closed it off himself.

Petitioner is more credible than Sanchez on this point. Sanchez originally testified that he went with Petitioner to the bathroom at 10:45 am, which would have been 30 to 45 minutes after the accident and 17 minutes after the Petitioner reported to the clinic for medical treatment according to the triage report. After reviewing his report, where the time of accident is listed as 10:15 am, he altered his testimony.

Further, the report itself does not appear to be accurate about the time of accident. Petitioner testified the accident happened shortly after 10:00 a.m. The triage report shows Petitioner arriving at the station at 10:27, and reporting that she fell 20 minutes prior.

Sanchez' report lists the time of the accident as 10:15 a.m. Sanchez testified that sometime after the accident occurred, he was notified on his radio of the accident. He then personally went and closed off the bathroom to investigate. After the investigation, he escorted Petitioner to triage. The intake note from triage shows the Petitioner arriving at 10:27 a.m. It is not likely that all of these events happened in the span of 12 minutes. Either his report or his testimony is inaccurate.

Petitioner's sequence of events is more likely. Therefore, it is also more likely that when Sanchez indicated he "closed off the bathroom", he did not do it personally, but rather by calling it in to maintenance, and who arrived before he did. Further, it is not credible that the job of physically closing off the bathroom falls to the security guard and not maintenance, and that they both have caution signs for this purpose, and that Sanchez keeps these signs at the security podium. These signs are commonly kept with maintenance supplies.

For these reasons, the Arbitrator finds Petitioner more credible than Sanchez on the issue of accident, and further finds that Petitioner proved an accident occurred that arose out of and in the course and scope of employment.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

Petitioner claims that she suffered a thoracic and lumbar injury as a result of her back hitting the toilet. The lumbar injury also resulted in radicular symptoms down her right leg greater than the left. Petitioner also claims that she suffered headaches and a neck strain from the fall, and that she injured her right wrist when she stretched out her arm to brace her fall.

Petitioner offers support in the medical records. When Petitioner was initially treating at Union Health Service, she was primarily complaining of pain in her lower back. She was eventually diagnosed with a severe contusion to her thoracic region.

While under the care and treatment of Miguel Jiminez and Dr. O'Keefe, Petitioner again initially reported mid and lower back pain, radiating into her right leg. On October 23, 2012, one week after the accident, the record indicates she began complaining of pain in her right hand. The MRI of her lumbar spine was normal, but she did have a positive EMG for L5-S1 radiculopathy, which correlated to her complaints of pain radiating into her right leg. Her treatment was on hiatus during her pregnancy, but when she returned to treatment around January 8, 2013, she continued to complain of lower back pain with radiating symptoms. At this time she began complaining of cervical symptoms as well including the headaches.

Petitioner's cervical and right wrist complaints were minor in comparison to her back complaints, and appeared to resolve with conservative treatment. Her lumbar complaints improved to the point that she could return to work, but they continue to cause her pain and discomfort on a daily basis.

In contrast, Respondent offered the opinions of their Section 12 examiner Dr. Julie Wehner. Dr. Wehner found that Petitioner suffered no more than a back contusion, that x-rays and 2-4 weeks of therapy and work restrictions was appropriate, and that any other treatment was not related. She further found that Petitioner's hand, cervical complaints and headaches were not related to the accident, presumably due to the fact that Petitioner's complaints with her hand do not appear in the medical records until October 23, 2012, and her cervical complaints not until January 8, 2013.

Dr. Wehner's opinions regarding the nature and extent of Petitioner's back injury are not based upon the entirety of the medical records. She simply dismisses Petitioner's ongoing radicular complaints. She did not even review the EMG, which only leaves Dr. O'Keefe's interpretation that they support Petitioner's complaints.

As to Petitioner's right wrist complaints, Dr. Wehner has a basis to form the opinion that these complains are not related to the fall. Petitioner testified that she had wrist pain from the day of the accident however, those complaints do not appear in the medical records until Petitioner seeks a second opinion at Central Medical Specialists on October 23, 2012, one week after the accident and four days after Petitioner has been told she could return to work full duty on October 19, 2012, by the doctor at Union Health Services. There is reason to believe that Petitioner is not credible about these complaints.

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As to Petitioner's cervical and headache complains, at the hearing the Petitioner testified that her head snapped back as she fell on the day of the accident, and that her headaches and neck pain started then, but that her back was much more painful. It does not make sense that Petitioner would complain of the back pain, radiating leg pain and wrist pain within one month of the injury, but not of the headaches until nearly three months later. Comparatively, these issues were minor. The Arbitrator cannot find that the complaints regarding the headaches and her wrist are causally related to her work injury.

Further supporting Petitioner's credibility regarding her complaints with respect to her low back and leg issues is the fact that she responded to medical treatment, and was able to return to her pre-accident position with Respondent without restriction. If not for the interruption in treatment created by Petitioner's pregnancy, presumably she would have been able to return sooner.

For these reasons, the Arbitrator finds Petitioner and Dr. O'Keefe more credible than Dr. Wehner with respect to the back, low back and radiating pain, tingling and numbness in her legs. The Arbitrator further finds that Petitioner current state of ill-being is causally related to her work injury.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

Based upon the foregoing discussion, The Arbitrator finds that the treatment received by Petitioner was reasonable and necessary, and related to her work injury as it pertains to her back, low back and legs.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

Based upon the foregoing discussion, the Arbitrator finds Petitioner's alleged period of temporary total disability, from October 18, 2012 to March 10, 2013, representing 20 3/7 weeks to be supported by the record.

In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusions of law:

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: Neither Petitioner nor Respondent presented an AMA Impairment Rating. Based on the failure to submit an AMA Impairment Rating the Arbitrator cannot consider this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a nursing clerk, who checks patients in and out of the clinic, handles paper work, schedules appointments and whatever other clerking duties that are required. She worked an eight hour shift beginning at 7:30 am and ending at 3:30 pm.

Petitioner testified that she continues to work at the same job that she had before her injury.

3. ***Age of the employee at the time of the injury***: Petitioner was 19 years old at the time of her accident. There is no evidence that Petitioner's age impacted her injury or created any permanent disability.

4. ***Employee's future earning capacity***: Petitioner testified that she continues to work at the same job that she had prior to the injury. That she still experiences some minor symptoms from time to time, but nothing that prevents her from doing her job.

Petitioner did not testify to any diminution of his earnings since this accident. There is no evidence of disability due to this factor.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained an injury to her back, thoracic and lumbar area with radicular numbness and tingling in her legs, the right more problematic than the left.

Based upon the foregoing discussion, the Arbitrator finds that Petitioner suffered 7% loss of use of a man as a whole as a result of the injury. Given the nature of the injury the Petitioner suffered to her back following the October 16, 2012, incident, she is entitled to have and receive from the Respondent compensation for 7% loss of use of the man as a whole, or 35 weeks at a weekly PPD rate of $220.00 / per week.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$220.00/week** for **35** weeks, because the injuries sustained caused the **7%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $220.00 / week for 20 3/7 weeks commencing October 18, 2012 through March 10, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received for her lower back and legs, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act.

Respondent is not liable for any treatment related to complaints regarding the neck, wrist or headaches.

Deborah L. Simpson
Signature of Arbitrator

3/13/14
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENNIS FRETTS,

Petitioner,

15IWCC0467

vs.

NO: 09 WC 16718
09 WC 26492

ABF FREIGHT SYSTEMS, INC.,

Respondent.

DECISION AND OPINION ON REMAND

These causes come before the Commission pursuant to Order of the Circuit Court of Cook County, Law Division Tax and Miscellaneous Remedies Section, entered September 30, 2014, in consolidated cases 14 L 050189 and 14 L 050277.

Petitioner appealed the November 08, 2012 Decision of Arbitrator Thompson-Smith, in consolidated claims 09 WC 16718 and 09 WC 26492, finding that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on December 01, 2007 and May 08, 2009, that Petitioner's condition of ill-being prior to May 08, 2009 was casually related to his December 01, 2007 accident, that his current condition of ill-being was causally related to his May 08, 2009 accident, that Petitioner was temporarily totally disabled for a period of 53-4/7 weeks, from December 07, 2007, through December 15, 2008, at the rate of $693.98 per week, that Petitioner was temporarily totally disabled for a period of 54-2/7 weeks, from May 12, 2009, through May 25, 2010, at the rate of $841.77 per week, under Section 8(b), that Respondent shall pay the sum of $17,683.48 or the balance of expenses for necessary medical services as provided in Section 8(a), and that Respondent shall pay Petitioner permanent partial disability benefits of $624.58 per week for 63.25 weeks because the injuries sustained caused 25% loss of use of the right arm as provided in Section 8(e) of the Act, or 12.65% loss of use of the whole person as provided in Section 8(d)2 of the Act.

15IWCC0467

The issues raised by the Petitioner on Review before the Commission were nature and extent of permanent disability, penalties and attorneys' fees, maintenance benefits, and vocational rehabilitation. The Commission, in a January 23, 2014 Decision, clarified and corrected the Decision of the Arbitrator, and otherwise affirmed and adopted the Decision. Petitioner appealed the Commission's Decision and Opinion on Review.

In a September 30, 2014 Order, the Circuit Court of Cook County affirmed the Commission's Decision in part and reversed in part, and remanded the matter to the Commission to address vocational rehabilitation benefits. The Court noted that on appeal Petitioner/Plaintiff argued that he is entitled to vocational rehabilitation benefits, as well as penalties and attorneys' fees, both of which were denied by the Commission. The Court affirmed the Commission's denial of an award of penalties and attorneys' fees, finding support for the Commission's finding that Respondent/Defendant did not act unreasonably in the decision to delay payment for Petitioner/Plaintiff. However, the Court, under an analysis of National Tea v. Industrial Commission, 97 Ill.2d 424 (1983), concluded the record provided evidence that Petitioner's injury caused a reduction in earning power and that rehabilitation would increase his earning capacity.

Pursuant to the Circuit Court's Order, and upon receipt of the record of proceedings in this matter, the Commission hereby vacates the prior permanent partial disability award under Section 8(d)2, addresses vocational rehabilitation benefits, finds that Petitioner is entitled to vocational rehabilitation and maintenance benefits under Section 8(a) of the Act, and remands this matter 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)..

With regard to the issue of vocational rehabilitation, the Commission finds Petitioner is entitled to a vocational assessment pursuant to Section 7110.10 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission and National Tea. Section 8(a) of the Act requires the respondent to pay for the "physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a). Section 7110.10 of the Rules requires the parties to work together to prepare a written assessment of the course of medical care, and, if appropriate, rehabilitation required to return the injured worker to employment when (as here) it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which she was engaged at the time of her injury or when the period of total incapacity for work exceeds 120 continuous days, whichever comes first. Petitioner has sustained an injury which has rendered him unable to return to work for Respondent. Petitioner has looked for work but to no avail. Petitioner's Exhibit No. 17, the job searches, demonstrates he has applied to approximately nine to fifteen jobs per week since June of 2010. (PX17). David Patsavas, a certified rehabilitation counselor, testified that he met with Petitioner at Petitioner's attorney's request, conducted an interview, reviewed medical records, and obtained background and work restriction information. Patsavas testified that Petitioner would be able to return to work earning $10.00 to $15.00 per hour, without direct job placement and/or statistical analysis. (PX16, T3-6). Patsavas issued an Initial Vocational Assessment Report dated August 13, 2010, and opined that based upon

Petitioner's "overall transferable skills, prior work history, completion of a high school diploma, and being released to work by his treating physician," that Petitioner was a candidate for vocational rehabilitation services, including job readiness and job seeking skills through a certified rehabilitation consultant, and that these services would be beneficial to return Petitioner back to gainful employment. Patsavas opined that while Petitioner's potential earnings at the time of his assessment were $10.00 to $15.00 per hour, this was a significant reduction in his earnings compared to his prior earnings of $1,000.00 per week while employed by Respondent. (PX16). The Commission finds that under these circumstances, that under National Tea, Petitioner's work related injury caused a reduction in his earnings, that there is evidence vocational rehabilitation will increase his earning capacity, and therefore a vocational assessment is in order.

With regard to the issue of maintenance, a review of the record reflects that on May 25, 2010, Petitioner's treating surgeon, Dr. Anthony Romeo, discharged him from care at maximum medical improvement, at which time he was provided with the following permanent restrictions: "medium-duty capacity from floor to waist, light-medium from waist to shoulder and light-duty capacity above shoulder level, which means from floor to waist he has a maximum lift of 50 pounds, from waist to shoulder, a maximum lift of 35 pounds and above shoulder maximum lift of 20 pounds." (PX6). Petitioner testified that following his release from Dr. Romeo, he was advised by Respondent that he could not return to work for them based on his permanent work restrictions. (T162-164). Petitioner further testified he attempted to obtain gainful employment following his release with restrictions, searching for work every week in person or on the phone, without the offer of assistance from Respondent, and that he has been unsuccessful in his job search efforts through the date of hearing. (T59-61).

Petitioner testified that following his release with permanent work restrictions he attempted to return to work, including driving a flatbed truck down to Louisiana for Havner Enterprises, but shoulder bothered him by the time he arrived back from that trip and he realized he was not going to be able to do that kind of work. Petitioner testified he also made one other trip for Havner, driving a pickup truck with a flatbed trailer, but that the same thing happened with regard to his shoulder bothering him too much from the bouncing around in the truck and constant shifting with his right hand hurt. Petitioner testified that based upon those two attempts to return to work he did not feel he could return to work as a driver. Petitioner testified that the total number of days he attempted to return to work as a truck driver was three days. (T36-41).

Taking into consideration the three attempts Petitioner made at returning to work, the Commission finds that Petitioner is entitled to 116-5/7 weeks of maintenance benefits under Section 8(a) for the periods of May 26, 2010 through July 01, 2011, July 03, 2011 through August 10, 2011, August 14, 2011 through September 25, 2011, and September 30, 2011 through the date of hearing, August 27, 2012, at the rate of $841.77 per week.

15IWCC0467

IT IS THEREFORE ORDERED BY THE COMMISSION that the prior Decision on Review filed January 23, 2014 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 08, 2012, as modified herein, is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $693.98 per week for a period of 53-4/7 weeks, for the period of December 7, 2007 through December 15, 2008, and the sum of $841.77 per week for a period of 54-2/7 weeks, for the period of May 12, 2009 through May 25, 2010, 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 $841.77 per week for a period of May 26, 2010 through August 27, 2012, the date of hearing, a period of 117-6/7 weeks, that being the period of maintenance benefits under § 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings consistent with this Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's prior award of the sum of $624.58 per week for a period of 63.25 weeks, representing 25% loss of use of the right arm under Section 8(e) or 12.65% loss of use of the person as a whole under §8(d)2 of the Act, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $17,683.48 for medical expenses under §8(a) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury, including Respondent's payment of $98,158.06 for temporary total disability benefits paid, $7,045.68 for temporary partial disability benefits paid, and $10,512.60 for a permanent partial disability advance.

15IWCC0467

IT IS FURTHER ORDERED BY THE COMMISSION that the matter is remanded to the Arbitrator for a determination of permanent disability award consistent with our decision, which is interlocutory and not immediately appealable.

DATED: JUN 19 2015
KWL/kmt
R- 06/15/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAN PERKINS,

Petitioner,

15IWCC0468

vs.

NO: 09 WC 044791

TURNER INDUSTRIES GROUP,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both parties herein and notice given to all parties, the Commission, after considering the issues of medical expenses, TTD, PPD penalties and fees, and evidentiary rulings and being advised of the facts and law, modifies the Second Corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Second Corrected Decision of the Arbitrator, which is attached hereto and made a part hereof.

Appearing before the Commission on May 5, 2015, the parties stipulated that the Order within the Second Corrected Decision of the Arbitrator erroneously gave Respondent credit in the amount of $255,199.31 for benefits paid to Petitioner under Section 8(b) of the Act. The parties agree that the proper amount of the credit should have been $235,199.31. The Commission, therefore, modifies the Second Corrected Decision of the Arbitrator to reflect this.

Modifying the credit Respondent is to receive for benefits paid to Petitioner under Section 8(b) of the Act necessitates that the Second Corrected Decision of the Arbitrator be modified further as to properly reflect the total amount of credit Respondent is to receive. Respondent, in addition to paying Petitioner benefits under Section 8(b), also paid Petitioner $18,836.79 in maintenance benefits as provided in Section 8(a) of the Act. Thus, the total amount Respondent paid to Petitioner under Sections 8(b) and 8(a) is $254,036.10. It is this total amount for which Respondent receives credit.

The parties also stipulated before the Commission on May 5, 2015, that Petitioner's motion under Section 19(f) is withdrawn and shall have no effect. Said motion was filed to cure the defect in the Second Corrected Decision of the Arbitrator. The Commission addressed this in the paragraphs immediately above.

15IWCC0468

The Commission affirms and adopts all other findings contained within the Second Corrected Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,243.00 per week for a period of 73.72 weeks, commencing November 25, 2009, through April 24, 2011, 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 $1,243.00 per week for a period of 89.29 weeks, commencing April 25, 2011, through January 8, 2013, that being the period of time Petitioner was entitled to maintenance benefits as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,243.00 per week for life, commencing January 9, 2013, as provided in §8(f) of the Act, for the reason that the injuries sustained caused permanent total disability for work.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $19,284.23 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 in the amount of $254,036.10 for amounts paid to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner penalties of $9,365.14, as provided in §16 of the Act and $15,608.57, as provided in §19(k) 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 §8(g) of the Act.

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

DATED: JUN 19 2015
KWL/mav
O: 05/05/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
SECOND CORRECTED

15IWCC0468

PERKINS, DAN
Employee/Petitioner

Case# 09WC044791

TURNER INDUSTRIES GROUP
Employer/Respondent

On 6/4/2014, 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:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
2nd CORRECTED

15IWCC0468

Dan Perkins
Employee/Petitioner

Case # 09 WC 44791

v.

Consolidated cases: _____

Turner Industries Group
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, 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. ☐ Did an accident occur that arose out of and in the course of 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 **Evidentiary rulings, Vocational Rehabilitation**

FINDINGS

On **September 24, 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 **$115,409.84**; the average weekly wage was **$2,219.42**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$235,199.31** for TTD, **$0** for TPD, **$18,836.79** for maintenance, and **$0** for other benefits, for a total credit of **$254,036.10**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,243.00**/week for **73.72** weeks, commencing **November 25, 2009 through April 24, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$1,243.00**/week for **89.29** weeks, commencing **April 25, 2011 through January 8, 2013**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$255,199.31** for TTD, **$0** for TPD, **$18,836.79** for maintenance, and **$0** for other benefits, for a total credit of **$274,036.10**.

Respondent shall pay reasonable and necessary medical services of **$19,284.23**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$1,243.00**/week for life, commencing **January 9, 2013**, 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.

Respondent shall pay to Petitioner penalties of **$9,365.14**, as provided in Section 16 of the Act; **$15,608.57**, as provided in Section 19(k) of the Act; and **$0**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

6/2/14
Date

ICArbDec p. 2

JUN 4 - 2014

STATEMENT OF FACTS

On September 24, 2009, Petitioner, Dan Perkins, was employed as a journeyman carpenter by Respondent, Turner Industries Group.

Petitioner testified that he graduated from High School in 1978 and began work as a carpenter at the age of 20, eventually joining Local 174 in April of 1985. For 29 years prior to his date of accident, Petitioner worked as a carpenter and held no other occupation. Petitioner provided that he did not go through an apprenticeship to become a carpenter. He did not have any OSHA training and had no computer training.

Petitioner testified that as a carpenter, he worked on various types of job sites including residential, commercial and concrete jobs. Petitioner's job duties included building homes, framing, finishing, building scaffolding and building bridges. While performing his job duties, Petitioner did a lot of heavy lifting, including lifting lumber weighing up to 80 pounds and concrete forms which could weigh from 20 to 100 pounds.

Petitioner testified that on September 24, 2009, he was building scaffolding at the CITGO refinery. While he was standing on the tips of his toes, reaching upward and pushing with his right arm to pass a 40 pound metal pan to a coworker, he felt pain in his right shoulder.

On September 24, 2009, Petitioner presented to Physician's Immediate Care complaining of right shoulder pain from a lifting accident at work. Petitioner was seen by Dr. Ronald Gregus who recommended a MRI of the right shoulder. (PX 11)

Petitioner underwent a MRI of the right shoulder on September 28, 2009, which revealed 1) subscapularis tendon tear with 1 cm retraction from lesser tuberosity, 2) subscapularis muscle strain/partial tearing, and 3) dislocated intrascapular long head of the biceps tendon, medially. (PX 11)

Following the MRI, Petitioner was referred to Dr. Roderick Birnie at the University of Chicago Medical Center who diagnosed Petitioner with a right shoulder subscapularis avulsion, with long head of the biceps subluxation. Dr. Birnie recommended surgical repair of the right rotator cuff. (PX 1)

On October 1, 2009, Petitioner was seen on a referral from Dr. Gregus by Dr. John H. Lee of Adventist Health Partners. Dr. Lee examined Petitioner's right shoulder and diagnosed a subscapularis tear with dislocated biceps tendon. Dr. Lee also noted neck pain upon his examination of Petitioner. During the examination, Petitioner exhibited a positive axial compression test and tenderness in the cervical spine. Surgery was discussed and Dr. Lee recommended that Petitioner follow up in 3 to 4 days for a recheck of his shoulder and neck. (PX 6)

On November 4, 2009, Petitioner was seen by Dr. Theodore Suchy for a Section 12 Examination at the request of Respondent. Dr. Suchy opined that Petitioner could perform light duty work with no use of the right hand and recommended continued rehabilitation. Dr. Suchy further opined that there was a causal relationship between the injury Petitioner sustained on September 24, 2009 and the development of a subscapularis tear with biceps tendon dislocation. (RX 2)

On November 25, 2009, Petitioner underwent right shoulder arthroscopy with biceps tenotomy, arthrscopic subacromial decompression, open rotator cuff repair, and open biceps tenodesis performed by Dr. Birnie at

University of Chicago Medical Center. The pre and post-operative diagnoses were complete tear rotator cuff subscapularis and subluxed biceps tendon. (PX 1)

Following surgery, Petitioner underwent a course of treatment at Brightmore Physical Therapy and continued to follow up with Dr. Birnie. (PX 1, PX 13)

While following up with Dr. Birnie on February 23, 2010, it was noted that Petitioner was complaining of occasional neck pain, along with continued shoulder issues. On April 6, 2010, Dr. Birnie again noted Petitioner's complaints of neck pain which he said were present prior to the shoulder surgery, but had significantly worsened since. Dr. Birnie assessed Petitioner with trapezial myositis contributing to pain in his neck and recommended physical therapy for that pain along with continued therapy for his shoulder. (PX 1)

Petitioner continued to follow up with Dr. Birnie and began a course of work conditioning in May of 2010. (PX 1, PX 13)

On June 29, 2010, Dr. Birnie recommended a cervical MRI, which was performed on June 30, 2010. The cervical MRI revealed mild spondylosis of the cervical spine with mildly bulging discs at C3-4 through C6-7. There was also mild to moderate impingement of the neural foramina bilaterally at C5-6 and on the right at C6-7 secondary to uncovertebral joint hypertrophy. (PX 12)

Petitioner continued physical therapy through July 9, 2010. (PX 13)

On August 3, 2010, Petitioner followed up with Dr. Birnie. The doctor noted that Petitioner still had shoulder discomfort and recommended a FCE to determine permanent restrictions. (PX 1)

On September 27, 2010, Petitioner was seen by Dr. Nikhil Verma for a Section 12 examination at the request of Respondent. Dr. Verma diagnosed Petitioner with mild persistent right shoulder pain with possible cervical radiculopathy status post injury. Dr. Verma opined that the condition of Petitioner's right shoulder was causally related to his September 24, 2009 work accident. He further stated that Petitioner had reached MMI and recommended a FCE to determine Petitioner's physical capabilities. Dr. Verma did not opine on causation as it related to Petitioner's cervical spine. (RX 1)

On January 17, 2011, Petitioner underwent a FCE at ATI Physical Therapy, which indicated that Petitioner could function at the medium physical demand level. Petitioner was able to occasionally lift 53 pounds floor to chair, 28 pounds above shoulders bilaterally, 21.6 pounds with his right arm and 26.2 pounds with his left arm, and carry 37 pounds with his right arm and 66.4 pounds with his left arm. The physical therapist at ATI noted that these capabilities were below the heavy physical demands of his previous occupation as a carpenter. (PX 8)

On January 20, 2011, Petitioner was seen by Dr. Leonard Cerullo. The doctor noted that he had seen Petitioner for lower back and neck pain in October of 2008, after which he was seen by Dr. Villoch in May of 2009. Petitioner underwent lumbar and cervical injections in May of 2009 and underwent physical therapy, after which he was "fairly stable." Dr. Cerullo noted Petitioner's September 24, 2009 work injury and the neck and shoulder pain he had experienced since that time. Dr. Cerullo diagnosed possible cervical radiculopathy in addition to the shoulder injury. He recommended an EMG/NCV of the right upper extremity. (PX 4)

On March 1, 2011, Dr. Birnie released Petitioner to return to work within the restrictions outlined by the January 17, 2011 FCE. (PX 1)

On March 14, 2011, Petitioner was seen by Dr. Christine Villoch for lower back and neck pain at North Shore Pain Center. (PX 2) Dr. Villoch noted Petitioner's accident, pain in his neck the day after the accident, and continued neck pain and discomfort through the date Petitioner was seen by Dr. Villoch. (PX 2)

Petitioner testified concerning the current condition of his right arm. He explained that "just about anything" caused him pain. Petitioner provided that when he performs activities such as using a drill, sawing or mowing grass, he experiences pain in the right shoulder and neck, sometimes going down into his right arm and hand. Petitioner indicated that if he reads for too long, holding the book at 90 degrees hurts his arm. When he drives a long distance or is stuck in traffic, he has to take his right hand off the steering wheel or he will develop pain. He further explained that he drops things a lot. He stated that his right hand will simply release and will let objects go.

After being released from care with permanent restrictions, Petitioner was not offered any light duty work by Respondent.

Vocational History

In 2011, Petitioner began working with Coventry vocational services. He testified that he took a test to determine what kind of job he should look for. Petitioner then performed a job search with the help of a vocational counselor from Coventry from April 2011 through January 8, 2013. (PX 20)

Petitioner testified that he looked for jobs doing just about anything, including working at Home Depot, Lowes, and Menards as well as searching for jobs such as TV repair, armored truck delivery and appliance repair. Petitioner testified that he looked for close to 1,000 jobs. He was not successful in finding a job over this time period.

On January 10, 2013, Petitioner received a letter from a company called Catalyst RTW offering him home based employment through a company called AllFacilities. Petitioner provided that he never applied to Catalyst and was not referred to Catalyst by Coventry. Petitioner stated that nobody from Catalyst ever interviewed him, spoke with him, or evaluated him in any way before offering this work opportunity.

On March 8, 2013, Petitioner interviewed with Kelly Koelling from AllFacilities via telephone. Petitioner was offered a position at that time, doing phone surveys from home to get information from various companies. Petitioner began this activity with AllFacilities on March 25, 2013.

Petitioner was paid $9.00 per hour and was instructed on how to submit his hours to AllFacilities. After beginning his work with AllFacilities, Petitioner's TTD checks were reduced from $1,234.00 per week to $991.41 per week. Petitioner's job consisted of going down a list of phone numbers and addresses for businesses and calling each business to ask for information and confirm the locations of the business.

For each of the businesses contacted, Petitioner filled out a form showing what information he was able to receive from the company and what questions they answered. Those forms are contained in Petitioner's Exhibit 27. The goal for each employee, set by AllFacilities, was to have the employee complete at least 16 calls per hour and get at least 2 "A leads" per hour, which meant answering at least 97% of the questions on the survey forms. Whereas a "B lead" was a form with only the majority of the questions answered. Petitioner testified that he tried as hard as he could to get "A leads" and make all the calls he was required to for the day.

According to Petitioner, the first time he was contacted by anyone from AllFacilities, after the three day training period, was on May 8, 2013 when he received a call from Wendy at AllFacilities. He told her that the phone

AllFacilities had provided him was buzzing terribly and that his arm and right hand both hurt when he was sitting at the desk working. Petitioner stated that while on the phone with Wendy, Kelly Koelling broke in on the line and told him that the only thing keeping him from working was himself and that he needed to get back to work.

On May 29, 2013, Petitioner received a letter from AllFacilities criticizing his work product as he had not completed enough "A leads" and AllFacilities felt there was a discrepancy between Petitioner's daily time sheets and the phone bill record of calls made from his work line. (RX 7) Petitioner testified that his time tracking sheets were "very accurate" and that the only possible explanation for the mismatch between the sheets and the phone records was that the calls he made that were not answered may not have shown up on the phone records. In June of 2013, the forms were amended to allow Petitioner a means by which to mark when calls were not answered.

In June of 2013, Petitioner was also referred by Dr. Birnie to Dr. Gregory Hawley for treatment of post injury depression. (PX 1, PX 3) Dr. Hawley's notes from June 17, 2013 reflect that Petitioner's job for the past three months with AllFacilities had been causing him stress and made him worse. He felt that the workers' compensation carrier was trying to get him to quit and his irritability and anger had grown over the previous three months. Petitioner also suffered from a depressed mood. Petitioner was prescribed medication to assist him. (PX 3)

On July 10, 2013, Petitioner was terminated by AllFacilities, citing his failure to produce enough "A leads" and not meeting his hourly work requirements. (RX 7)

On July 15, 2013, Petitioner followed up with Dr. Hawley. The doctor noted Petitioner was upset after being terminated by AllFacilities and was continuing to experience irritability and anger. Petitioner was again prescribed medication. (PX 3)

Petitioner testified that while working for AllFacilities, he experienced a great deal of anxiety. He got more aggravated and mad as time went on. He was angry that he was made to take a job that he had never applied for. Petitioner had no desire to work out of his home. He explained that out of all of the job leads he was given while searching for employment, this at-home work was the one job that he would not have applied for himself. Petitioner also experienced anxiety, which manifested itself as a lack of sleep, scratching his hands, and chewing on his lips. Petitioner testified that he had never received psychological treatment prior to this or had any problems with anxiety prior to working for AllFacilities.

On cross-examination, Petitioner testified that while working with Coventry, he applied for about 1,000 jobs and filled out job search logs when he contacted each employer. Most of his contacts were made by phone with a little over 100 contacts made in person. Petitioner also went to the library to apply for jobs online.

Petitioner testified that while working for AllFacilities, he turned in his work hours to AllFacilities via a pre-paid envelope they provided to him. Petitioner stated that he had been contacted once by AllFacilities about not turning his sheets in a timely fashion.

Petitioner testified that the last time he looked for a job was the last job lead he was provided with by Coventry.

On re-direct examination, Petitioner explained that AllFacilities never told him he was not filling out the forms correctly for his call logs. He tried to get at least two "A leads" per hour, but stated that it was virtually impossible.

Petitioner was never informed by AllFacilities that his odds of getting a job with AllFacilities after the subsidized period of employment was less than .5%. He took the job because he knew that his workers' compensation benefits would have been reduced or stopped if he didn't.

On re-cross examination, Petitioner testified that he was still receiving benefits, but getting the reduced rate he was getting while working for AllFacilities.

Testimony of Susan Entenberg

Susan Entenberg is a certified rehabilitation counselor (CRC), which she explained is the national certification for rehabilitation counselors. According to Ms. Entenberg, job placement is helping an individual look for appropriate employment and is a form of vocational rehabilitation. Ms. Entenberg explained that there is a code of ethics that applies to vocational rehabilitation counselors and it is contained in Petitioner's Exhibit 23.

In December of 2009, Petitioner met with Alan Olken from Ms. Entenberg's office, and a counselor from Coventry at the request of Petitioner's attorney. After that first meeting, Ms. Entenberg herself had met and spoken with Petitioner on numerous occasions over the years.

Ms. Entenberg drafted her first report regarding Petitioner on November 29, 2012. At that time, she reviewed medical records and Petitioner's job search through that date. At that time Petitioner had applied to over 600 jobs with only two interviews and no job offers. (PX 14) She felt that Petitioner's job search had been very diligent. Prior to Petitioner's accident, he worked as a journeyman carpenter, which is a heavy job with lots of overhead work. Based upon Petitioner's permanent restrictions, Ms. Entenberg opined that he was unable to return to that profession. Ms. Entenberg further testified that Petitioner's previous employment gave him no transferrable skills within his restrictions.

Based upon Petitioner's work experience, lack of computer skills, lack of transferrable skills, rural geographic area, and diligent yet unsuccessful job search, it was Ms. Entenberg's opinion that no stable labor market existed for him. (PX 14)

On February 18, 2013, Ms. Entenberg produced another report. That same day, she had the opportunity to speak with Renee Concolino, a CRC from Catalyst whose name appeared on the January 10, 2013 letter to the Petitioner offering him a job with AllFacilities. Ms. Entenberg's report further details information regarding the functioning of Catalyst as a company, which she received from Ms. Concolino and Tom King, a marketing representative from Catalyst. Ms. Entenberg describes Catalyst as an "insurance claims based resource" that establishes home-based telecommuting employment with a company called AllFacilities. Catalyst is paid a referral fee by the referring insurance company, then installs a telephone line into the injured person's home, also at the carrier's expense. The insurance carrier then fully subsidizes the first 400 to 750 hours of work through AllFacilities. Catalyst is paid an additional fee from the insurance carrier upon an offer of employment from AllFacilities to the injured person. (PX 15)

After reviewing the information regarding Petitioner's job offer from Catalyst, Ms. Entenberg concluded that "the job with AllFacilities is not a legitimate job offer." She noted that Petitioner had been offered this job without ever applying for it. Furthermore, the insurance carrier paid a fee of $4,500 plus expenses of set up for Petitioner to be placed in this position, in addition to paying a full subsidy of Petitioner's wages for up to the first 750 hours he worked at AllFacilities. There was no guarantee of employment after the subsidized period and no objective standards to determine Petitioner's job performance. She concluded that the job with AllFacilities was non-competitive employment and a stable labor market did not exist in the general economy within those parameters. (PX 15)

Prior to testifying in this matter, Ms. Entenberg also reviewed the depositions of Renee Wallace and Kelly Koelling. She further reviewed Petitioner's daily tracking sheets, tally sheets and call logs from his work with AllFacilities.

After reviewing the AllFacilities work information and depositions, Ms. Entenberg's opinions regarding Petitioner's employability had not changed. She further opined that the activity of a home based survey worker at AllFacilities was not a real job and that work with AllFacilities was not competitive employment. Since the work performed by Petitioner at AllFacilities was subsidized, it did not constitute competitive employment or a substantial gainful activity. There is no stable labor market with similar work. Ms. Entenberg noted that Ms. Koelling testified she was not aware of any competition performing the same work as AllFacilities. The survey taking position with AllFacilities is not skilled work.

Based upon the fact that a CRC signed the letter from Catalyst when Petitioner was offered a job with AllFacilities, Ms. Entenberg felt that Catalyst was holding itself out as a vocational rehabilitation vendor for Petitioner and that Renee Wallace from Catalyst was holding herself out as a vocational rehabilitation counselor. Ms. Entenberg had also looked at the website and promotional materials from Catalyst RTW and concluded that they hold themselves out as vocational rehabilitation providers.

When it was explained to Ms. Entenberg that approximately .4% (that is 4/10 of 1%) of the referred cases from Catalyst to AllFacilities end up as full time employees after the subsidized work period, she explained that one of the factors considered in *National Tea v. Industrial Commission* regarding the appropriateness of vocational rehabilitation is the prospect of return to work, and that a .4% employment number is miniscule and does not represent a good job prospect at all.

Ms. Entenberg concluded that Catalyst and AllFacilities are simply an insurance based resource to put people on a job "with a great possibility of failure."

On cross-examination, Ms. Entenberg pointed out that Petitioner had already had training set up to begin his activities for AllFacilities before the interview with AllFacilities had even taken place. Again, she testified that Catalyst was holding itself out as a vocational rehabilitation provider.

On redirect examination, Ms. Entenberg clarified that the work done by Petitioner with AllFacilities was not telemarketing. She further stated that she had never referred a client to Catalyst because they do not provide a legitimate service to the injured employee.

On recross-examination, Ms. Entenberg testified that Petitioner was paid by AllFacilities and that they could hire or fire him. She testified on further re-direct examination that the position with AllFacilities was not a real job, as it was completely subsidized and AllFacilities charged administration fees and fees for interviews.

Testimony of Lisa Helma

Lisa Helma is a certified rehabilitation counselor (CRC). She confirmed that CRC is the national certification for rehabilitation counselors. According to Ms. Helma, job placement is a form of vocational rehabilitation.

Ms. Helma met with Petitioner in this matter and produced a report dated February 27, 2013. Ms. Helma reviewed Petitioner's medical records, educational history, vocational history, and the records from his job search. She concluded that Petitioner could not return to his previous occupation as a carpenter. She further opined that, based upon his unsuccessful but diligent rehabilitation efforts for the 20 months prior to meeting

with Ms. Helma, in addition to his age, limited education, narrow work history, and physical restrictions, Petitioner was totally disabled from employment. Ms. Helma also reviewed information regarding Catalyst RTW and concluded that the position with Catalyst RTW was not a legitimate position as it does not exist in the normal labor market. Ms. Helma also had the opportunity to speak directly with Renee Wallace from Catalyst and review Catalyst RTW promotional materials. Ms. Helma concluded, "Given the fact that the insurance company must pay for placement, along with the first 400 to 700 hours of employment, as well as Catalyst's sales literature, it is the opinion of this consultant that Catalyst's mission is to lower the cost of insurance claims. It does not provide for a stable labor market." (PX 17)

Ms. Helma explained that Petitioner's previous work as a carpenter was heavy in some aspects of the work. Ms. Helma opined that Petitioner could not return to his previous profession as a construction carpenter within his permanent physical restrictions and that he had suffered a loss of his career.

Ms. Helma reviewed Petitioner's job search while working with Coventry and opined that Petitioner had performed a diligent job search during that time. There was no indication that Petitioner was ever non-compliant during his job search with Coventry.

After reviewing Petitioner's case, Ms. Helma found that schooling or training was not a reasonable option for Petitioner. She stated that given his situational factors, including his age and lack of work since 2009, schooling would have simply increased the time Petitioner was out of the work force and actually would make him less marketable.

After reviewing Petitioner's age, restrictions, prior education and job search, Ms. Helma opined that there was no stable labor market available to Petitioner.

Ms. Helma testified that she had personally conducted research regarding home based employment and found that while there is a stable labor market for home based work, it must be based on the individual's background and only certain fields of employment have the ability to work from home. Most home based opportunities were based in the medical or information technology fields and required certain educational degrees. Ms. Helma concluded that Petitioner was not a qualified candidate for home-based employment.

Ms. Helma reviewed the depositions from Renee Wallace and Kelly Koelling, as well as the correspondence from AllFacilities to Petitioner and daily tracking and tally sheets filled out by Petitioner for Catalyst. After reviewing the information regarding Petitioner's work with AllFacilities, Ms. Helma concluded that the home based survey associate position with AllFacilities was not a real job. She further stated that Petitioner developed no transferrable skills while at AllFacilities and that the work with AllFacilities was not competitive employment, as the position was subsidized. Ms. Helma explained that Petitioner's position at AllFacilities was not a legitimate position as it was not a position that normally exists in the labor market. Furthermore, the position at AllFacilities provided no transferrable skills, was subsidized employment, and the majority of people referred to work by Catalyst were sent to AllFacilities for this type of work. Ms. Helma's research was unable to find any other position like the one at AllFacilities. According to Ms. Helma, Catalyst RTW held themselves out as a vocational rehabilitation provider by informing Petitioner that they had found him employment and arranging training. Further, the letter from Catalyst informing Petitioner of the position with AllFacilities was signed by a CRC. (RX 1 in deposition transcript of Renee Wallace (RX 4))

Ms. Helma went on to indicate that she believed there may be ethical issues involved with placement through Catalyst RTW. She explained that Catalyst made no disclosures of possible conflicts. Also, the fees from Catalyst were to be refunded if the individual was not placed in a position. Ms. Helma explained that her company, Vocamotive, never pays an employer for placement and no employer ever pays them, so there is no

ethical issue. When presented with the proposition that .45% (less than ½ of 1%) of the referrals from Catalyst turn into full time employment with AllFacilities after the subsidized work period, Ms. Helma opined that same did not establish a stable labor market. Finally, Ms. Helma opined that the work at AllFacilities was not evidence of a stable labor market for Petitioner as there was no evidence that AllFacilities had any competition.

Ms. Helma testified that if Renee Wallace's testimony that she was not providing vocational services to Petitioner in this case was accurate, then that the individual who was directing the decisions of Catalyst RTW to return Petitioner to work would have been acting as a vocational counselor in this case. In this instance, that person would have been the insurance adjuster, if the insurance adjuster knew that by referring the file to Catalyst, Petitioner was going to be placed with AllFacilities.

Deposition Testimony of Renee Wallace – October 30, 2013

Renee Wallace is the vice-president of vocational services for Catalyst RTW. She has been with Catalyst for about 10 years and was with a company called Expediter for 12 years prior to that, where she was a vocational consultant managing a home-based employment program. She has a bachelor's degree in business and personnel management and a certification as a workers' comp professional (CWCP) from Michigan State University. The CWCP is a week long course in general workers' compensation with a test at the end to get a certification. (RX 4 @ 4-6)

Ms. Wallace manages the other vocational consultants at Catalyst, performs labor market surveys and vocational assessments and represents the company at various trade shows and functions. Ms. Wallace explained that the majority of Catalyst's work is in their home-based return to work program. Referrals for this program come from insurance companies. She provided that Petitioner was referred to Catalyst by ESIS, the insurance carrier. After receiving the referral, Catalyst reviewed Petitioner's restrictions then scheduled him for an interview with AllFacilities. (RX 4 @ 7-8)

Petitioner's attorney objected to the vocational opinions of Ms. Wallace, stating that Ms. Wallace was acting as a vocational rehabilitation counselor by scheduling an interview with AllFacilities, even though Ms. Wallace is not a certified rehabilitation counselor. Petitioner moved to strike all testimony from Ms. Wallace on the grounds that she is not qualified to render vocational opinions. (RX 4 @ 8; 11; 12-13; 16; 95)

This interview was scheduled by a vocational counselor, Renee Concolino, that was supervised by Ms. Wallace. Petitioner was not met with by anyone from Catalyst prior to scheduling the interview with AllFacilities. Ms. Wallace explained that "the purpose of the interview was to place him with AllFacilities in a home-based customer service associate position." (RX 4 @ 10-12)

Ms. Wallace provided that Petitioner was offered a position as a customer survey associate by AllFacilities. This job involves contacting businesses to verify the contact information for the company, obtain the name of a decision maker, then ask a set of survey questions. (RX 4 @ 13). She indicated this was a sedentary job, requiring less than two pounds lifting and allowing Petitioner to work from home in whatever position they choose. The rate of pay for this job is $9.00 per hour. (RX 4 @ 14-15).

Ms. Wallace testified that the job at AllFacilities is subsidized by the insurance carrier. The first 400-750 hours of the job, or 10 to 20 weeks, is subsidized by the insurance carrier. Once the individual meets the productivity standard of 16 dials per hour and two completed surveys per hour, the subsidy ends and their employment is ongoing. (RX 4 @ 15)

Petitioner was sent a letter with a job description and an application for employment at AllFacilities that he needed to fill out prior to the interview. (RX 4 @ 16) Petitioner was offered a job at AllFacilities and began training on March 19, 2013. After training, Petitioner's first full day of work was March 25, 2013. (RX 4 @ 18-19)

On April 30, 2013, a review letter was drafted regarding Petitioner's job performance in which there were discrepancies between his tally sheets and time records. Subsequently, AllFacilities terminated Petitioner. From the beginning of his work with AllFacilities through the date of his termination, Petitioner was not contacted by Catalyst and Petitioner did not contact Catalyst. (RX 4 @ 20)

Ms. Wallace went on to testify that between 5 and 10 percent of people who go through the interview process with AllFacilities complete the subsidy period and go on to continued employment with AllFacilities. After an individual has completed the subsidy period, Catalyst follows up with them from 8 to 10 weeks, then closes their file. They are not aware of what happens to those people afterward. (RX 4 @ 22-23)

According to Ms. Wallace, after an individual has worked as a survey worker for a period of time, they're given training on data entry. There are some positions within AllFacilities that could be moved on to or other jobs could be found in the general labor market. (RX 4 @ 24) The job with AllFacilities is a full time, 40 hour per week job. (RX 4 @ 26)

On cross-examination, Ms. Wallace explained that she took the 5 day workers' compensation class at Michigan State University in 2004, while she was an employee of Catalyst. The course was held somewhere in Michigan, in a hotel, other than on the campus of Michigan State and was taught by a number of instructors. According to Ms. Wallace, this class covered all aspects of workers' compensation in five days. (RX 4 @ 27-29) Ms. Wallace indicated that she is not a certified vocational rehabilitation counselor (CRC) and is not certified in the State of Illinois. (RX 4 @ 31)

Ms. Wallace testified that Dan Heit is the current owner of Catalyst RTW and was the previous president of Expediter which also does home-based employment work. She provided that Catalyst markets to workers' compensation insurance companies in the United States. They do not market themselves to the Illinois Trial Lawyers' Association or to the Workers' Compensation Lawyers' Associations in the State of Illinois. (RX 4 @ 33-36)

Ms. Wallace testified that although Catalyst's marketing materials mention that they incorporate rigorous behavior management methods, they did not incorporate any in this case. She provided that the materials also mention cognitive restructuring, but none was offered in this case. Furthermore, where the materials indicate that Catalyst offers support, Ms. Wallace testified that the letters they sent him during his work with AllFacilities constituted that support. She stated that no meeting was ever set up with Petitioner, indicating it was on him to contact Catalyst if he needed anything. (RX 4 @ 37-39)

Ms. Wallace testified that approximately 90% of Catalyst's work is with AllFacilities. Catalysts' clients are the insurance companies, self-insured companies or TPAs. Ms. Wallace stated that Catalyst holds itself out as offering labor market surveys, transferrable skills analysis, earning power assessments and job development, but none of those were offered to Petitioner. (RX 4 @ 40-41)

Ms. Wallace testified that Catalyst's literature markets that workers' compensation cases settle for less money when they are involved in the case. (RX 4 @ 44-45) Catalyst also markets that if the individual is non-cooperative, declines the offer of work or is terminated for cause they will document those facts and be available for testimony. (RX 4 @ 46, 48) Ms. Wallace stated she testifies on behalf of Catalyst from 25 to 30

times per year. (RX 4 @ 47) Ms. Wallace agreed that cases where people are otherwise unemployable are the types of cases that they work on. (RX 4 @ 51)

Ms. Wallace testified that Petitioner's phone records did not line up with his logs, leading to his termination. However, she did not have his phone records or information regarding what phone number he was placing calls from. (RX 4 @ 52-53). She did not check the phone records to see if they were in fact a mismatch with the logs. (RX 4 @ 53-54). She added that all calls made by Petitioner while working for AllFacilities were cold calls and he asked the same questions all day. (RX 4 @ 54)

Ms. Wallace agreed that part of their marketing campaign is that they can reduce the costs for workers' compensation insurance companies and that by showing that some sort of work is available, they could reduce the value of a possible permanent total case. (RX 4 @ 54-55) She stated that "We do market for those impossible cases or cases going to perm total, yes." (RX 4 @ 55)

Ms. Wallace testified that she was not familiar with the Code of Professional Ethics for rehabilitation counselors. [(RX 4 @ 55) (PX 1 – Code of Ethics, attached to RX 4)] She is not familiar with the rule that the obligation of a rehab counselor is to the client, who would be Petitioner in this case. (RX 4 @ 60) She is not familiar with any of the rules regarding ethics for vocational rehab counselors. (RX 4 @ 61) Ms. Wallace claimed that they were not hired to perform and vocational services to Petitioner, but simply to place him in a position. (RX 4 @ 64)

Ms. Wallace testified that Petitioner was referred by the workers' compensation insurance company to Catalyst on the same day that they terminated Petitioner's vocational rehabilitation through Coventry. (RX 4 @ 67-68) (Ex. 2 and 3, attached to RX 4) Ms. Wallace did not recall whether she had been informed that all vocational rehab efforts prior to the referral to Catalyst had failed or that Petitioner had applied to 902 employers prior to December 21, 2012. (RX 4 @ 69) She stated that nobody from Catalyst analyzed Petitioner's work history, verbal skills, communication skills, reading skills or tolerance for working in a home-based environment. (RX 4 @ 69-70) Ms. Wallace further indicated that she was not familiar with the Illinois Supreme Court case of *National Tea v. Industrial Commission.* (RX 4 @ 70)

Ms. Wallace estimated that in 2013, 230 cases had been referred to Catalyst by workers' compensation insurance companies. In 2012 there were 285 referrals and somewhere between 200 and 300 in 2011. (RX 4 @ 73-74) Approximately 98% of these cases are unemployed when referred to Catalyst. About 90% of these people are referred for home-based survey work. 100% of the home-based survey workers are initially subsidized by the workers' compensation insurance carrier. About 50% of the referred injured workers agree to the initial interview. Catalyst charges a fee of $4,750 whether the injured worker accepts the interview or declines it, it does not matter. (RX 4 @ 75-77) Ms. Wallace is aware that an injured worker declining an interview may give the insurance company a basis to cut that person off their benefits. (RX 4 @ 79) If the person accepts the interview, AllFacilities receives $375.00. (RX 4 @ 80) This fee to AllFacilities is paid whether the person accepts or declines the job. (RX 4 @ 81) If the individual accepts the job, there is approximately a $1,100.00 charge by Catalyst to set the individual up for work in their home. She stated that of the 90% of cases that are referred to AllFacilities by Catalyst, maybe 10% of those cases have aptitude testing, transferrable skills analysis, interest testing, or other such things done on them. Of the cases that are referred by Catalyst to AllFacilities around 5% do not receive job offers. (RX 4 @ 82- 83) If the interview has occurred by AllFacilities and no job offer is made, a portion of the $4,750 paid to Catalyst is returned, based upon how much work they had done to that date, ranging from a $3,000 to $4,000 refund to the insurance company. (RX 4 @ 83-84) If the interview is done by AllFacilities and the job is not offered, AllFacilities normally refunds the $375 they were paid as well. (RX 4 @ 84-85)

Ms. Wallace testified that the injured worker's work with AllFacilities is subsidized for the first 400 to 750 hours. (RX 4 @ 85). During the subsidy period, in addition to the subsidized wages, AllFacilities is paid a weekly $180 administration fee by the insurance company. She provided that every two weeks, the injured worker receives a paycheck from AllFacilities who then invoices Catalyst and Catalyst invoices the carrier. Catalyst pays AllFacilities the weekly subsidy for each worker up front, then bills the insurance carrier to pay them. (RX 4 @ 86-87)

Ms. Wallace testified that as of the date of the deposition, approximately 15 to 20 individuals were performing the task of a home survey worker for AllFacilities and being subsidized by a workers' compensation carrier. (RX 4 @ 89) Ms. Wallace further estimated that between 5 and 7 workers were working for AllFacilities, past their subsidy period, and past the 1,000 hours it requires to get benefits. (RX 4 @ 90)

When asked whether Petitioner receiving less money from the workers' compensation carrier in this case after he was fired by AllFacilities was a successful outcome for Catalyst RTW, Ms. Wallace stated, "One of the outcomes is that the insurance carrier can save money, yes." (RX 4 @ 95)

On re-direct examination, Ms. Wallace testified that the 10% of cases that are referred to companies other than AllFacilities are sent to charities or non-profits, depending on the individual's needs, restrictions and language barriers. Those jobs are paid. (RX 4 @ 95-96)

Ms. Wallace explained that the $180 administration fee per week charged by AllFacilities was for monitoring sessions, additional training sessions, or other additional work that needs to be done. (RX 4 @ 98)

Deposition Testimony of Kelly Koelling – October 30, 2013

Kelly Koelling is the human resource manager for AllFacilities. Ms. Koelling had been employed by AllFacilities for about one year. She holds bachelor's degrees in behavioral analysis, business from Kaplan University and a master's degree in industrial organizational psychology from Capella University. Ms. Koelling has worked in human resources for 15 to 20 years. Ms. Kaplan does employee evaluations, hiring, maintaining, overseeing hourly reports, time records, policy procedures, and benefits administration. (RX 3 @ 4-7) She provided that AllFacilities specializes in data management in the energy field by calling businesses and generating customers for energy companies. (RX 3 @ 8)

Ms. Koelling testified that there are currently 15 to 20 employees working at AllFacilities, which is located across the street from Catalyst RTW. There are ten in-house employees and 7 or 8 doing survey work at home. 90% of the at-home workers are referred there by Catalyst. (RX 3 @ 9-10)

Ms. Koelling testified that she does the monitoring and evaluations of the at-home workers. She provided that after the data is collected by at-home survey callers, the data is brought in-house where internal employees will contact individuals collected from the leads to try to strike up business for AllFacilities' energy clients. (RX 3 The at-home customer service associates are provided with call lists and call companies from those lists. (RX 3 @ 10-12)

When an individual is referred from Catalyst, Ms. Koelling reviews their application and calls them for an interview. Approximately 80% of those interviewed are offered positions. She stated that the interview and application are meant to see if the person can have a conversation, answer questions accurately, completely and cooperatively. (RX 3 @ 12-13)

After a job offer is made, the individual is scheduled for training, sent all of the materials related to their positions, payroll, and equipment and are trained via phone. The new employee is paid $9 per hour after the subsidy period. After 6 months, the pay could increase by $1 per hour, based upon performance standards. Ms. Koelling provided she is the person who does the evaluations of the work submitted, making sure they are working their hours, turning in their work and that the hours represent the time that they are actually working. Employees also receive a bi-weekly check for $125 dollars for health care. (RX 3 @ 14-16)

Ms. Koelling testified that the subsidy period at the beginning of an employee's work with AllFacilities lasts for 750 hours, or approximately 19 weeks at 40 hours per week, with no overtime. Some employees have continued working at AllFacilities past the subsidy period. Some employees have also transferred to data collection within AllFacilities. (RX 3 @ 16-17) Ms. Koelling added that she has received a call in the past for an at-home employee reference check when that employee was applying for a job with another call center. (RX 3 @ 18-19)

Ms. Koelling testified that Petitioner was referred to AllFacilities through Catalyst RTW. (RX 3 @ 20). Ms. Koelling interviewed Petitioner on March 8, 2013. (RX 3 @ 21). After the interview, Petitioner was sent payroll and job documentation and was scheduled for training, which was conducted over the phone. (RX 3 @ 22-23)

Ms. Koelling explained that when the worker makes a call, they are required to fill out a survey form. The purpose of the forms is to collect business leads for AllFacilities. The employee has the responsibility to fill out the survey form boxes during the calls, then sending the survey forms to AllFacilities. The worker also keeps a daily tally sheet of all calls made. These daily sheets are sent to Ms. Koelling. (RX 3 @ 24-29)

Ms. Koelling provided that at-home callers are expected to obtain two A-leads per hour, meaning that 97-100% of the information is completed on the survey. Phone records are used to verify that the worker is making the required calls. (RX 3 @ 30). Ms. Koelling utilizes an internal report to compare reported dials from the worker to the phone bill. The phone bill is compared to the tally sheet turned in by the employee each week. (RX 3 @ 32)

Ms. Koelling claimed that the dials reported by Petitioner's tally sheets differentiated from the phone bills by 55 to 70 off per day, which she claimed was consistent since the onset of his employment. Ms. Koelling stated she wrote Petitioner a letter addressing the issue and scheduled him for monitoring. The monitoring included listening to calls and making suggestions and tips afterward. (RX 3 @ 33-36) The bills from the phone lines get sent directly to AllFacilities. (RX 3 @ 38)

Ms. Koelling testified that after being placed on probation, Petitioner continued with his failure to meet his goal of A-leads. She ran another productivity report, which she claims showed that Petitioner was falsifying his dials, due to the variance between the phone bills and his tally sheets. Ms. Koelling then terminated Petitioner for not meeting his A-leads and not working full time hours. (RX 3 @ 38-40)

Ms. Koelling explained that 30-40% of employees have difficulty reaching their A-leads, but monitoring usually will assist them in correcting that. (RX 3 @ 44)

On cross-examination, Ms. Koelling explained that the referrals received from Catalyst are for people with some type of disability. In the year she has worked for AllFacilities, she estimated that Catalyst had referred about 50 cases to them. (RX 3 @ 49-50) The fee for an interview for home-based work from AllFacilities is $375 This fee is charged whether or not the person accepts a job with AllFacilities. She stated that AllFacilities pays to set up the equipment and phone for the at-home workers. When AllFacilities bills, they bill Catalyst, not the workers' compensation insurance company. (RX 3 @ 52-54)

Ms. Koelling provided that AllFacilities currently had 15 to 20 employees, six of whom were at-home employees. (RX 3 @ 54-55, 62) 5 other employees are management, not referred by Catalyst. Of the 5 to 9 remaining employees, 4 are office employees, making calls based off of the surveys taken by the at-home callers. (RX 3 @ 57-59) These 4 are not subsidized, but Ms. Koelling did not know if they came from Catalyst. Currently there were 3 unsubsidized home-call workers and 3 subsidized workers, all of whom were referred by Catalyst. (RX 3 @ 60-61).

Ms. Koelling explained that Petitioner's interview took 20 minutes to a half hour. She indicated that Petitioner's home environment, psychological skills, and reading skills were not tested. Ms. Koelling was not aware that money could be taken from an individual who declined an interview with her. Sha also provided that Petitioner's work experience in an indoor environment was not evaluated. (RX 3 @ 66-68)

Ms. Koelling testified that she was Petitioner's supervisor. (RX 3 @ 69). She also testified that the job of customer service associate is not advertised anywhere but Craigslist and had not been advertised at all for weeks prior to the deposition. (RX 3 @ 71)

Ms. Koelling explained that she earned her bachelor's degree in a year and a half while working. (RX 3 @ 74) Her master's degree would be from Capella University, an online university, but she had not finished it yet. (RX 3 @ 74)

Ms. Koeling indicated that approximately 80% of referrals from Catalyst who are interviewed are offered the job and 60-70% of those accept the position. (RX 3 @ 77) After the initial 750 hours of work, if the worker can prove that they have health insurance, they will receive the $125 twice a month extra to use toward that. A 401K plan with 3% matching is also offered to full time employees. No other benefits are offered. Ms. Koelling estimated that she spends 10 to 15 hours per week, out of her 40 hour work week, working with Catalyst referrals. (RX 3 @ 78-82)

Ms. Koelling testified that she was not aware of Petitioner's issues with his job that lead him to the care of a psychiatrist. She was not aware that Petitioner was placed on medication in his attempt to stay on the job. Ms. Koelling testified that was not aware of any of the litigation or medical issues involved in this or any of her cases. (RX 3 @ 82-84)

Ms. Koelling did recall a report from Petitioner about a buzzing sound in his phone, but did not recall cutting into a conversation between Petitioner and Wendy, another AllFacilities employee, and telling Petitioner that he was the only thing keeping himself from doing his job, rather than the pain in his hand, arm and shoulder that he was complaining of. (RX 3 @ 84-85) She stated that when Petitioner called to complain of the buzzing in his phone, the phone company was called to go to his house and address the buzzing. She noted Petitioner received a new phone. (RX 3 @ 89)

On re-direct examination, Ms. Koelling explained that they do not get referrals at AllFacilities exclusively from Catalyst. Ms. Koelling explained that the people who work for them that are no longer subsidized, work 40 hours per week and receive a paycheck. (RX 3 @ 91-92) She also testified that the decision to hire is not made prior to an interview. (RX 3 @ 95)

Specific Evidentiary Ruling

During the deposition of Renee Wallace, counsel for Petitioner objected to all opinions given by Ms. Wallace, stating that she was unqualified to give any vocational opinions in this matter. While the arbitrator agrees that Ms. Wallace is not qualified to render vocational opinions, Ms. Wallace did not actually testify to any vocational opinions. Rather, Ms. Wallace's testimony was limited to information regarding Catalyst, AllFacilities, and the subsidized work activities provided to Petitioner through those companies. Therefore, Petitioner's objection and movement to strike the testimony of Ms. Wallace is denied.

With respect to issue (F) Whether Petitioner's current condition of ill-being is causally related to his work accident, the Arbitrator hereby finds:

On the date of accident, September 24, 2009, Petitioner presented to Physician's Immediate Care complaining of right shoulder pain from a lifting accident at work. Petitioner was seen by Dr. Ronald Gregus who recommended a MRI of the right shoulder. Petitioner underwent the MRI of the right shoulder on September 28, 2009, which revealed 1) subscapularis tendon tear with 1 cm retraction from lesser tuberosity, 2) subscapularis muscle strain/partial tearing, and 3) dislocated intrascapular long head of the biceps tendon, medially.

Following the MRI, Petitioner was referred to Dr. Roderick Birnie at the University of Chicago Medical Center who diagnosed Petitioner with a right shoulder subscapularis avulsion, with long head of the biceps subluxation. Dr. Birnie recommended surgical repair of the right rotator cuff.

On October 1, 2009, Petitioner was seen on a referral from Dr. Gregus by Dr. John H. Lee of Adventist Health Partners. Dr. Lee examined Petitioner's right shoulder and diagnosed a subscapularis tear with dislocated biceps tendon. Dr. Lee also noted neck pain upon his examination. During the examination, Petitioner exhibited a positive axial compression test and tenderness in the cervical spine. Dr. Lee recommended that Petitioner follow up in 3 to 4 days for a recheck of his shoulder and neck.

On November 4, 2009, Petitioner was seen by Dr. Theodore Suchy for a Section 12 Examination at the request of Respondent. Dr. Suchy opined that Petitioner could perform light duty work with no use of the right hand and recommended continued rehabilitation. Dr. Suchy further opined that that there was a causal relationship between the injury Petitioner sustained on September 24, 2009 and the development of a subscapularis tear with biceps tendon dislocation.

On November 25, 2009, Petitioner underwent right shoulder arthroscopy with biceps tenotomy, arthrscopic subacromial decompression, open rotator cuff repair, and open biceps tenodesis performed by Dr. Birnie at University of Chicago Medical Center. The pre and post-operative diagnoses were "complete tear rotator cuff subscapularis and subluxed biceps tendon."

Following surgery, Petitioner underwent a course of treatment at Brightmore Physical Therapy and continued to follow up with Dr. Birnie. On February 23, 2010, Dr. Birnie noted that Petitioner was complaining of occasional neck pain, along with continued shoulder issues. On April 6, 2010, Dr. Birnie again noted Petitioner's complaints of neck pain which he said were present prior to the shoulder surgery, but had significantly worsened since. Dr. Birnie assessed Petitioner with trapezial myositis contributing to pain in his neck and recommended physical therapy for that pain along with continued therapy for his shoulder.

Petitioner continued to follow up with Dr. Birnie and began a course of work conditioning in May of 2010. On June 29, 2010, Dr. Birnie recommended a cervical MRI, which was performed on June 30, 2010. The cervical MRI revealed mild spondylosis of the cervical spine with mildly bulging discs at C3-4 through C6-7.

There was also mild to moderate impingement of the neural foramina bilaterally at C5-6 and on the right at C6-7 secondary to uncovertebral joint hypertrophy.

On August 3, 2010, Petitioner followed up with Dr. Birnie. Dr. Birnie noted that Petitioner still had shoulder discomfort and recommended a FCE to determine permanent restrictions.

On September 27, 2010, Petitioner was seen by Dr. Nikhil Verma for a Section 12 examination at the request of Respondent in this matter. Dr. Verma diagnosed Petitioner with mild persistent right shoulder pain with possible cervical radiculopathy status post injury. Dr. Verma opined that the condition of Petitioner's right shoulder was causally related to his September 24, 2009 work accident. He further stated that Petitioner had reached MMI and recommended a FCE to determine Petitioner's physical capabilities. Dr. Verma did not opine on causation as it related to Petitioner's cervical spine.

On January 17, 2011, Petitioner underwent a FCE at ATI Physical Therapy, which indicated that Petitioner could function at the medium physical demand level. Petitioner was able to occasionally lift 53 pounds floor to chair, 28 pounds above shoulders bilaterally, 21.6 pounds with his right arm and 28.2 pounds with his left arm, and carry 37 pounds with his right arm and 66.4 pounds with his left arm. The physical therapist at ATI noted that these capabilities were below the heavy physical demands of Petitioner's previous occupation as a carpenter.

On January 20, 2011, Petitioner was seen by Dr. Leonard Cerullo. The doctor noted that he had seen Petitioner for lower back and neck pain in October of 2008, after which he was seen by Dr. Villoch in May of 2009. Petitioner underwent lumbar and cervical injections in May of 2009 and underwent physical therapy, after which he was "fairly stable." Dr. Cerullo noted Petitioner's September 24, 2009 work injury and the neck and shoulder pain he had experienced since that time. Dr. Cerullo diagnosed possible cervical radiculopathy in addition to the shoulder injury. He recommended an EMG/NCV of the right upper extremity.

On March 1, 2011, Dr. Birnie released Petitioner to return to work within the restrictions outlined by the January 17, 2011 FCE.

On March 14, 20111, Petitioner was seen by Dr. Christine Villoch for lower back and neck pain at North Shore Pain Center (Petitioner is not claiming that his lower back pain is related to his work accident in this case, but that the neck pain is related). Dr. Villoch noted Petitioner's accident, pain in his neck the day after the accident, and continued neck pain and discomfort through the date Petitioner was seen by Dr. Villoch.

It is clear from the testimony of Petitioner and the medical records in this case that Petitioner had no previous issues with or medical treatment for his right shoulder. There are also no records in evidence to reflect that he had not reached a stable medical condition after his cervical treatment in May of 2009. Dr. Cerullo even notes in his January 20, 2011 record that Petitioner had become stable. However, after his September 24, 2009 work accident, Petitioner's right shoulder and cervical spine were continuously painful and required treatment. Immediately after the accident, Petitioner began treating for his injured right shoulder. Within one week of the accident, the records reflect that Petitioner was also examined for neck pain and stiffness by Dr. Lee.

There is no evidence or testimony in this case to dispute the causal connection between Petitioner's September 24, 2009 work accident and his right shoulder injury. In fact, both of Respondent's IME physicians, Dr. Verma and Dr. Suchy opined that the condition of Petitioner's right shoulder was causally related to his work accident. Also there is no evidence or testimony in this case to dispute the causal connection between the September 24, 2009 work accident and the condition of Petitioner's cervical spine. Although Petitioner had some cervical

treatment in May of 2009, Dr. Cerullo noted that Petitioner had become stable, but had an accident in September of 2009 which began the cervical pain anew.

The Arbitrator finds the testimony of Petitioner in this case regarding his medical conditions is honest and credible. After September 24, 2009, he had consistent pain and discomfort in the spine, necessitating medical treatment with Dr. Birnie, Dr. Cerullo, and Dr. Villoch, as well as diagnostic testing and physical therapy.

Respondent contends that the absence of Petitioner's previous treatment records for his cervical spine should lead to a presumption that those records were negative for Petitioner, Respondent has offered no evidence or testimony to dispute causal connection of the cervical spine in this case and has offered no evidence or testimony to cast doubt on Dr. Cerullo's notation that Petitioner had been reasonably stable after the May 2009 treatment and had cervical pain begin after the September 24, 2009 accident.

In addition to the shoulder and cervical injuries, Petitioner also sought treatment for psychological issues after beginning work with AllFacilities. The records reflect that Petitioner was referred from Dr. Birnie to Dr. Hawley, a psychiatrist, for treatment of post injury depression. Petitioner testified that he became more and more angry and frustrated while working for AllFacilities and needed to seek treatment. Dr. Hawley prescribed medication which was helpful. Dr. Hawley's Axis I Diagnosis included mood disorder, anger, alcohol abuse and pain disorder. Records indicate alcohol abuse condition has developed over the last few months. Petitioner had never sought psychological treatment before his treatment with Dr. Hawley. Respondent has offered no evidence or testimony to dispute the causal connection between Petitioner's post injury depression and his work related injury on September 24, 2009.

Therefore, based upon a review of all evidence and testimony in this case, the Arbitrator hereby finds that the current conditions of ill-being with respect to Petitioner's right shoulder and cervical spine, as well as the permanent physical restrictions associated with those injuries, are causally related to his September 24, 2009 work accident. Further, the Arbitrator finds that the psychological treatment received by Petitioner from Dr. Hawley was causally related to his September 24, 2009 work accident.

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

As detailed above, the Arbitrator has found that Petitioner's cervical spine and right shoulder current conditions of ill-being are causally related to his September 24, 2009 work injury.

Based upon the requisite causal relationship and the review of the medical records and testimony in this case, the Arbitrator further finds that all care and treatment for Petitioner's right shoulder and neck were reasonable and necessary treatment.

Therefore, the Arbitrator orders Respondent to pay outstanding medical bills as follows:

Provider	Beginning	Ending	Total Charges	Balance
Dr. Hawley	6/17/2013	8/19/2013	$465.00	$465.00

Dr. Jurak	4/25/2013	4/25/2013	$78.00	$78.00
Dr. Peter Analytis	2/4/2011	2/4/2011	$1,160.00	$1,160.00
Morris Hospital	2/4/2011	2/4/2011	$450.00	$450.00
Northshore Unversity Medical	1/20/2011	11/10/2011	$14,711.23	$14,711.23
Open MRI of Plainfield	6/30/2010	3/17/2011	$2,420.00	$2,420.00
Balance			**$19,284.23**	**$19,284.23**

The Arbitrator hereby order respondent to pay reasonable and necessary medical services of $19,284.23, as provided in Sections 8(a) and 8.2 of the Act.

With respect to (K.) What temporary total disability and maintenance benefits are in dispute, the Arbitrator hereby finds:

TTD

Following his injury on September 24, 2009, Petitioner was placed on light duty restrictions and testified that he continued working within those restrictions for Respondent through November 24, 2009. On November 25, 2009, Petitioner underwent right shoulder surgery and was placed on an off work status by his treating physician, Dr. Birnie. On December 8, 2009, Petitioner was cleared by Dr. Birnie to return to work with restrictions of no pushing, pulling, lifting or overhead use of the right upper extremity. There is no evidence that Respondent offered Petitioner light duty work within those restrictions.

On May 18, 2010, Dr. Birnie amended Petitioner's restrictions to waist level lifting only, no overhead use of the right arm and no lifting over 20 pounds even at waist level. Again, there is no evidence that light duty work was offered to Petitioner within those restrictions.

Petitioner remained on those restrictions through March 1, 2011 when he was placed at MMI and discharged by Dr. Birnie within the restrictions outlined by the FCE. Those restrictions include occasionally lifting 53 pounds floor to chair, 28 pounds above shoulders bilaterally, 21.8 pounds with his right arm and 26.2 pounds with his left arm, and carrying 37 pounds with his right arm and 66.4 pounds with his left arm.

Again, Respondent failed to offer light duty work within Petitioner's permanent restrictions and on April 25, 2011, Petitioner began vocational rehabilitation with Coventry, per the vocational rehabilitation plan filed with the Workers' Compensation Commission. (PX 21)

Based upon all evidence and testimony in this case, the Arbitrator hereby finds that Petitioner was temporarily and totally disabled from November 25, 2009 through April 24, 2011, a period of 73.72 weeks, as provided in Section 8(b) of the Act.

Maintenance

From April 25, 2011 through January 8, 2013, Petitioner underwent a job search which was assisted by a vocational rehabilitation company referred by the insurance carrier, Coventry. Petitioner's job search logs during that time are contained in Petitioner's Exhibit 20. Both Susan Entenberg and Lisa Helma reviewed the job search logs and the vocational records of Coventry. They opined that Petitioner had performed a diligent job search during that period of time. Their testimony stands unrebutted regarding the job search.

The Arbitrator has reviewed the job search logs and has concluded that Petitioner's job search was diligent and appropriate.

Based upon all evidence and testimony in this case, the Arbitrator hereby finds that Petitioner was due maintenance benefits from April 25, 2011 through January 8, 2013, while he was undergoing vocational rehabilitation efforts directed by Coventry.

Respondent shall pay Petitioner maintenance benefits of $1,243.00/week for 89.29 weeks, commencing April 25, 2011 through January 8, 2013, as provided in Section 8(a) of the Act.

With respect to (L.) What is the nature and extent of Petitioner's injuries, the Arbitrator hereby finds:

On March 1, 2011, Petitioner underwent a FCE which showed that he was capable of occasionally lifting 53 pounds floor to chair, 28 pounds above shoulders bilaterally, 21.8 pounds with his right arm and 26.2 pounds with his left arm, and carrying 37 pounds with his right arm and 66.4 pounds with his left arm. Petitioner was released with permanent restrictions consistent with the FCE findings by Dr. Birnie.

There is no dispute that Petitioner has permanent physical restrictions that prevent him from returning to his usual and customary occupation as a journeyman carpenter.

The main question before the Arbitrator is whether Petitioner qualifies as an odd lot permanent total pursuant to Section 8(f) of the Act or whether he is entitled to a wage differential pursuant to Section 8(d)(1). In that light, the Arbitrator must also determine whether a stable labor market exists for Petitioner and whether the position Petitioner was placed in with AllFacilities, through Catalyst RTW, at the request of the workers' compensation insurance carrier, was a legitimate job and whether it represents a stable labor market for Petitioner.

A Petitioner can satisfy his burden of proving he is not capable of obtaining gainful employment by showing either of the following: 1) that work was not available, in other words a diligent but unsuccessful attempt to find work; or 2) that based upon his age, experience, training, and education, he is unable to perform any but the most unproductive tasks for which no stable labor market exists. *Alano v. Industrial Commission*, 282 Ill.App.3d 531, 534-5 (Ind. Comm. Div. 1996).

The burden is on the employee to initially prove that his condition is such that he is unable to perform any services for which there is a reasonably stable market. The burden then shifts to the employer to show that some kind of suitable work is regularly and continuously available. *Sterling Steel Casting Co. v. Industrial Commission*, 74 Ill.2d 273, 384 N.E.2d 1326, 1329, 24 Ill.Dec. 168 (1979).

The only vocational opinions offered in this case by either party were the opinions of Susan Entenberg and Lisa Helma, each of whom testified at trial. Both Ms. Entenberg and Ms. Helma opined that no stable labor market exists for Petitioner. Respondent has offered no vocational opinion to dispute Ms. Entenberg or Ms. Helma.

Petitioner has fulfilled both of the methods of proving odd lot disability outlined by *Alano*. Through a diligent yet unsuccessful job search and the unrebutted vocational opinions of Ms. Entenberg and Ms. Helma, Petitioner has proven that his condition is such that he is unable to perform any services for which there is a reasonably stable labor market. Therefore, the burden of proving that a stable labor market exists shifts to the employer.

Respondent in this claim relies upon the argument that a stable labor market exists for Petitioner based upon at-home activities he performed for AllFacilities.

After having reviewed all the depositions and evidence in this case, the Arbitrator concludes that Respondent has not proven a stable labor market exist for Petitioner. The Arbitrator finds Petitioner is an odd lot permanent total, and awards permanent total benefits under Section 8(f) of the act. The Arbitrator finds that the activities performed by Petitioner at All Facilities did not constitute competitive employment, did not constitute a real job, and provided Petitioner with no transferrable skills that would lead to a real job. The activities performed for AllFacilities are not part of any known sector of the United States labor market.

A review of the testimony and evidence in this case reveals that the system of referrals from a workers' compensation insurance company to Catalyst RTW and from Catalyst RTW to AllFacilities is suspect. As detailed below, the at-home work positions with AllFacilities are not competitive employment. It is clear that a referral to AllFacilities through Catalyst RTW has a nearly non-existent chance of turning into long term employment. Less than ½ of 1% of the individuals referred to AllFacilities from Catalyst in the last 3 years continue their employment with AllFacilities after their subsidized work period has ended. Catalyst's purpose in cases such as the one at bar is to assist companies in saving money on workers' compensation claims and even markets itself as providing lower workers' compensation settlements when they have been involved in a case. (RX 4 @ 44-45). Catalyst specifically markets that if an individual is non-cooperative, declines the offer of work or is terminated for cause they will document those facts and be available to testify for Respondent. (RX 4 @ 46, 48). Ms. Wallace testifies about 25 to 30 times per year, or more than twice every month. (RX 4 @ 47). A review of the testimony of Ms. Wallace and Ms. Koelling leads the Arbitrator to the conclusion that the system in place between Catalyst and AllFacilities is not a legitimate attempt to return the injured worker into the job market. Ms. Entenberg explained in her testimony that Petitioner was doomed to fail.

Ms. Helma's research revealed that Catalyst even champions itself as working with "impossible or non-existent medical release(s)" and calls itself "The Resolution Authority." Catalyst admittedly markets itself as a company that will reduce the value of insurance claims (see the *$1,000,000.00* bill attached as PX4 to the deposition of Renee Wallace, RX 4). As noted above, this does not appear to be a legitimate attempt to return the injured worker into the workforce. The activities provided for an injured worker at AllFacilities through Catalyst RTW are part of a complex scheme that does not appear to provide a real job. There is no benefit to the injured worker, based upon the credible testimony of Ms. Entenberg and Ms. Helma, the only vocational counselors who rendered opinions in this case. Through Catalyst and AllFacilities, an insurance company can pay to give short term, fully subsidized work activity to individuals for whom no real competitive stable labor market exists.

In this case, from April 25, 2011 through January 8, 2013, Petitioner searched for work assisted by a vocational counselor from Coventry. During that time Petitioner applied for hundreds of positions, as detailed in his job search logs. Both Susan Entenberg and Lisa Helma testified, after a review of Petitioner's job search logs, that Petitioner had performed a diligent job search while working with Coventry. Despite his diligent efforts, he received no job offers.

On January 8, 2013, vocational services through Coventry were unilaterally terminated by the adjuster for the workers' compensation insurance carrier involved in this case, Jaynee Stump of ESIS. Petitioner's Deposition Exhibit #2, attached to RX 4, is a letter from Coventry dated January 8, 2013, indicating that their file in this case had been closed at the request of the account (ESIS). On that same date, Ms. Stump filled out an online referral to Catalyst RTW, as documented in Petitioner's Exhibit 3, attached to RX 4.

Petitioner then received a letter from Catalyst RTW dated January 10, 2013 informing him that "home-based employment" had been identified for him within the restrictions imposed by Dr. Birnie. Although the letter included with it an application to fill out, the Arbitrator notes that training had already been scheduled and

Petitioner had already been assigned a supervisor at AllFacilities, Kelly Koelling. Of specific importance is that no vocational rehabilitation counselor referred Petitioner to Catalyst RTW. Renee Wallace from Catalyst contended in her deposition testimony that Catalyst was never performing vocational rehabilitation when they placed Petitioner with AllFacilities, even though the January 10, 2013 letter from Catalyst is countersigned by a certified vocational rehabilitation counselor and both signatories on the letter are identified as vocational counselors. (RX 4 @ 57-58; RX 7)

During their depositions in this case, Ms. Koelling from AllFacilities and Ms. Wallace from Catalyst RTW each testified regarding the arrangement between the two companies and how the job offers through AllFacilities come about. Ms. Wallace testified that Catalyst receives referrals from insurance companies, then sets up interviews with AllFacilities. The purpose of Petitioner's interview was "to place him with AllFacilities in a home-based customer service associate position." Approximately 90% of Catalyst's work is with AllFacilities. Ms. Koelling explained that the interview and application are required simply to see if the person can have a conversation, answer questions accurately, completely and cooperatively.

When a case is referred from an insurance company to Catalyst, the insurance company is charged a fee of $4,750.00 by Catalyst to set up an interview with AllFacilities. This fee is paid to Catalyst whether the individual accepts or declines the interview. AllFacilities is also paid $375.00 by the insurance company to interview the individual. However, if the injured worker is not offered a job by AllFacilities, AllFacilities refunds that $375.00 and Catalyst refunds a portion of the $4,750.00 they had been paid, which can range from a refund of $3,000 to $4,000 depending on the amount of work Catalyst had done to that date. (RX 4 @ 83-85)

When the injured worker begins their activities with AllFacilities, their work is fully subsidized by the insurance company for the first 400 to 750 hours. During that time, all wages are paid by the insurance company and AllFacilities is paid an additional administration fee of $180.00 per week. A review of the records indicates that the carrier was charged $39.00 per day by Catalyst as the "employment administration fee." Catalyst is charging $195 per week while AllFacilities is charging $180 per week. Catalyst profit is $15 per week for the "administrative fee." Bills from AllFacilities are not sent directly to the insurance company, but rather are sent to Catalyst, who obtains the payments for them from the carrier. Ms. Wallace explained that Catalyst pays AllFacilities the weekly subsidy for each referred worker up front, and then bills the insurance carrier for it. Upon reviewing the invoices from Catalyst to the workers' compensation insurance carrier in this case, the Arbitrator notes that although Petitioner was paid $9.00 per hour, Catalyst charges the insurance carrier $10.30 per hour, apparently adding another fee upon that charge to the carrier. (PX 29; PX 32). Catalyst RTW is therefore earning a profit of $1.30 per hour on top of the wages of Petitioner. This is $52.00 per week in profit for Catalyst RTW.

After the subsidy period, if the injured worker retains their employment with AllFacilities, they are paid directly by AllFacilities. However, in the years 2011, 2012 and 2013, Ms. Wallace estimated that 735 cases had been referred to Catalyst, of which 90%, or approximately 661 cases were referred by Catalyst to AllFacilities. As of the date of her deposition, Ms. Koelling explained that 3 unsubsidized workers were employed by AllFacilities that she knew had been referred by Catalyst. The Arbitrator notes that of the approximately 661 referrals from Catalyst to AllFacilities in 2011, 2012 and 2013, Ms. Koelling was aware of only 3 individuals who remained at AllFacilities past the subsidized work period and through her October 30, 2013 deposition date. Two of the three surviving employees were hired in the last 12 months prior to her deposition. This would equate to approximately .45% of the workers referred to AllFacilities by Catalyst in 2011, 2012 and 2013 who have retained employment at the unskilled, sedentary positions offered by AllFacilities. This is less than 1/2 of 1%, or less than one out of 200

After reviewing the transcripts from Ms. Wallace and Ms. Koelling's depositions, both Ms. Entenberg and Ms. Helma testified that the work offered by AllFacilities was not competitive employment. Both Ms. Entenberg and Ms. Helma cited the fact that the work was wholly subsidized. Ms. Entenberg, in her February 18, 2013 report, further noted that there was no guarantee of employment after the subsidized period and that Petitioner had never even applied with Catalyst for a job before being offered a position. In addition, Ms. Helma testified that she had performed research attempting to find another job like the one offered to Petitioner at AllFacilities, but found none. She felt that the position offered to Petitioner was not a legitimate job as it did not exist in a stable labor market. Both Ms. Entenberg and Ms. Helma also testified that Petitioner's subsidized position at AllFacilities was not a real job.

It is clear from the record that Petitioner did not apply to work for AllFacilities but rather was given a position at AllFacilities, through Catalyst, at the request of the Jaynee Stump, the workers' compensation insurance adjuster. Had the insurance company not requested and fully paid for Petitioner to be retained by AllFacilities through Catalyst, it is clear that he would never have been placed in that position. There was no competition for this position as the insurance company paid Catalyst to arrange the interview, paid AllFacilities to hold the interview, paid Petitioner's wages while at AllFacilities, paid an administration fee to AllFacilities to allow Petitioner to perform this activity, and would have gotten a refund of their initial costs if AllFacilities had not offered Petitioner work. Furthermore, the testimony of Ms. Helma and Ms. Entenberg is that positions like the one at AllFacilities do not exist in the general job market, with Ms. Helma further noting that there appears to be no competition for AllFacilities. The position with AllFacilities was wholly subsidized by the workers' compensation insurance company and was clearly not found in a competitive job market. This is not competitive or real employment.

The Arbitrator further adopts the opinions of Ms. Entenberg and Ms. Helma that Petitioner gained no transferrable skills from his work at AllFacilities. As Ms. Helma explained in her testimony, although some job market exists for at home work in certain fields, there are specific qualifications for those fields. Ms. Helma explained that fields such as vocational rehabilitation professionals and health care professionals had at home opportunities, but required qualifications that Petitioner does not possess. Ms. Helma concluded that Petitioner is not qualified for at home work. Respondent introduced a document from the U.S. Census Bureau regarding home based employment in the United States in 2010. (RX 9) However, the Arbitrator finds that information to be irrelevant in this case. The document introduced does not detail the qualifications needed and it is unclear how those general statistics apply to Petitioner's case. There is no supporting evidence suggesting the statistics have any probative value in this case. The only two vocational opinions offered in this claim, from Ms. Entenberg and Ms. Helma, concurred with one another that there is no stable labor market for Petitioner and that he gained no transferrable skills from his time at AllFacilities.

In addition, the Arbitrator concludes that Catalyst RTW held themselves out as a vocational rehabilitation vendor operating in the State of Illinois in their written communications. Specifically, the letter of January 10, 2013 which is signed by a Renee Concolino, MS, CRC and Renee Wallace, CWCP, who are collectively identified by the letter as "vocational consultants." (RX 7)

Section 8(a) of the Act states:

> Any vocational rehabilitation counselors who provide service under this Act shall have appropriate certifications which designate the counselor as qualified to render opinions relating to vocational rehabilitation. Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising a job search program, and vocational retraining including education at an accredited learning institution. The employee or employer may petition to the Commission

to decide disputes relating to vocational rehabilitation and the Commission shall resolve any such dispute, including payment of the vocational rehabilitation program by the employer.

After reviewing the evidence, the Arbitrator concludes that Catalyst RTW misrepresented themselves by holding themselves out as a vocational rehabilitation provider, when the testimony of Renee Wallace specifically denied providing vocational services to Petitioner. Rather, she testified that Catalyst was simply providing job placement services at the request of the insurance adjuster, Jaynee Stump. (RX 4 @ 57-58, 99-100) However, based upon the unrebutted testimony of both Lisa Helma and Susan Entenberg, the Arbitrator further concludes that the activity of job placement, as performed in this case by Catalyst at the request of the insurance adjuster is a form of vocational rehabilitation.

Furthermore, one can deduce that Jaynee Stump, the insurance adjuster, was attempting to perform vocational rehabilitation services when she terminated Petitioner's vocational services from Coventry and retained Catalyst to place Petitioner in at home service work. Ms. Stump and Ms. Wallace each acted as vocational rehabilitation counselors despite their lack of proper qualifications.

The Arbitrator accords little weight to the evidence that Petitioner falsified his phone call records as claim by the witness from AllFacilities, or did not complete enough "A" leads per hour. Petitioner appeared credible in his testimony. There is no suggestion anywhere in the record that at any time Petitioner behaved in an inappropriate manner. It appears that Petitioner made a good faith attempt to succeed at the activity supplied by AllFacilities, even to the point where he sought psychiatric care due to increased stress and anxiety. He performed an activity he did not want to do, and according to Lisa Helma, he was unfit to perform. Susan Entenberg testified it was doomed to fail.

The Arbitrator notes that both Susan Entenberg and Lisa Helma have indicated their concerns that vocational ethical violations may have been made in this case by Catalyst and anyone acting as a vocational counselor without proper credentials to do so. Ms. Entenberg, in her December 3, 2013 report specifically states that there were violations of the canons of ethics that apply to vocational rehabilitation counselors by Catalyst RTW in this case. She further states that if Catalyst was not providing vocational rehabilitation services in this case, then the adjuster from ESIS was providing those services. (PX 16)

The Arbitrator has serious concerns that the vocational rehabilitation code of ethics (PX 23) was breached in this matter. Because the Workers' Compensation Commission is not the appropriate forum for such an investigation, the Arbitrator recommends a referral of this matter to the appropriate review board or body to investigation apparent violations of the ethical cannons for vocational rehabilitation counselors. The consequences for Petitioner of the vocational decisions made by uncertified individuals in this case, in violation of Section 8(a) of the Act, were real and should be examined accordingly.

Based upon all evidence and testimony in the record, the Arbitrator hereby finds that Petitioner was permanently and totally disabled, pursuant to Section 8(f) of the Act, as of July 9, 2013.

With respect to (M.) Whether penalties and attorneys' fees should be imposed on Respondent, the Arbitrator hereby finds:

The Arbitrator has reviewed all records and evidence in this matter and finds that Respondent has had no reasonable basis for reducing the benefits after January 8, 2013. Petitioner should have been paid $1,243.00 per week through the date of hearing, rather than having his benefits reduced to $991.41 per week. The

withholding of such benefits was done vexatiously and solely for the purpose of delay. The withholding of these benefits was based upon a complex scheme involving Catalyst RTW, AllFacilities with no intent of providing any real chance of future employment, transferrable skills or a real job. Petitioner was systematically referred to a job that does not exist in any known sector of the United States labor market. As detailed above, Petitioner performed a diligent, yet unsuccessful job search in this case and the only two vocational counselors who have rendered opinions, Susan Entenberg and Lisa Helma, both opined that no stable labor market exists for Petitioner.

Petitioner's workers' compensation benefits have been diminished since he started working for AllFacilities, then was discharged by All Facilities, all of which is consistent with the marketing plan of Catalyst RTW. As Ms. Entenberg pointed out, Catalyst and AllFacilities are simply an insurance based resource to put people on a job "with a great possibility of failure." Respondent's referral of Petitioner to Catalyst was not made to further Petitioner's vocational rehabilitation goals or to fulfill the purpose of the Act to promote the health and welfare of the citizens of the state and to afford protection to workers by providing prompt and equitable compensation for workplace injuries (See *Kelsay v. Motorola, Inc.*, 74 Ill. 2d 172, 180-181, 384 N.E.2d 353, 356-357 (1978)). Rather, the referral was made only to vex Petitioner and lessen his compensation by sending him to a job that is not real.

In denying compensation, Respondent has not met the burden of demonstrating a reasonable belief that its denial of liability was justified under the circumstances, as required by *Continental Distrib. Co. v. Indus. Comm'n*, 98 Ill.2d 407, 456 N.E.2d 847 (1983), *Bd. of Educ. v. Indus. Comm'n*, 93 Ill.2d 20, 442 N.E.2d 883 (1982) ("*Norwood*" case) and *Bd. of Educ. v. Indus. Comm'n*, 93 Ill.2d 1, 442 N.E.2d 861 (1982) ("*Tully*" case). The Court in *Norwood* stated that the question whether an employer's conduct justifies the imposition of penalties is a factual question for the Commission. The employer's conduct is considered in terms of reasonableness. 442 N.E.2d at 885. Moreover, the Appellate Court has noted that the burden of proof of the reasonableness of its conduct is upon the employer. *Consol. Freightways, Inc. v. Indus. Comm'n*, 136 Ill.App.3d 630, 483 N.E.2d 652, 654 (1985); accord, *Ford Motor Co. v. Indus. Comm'n*, 140 Ill.App.3d, 488 N.E.2d 1296 (1986).

The Arbitrator finds Respondent's behavior in this case to be unreasonable, vexatious and solely for the purpose of delay.

Accordingly, the Arbitrator finds that Respondent shall pay penalties under §19(k) in the amount of $15,608.57, representing fifty percent of the total amount due to date in unpaid benefits and medical expenses. The Arbitrator calculated this amount as follows:

Respondent in this matter began paying Petitioner a reduced rate of $991.41 per week, rather than $1,243.00 per week on January 9, 2013, based upon the work activity he was performing at AllFacilities. From January 9, 2013 through the date of trial, December 6, 2013, Pespondent continued payments of $991.41. Therefore, Respondent has underpaid Petitioner $251.59 per week for 47.43 weeks = $11,932.91 due in underpaid benefits.

$11,932.91 in underpaid benefits + $19,284.23 unpaid medical = $31,217.14

$31,217.14 / 2 = $15,608.57 due pursuant to Section 19(k)

SECTION 16

Pursuant to §16 of the Act, the Arbitrator finds that Respondent shall pay attorneys' fees calculated upon twenty percent of the unpaid TTD and maintenance to date; twenty percent of the unpaid medical expenses to date and

twenty percent of the §19(k) award. Accordingly, Respondent shall pay the sum of $9,365.14 in attorneys' fees, with the remainder of Petitioner's attorneys' fees, if any, to be paid by Petitioner to his attorneys. This award was calculated by the Arbitrator as follows:

$15,608.57 in Section 19(k) + $11,932.91 in underpaid benefits, as detailed above + $19,284.23 in outstanding medical = $46,825.71.

$46,825.71 x .2 = $9,365.14 in Section 16 fees.

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 Christiansen,
Petitioner,
vs.
United Parcel Service,
Respondent,

NO: 13WC 37034

15IWCC0469

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 10, 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 $14,351.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 19 2015
MJB/bm
o-06/16/15
52

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

NOTICE OF ARBITRATOR DECISION

CHRISTIANSEN, DAVID
Employee/Petitioner

Case# **13WC037034**

15IWCC0469

UNITED PARCEL SERVICE
Employer/Respondent

On 12/10/2014, 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 0.09% 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:

0926 LEONARD LAW GROUP LLC
MATTHEW J LEONARD
300 S ASHLAND AVE SUITE 101
CHICAGO, IL 60607

2461 NYHAN BAMBRICK KINZIE & LOWRY
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

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

David Christiansen
Employee/Petitioner
v.
United Parcel Service
Employer/Respondent

Case # **13** WC **37074**

15IWCC0469

An *Application for Adjustment 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 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 _____

15IWCC0469

FINDINGS

On **February 18, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$78,709.80**; the average weekly wage was **$1,513.65**.

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

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

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

Respondent shall be given a credit of **$8,793.59** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,793.59**.

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 **20** weeks, because the injuries sustained caused the **4%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Milton Black
Signature of Arbitrator

December 10, 2014
Date

ICArbDec p. 2

DEC 10 2014

FACTS

Petitioner is a package car driver for Respondent. The position requires him to deliver packages ranging between one and one hundred fifty pounds. Petitioner estimated he made approximately 170 stops on a typical day. On February 18, 2013, Petitioner felt a pulling sensation in his right groin while pushing a crate. The accident is not disputed.

Petitioner was seen at U.S. Healthworks the day of his incident. (Px1) He was diagnosed with a right inguinal hernia and restricted from lifting more than 20 pounds. A referral was made to a general surgeon. Petitioner chose to see Dr. Sulkowski.

Petitioner testified that Respondent accommodated his work restrictions until Dr. Sulkowski performed a surgical repair of the hernia on March 20, 2013. A Lichtenstein repair was performed, which included placement of an unspecified amount of mesh placed securely over the defect. During the procedure, a moderate sixe cord lipoma was also removed (Px2, pp5-6) Postoperatively, Petitioner saw Dr. Sulkowski in April and was discharged on May 7, 2013. He was not released to return to work until May 20, 2013.

Petitioner was examined by Dr. John Koehler for an impairment rating pursuant to Section 8.1b of the Act. Dr. Koehler's evidence deposition was conducted on February 24, 2014, and the transcript admitted into evidence as Respondent's Exhibit 1.

Dr. Koehler testified that Petitioner had no physical findings and assessed him with 0% impairment pursuant to the American Medical Associations *Guide to Evaluation of Permanent Impairment* (Sixth Ed.), and referenced table 6-10 on page 122. (Rx1, p.11)

Petitioner testified that after the surgical repair he noticed occasional discomfort and some pain when he got in and out of his truck, pivoted or turned, and lifted heavier objects. He described the sensation as a pinch or stinger. Petitioner testified on cross examination that he feels his hernia has been completely repaired to his satisfaction.

On April 10, 2014, Petitioner returned to Dr. Sulkowski complaining of mild occasional right groin discomfort, particularly with activity. Petitioner's physical examination showed a well-healed vertical incision. Dr. Sulkowski noted that Petitioner's complaints appeared to be normal postoperative discomfort. (Px2, p10)

CAUSATION

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

This finding is based upon Petitioner's testimony and Dr. Sulkowski medical records.

NATURE AND EXTENT

Petitioner sustained a right inguinal hernia. He was ultimately released to unrestricted work.

The date for this injury is subject to Section 8.1b of the Act. The Arbitrator notes the following:

Evidence of impairment - A 0% impairment rating was submitted and testified to.

Occupation - Petitioner is a package car driver. Occasionally he lifts heavy objects of up to 150 pounds.

Age - Petitioner was 37 years old when his accident happened.

Future earning capacity – Petitioner has returned to the job he worked at the time of his injury. .

Evidence of disability corroborated by the medical records – Petitioner's medical records corroborate his testimony of physical complaints.

Based upon the above, the Arbitrator finds Petitioner sustained 4% loss of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melody Arthur,
Petitioner,
vs.
City of Chicago,
Respondent,

NO: 09WC003843

15IWCC0470

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, permanent total disability, wage differential, 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 2, 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: JUN 19 2015
MJB/bm
o-06/16/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

ARTHUR, MELODY
Employee/Petitioner

Case# **09WC003843**

15IWCC0470

CITY OF CHICAGO
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0494 JOSEPH J SPINGOLA LTD
47 W POLK ST
SUITE 201
CHICAGO, IL 60605

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN SUITE 700
CHICAGO, IL 60603

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

MELODY ARTHUR
Employee/Petitioner

Case #09 WC 3843

v.

15IWCC0470

CITY OF CHICAGO
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on August 18, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On December 9, 2008, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $60,033.23; the average weekly wage was $1,154.49.
- At the time of injury, the petitioner was 51 years of age, single with no children under 18.
- The parties agreed that the respondent is not liable for any unpaid medical bills.
- The parties agreed that the respondent paid $219,111.12 in benefits and that the petitioner is entitled to benefits for 285-6/7 weeks through August 18, 2014.

ORDER:

- The respondent shall pay the petitioner the sum of $522.99/week for the duration of her disability as provided in Section 8(d)1 of the Act.
- The respondent shall pay the petitioner compensation that has accrued from December 9, 2008, through August 18, 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.

Robert E. Williams

Signature of Arbitrator

August 26, 2014

Date

SEP 2 - 2014

FINDINGS OF FACTS:

15IWCC0470

On December 9, 2008, the petitioner, a laborer with the sanitation department, slipped on ice, fell and injured her left ankle and leg. She received immediate care with Dr. Steven Anderson at MercyWorks, where x-rays revealed no acute fractures. She was treated with an air cast for a sprain. Physical therapy was started on the 19th, which provided some improvement. Dr. Anderson noted on January 19, 2009, that an MRI revealed a non-displaced fracture of the lateral margin of the posterior tibia and an ATFL tear at its insertion. The doctor also noted that the petitioner was treating with a Chatham foot specialist; however, their treating records are not in evidence. The petitioner followed up with Dr. Anderson approximately every two weeks with continued complaints of pain, weakness and swelling in her left ankle. Dr. Simon Lee evaluated the petitioner pursuant to Section 12 of the Act on May 7th. He noted that the petitioner ambulated with a CAM boot and crutches, that prior and current x-rays showed an intact mortise and no discrete fracture, dislocation or bony lesion and that an MRI and CT scan showed evidence of a posterior malleolar fracture of the tibia, swelling and edema.

On June 12, 2009, Dr. Anderson noted complaints of left heel, ankle and foot pain and that the petitioner was using a TENS unit. Dr. Anand Vora noted on June 19th that he evaluated the petitioner's left foot and ankle. He opined that she had a healed left posterior malleolus non-displaced fracture and diabetic neuropathy. He started therapy program for strengthening. Dr. Vora noted on July 31st and August 28th that the petitioner's complaints were not supported by the objective and radiological findings. An FCE on September 30th demonstrated minimal and inconsistent effort by the petitioner. Podiatrist Neal Frankel opined on October 15th that based on his finding and the

petitioner's complaints of pain she had an internal derangement or tear of the internal capsular or articular structures of the joint. She had follow-ups with Dr. Frankel on October 20th and November 3rd. A three phase bone scan was suggestive of asymmetrical activity in left lower leg. Dr. Lubenow gave the petitioner many left lumbar sympathetic nerve blocks at L2 and L3 for complex regional pain syndrome from May through July 2010. The petitioner reported to Dr. Anderson that the blocks provided only short-term relief. She reported to Dr. Anderson that Bier blocks on August 25th did not provide any improvement and that the second blocks only improved her symptoms that night. Dr. Anderson noted that the petitioner's five-day hospital stay for indwelling ESI on January 31, 2011, initially provided 2-3% improvement but she denied any improvement on March 4, 2011. The petitioner received a spinal cord stimulator on August 1, 2011, which was revised on October 31, 2011. Dr. Anderson noted on August 10, 2012, that the petitioner worked May 11 through July 23, 2012, and that Dr. Lubenow felt she was at MMI on July 25, 2012. The doctor noted that she ambulated within normal limits.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that she is obviously incapable of employment or that she cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable labor market for them. The petitioner can perform some form of employment without seriously endangering her health or life. Moreover, an FCE on September 30, 2009, demonstrated minimal and inconsistent effort by the petitioner and on July 25, 2012, Dr. Lubenow felt the petitioner ambulated within normal limits and gave her permanent restrictions that have not been

changed. Dr. Chmell's and Mr. Blumenthal's opinion are conjecture and are not supported by the evidence.

The petitioner proved that she sustained a diminution in her earning capacity pursuant to Section 8(d)1 of the Act. Her current earning capacity is $9.25 per hour or $370.00 per week. Her prior wages of $1,154.49 is the only evidence of the current wages of a laborer with the respondent. The respondent shall pay the petitioner the sum of $522.99/week for the duration of her disability as provided in Section 8(d)1 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Tucker,
Petitioner,

vs.

No: 11 WC 08197

Rush University Medical Center,
Respondent.

15IWCC0471

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical treatment, benefit rate, and temporary disability, and being advised of the facts and law, affirms with additional reasoning the September 9, 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).

Arbitrator Carolyn Doherty found Petitioner proved she sustained an accident that arose out of and in the course of employment on January 22, 2011 and also proved that her current condition of ill-being through March 1, 2012 was causally related to that accident. The Arbitrator awarded Petitioner medical expenses and temporary total disability benefits through March 1, 2012 and denied any benefits after March 1, 2012 based on her finding of casual connection for Petitioner's condition.

After considering the entire record, including surveillance footage, the Commission affirms the September 9, 2014 Decision of the Arbitrator. The Commission further provides additional reasoning in support of the Arbitrator's finding regarding Petitioner's earnings and benefit rate as set forth below.

Petitioner testified that she began working approximately 24-30 hours a week as a nurse on a night shift at Norwegian Hospital in July 2010. She testified she obtained a full time position as a nurse with Rush University Medical Center in August of 2010, working 7:00 pm to 7:00 am three days a week. Petitioner testified that Respondent Rush was aware of her concurrent employment as she mentioned it on her job application with Respondent.

At arbitration, Petitioner requested an average weekly wage that included her earnings from her job with Respondent, as well as the earnings from her job at Norwegian, as reflected in Petitioner's Exhibits 10 and 11. Petitioner's exhibit 10 is her 2010 W2 from Norwegian with year to date total earnings of $3,954.40. Petitioner's exhibit 11 contains wage statements for Petitioner's work at Norwegian for the period October 23, 2010 through November 20, 2010 which matches the total wages earned at that facility for the year 2010. There is no documentary evidence in the record to substantiate Petitioner's claim that she started working for Norwegian in June or July of 2010 or that she worked there after November of 2010. Petitioner's testimony regarding the hours she worked for Norwegian weekly and the dates she worked are contradicted by the documentary evidence submitted in the record. The record is also void of any documentary evidence showing Petitioner's earnings for Respondent Rush in the 52 weeks prior to the accident. No hourly rate testimony was offered and no wage exhibits were offered pertaining to Petitioner's work for Respondent. Respondent stipulated to an average weekly wage of $1,353.24 on the Request for Hearing form admitted as Arbitrator's Exhibit 1. The Arbitrator found the Petitioner's average weekly wage to be $1,353.24, as stipulated to by Respondent at hearing.

Petitioner bears the burden of proving, by a preponderance of the evidence, the elements of her claim, including average weekly wage. *Ricketts v. Industrial Comm'n*, 251 Ill. App. 3d 809, 810, 623 N.E. 2d 847 (1993). There is no documentation in the record regarding Petitioner's earnings at Respondent. Petitioner testified that she worked a 12 hour shift for Respondent three days a week, but she did not testify to her hourly wage for Respondent. Respondent stipulated Petitioner earned an average weekly wage for work at Rush Medical of $1,353.24.

With regard to concurrent employment, Section 10 of the Act provides that if an employee is working concurrently for two or more employers and the Respondent has knowledge of such employment prior to the injury, her wages from all such employers shall be considered as if earned from the employer liable for compensation. 820 ILCS 305/10. Case law provides insight into the meaning of "concurrent." The Appellate Court in *Village of Winnetka v. Industrial Commission*, 250 Ill.App.3d 240, 621 N.E.2d 150, 190 Ill. Dec. 281 (1993), found that when calculating average weekly wage with concurrent employment, the average weekly wage of each job is computed separately and then added together to arrive at the average. The Appellate Court stated that the manner of calculation is to "fairly represent the claimant's earning power at the time of his injury." 621 N.E.2d at 153. *Jacobs v. Industrial Comm'n*, 269 Ill. App. 3d 444 (2nd Dist. 1995) goes further into the Court's analysis of concurrent employment. In *Jacobs*, the Petitioner was injured working for an apartment complex while on scheduled layoff as a sheet metal worker. The Court noted that the Act doesn't define "concurrently" and therefore, the decision then turns to what the Court determines the word to mean in the context of the case. It noted that the underlying purpose of the Act is to provide

financial protection for workers whose earning power is interrupted or terminated due to injuries arising out of their employment. *Id.* at 447. In *Jacobs*, the Petitioner worked at the apartment complex even when he was not laid off from sheet metal work, and his sheet metal work regularly was subject to short layoff periods which did not sever his employment relationship. The Commission also notes the finding of the Court in *Zanger v. Industrial Comm'n*, 306 Ill. App. 3d 887, 240 Ill. Dec. 80, 715 N.E. 2d 767 (4th Dist. 1999). In *Zanger*, the Court found that although average weekly wage is calculated over a 52 week period, the earnings considered are those from the employment in which claimant *was working when injured*; thus, the claimant's earnings from a prior employer over the prior 52 weeks, for which he did not work after he was laid off and was not working at the time of the injury, could not be considered in determining his average weekly wage. (emphasis added). *Id.* at 892. Section 10 of the Act defines the computation of a Petitioner's average weekly wage as "the actual earnings of the employee in the employment in which he was working *at the time of the injury* during the period of 52 weeks...divided by 52. 820 ILCS 305/10 (emphasis added). Petitioner worked concurrently at Norwegian and Respondent Rush for a period of four weeks from October 23, 2010 to November 20, 2010 as documented in PX10 and PX11. Petitioner terminated her employment with Norwegian approximately nine weeks prior to the accident date and there is no evidence in the record that it was a temporary layoff or that she intended to resume employment at Norwegian. The Commission finds no evidence in the record to support Petitioner's claim for concurrent employment wages to be included in the calculation of her benefit rates. For the foregoing reasons, the Commission affirms the Arbitrator's finding of Average Weekly Wage rate of $1,353.24 pursuant to the stipulation of Respondent at hearing.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the September 9, 2014 Decision of the Arbitrator is affirmed and adopted with additional reasoning, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $902.16/week for a period of 55 4/7 weeks, commencing February 7, 2011 through March 1, 2012, that being the period of temporary total disability from work under Section 8(b) of the Act. Respondent to receive credit for benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical expenses contained in the record and incurred in the care and treatment of Petitioner's causally related condition through March 1, 2012, as provided in Sections 8(a) and 8.2 of the Act. Respondent to receive credit for expenses paid.

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.

15IWCC0471

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 $50,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 1 9 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/22/15
jdl/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

TUCKER, ANGELA
Employee/Petitioner

Case# **11WC008197**

RUSH UNIVERSITY MEDICAL CENTER
Employer/Respondent

15IWCC0471

On 9/9/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2988 CUDA LAW OFFICES
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

Angela Tucker
Employee/Petitioner

v.

Rush University Medical Center
Employer/Respondent

Case # **11** WC **8197**

Consolidated cases:

15IWCC0471

An *Application for Adjustment 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 **August 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Prospective Medical under Section 8(a)

FINDINGS

On **1/22/11**, 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 these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

Petitioner's condition of ill-being through 3/1/12 is causally related to the accident. Petitioner's condition subsequent to 3/1/12 ***is not*** causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned **$70,368.48**; the average weekly wage was **$1,353.24**.

On the date of these accidents, Petitioner was **40** 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 **$56,707.20** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$41,207.16** for other benefits, for a total credit of **$97,914.36.**

ORDER

Respondent shall pay Petitioner temporary total disability benefits for the period of 55-4/7 weeks at $902.16 per week commencing 2/7/11 through 3/1/12 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of Petitioner's causally related condition through 3/1/12 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

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

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

Signature of Arbitrator

9/9/14
Date

ICArbDec p. 2

SEP 9 – 2014

FINDINGS OF FACT

At trial, the parties stipulated to the issues of accident and notice. ARB EX 1. Petitioner testified that she has a nursing degree and has worked as a nurse since 1997. In 2010, Petitioner began working for Respondent, Rush University Medical Center, as a nurse. On 1/22/11, Petitioner worked full time for Respondent in the form of 12 hour shifts 3 days per week. Petitioner further testified that she also began working at Norwegian Hospital in June 2010 and that she worked at Norwegian concurrently. At Norwegian, Petitioner worked 24 to 30 hours per week at the base pay of $33.50 per hour plus a night differential. Petitioner testified that Respondent was aware of her concurrent employment with Norwegian.

While working for Rush, Petitioner was assigned to the neuro intensive care unit between August 2010 and her accident at work on 1/22/11. Her duties included rendering emergency medical treatment and the physical handling of patients. Petitioner testified that she was required to turn patients every 2 hours to avoid bed sores. She further testified that the job posed heavy lifting requirements.

Petitioner testified that prior to 1/22/11 she was never under any care of a doctor for any reason. She testified that she was very active in that she worked out 3 times per week, jogged, cooked and sewed.

The parties stipulated that on 1/22/11 Petitioner was injured while transporting a large male patient from surgery to ct scan. Petitioner testified that during the transport, the patient awoke from sedation and became very agitated and combative. Petitioner testified that as she was pushing the rolling bed down a hallway, Petitioner grabbed her left wrist and violently twisted Petitioner's left arm in a direction opposite to her body. Petitioner testified that the violent jerking and twisting of her left arm continued for 3 to 5 minutes during which time 3 people came to her assistance. The patient's hands had to be pulled away from Petitioner. Petitioner testified that when her left hand was freed, it was throbbing in pain. Petitioner is right handed. The Arbitrator notes that Petitioner sat for the duration of the trial holding her left arm bent at the elbow crossed over her upper chest with her left hand resting on her right shoulder.

Petitioner testified that she immediately went to the hospital emergency room and was given a splint, sling and x-rays. On Monday, Petitioner was seen at Employee Health and then sent to hand specialist, Dr. Derman on 1/26/11. Dr. Derman recorded a consistent history of injury. A fluroscan revealed no sign of wrist abnormality. Exam revealed significant pain and tenderness located in the region of the first dorsal compartment and tenosynovitis over the radius in that region. He noted "remarkably positive" Finkelstein's test. PX 3. Dr. Derman diagnosis a strain of the left wrist and De Quervain's syndrome with first dorsal compartment tendosynovitis. He found no indication of any subluxation or dislocation of the wrist bones or of any fracture but did find evidence of a strain at the 2nd MCP joint. Dr. Derman commenced conservative treatment of the De Quervain's syndrome in the form of injections and physical therapy. PX 3. As of 3/18/11, Dr. Derman noted the development of left long finger trigger finger which he noted was " ... due to increasing her activities and now the fracture located near the MCP joint is giving less room for the tendons to glide." Trigger finger injections were also administered. PX 3.

Petitioner remained off work during her treatment per Dr. Derman. PX 3. Conservative care failed to relieve Petitioner's symptoms and on 6/15/11, Dr. Derman recommended surgery. He noted at that time that the surgery would be very difficult and that she "could be even worse after surgery." The surgery would be followed by extensive rehabilitation and occupational therapy. Finally, he noted that Petitioner

may develop chronic regional pain syndrome. Petitioner was advised and stated that she wanted to proceed with surgery in that she "can't go on like this." Petitioner reported continued "excruciating" pain.

On 6/28/11, Petitioner underwent surgery. The preoperative diagnosis was "exquisite pain of the left radial wrist dorsum with De Quervain syndrome, with superficial radial neuritis and scar of the radial dorsum of the left upper extremity, with fracture of the left long finger and resultant painful trigger of the left long finger with digital neuritis. The procedures performed included "microneurolysis of the left superficial radial nerve with transposition of the lft superficial radial nerve; release of left first dorsal compartment; release of intracompartmental band about the extensor pollicis brevis in the first dorsal compartment; scar excision on the dorsum of the left hand with local tissue advancement for reconstruction of defect; neurolysis of the common radial digitial nerve to the left long finger; release of trigger of the left long finger; casted splint application. PX 4.

Following the surgery, Petitioner's hand remained swollen, red and painful in her wrist and thumb area extending to the left elbow. At the visit of 7/8/11, Dr. Derman noted that Petitioner was pleased with her progress with markedly diminished pain and no signs of chronic regional pain syndrome. PT was initiated. Petitioner testified that her pain continued after surgery but that it would fluctuate with medication. Specifically, she testified that any motion or manipulation of her hand and fingers caused more pain. Dr. Derman noted throughout July 2011 that Petitioner was progressing in therapy but that different medications were necessary to address continued pain on the radial side of the wrist. He further noted no signs of CRPS. PX 3. On 7/22/11, Dr. Derman noted that Petitioner could continue with PT for another 5 to 6 weeks and potentially return to work thereafter. PX 3. As of 7/29/11, Dr. Derman noted decreased wrist motion which developed when her activities increased. He discussed a return to one handed work at that time.

As of 9/14/11, Dr. Derman prescribed Lyrica and Ibuprofen and continued one hand work restriction. He again noted no signs of CRPS. In October and November 2011, Dr. Derman continued the work restriction noting continued signs of objective improvement. PX 3.

On 1/27/12, Dr. Derman ordered an MRI of the left wrist and distal 1/3 of the forearm with and without contrast under a diagnosis of "post-traumatic pain and swelling of left arm (s/p release of 1st compartment superficial radial nerve injury." On 2/10/12, Dr. Derman noted, "patient had MRI study --- radiologists take is no signs of superficial radial nerve problems". Dr. Derman referred Petitioner to Dr. Lubenow for consultation due to persistent neurogenic pain. PX 3, PX 8.

Petitioner first saw Dr. Lubenow on 3/1/12. He noted a traumatic development of De Quervain's tenosynovitis following an attack by a patient at work. Petitioner reported no great improvement in her pain following surgery. She further reported continued restricted range of motion and constant throbbing of the left wrist with occasional burning whenever her thumb is moved with shooting pains going up her left arm to the elbow. Lyrica helped as did conservative therapy. Physical exam showed limited left wrist flexion and extension to 40 degrees bilaterally. Petitioner was unable to participate with flexion or extension at the wrist secondary to pain. He further noted that Petitioner demonstrated allodynia over the left wrist over the area over her scar and hyperpathia which is pain that persists after stimuli is withdrawn. He further noted dysdiadokinesis of the left hand and slightly asymmetric temperature and sweat test readings showing subtle asymmetry. Dr. Lubenow concluded, "although she does meet the criteria for

CRPS it is likely a mild case. He prescribed continued Lyrica and PT as well as stellate ganglion blocks. Finally, he recommended that Petitioner speak with the pain psychologist to further assess her pain state.

Petitioner saw the psychologist, Dr. Merriman on 3/1/12 and was assessed with an appropriate level of affective distress given her current stressors including pain and financial issues following her accident and injury. Dr. Merriman noted that Petitioner was strongly motivated to return to work and that she pushed herself to increase her functionality. PX 6. No Axis I diagnosis was rendered but Dr. Merriman recommended that Petitioner could benefit from several sessions of pain management counseling to assist her in the development of some additional behavioral pain management strategies with a focus on progressive muscle relaxation and tactics for decreasing sympathetic arousal. PX 6.

Dr. Lubenow administered ganglion blocks on 3/15/12, 3/17/12 and 5/23/12. Petitioner testified that she had slight improvement with the first block in 3/12 when her pain went from 8/10 to 5/10. However she reported no improvement from the blocks in May 2012.

Dr. Lubenow testified via evidence deposition in July 2013. He testified that his last visit with Petitioner was on 1/2/13. PX 9, p. 28. Petitioner reported constant left wrist pain exacerbated by temperature change, 7/10 pain, and an allodynia score at 9/10. Petitioner complained of edema and a worsening of her symptoms. Dr. Lubenow noted a decreased range of motion at the elbow and that her wrist locked in a neutral position with a slight degree of ulnar deviation and decreased strength in the left wrist. Dr. Lubenow noted that the newly noted decreased elbow range of motion was a rostral migration of CRPS common in patients not receiving or responding to treatment. PX 9, p. 29. Dr. Lubenow testified that his treatment plan for Petitioner included an in-patient continuous epidural infusion of medications to provide pain relief coupled with an exercise regime to improve use and range of motion. PX 9, p. 31-32. Dr. Lubenow further opined that in addition to the inpatient infusion he also recommended the implantation of a spinal cord stimulator as a permanent treatment. PX 9, p. 58-59. He opined Petitioner's condition was causally related to her accident at work, that all of her treatment was reasonable and necessary and that she could not work during her period of treatment. PX 9, p. 33.

Petitioner attended four Section 12 exams with Dr. Vendor at Respondent's request. Dr. Vender agreed with Dr. Derman's findings regarding Petitioner's DeQuervain's tenosynovitis and recommended steroid injections and a possible release of the first extensor compartment for DeQuervain's disease and release of the middle finger flexor tendon sheath. RX 7. Dr. Vender examined Petitioner on October 7, 2011 after her procedure and advised she could return to her normal job duties and follow up if her subjective symptoms do not improve to correlate them with objective findings. RX 6. Dr. Vender again saw Petitioner on March 23, 2012 with increased complaints of pain in the left hand. RX 5. Dr. Vender's report indicates Petitioner explained she "could not do anything with her left hand. This includes driving or lifting." RX 5. On examination, Dr. Vender found no significant findings of swelling, discoloration, sweating or temperature changes in the left hand. RX 5. Dr. Vender noted Petitioner's range of motion of her fingers in the left hand was normal. Dr. Vender finally saw Petitioner on March 22, 2013. Dr. Vender noted Petitioner stated she was unable to cook, hold anything or do her hair. RX 4. She demonstrated "the limited function of her left extremity by placing her cell phone balanced against the hand which is resting on her chest. RX 4. On physical examination, Petitioner was leaning back in a chair with her arm adducted to her torso. RX 4. When asked to move the shoulder, Petitioner demonstrated she was unable and exhibit pain and grimacing. RX 4. It was Dr. Vender's opinion considering the non-physiological findings of Petitioner's pain complaints coupled with the normal appearance of Petitioner's skin,

Petitioner did not suffer from CRPS. RX 4. It was his opinion her inability to use her left hand was not related to any pathology in her left hand. RX 4.

Petitioner was also seen by Dr. William Strecker on April 29, 2014 at Respondent's request. Dr. Strecker noted Petitioner exhibited pain with any movement of the hand, wrist, elbow, or fingers. RX 2. Dr. Strecker observed Petitioner to have her hand adducted to her chest. RX 2. Dr. Strecker found Petitioner's 'physical examination and response to treatment is non-anatomic." RX 2. Dr. Strecker noted "the only finding she has of complex regional pain syndrome is the allodynia which she experiences. RX 2. Dr. Strecker found no trophic changes existed that would suggest Petitioner suffers from CRPS and found Petitioner to be at maximum medical improvement.

Petitioner also underwent a series of vocational rehabilitation meetings in an effort to bring her back to work. These meetings detail difficulties in Petitioner making meetings, following up on job leads and repeatedly cancelling appointments with Respondent's vocational expert. Petitioner's vocational rehabilitation was terminated on February 17, 2012.

Respondent offered into evidence a disk containing surveillance video on September 12, 2011, October 7, 2011, March 1, 2012 and March 22, 2013. RX 17. The Arbitrator viewed the surveillance video in its entirety. On September 12, 2011, Petitioner is observed entering a car. On October 7, 2011, Petitioner is observed walking down the street holding a purse on her elbow. She does not appear to be in any distress at this time. Petitioner is observed driving her car. On March 1, 2012, Petitioner is observed speaking with several individuals, carrying a purse on her left elbow and holding her arm in a normal fashion at her side. She is seen holding her keys in her left hand and enters her car utilizing both hands to open and close her car door. She does not appear to be in pain. On March 22, 2013, Petitioner is observed exiting her car from the driver's seat. She has her hand held at her side and utilizes both right and left hands to pay a parking meter. She does not appear to hesitate when using her left hand and holding her keys and some papers in her left hand. The Arbitrator notes that her left arm is not in the sleeve of her coat and that when entering and leaving the physician's office her left arm is held in the cross body fashion as it was at trial.

Petitioner testified that she has not received benefits since May 2012. He has since relocated to St. Louis to live with her mother. Petitioner testified that she has no full use of her left arm and that she experiences constant throbbing and pain in her left arm. Petitioner testified that her left arm locks from her wrist to her elbow and that she is unable to put her arm in a neutral position.

Petitioner further testified that she does not take medication as "they took her off of it." She has difficulty sleeping due to pain and throbbing in her arm caused by motion and pressure. Her arm is affected by changes in the temperature. Petitioner testified that early in her treatment with Dr. Derman she was able to lift up to 5 pounds and could carry something on her left arm. At trial, she testified that she no longer uses her left arm or the wrist area. Petitioner holds her arm elevated with the wrist rotated outward. On cross exam, Petitioner testified that her pain is constant from the wrist to the elbow and that she is unable to grip or push with her left hand. Again, she testified that her pain in her wrist to elbow is caused by any activity and has been constant since the injury.

Petitioner's mother, Barbara Rycraw testified that Petitioner came to live with her in 2012 because Petitioner was unable to care for herself. She testified that Petitioner is occasionally able to drive but most of the driving is done by the witness.

With regard to wage, Arb Ex 1 indicates that Petitioner alleges a yearly income of $164,728.20 and an average weekly wage of $3,167.85 which includes alleged concurrent wage of $3,943 from Norwegian American Hospital. Petitioner offered testimony at trial to the number of hours worked for Respondent per week in that she worked three 12 hour shifts per week. However, no evidence was offered at trial to support a total earnings figure for Petitioner's employment with Respondent. No hourly rate testimony was offered and no exhibits were offered proving a total wage for Petitioner's work with Respondent.

PX 10 is a 2010 W2 form from Norwegian that indicates gross earnings of $3,943. PX 11 is actual check stubs from Norwegian covering the period of October 2010 through December 2010 totaling $3,943. Petitioner testified that at Norwegian she was paid $33.50 per hour plus shift differentials and these differentials are included in the total pay earned of $3,943 according to PX 10 and PX 11.

CONCLUSIONS OF LAW

The Arbitrator finds in relationship to issue (F), whether Petitioner's current condition of ill-being causally related by the injury:

Upon consideration of the entire record as a whole as well as Petitioner's trial testimony and demeanor, the Arbitrator finds Petitioner's condition of ill-being subsequent to March 1, 2012 is not causally related to her injury. Petitioner's condition of ill-being through March 1, 2012 is causally related to her accident and injury. In so finding, the Arbitrator notes that Petitioner's credibility is adversely affected by the video surveillance of her activity level and ability in RX 17, when compared to Petitioner's demeanor at trial and her complaints to her treating physicians and Section 12 examiners. At trial, Petitioner sat with her left arm crossed up and over her chest with her left hand resting on her right shoulder. She testified that she has had continuous and severe pain with any activity involving the left hand or wrist since the accident. Petitioner further testified that she is only able to drive occasionally and that she is unable to lift anything, cook, do her hair or generally move her arm in a manner that is pain free.

The video dates of March 1, 2012 and March 22, 2013 are dates on which Petitioner was seen by Dr. Merriman and Dr. Vender respectively. On March 1, 2012, Petitioner is seen on video exiting a restaurant and walking with her purse on her left forearm and holding car keys in her right hand. Petitioner is seen using both hands to open the car door and then her left arm to pull it closed. Petitioner is seen numerous times getting in and out of her car holding papers and other items in her left hand and arm without any apparent pain or difficulty. Her arm does not seem affected by any movement and she is not seen with her arm locked in a raised position. Her depicted activity and ability is in marked contrast to her statements to Dr. Merriman of the same date including Petitioner's report of pain generation with "any movement of the arm" and noted pain behavior as resting her elbow on the armrest of a chair and holding her left hand and forearm pointing upward. PX 6. Shortly after her March 1, 2012 visit with Dr. Merriman and the video surveillance of that date, on March 23, 2012, Petitioner told Dr. Vender that she "cannot do anything with her left hand. This includes activities such as driving and lifting." RX 5.

Petitioner's reported appearance on March 22, 2013 to Dr. Vender mirrors that of her appearance at trial. Petitioner reportedly could not remove her hand from her chest and grimaced in pain when asked to do so. Petitioner reported that she could not move the left upper extremity and that she has no use of her left

upper extremity. Dr. Vender noted, "she demonstrates the limited function of her left upper extremity by placing her cell phone balanced against the hand which is resting against her chest." RX 4. The video surveillance of the same day, March 22, 2013, depicts Petitioner parking her car and using both hands while paying the parking meter. Although her left arm does not appear to be in the sleeve of her coat, it is in a regular position such that she uses the left arm and hand while paying the parking meter. She does not appear in pain. After paying the meter, Petitioner is then seen walking into and leaving the office with her arm bent across her chest more in line with her posture at trial. The Arbitrator does note Dr. Lubenow's testimony that Petitioner's condition worsened between 2012 and 2013. However, the Arbitrator remains unable to reconcile the basis for Dr. Lubenow's diagnosis and Petitioner's depicted activity levels.

Based on the inconsistencies between Petitioner's trial demeanor and the video depiction of Petitioner's activity level, the Arbitrator places greater weight on the conclusions and opinions of Drs. Vendor and Strecker in finding causal connection through March 1, 2012 only. Dr. Vender and Dr. Strecker's findings of non-anatomic pain complaints align more closely with Petitioner's observed appearance when she is not being examined. Dr. Lubenow's "mild" CRPS diagnosis is not supported by the objective evidence.

The Arbitrator notes that at Petitioner's March 28, 2012 exam with Dr. Vender, he found that Petitioner showed no indication of CRPS and opined that she could return to work in her former position. Noting the aforementioned inconsistencies buttressing the opinions of Drs. Vender and Strecker the Arbitrator finds Petitioner's condition of ill-being subsequent to March 1, 2012 to be unrelated to Petitioner's January 22, 2011 accident and injury. The Arbitrator finds causal connection for Petitioner's condition of ill-being after the accident of 1/22/11 through 3/1/12 only.

The Arbitrator finds in relationship to (J) whether the medical services that were provided to the Petitioner were reasonable and necessary and (O) whether prospective medical should be awarded under Section 8(a):

Based on the finding of causal connection for Petitioner's condition of ill-being through 3/1/12, the Arbitrator further finds that Petitioner is not entitled to the requested prospective medical treatment recommended by Dr. Lubenow. Further based on the finding of causal connection for Petitioner's condition through 3/1/12, the Arbitrator finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her condition through 3/1/12 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

The Arbitrator finds in relationship to (K) amount of compensation due for Temporary Total Disability for Petitioner's alleged injury:

Based on the finding of causal connection for Petitioner's condition of ill-being through 3/1/12, the Arbitrator further finds that Petitioner is entitled to TTD for the period of 55-4/7 weeks commencing 2/7/11 through 3/1/12 while authorized off work by her treating physicians pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid. ARB EX 1.

The Arbitrator finds in relationship to (G), what were Petitioner's earnings:

At trial, Petitioner requested an AWW that included her earnings from her job with Respondent and her earnings from her job at Norwegian. With regard to the earnings at Norwegian, the Arbitrator finds those earnings reflected on PX 10 and PX 11 in the total amount of $3,943 to be concurrent such that they would properly be included in Petitioner's average weekly wage.

However, the Arbitrator notes that the record is devoid of any evidence showing Petitioner's earnings *for Respondent Rush* in the 52 weeks prior to the accident. Although Petitioner testified that she worked 36 hours per week for Respondent Rush, no evidence was offered at trial to support a total earnings figure for Petitioner's employment with Respondent. No hourly rate testimony was offered and no wage exhibits were offered pertaining to Petitioner's work for Respondent Rush. Specifically, there is no evidence in the record to support Petitioner's alleged yearly earnings of $164,728.20 or the AWW of $3,167.85 as claimed on the Request for Hearing form at ARB EX 1. Therefore, although Petitioner may have shown a concurrently earned wage, there is no evidence of any earnings for Respondent to which the concurrent wage could be added.

Accordingly, the Arbitrator finds that Petitioner's average weekly wage was $1,353.24 as offered and stipulated to by Respondent at trial. ARB EX 1.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

☒ 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

Mark Kunz,
Petitioner,
vs.

15IWCC0472

NO: 08 WC 30812

Liebovich Brothers, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, 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 October 21, 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: JUN 19 2015
KWL/vf
O-6/16/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0472

KUNZ, MARK
Employee/Petitioner

Case# **08WC030812**

LIEBOVICH BROTHERS INC
Employer/Respondent

On 10/21/2013, 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:

2489 LAW OFFICES OF JIM BLACK & ASSOC
BRAD REYNOLDS
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

4696 POULOS & DIBENEDETTO LAW PC
DAVID T POULOS
850 W JACKSON BLVD SUITE 300
CHICAGO, IL 60607

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

15IWCC0472

Mark Kunz
Employee/Petitioner

v.

Liebovich Brothers, Inc.
Employer/Respondent

Case # **08** WC **30812**

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 **Rockford**, on **10/29/12; 7/16/13**. 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 _____

15IWCC0472

FINDINGS

On **June 7, 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 accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$39,936**; the average weekly wage was **$768.00**.

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

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

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

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

Respondent is entitled to a credit of **$29,302.62** under Section 8(j) of the Act.

ORDER

Denial of benefits

Because Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment with Respondent, benefits are hereby denied.

Credits

Respondent shall be given a credit of **$29,302.62** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall be given credit for **$29,302.62** 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.

Carl Cee

Signature of Arbitrator

10/17/13

Date

OCT 21 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

MARK KUNZ,	)	**15IWCC0472**
	)	
Petitioner,	)	
	)	Case No. 08 WC 30812
v.	)	
	)	
LIEBOVICH BROTHERS, INC.,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF THE ARBITRATOR

FINDINGS OF FACT

Petitioner, a 59-year-old male, worked for Respondent as a welder/fabricator. Petitioner claims a date of accident of June 7, 2008 on his Application for Adjustment of Claim. (Arbitrator's Exhibit 1) Petitioner testified that he welded steel beams and tanks while working for Respondent (Tx. 8).

Petitioner testified that he told Dr. Norem, his family physician, that his job as a fabricator was causing problems to his knees (Tx. 14). Petitioner testified that he gave notice of his knee problems to his supervisor, Ron Polhill, in 2007 (Tx.14-15). Petitioner testified that his last day worked for Respondent was June 7, 2008, the claimed date of accident and the day before Petitioner's total right knee replacement surgery (Tx. 16). Petitioner also testified that he told people at Respondent's workplace that he hurt his knees at work in 2007 (Tx. 24). Petitioner later testified on cross examination that he gave notice of his injury to Chris Polhill, and Petitioner and Mr. Polhill were in the supervisor's office in the plant when that conversation took place (Tx. 24-25). Petitioner testified that he could not remember what month it was that he spoke to Chris Polhill, but recalled that the season was Fall (Tx. 25). Petitioner testified to telling Chris Polhill his condition was job-related from being on concrete floors (Tx. 27). Petitioner could not remember anything specific about that conversation, however (Tx. 27).

Later, on cross examination, Petitioner testified that he complained of knee pain or problems at work to Dr. Norem "every time I went to my G.P." (Tx. 28). Petitioner also admitted on cross examination that he never complained to anyone at Respondent regarding any knee pain or problems (Tx. 32). Petitioner denied that he had ever twisted his knees at home in the past (Tx. 35). He denied having any other incidents with his knees except for while working for Respondent (Tx. 35).

Petitioner testified that he created a hand-written job search log in order to find employment (Tx. 148, Px. 9). Petitioner testified on cross examination that he created this document over the course of two years, from 2008 through 2010 (Tx. 149). Petitioner admitted that he does not have specific dates on which he contacted the companies alleged in the job

search log. He also admitted that he does not know the specific dates on which he allegedly appeared in person to interview with any of these companies (Tx. 150). When asked regarding the person with whom he spoke regarding each of these positions, Petitioner testified, "Secretary." He testified that he spoke with a secretary, and not a hiring person, at each company. Petitioner testified that he did not have an interview with any of the companies (Tx. 151).

Short Term Disability Benefits

Petitioner admitted to applying for and receiving short term disability benefits through Respondent in 2007 and 2008 (Tx. 45). Earlier under cross examination, Petitioner denied having applied for short term disability benefits in November of 2007 (Tx. 36). When Petitioner was shown the Northern Illinois Health Plan questionnaire for disability benefits dated November 29, 2007 (Rx. 1), Petitioner identified the employee signature on the second page as his own (Tx. 38). Petitioner admitted to checking "No" to the inquiry, "was the medical treatment as a result of an accident or injury?" (Tx. 39). Petitioner admitted on cross examination that he did not check the box indicating "work-related" on Rx. 1, even though he had the option to do so on the form (Tx. 40). Petitioner admitted that he did not indicate anything on the form when asked whether the "claim is as a result of any injury you received on the job site or related to your employment" (Tx. 41). Petitioner also admitted to checking "No" on the form when prompted to answer whether he had filed a report of injury with his employer. Petitioner admitted to signing this document and understanding at the time of execution that he would receive payments for medical conditions from Respondent's health plan. Petitioner admitted on cross examination to signing another Northern Illinois health Plan questionnaire for disability benefits dated September 4, 2008 (Rx. 2, Tx. 43). He admitted to indicating "No" when prompted to indicate on the form whether the medical treatment was the result of an accident or injury. Petitioner testified that he did not remember how he received the forms with which to apply for short term disability benefits (Tx. 46).

Treatment Records

Petitioner testified on cross examination that he had seen Dr. Dennis Norem for treatment related to his knees since he began treating with Dr. Norem "sometime in the mid-90's" (Tx. 28). Petitioner testified, "...I've had Dr. Norem for probably – oh, 15 years or better." (Tx. 28). On April 27, 2007, Petitioner was seen by Dr. Norem for a reevaluation (Rx. 10). Dr. Norem stated in his evaluation note the following: "Second issue is some swelling in his lower extremities. He has had some problems with arthritis in his knees. He strained his knee recently and wants me to check on this." (Rx. 10). On October 19, 2007, Petitioner was seen by Dr. Norem for knee pain. Dr. Norem diagnosed Petitioner with significant moderate osteoarthritis (Rx. 10).

Petitioner was seen by Dr. Robin Hovis at Rockford Health Physicians on March 12, 2008 (Rx. 4). In the clinic note, Dr. Hovis noted that "he stands 12 hours a day, and he has just not able to do that because of right knee pain." (Rx. 4). On cross examination, Petitioner testified that he told Dr. Hovis that he stands for 12 hours a day (Tx. 59). Nowhere in this note is any mention of Petitioner's work activities.

Petitioner was seen by Dr. Michael Chmell at Rockford Orthopedic Associates, Ltd. on March 18, 2008 (Rx. 5). Petitioner was referred to Dr. Chmell by Dr. Norem. Dr. Chmell's evaluation note indicates, "This 59 year-old male presents for evaluation of bilateral knee pain,

referred by his family physician, Dr. Norem. Patient states this happened over time." (Rx. 5). According to Dr. Chmell's report, "Symptoms are made worse by walking, standing, and stairs. Symptoms are improved with rest." (Rx. 5). In this report, there is no mention of Petitioner's work activities making his symptoms worse. On cross examination, when questioned regarding what Petitioner told Dr. Chmell on this date, Petitioner testified that he did not recall whether he reported to Dr. Chmell that his knee pain happened over time (Tx. 61). Petitioner testified that he did not recall whether he told Dr. Chmell that his knee pain was related to his job (Tx. 61). Petitioner later admitted that he did not tell Dr. Chmell on March 18, 2008 that his injury happened at work or was work-related in any way (Tx. 62). He admitted that he did not mention his employment at all to Dr. Chmell, and admitted to not describing to Dr. Chmell what he does at work (Tx. 62).

Petitioner testified on re-direct examination that he told Dr. Norem and Dr. Hovis about his job duties well before he saw Dr. Chmell (Tx. 77-78).

Testimony of Cynthia Garner

Cynthia Garner, Director of Human Resources for Respondent Liebovich Brothers, testified on behalf of Respondent. Ms. Garner testified that she is involved with workers' compensation cases and dealing with employees who were injured on the job (Tx. 83). She testified that when an employee reports that he or she has been injured while working, an accident report is filled out, and the report is forwarded to the workers' compensation carrier (Tx. 84). Ms. Garner testified that she never received notice from Petitioner that he sustained an injury while working. Ms. Garner also stated that she never created an injury report for Petitioner while working at Liebovich Brothers (Tx. 85). During cross examination, Petitioner admitted that he knew Cynthia Garner, and had met her before (Tx. 51). Petitioner testified on cross examination that he did not recall speaking to Ms. Garner about his injury (Tx. 52). Ms. Garner testified that Petitioner did not tell her that the problems with his knees were related to work (Tx. 87). Ms. Garner testified that she sent Petitioner a letter dated July 11, 2008 (Rx. 3) stating that Petitioner "previously received short term disability benefits under the company's program, which as you know are not available for alleged work-related injuries" (Tx. 88-90). This letter to Petitioner also stated the following: "As you know, you had previously indicated, on a repeated basis, that this injury had nothing to do with work." (Rx. 3). Ms. Garner testified that she did not have any other conversations with Petitioner regarding alleged knee injuries at work after this letter was issued (Tx. 90-91). Further, there has never been an instance in writing or verbally from Petitioner to Ms. Garner indicating that there was a work-related accident (Tx. 92).

Testimony of Chris Polhill

Chris Polhill testified that he has been an employee of Respondent for approximately 21 years. He testified that his job title was Shop Superintendent. This position entails scheduling all production, as well as supervisory responsibilities over employees at the plant (Tx. 95-96). Mr. Polhill testified that he had supervisory responsibility over Petitioner during Petitioner's employment with Respondent, and that, in his position, he saw Petitioner on a daily basis (Tx. 96). Mr. Polhill testified that he and Petitioner had a conversation in 2007 while at work during which Petitioner told Mr. Polhill that over the weekend he twisted his knee in a gopher hole while playing with his granddaughter (Tx. 97-98). According to Mr. Polhill's testimony, Petitioner never spoke to him about injuring his knees in any way at work (Tx. 98).

Mr. Polhill testified that he signed the Job Description for Petitioner's position of Fit-up Welder (Rx. 7) (Tx. 101). Mr. Polhill testified that, regarding the amount of time during the average work week Petitioner would be required to kneel, "I'd say 20, 25 percent." Chris Polhill testified that Petitioner never gave him notice of any accident that occurred at work (Tx. 103). The Petitioner testified on re-cross examination that he agreed with the job description entered into evidence by Respondent (Rx. 7), and testified that he agreed with this document's description of the amount of time that the job requires kneeling and standing to do the job (Tx. 80).

Mr. Polhill also testified that he never filled out a Form 45 with regard to Petitioner's alleged injuries to his knees, and that filling out a Form 45 would be standard protocol when a work-related injury was reported (Tx. 104). Mr. Polhill testified to creating and signing a document dated September 10, 2008 (Rx. 8), which states the following: "I do not recall at any time Mark Kunz informing me of any injury occurring during his shift. There hasn't been a verbal or a written injury report given to me. It was my understanding that Mark had twisted his knee at home a few years ago" (Tx. 105) (Rx. 8). On cross examination, Mr. Polhill testified that he did not see a difference between his height and Petitioner's height as far as the requirements on kneeling while working as a welder/fabricator (Tx. 112). Mr. Polhill testified that he performed the same duties in the same position as Petitioner at a certain time in his career with Respondent.

Testimony of Ron Polhill

Ron Polhill, a witness for Respondent, testified that he was Job Superintendent at Liebovich Brothers/Custom Fab for 25 years, and that he was Petitioner's direct supervisor until his retirement on May 6, 2007 (Tx. 124-125). Ron Polhill testified that his job entailed hiring and firing employees, getting work done, passing out the work, and overseeing the shop. He testified that in his position with Respondent he had an opportunity to get to know Petitioner (Tx. 125). Mr. Polhill testified that he never had a conversation with Petitioner about any injury that he might have suffered to his knees (Tx. 126). Mr. Polhill testified that there was one conversation with Petitioner regarding an injury. He testified that [Petitioner] "came in limping so bad that I asked him what had happened to him, because I'm out in the shop when the employees enter in the morning and stuff most of the time. I see a lot of them come in or in the break room, whatever. He come in limping like crazy. I asked him what the heck happened with him." (Tx. 128). Ron Polhill further testified, "He [Petitioner] said he was playing with his grandkids out in the yard, and he stepped in a hole." (Tx. 130). Petitioner testified on re-cross examination, regarding when this conversation with Ron Polhill took place, "Years ago. Can't really recall." (Tx. 134). When asked how many years ago this conversation took place, Petitioner responded, "6, 7, 8, 9, 10, 11, 12." (Tx. 134).

Deposition of Dr. Charles Bush-Joseph

Dr. Charles Bush-Joseph testified in a deposition dated June 1, 2009 that he performed an independent medical evaluation on Petitioner on January 9, 2009 (Rx. 9, 9). Dr. Bush-Joseph testified that Petitioner gave the following history during the IME: "...[H]e told me that he was employed as a welder and a fitter. I think he had worked for Liebovich Brothers about 11 years. I think he said there was some off and on in between where he didn't, but essentially he worked there 11 years in the same location. And he told me that he started having knee pain sometime in

2005. You know, as I state in my letter, I asked him several times, 'Was there a trauma? Did you fall? Did you injure it? Did you bang it or did something traumatic occur to it?' No – I think he responded no, and so I used the term in my letter that he essentially had an insidious onset. And I believe that he was treated by various practitioners including his family practice doctor and had treatments including attempted injections and things like that, but then the symptoms just got severe as of – what was it – April of 2008." (Rx. 9, 12).

Dr. Bush-Joseph testified that he did not note an exact date of when Petitioner's problem started (Rx. 9, 13). He testified that upon physical examination, the his findings were typical of a patient who was six to nine months after knee replacement on the right side with some arthritic changes also on the left side as well (Rx. 9, 14-15). Dr. Bush-Joseph testified that he noted bilateral degenerative arthritis, right greater than left, for his impression of Petitioner (Rx. 9, 16). Dr. Bush-Joseph also testified that he reviewed Petitioner's job description (Rx. 9, 17). In Dr. Bush-Joseph's opinion, Petitioner's symptoms and findings were clearly consistent with progressive degenerative arthritis of both knees, with a pure degenerative type of arthritis with superimposed traumatic worsening (Rx. 9, 19-20).

Dr. Bush-Joseph testified that, in his opinion, the activities described by Petitioner which included normal activities of daily living, as well as those activities of work, are typical to produce symptoms, but in no way caused or produced the arthritic condition of Petitioner's knees that necessitated treatment or surgery (Rx. 9, 20). He also testified that there was no evidence of aggravation or acceleration of Petitioner's arthritic condition (Rx. 9, 22). Dr. Bush-Joseph noted that after reviewing the job description, the majority of Petitioner's activities were standing (Rx. 9, 23). Lastly, Dr. Bush-Joseph testified that he did not believe that Petitioner's repetitive activities of daily living or repetitive activities of work would have either produced or aggravated the degenerative arthritic symptoms necessitating surgery in both knees (Rx. 9, 23-24). Dr. Bush-Joseph testified that he does not consider kneeling on a hard surface to be a traumatic type of situation (Rx. 9, 33). He testified, "I don't believe that the act of kneeling produces – produces an anatomic wear or demonstrable worsening of the condition."

CONCLUSIONS OF LAW

The Arbitrator addresses the specific areas of dispute below:

In support of the Arbitrator's decision relating to Disputed Issue "C" – Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent and Disputed Issue "F" - Is the petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following:

The Arbitrator had the opportunity to observe Petitioner on this matter when he testified. The Arbitrator concludes Petitioner is not a credible witness. Petitioner contradicted himself on several occasions during his testimony, and was contradicted by credible testimony of other witnesses. Thus, Petitioner's statements should be given less weight.

Petitioner's testimony with regard to his application for short term disability benefits through Respondent is particularly noteworthy. During cross examination, Petitioner denied having applied for or receiving short term disability benefits in November of 2007 (Tx. 36). However, after being shown the Northern Illinois Health Plan questionnaire and application for

disability benefits (Rx. 1), petitioner admitted to applying for and receiving short term disability benefits (Tx. 45). Petitioner also admitted to receiving short term disability benefits in 2008 through Respondent's plan when shown the application dated September 4, 2008 containing his signature (Rx. 2).

Several inconsistencies are also present with regard to Petitioner's testimony regarding notice to his supervisors. The Arbitrator notes that Petitioner testified to notifying his supervisor, Ron Polhill, of his knee problems in 2007 (Tx. 14-15). However, when Ron Polhill was called as a witness, he testified that he never had a conversation with Petitioner about any injury he might have suffered to his knees (Tx. 126). Ron Polhill testified that he retired from Respondent in May of 2007, and the Arbitrator finds that Chris Polhill took over as supervisor at that time. Petitioner testified during cross-examination that he gave notice of his injury to Chris Polhill while having a conversation in Chris Polhill's office (Tx. 24-25). Petitioner testified that he could not remember anything specific about that conversation, and the only detail about that conversation he could recall is that the season was Fall (Tx. 25, 27). Chris Polhill testified that Petitioner never spoke to him about injuring his knees in any way at work (Tx. 98). In addition, Chris Polhill testified that Petitioner informed him during a conversation in 2007 that he had twisted his knee in a gopher hole while playing with his granddaughter (Tx. 97-98). The Arbitrator finds that the testimony of Chris Polhill and Ron Polhill was credible, and that Petitioner failed to contradict their statements.

Petitioner testified inconsistently when questioned as to how he obtained the applications for short term disability benefits. He testified that he did not remember how he received the forms to apply for short term disability benefits (Tx. 46).

With regard to the forms completed and signed by Petitioner in order to receive short term disability benefits, the Arbitrator finds Petitioner's credibility to be in question. When initially asked about whether he applied for short term disability benefits in November of 2007, Petitioner denied having done so. (Tx. 36). Petitioner later admitted to applying for and receiving short term disability benefits. Petitioner indicated "No" on these forms when asked whether his medical treatment was as a result of an accident or injury. Petitioner was also given the opportunity to indicate that his medical condition was work-related, but he failed to check the corresponding boxes on these forms. He admitted that he did not answer affirmatively when prompted to answer whether the claim is as a result of any injury he received on the job site or related to his employment. Furthermore, Petitioner admitted to answering "No" when he was asked whether he had filed a report of injury with his employer. Petitioner provided no testimony to rebut his responses to the questions on Rx. 1 and Rx. 2.

Cynthia Garner's testimony supports the finding that Petitioner is not a credible witness. Ms. Garner testified that she never created an injury report for Petitioner while Petitioner worked at Liebovich Brothers. She testified that it was standard procedure to fill out an accident report when an employee reported a work-related injury. Petitioner testified that he had met Ms. Garner before, but admitted that he did not recall speaking with her about his injury. Ms. Garner testified that Petitioner never indicated to her, whether orally or in writing, that the problems with his knees were related to work.

The Arbitrator notes that Petitioner's original alleged date of accident was listed as June 7, 2008. At the hearing of October 29, 2012, Petitioner's counsel advised that the date of accident was being changed to October 19, 2007 in order to conform Petitioner's date of loss to

his testimony. At the second hearing on July 16, 2013, prior to the closing of proofs, Petitioner's counsel advised that the date of accident was being amended again, back to June 7, 2008. The date of accident was changed back in order to conform the alleged accident to the testimony heard at the October 29, 2012 hearing. However, the amending of the date of accident only serves to make Petitioner appear less credible, as he is still unable to prove that any accidental injury occurred while he worked for Respondent.

The Arbitrator also finds inconsistencies in Petitioner's testimony with regard to an incident outside of work to which both Chris Polhill and Ron Polhill testified. Chris Polhill testified that in 2007 he and Petitioner had a conversation during which Petitioner stated that over the weekend he twisted his knee in a gopher hole while playing with his granddaughter. Chris Polhill signed a document in 2008 stating that, to his knowledge, Petitioner twisted his knee a few years ago while at home (Rx. 8). On cross-examination, Petitioner stated he had never twisted his knees at home in the past. Petitioner testified that he informed Chris Polhill of his work-related knee problems. Chris Polhill, however, testified that Petitioner never had a conversation with him about any work-related knee problems. Significantly, later in cross examination, Petitioner admitted that he never told anyone at Liebovich Brothers or Custom Fab about a work-related knee problem. Ron Polhill testified to a conversation with Petitioner during which Petitioner stated he had been playing with his grandchildren in the yard and stepped in a hole. When Petitioner was cross-examined regarding this conversation, he testified that it occurred "years ago." When questioned shortly thereafter about how many years ago it took place, Petitioner testified, "6, 7, 8, 9, 10, 11, 12." First Petitioner testified he had never twisted his knees at home in the past, then he admitted to having a conversation about twisting his knees at home with Ron Polhill. Petitioner's testimony and the testimony of Respondent's witnesses damaged the credibility of Petitioner.

After considering the complete testimony of Petitioner, the witnesses for Respondent, and the medical evidence, the Arbitrator concludes that Petitioner is not credible, and more weight should be credited to the testimony of Respondent's witnesses and medical experts than to that of Petitioner.

The Arbitrator also concludes that Petitioner failed to prove that he sustained a compensable accident that arose out of an in the course of his employment with Respondent under a repetitive trauma theory. Therefore, all requests for compensation are hereby denied.

The medical records indicate that Petitioner was experiencing arthritis in his knees well before the alleged date of accident on June 7, 2008. The early treatment records from Dr. Norem indicate that Petitioner was dealing with swelling in his lower extremities as of April 27, 2007. The evaluation note from April 27, 2007 states, "Second issue is some swelling in his lower extremities. He has had some problems with arthritis in his knees. He strained his knee recently and wants me to check on this." (Rx. 10). This evaluation report by Dr. Norem does not mention Petitioner's work activities in this note. Petitioner was seen by Dr. Norem on October 19, 2007 and presented with knee pain, and complained of ongoing knee pain over the past several years. Dr. Norem indicated in this note that Petitioner "is working with a lot of cranes, weights, walking, standing." (Rx. 10). Dr. Norem noted that Petitioner displayed degenerative arthritis in his knees. This note did not indicate Petitioner complained of any kneeling. In addition, on February 26, 2008 Petitioner was seen by Dr. Norem for a follow up visit. In his clinic note, Dr. Norem notes the following, "His major issue continues to be his knees. He has been seeing

rheumatology. He is trying to keep going in terms of his work." (Rx. 10). Again, there is no indication that Petitioner's knee issues are related to his work activities.

The treatment record of Dr. Hovis dated March 12, 2008 indicates that Petitioner "stands for 12 hours a day, and he has just able to do that because of right knee pain." (Rx. 4). Dr. Hovis does not opine in this note with regard to Petitioner's knees or kneeling while at work. Rather, the note indicates that Petitioner does nothing but stand while at work. The mere act of standing during work is not a risk of harm greater than that to which the general public is exposed.

In addition, the records of Dr. Chmell fail to relate Petitioner's job activities to his knee condition. Rx. 5, Dr. Chmell's evaluation note dated March 18, 2008, reads: "Patient states this happened over time," in reference to Petitioner's bilateral knee pain. The evaluation note does not mention Petitioner's work activities. The note also states, "Symptoms are made worse by walking, standing and stairs." (Rx. 5).

Dr. Bush-Joseph, Respondent's IME physician, testified that Petitioner told him he started having knee pain some time in 2005 (Rx. 9). After reviewing Petitioner's job description and examining Petitioner, Dr. Bush-Joseph testified that petitioner's symptoms were consistent with progressive degenerative arthritis in both knees. Dr. Bush-Joseph also testified that there was no evidence of aggravation or acceleration of Petitioner's arthritic condition as a result of Petitioner's work activities. According to Dr. Bush-Joseph, Petitioner's activities of work in no way caused or produced the arthritic condition of Petitioner's knees that necessitated treatment or surgery (Rx. 9).

An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n,* 224 Ill.2d 53, 65 (2006). An employee's injury is compensable under the Act only if it arises out of and in the course of his employment. "For an injury to 'arise out of' the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58 (1989). An injury arises out of the employment, as required for injury to be compensable under Workers' Compensation Act, if the claimant was exposed to a risk of harm beyond that to which the general public is exposed. *City of Springfield v. Illinois Workers' Comp. Comm'n*, 388 Ill. App. 3d 297 (4th Dist. 2009).

The Arbitrator concludes that, in the present case, Petitioner, as a welder/fabricator for Respondent, failed to prove by a preponderance of the evidence that he sustained accident injuries arising out of and in the course of employment. It is clear that Petitioner's bilateral knee condition was and is severe, but Petitioner failed to prove that the condition arose out of his employment with Respondent. The record shows that Petitioner was not exposed to a risk of harm beyond that to which the general public is exposed. From the medical records entered into evidence, the Arbitrator finds that Petitioner had developed severe degenerative arthritis in his bilateral knees over time. The testimony of Dr. Bush-Joseph is more convincing than that of Dr. Coe. Dr. Bush-Joseph opined that Petitioner's work activities and his activities of daily living would not have aggravated or produced Petitioner's degenerative arthritic symptoms. There was no indication that Petitioner was exposed to a risk of aggravation of his pre-existing condition due to his work activities. Merely standing up would have produced symptoms, and this is not a risk of harm beyond that to which the general public was exposed. *City of Springfield.* This

conclusion is based on the petitioner's treatment records with Dr. Norem, Dr. Hovis, Dr. Chmell, as well as the deposition testimony of Dr. Bush-Joseph. When considering the totality of the medical evidence, the Arbitrator is forced to conclude that Petitioner failed to prove that he sustained a compensable accident arising out of and in the course of his employment with Respondent.

In support of the Arbitrator's decision relating to Disputed Issue "E" – Was Timely notice of the accident given to Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner failed to provide Respondent with timely notice of a repetitive trauma claim. The evidence regarding Petitioner's claims for short term disability benefits, the medical records, Petitioner's testimony and the testimony of Respondent's witnesses, shows that Respondent was not made aware of Petitioner's alleged work-related knee condition. The Arbitrator notes that Petitioner's original alleged date of accident was listed as June 7, 2008. At the arbitration hearing on October 29, 2012, Petitioner amended the date of accident to October 19, 2007. When the matter was bifurcated and the hearing concluded on July 16, 2013, Petitioner amended the date of accident back to June 7, 2008. No accident or manifestation of symptoms is indicated by the medical records that Petitioner has submitted into evidence. The Arbitrator also notes that the alleged date of accident of June 7, 2008 was the day before Petitioner underwent total knee replacement surgery.

Petitioner testified that he applied for and received short term disability benefits through Respondent's group health insurance carrier. Respondent's Exhibits 1 and 2 are the corresponding applications and questionnaires for these short term disability benefits. These forms required Petitioner to indicate whether the medical treatment was a result of an accident or injury. Petitioner indicated "No" in response to this question. In the inquiries contained in Rx. 1, Petitioner had the opportunity to indicate that his condition was "work-related," but did not check the corresponding box on the form. Petitioner also admitted that he did not indicate anything specific on these forms when prompted to answer whether the claim is as a result of any injury he received on the job site or related to his employment. Moreover, Petitioner admitted that he answered "No" when the application asked whether he had filed a report of injury with his employer. Given the Petitioner's responses to the questions presented in these exhibits, it is clear that there was neither notice to Respondent of a work-related injury on November 19, 2007 nor on September 4, 2008. The opposite conclusion is evident: Petitioner went out of his way to indicate to his employer that his condition was not related to his work activities in any way. In fact, Petitioner had the opportunity in the September 4, 2008 application to indicate that his condition was related to his work activities, but chose not to. September 4, 2008 was 90 days after the alleged date of accident of June 7, 2008.

As stated above, Petitioner testified on re-direct examination that he told Dr. Norem and Dr. Hovis about his job duties before he was seen by Dr. Chmell. The record does not support this statement, however, as the relevant medical records do not indicate that these providers gave opinions regarding the relation between his condition and his job activities. In fact, the medical records indicate another example of Petitioner's diminished credibility with regard to the alleged accident as well as notice to Respondent.

Cynthia Garner testified credibly regarding Respondent's notice of Petitioner's injury. Ms. Garner testified to the injury reporting process for Respondent, in which an accident report is completed when an employee reports that he or she has been injured while working. She

testified that she never received notice from Petitioner that he sustained any injury while working for Respondent. Petitioner admitted on cross examination that he did not recall speaking to Ms. Garner about his injury. Ms. Garner testified that Petitioner never told her that the problems with his knees were related to work. Ms. Garner's letter to Petitioner dated July 11, 2008 stated the following: "As you know, you had previously indicated, on a repeated basis, that this injury had nothing to do with work." (Rx. 3). The Arbitrator finds that Petitioner failed to produce any testimony to contradict Ms. Garner's statements. In fact, importantly, Petitioner admitted during cross examination that he never complained to anyone at Liebovich Brothers regarding any knee pain or problems.

It has been found that a letter from Respondent's representative, confirming the alleged injury is not work-related, will contribute to a finding of a lack of timely notice to Respondent. *Rosie Smith v. Ford Motor Company*, 03 IL.W.C. 8679 (Ill. Indus. Com'n Oct. 10, 2007). In *Smith v. Ford Motor Co.*, Respondent's workers' compensation administrator issued a letter to Petitioner stating that Petitioner's knee complaints are not work-related. *Id.* The Illinois Workers' Compensation Commission sustained the Arbitrator's finding that Petitioner failed to give timely notice to Respondent. *Id.* Similarly, in the present case, Cynthia Garner, Director of Human Resources for Respondent, sent a letter to Petitioner advising that the problems with Petitioner's knees are not related to work (Rx. 3). This letter confirms that Respondent had no knowledge of any work-related injury, but Respondent did know about Petitioner's non-occupational knee complaints. The fact that Cynthia Garner had knowledge of some unrelated bilateral knee problems does not constitute notice of his claim of a work-related accident. Simply telling the Human Resources department about physical complaints that are not related to work is not notice for the purpose of a claim for benefits under the Workers' Compensation Act.

Petitioner testified that he informed supervisors Ron Polhill and Chris Polhill of injuries to his knees while working for Respondent. However, notice to these individuals is not supported by the record. Chris Polhill testified that Petitioner never gave him notice of any accident that occurred at work. He also testified that at no time did Petitioner speak with him about injuries to his knees at work. Chris Polhill testified to drafting and signing Rx. 8, which was a letter stating that Petitioner never informed him of an injuring occurring during his shift. According to this writing, "There hasn't been a verbal or written injury report given to me. It was my understanding that Mark had twisted his knee at home a few years ago." Similarly, Ron Polhill testified that while he was Petitioner's supervisor, he never had any conversations with Petitioner about any injury he might have suffered to his knees. Ron Polhill testified that the only time Petitioner mentioned his knees was one instance in which Petitioner came into work limping, and Petitioner told Ron Polhill that he had been playing with his granddaughter and stepped in a hole. The testimony of Chris Polhill and Ron Polhill was not rebutted by petitioner.

The Arbitrator notes that both Chris Polhill and Ron Polhill testified to having conversations with Petitioner regarding incidents in which Petitioner twisted his knee at home while playing with his grandchild. Chris Polhill testified that Petitioner told him that Petitioner had twisted his knee in a gopher hole while playing with his granddaughter. Later, Ron Polhill testified that he had a conversation in which Petitioner told him he was playing with his grandkids over the weekend and stepped in a hole. According to Ron Polhill's testimony, Petitioner came in to work the following Monday limping, prompting Mr. Polhill to inquire as to the incident. Both witnesses testified that these were the only conversations they ever had with Petitioner regarding any issues with Petitioner's knees.

Based on the above, the Arbitrator finds that Petitioner failed to provide timely notice of his injury to Respondent. As such, Petitioner's claim for workers' compensation benefits is hereby denied.

In support of the Arbitrator's decision relating to Disputed Issue "J" – Were the medical services that were provided to Petitioner reasonable and necessary, the Arbitrator finds the following:

Given the medical records provided and Petitioner's testimony, and most notably since the Arbitrator did not find that Petitioner's present condition of ill-being is causally related to the alleged incident of June 7, 2008, the Arbitrator finds that the medical services were not reasonable or necessary, nor should the Respondent be held liable. Accordingly, all benefits for medical services are hereby denied.

In support of the Arbitrator's decision relating to Disputed Issue "K" – What temporary benefits are in dispute, the Arbitrator finds the following:

Based upon the totality of facts and circumstances presented, the Arbitrator finds that Petitioner is not entitled to any temporary total disability benefits since the alleged injury did not arise out of or occur in the course of Petitioner's employment. Accordingly, all temporary total disability benefits are hereby denied.

Petitioner has requested Maintenance benefits from Respondent, citing the hand-written job search log created by Petitioner (Px. 9). The Arbitrator finds that this job search log is not sufficient to establish a claim for Maintenance, and Petitioner's job search was not made in good faith. The Petitioner admitted on cross-examination that he did not know the dates on which he allegedly contacted the companies in this log. He also testified that he personally appeared to interview at these companies, but later admitted that he did not know the dates on which he appeared, nor did he actually have an interview with any of them. Petitioner testified that, at each of these companies, he spoke only with a secretary, and not with any employee with hiring responsibility. This shows a lack of a good-faith attempt at securing employment. Accordingly, Maintenance benefits are hereby denied.

In support of the Arbitrator's decision relating to Disputed Issue "L" – What is the nature and extent of the injury, the Arbitrator finds the following:

Based on the facts presented, the Arbitrator finds that Respondent is not liable for any permanent partial disability for either of Petitioner's knees. This is due to the fact that the Arbitrator concluded that Petitioner failed to prove under a repetitive trauma theory that he sustained injuries arising under and in the course of employment with Respondent. In addition, Petitioner failed to prove that his condition is causally related to his job activities as a welder for Respondent. Accordingly, the Arbitrator finds that no permanent partial disability benefits are to be paid to Petitioner.

In support of the Arbitrator's decision relating to Disputed Issue "N" – Is Respondent due any credit, the Arbitrator finds the following:

Based upon the totality of facts and circumstances presented, Respondent shall be given credit for all short term disability benefits paid to Petitioner by Respondent. Petitioner testified

during cross examination that he applied for and received short term disability benefits through Respondent's short term disability benefit program in 2007 and 2008. Petitioner admitted to signing the Northern Illinois Health Plan questionnaires for disability benefits dated November 29, 2007 and September 4, 2008. The evidence clearly demonstrates that Petitioner received a total of $29,302.62 in short term disability benefits that were fully funded by Respondent. As such, the Arbitrator finds that respondent is due credit for $29,302.62.

Arbitrator Edward Lee

10/17/13
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Tolbert,
Petitioner,

vs.

NO: 10 WC 43745

Prairie Central Cooperative,
Respondent.

15IWCC0473

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to remand Order of the Appellate Court for a determination of an amount for TTD, medical and prospective medical benefits.

In his §19(b) Decision filed May 24, 2011, Arbitrator Mathis found Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on October 4, 2010. The Arbitrator further found that an employee-employer relationship did not exist between Petitioner and Respondent on that date, that timely notice was not given to Respondent and that Petitioner's current condition of ill-being was not causally related. The Arbitrator denied Petitioner's claim for compensation, medical expenses and prospective medical care. Petitioner reviewed the Arbitrator's Decision. In its Decision and Opinion on Review dated April 17, 2012, the Commission affirmed and adopted the Arbitrator's Decision and made an additional finding that Petitioner failed to prove that he was exposed to histoplasmosis at his workplace. Petitioner appealed the Commission's Decision to the Circuit Court of McLean County. The Circuit Court entered a judgment confirming the Commission's Decision, finding that it was not against the manifest weight of the evidence as to the issues of causal connection, date of accident, employer-employee relationship and notice.

Petitioner appealed to the Appellate Court. In its Opinion filed June 5, 2014, the Appellate Court found that Petitioner presented credible medical evidence that his workplace environment caused him to contact histoplasmosis and that his conditions of ill-being are caused by the lung infection. The Court found that the Commission's conclusion that Petitioner's current conditions of ill-being are unrelated to a workplace exposure to the fungus causing

histoplasmosis is contrary to the manifest weight of the evidence. The Court further found that the Commission's finding that Petitioner had failed to give any notice was against the manifest weight of the evidence. The Court found that Petitioner gave notice as complete as he was capable of giving as to the course of his conditions of ill-being on September 1, 2010, when he told his supervisor Mr. Heil that he could no longer work. The Court found that this conversation took place within 45 days of Petitioner's exposure to the fungus causing histoplasmosis. The Court noted that Petitioner inhaled potentially infectious dust over a period of time between July 28, 2010 and August 26, 2010, his last date of work. On October 4, 2010, Petitioner learned for the first time that his conditions of ill-being were causally related to a workplace exposure to histoplasmosis when his lung biopsy revealed that he had the lung infection. The Court also found that regardless of the oral notice of September 1, 2010, Respondent received written notice on November 9, 2010, when Petitioner's attorney sent a letter to Respondent stating that Petitioner contracted histoplasmosis as a result of his work conditions. This letter was sent within 45 days after Petitioner learned that his conditions of ill-being were causally related to a workplace accident. The Court found that the letter also fulfilled the notice requirements under §6(c) of the Act. Regarding employment relationship, the Court found that the evidence established that Petitioner's conditions of ill-being are causally connected to an accident that occurred when the employer-employee relationship existed, although the causal connection between the accident and the conditions of ill-being was not apparent until after the employment had ended. The Appellate Court reversed the Circuit Court's judgment that confirmed the Commission's Decision, reversed the Commission's Decision denying Petitioner's claim and remanded for a determination of Petitioner's request for TTD, medical expenses and prospective medical care.

On remand, the Commission finds Petitioner was temporarily totally disabled from September 30, 2010 through March 21, 2011, the date of the arbitration hearing, a period of 24-5/7 weeks, that the treatment rendered through the date of arbitration was reasonable and necessary and that Respondent is liable for the treatment rendered to Petitioner at OSF Saint James – John W. Albrecht Medical Center emergency room, treatment with Dr. Norris, treatment with OSF St. Joseph Medical Center and Dr. Farah and that Petitioner is entitled to prospective medical care 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 testified that he last worked for Respondent on August 26, 2010 (Tr 11). Respondent is a grain elevator (Tr 11). Petitioner's job was a grain handler. Trucks would bring grain and dump it and Petitioner would clean up grain and ship it out (Tr 11). This job was seasonal (Tr 11). Petitioner worked for Respondent that season beginning in July 2010 (Tr 11).

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He had worked for Respondent in previous years (Tr 12). He first worked for Respondent in 1998, part time to begin with, but then got full time at the end of harvest season that year in 1998 (Tr 12). Petitioner continued to work for Respondent up to 2008 (Tr 12). In 2008, Petitioner worked for Respondent full time loading train cars, dumping grain trucks and general maintenance. In August 2008, his duties were to clean up grain flats, grain elevators and grain bins (Tr 12). He described cleaning up a grain elevator as moving grain using a Bobcat (Tr 13-14). Petitioner described that he was moving corn and in the corn was a bunch of dust, rat feces, bird droppings and foreign material, such as corn husks and just general dust (Tr 14). In the grain flat at that time, the material had been there for 6 years; the material is rotated around every so often and more is put in. At that time, Petitioner was cleaning up this flat to get ready for the next harvest (Tr 14-15). When using the auger, he wore blue jeans, a T-shirt, a safety shirt, hard hat, dust mask and gloves (Tr 15). He would use 3 to 5 dust masks a day (Tr 15). Petitioner had brought a dust mask to court and it was viewed (Tr 15-16). That particular mask was mild. The masks are generally a lot worse than that mask. Petitioner stated that most of the dust had been banged out of that mask (Tr 16). From time to time, he had to get out of the Bobcat and climb up the side to tie up the temperature cables and all the way up and down the grain pile, which he was constantly in (Tr 16).

Petitioner had seen lots of pigeons in this particular flat (Tr 17). In July and August 2010 while working in this flat cleaning out the foreign material, Petitioner started feeling a lot more weak and started coughing, had a lot of phlegm, a lot of black dust and dirt, occasional blood from time to time and started getting really bad chest pains (Tr 17). Every time he coughed, he would hack up this big yellow or black substance and sometimes blood (Tr 17). At that time, Petitioner noticed his breathing would down and down and he would get shortness of breath with activities such as climbing up the sides (Tr 18). Petitioner noticed he was doing a lot of hard breathing, there was a lot of black snot and dryness (Tr 18). He worked 2 or 3 weeks in this flat for the whole work day (Tr 19). The flat is a dark, hot, dusty and moist environment and smelled of mold (Tr 19). August 26, 2010 was the last day he worked for Respondent (Tr 20). At that time, Petitioner noticed weakness, numbness in his hands and feet, shortness of breath, chest pains and swollen toes (Tr 20).

Petitioner testified he went to the emergency room at St. James Hospital in Pontiac, Illinois on August 26, 2010 for complaints of chest pains and shortness of breath (Tr 20). He felt a real bad squeezing across his chest (Tr 21). After this emergency room visit, Petitioner followed-up with Respondent's president Mark Heil (Tr 21-22). He advised Mr. Heil that he had gone to the emergency room and that his doctor did not want him working around grain dust (Tr 22). Mr. Heil did not tell Petitioner that he could return to work in any other position (Tr 23). Petitioner testified he would have returned to work to any other position at Respondent that did not involve grain dust (Tr 23). Petitioner had no prior lung problems (Tr 23). Several years before this, he had chest pain (Tr 23). He had a lot less chest pain back then and described it as pressure, like someone was sitting on his chest (Tr 23). Now it felt like a big squeeze, like someone just squeezing him from the inside (Tr 24). On October 4, 2010, Petitioner had a

biopsy and was diagnosed with exposure to histoplasmosis with chronic primary histoplasmosis (Tr 24). He informed Mark Heil of his diagnosis by text message (Tr 25).

Petitioner saw his primary care physician Dr. Norris, his nurse Mary Jo Krol and Dr. Farah, a lung specialist (Tr 26). He has also treated at some emergency rooms (Tr 26). Respondent has not requested he be seen for an independent medical evaluation (Tr 26). Petitioner then stated he has reviewed an independent medical evaluation report (Tr 26). The biopsy was done by Dr. Ray at St. Joe's in Bloomington, Illinois (Tr 27). Petitioner never had a diagnosis of histoplasmosis prior to October 4, 2010 (Tr 27). This condition has changed his daily living activities. He cannot breath very well, he cannot walk for long period of times and his legs and arms get weak, he cannot lift anything, he cannot stand or sit for very long, he has to get up and move because his joints are aching and his muscles are tightening up, he is coughing all the time and has headaches and back pain (Tr 27). He has not worked anywhere since August 26, 2010 (Tr 27). Dr. Norris has him authorized off work (Tr 28).

In August and September 2010, Petitioner had no idea what was going on at first. Petitioner testified the doctors thought he had cancer, until the biospsy showed histoplasmosis (Tr 28). At first he just thought that it was something that would eventually go away (Tr 28). Petitioner currently noticed numbness in his hands and feet, shortness of breath, weakness in the arms and legs, coughing, a little bit of blood in his spit, from time to time he urinates blood, pain in his back that feels like two fists coming out of his back all the time and the worst are the chest pains (Tr 29). Petitioner takes Intrazonozole for fungus, Vicodin for pain and muscle relaxers (Tr 29). He takes over-the-counter aspirin for his headaches, but this does not work (Tr 29). Nothing really works for him (Tr 29-30). Petitioner has not received any workers' compensation benefits while being off work or on light duty (Tr 30). Petitioner has submitted his medical bills through public aid (Tr 30).

On cross-examination, Petitioner testified he started working again for Respondent on July 28, 2010 as a seasonal worker (Tr 30). The last time he worked for Respondent before that was in 2008 (Tr 31). He worked seasonally for Respondent in 2009 (Tr 31). The normal season started when the farmers get the corn out of the field, usually starting at the end of July and usually goes to December or January (Tr 32). Petitioner worked full time for Respondent from 1998 until around the beginning of 2008 (Tr 32). In 2008, 2009 and 2010, Petitioner was seasonal (Tr 32). He worked from July 28, 2010 through August 26, 2010 (Tr 33). At the end of August 2010, Petitioner had a conversation with Mark Heil (Tr 22). He stated that he told Mr. Heil that his doctor did not want him to work around grain dust anymore and that he had been to emergency rooms and was still waiting for results (Tr 33). Petitioner told Mr. Heil he could not work around grain dust (Tr 34). He did not tell Mr. Heil that he was having a personal health issue that did not have anything to do with work (Tr 34). Petitioner's attorney stated it is his understanding this conversation occurred September 1, 2010 (Tr 34). Petitioner did tell Mr. Heil that he had some doctor appointments set up and could not work and attend those appointments (Tr 36). He denied he told Mr. Heil that he believed this was related to cancer (Tr 36). The

appointments were going to be set up with primary care physician Dr. Norris, but he was not in at that time (Tr 36).

In November 2010, Petitioner treated with Dr. Farah. He did tell Dr. Farah that he had been smoking on and off since age 15 (Tr 37). He is 36 years old. Dr. Farah told him he needed to quit smoking (Tr 37). He had quit and was currently using an electric cigarette, but slips from time to time (Tr 37). Petitioner had shortness of breath and chest pains before July 28, 2010, but not very often; basically when he got a chest cold (Tr 37-38). He got chest pain, but not very often (Tr 38). He did not have fatigue before July 28, 2010 (Tr 38). On July 9, 2010, Petitioner saw Dr. Kashyap at OSF Medical Group and he recorded a history of chest pain, dizziness, headache and fatigue (Tr 39). Petitioner had undergone a sleep study in April 2010 (Tr 39). At that time, he was falling asleep during the day and in the car and snoring (Tr 39). The sleep study report also mentioned a history of chest pain and shortness of breath (Tr 40). Petitioner stated the chest pain at that time was more like pressure and he had a cold back then (Tr 40). The chest pain at the time of the sleep study he believed was related to a cold (Tr 41). The chest pain he has now started in August 2010 (Tr 41). It was not an ongoing problem before July 2010 (Tr 41).

When he conversed with Mark Heil on September 1, 2010, Petitioner stated he told him that ingesting grain dust was probably causing his coughing (Tr 42). Before July 28, 2010 when he began working for Respondent, he was having headaches very often, then stated once a week. There was no dizziness (Tr 42). He had a little dizziness caused by bad ears (Tr 42). His prior chest pains would go away pretty quickly (Tr 42). He coughed a lot, but did not cough when he smoked (Tr 43). He was not coughing at night time. All the foreign material grain dust he was inhaling was causing the coughing (Tr 43). A grain flat was 660' X 300' and had bay doors (Tr 44). There is ventilization in these flats (Tr 45). Bin #18 is noted on one of his time cards (Tr 45). Bin #18 is a round bin 200' in diameter and has one big metal door; a semi-truck fits through the door (Tr 45-46). Loading a train is done outside (Tr 46). There was a lot of dust when working in a flat or a bin or in the train cars (Tr 47). Petitioner wore a dust mask while loading the train (Tr 47). Petitioner filled out his time cards at the end of the week and not everything he did is listed on them (Tr 48).

Petitioner underwent a lung biopsy on October 4, 2010. His employment had ended on August 26, 2010 (Tr 50). Petitioner underwent pulmonary function testing which showed a small drop (Tr 52). In his text to Mark Heil in late September 2010, Petitioner did not tell him he just needed money and did not tell him something specific about having a work injury (Tr 52).

On re-direct examination, Petitioner testified that the chest pains that he had around the time of the sleep study were different than the ones he had at the end of August 2010 (Tr 54). The chest pains around the time of the sleep study were a pressure like someone sitting on his chest. The chest pains now are like someone squeezing the inside of his chest (Tr 54). The sleep study results were normal (Tr 54). Petitioner did not quit his job at Respondent and had not been told he was fired (Tr 57).

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On re-cross examination, Petitioner testified that after the September 1, 2010 conversation with Mark Heil, he brought him a slip from his doctor, but did not give it to him (Tr 58). Petitioner would have done other jobs at Respondent if available (Tr 58). Petitioner testified he did ask Respondent if other jobs were available (Tr 58). Mark Heil told him there was nothing available (Tr 59). Petitioner testified he helped develop the computer system that Respondent uses and has run the computer when train cars are being loaded (Tr 59). There is grain dust in Respondent's office, about the same amount of dust as in the bins and flats (Tr 59). He had not worked the scales or probing the grain trucks (Tr 60-61). Everything else would be in the grain dust (Tr 61).

2. Mark Heil testified that his is general manager of Respondent (Tr 63). He had worked for Respondent for 8 years and has been general manager for 2 years (Tr 63). He is familiar with the job duties of the laborers (Tr 64). Petitioner's job was to get grain moved out of the grain bins and loading rail cars (Tr 64). The season in 2010 was from end of July through the end of August (Tr 64). Petitioner was a seasonal employee in 2010 and in 2009 (Tr 64). He believed Petitioner was a full-time employee before that (Tr 65).

At the end of the 2010 season, Petitioner contacted him and they set up a meeting. In the morning of September 1, 2010, Petitioner walked through the door of his office and said that he had cancer (Tr 66). Mr. Heil did not remember Petitioner telling him where, but he knew Petitioner had lung issues or chest issues before; he had heard Petitioner say that he had chest issues (Tr 66). Petitioner informed him he had doctor's appointments set up for later in the month and that if he continued to work, those appointments would get pushed into the fall. Petitioner informed that for that reason, he was needing to leave Respondent at that time (Tr 67). There was no seasonal work or other job duties (Tr 67). At that point in time Petitioner was moving on and he wished him the best of luck and they shook hands (Tr 67). That same day after their conversation, Mr. Heil sent a text to Karen White of Respondent's human resources and others in the west that Petitioner could no longer be with Respondent. Petitioner had asked him for confidentiality, so he did not use the word cancer in his text messages (Tr 68). Petitioner did not give him any documentation of anything (Tr 70). During that time Respondent had 30 full time employees and 40 to 50 seasonal employees (Tr 70). Some documentation for the Department of Employment Security was filled out by Karen White and himself. For the question of what circumstance, incident or reason that caused claimant to leave employment, Mr. Heil wrote, "Mark told us that he had personal health issues that needed to be taken care of. We asked that he get an okay from doctor after he told us the doctor told him he needed to tell his employer of his health status. Mark then decided to leave work and then take care of his health issues over the next few weeks to a month." (Tr 72-73). At that time there was no discussion and Petitioner did not ask if he could do any other positions within the company and that he could not be working in these grain bins or flats (Tr 73). If Petitioner had stayed on during harvest, he possibly could have been a truck probe operator, which is like playing a video game, putting the probe into the grain car or truck and getting a sample (Tr 73-74). Petitioner also could have run a computer on a scale and also helped with loading the trains, which could have been in an office

if he wanted to do that (Tr 74). The office had an office environment (Tr 74). When running the probe, the operator is inside and the probe outside (Tr 75). The flat building is 600' X 300' (Tr 75). Bin #18 is a 2 million bushel building at least 100 feet diameter (Tr 76). Bin #18 has a garage door over a wide opening and equipment comes in and out (Tr 76). Equipment consists of semi-tractor, tractor and others (Tr 76).

After the September 1, 2010 conversation, Mr. Heil received a text message from Petitioner, but he did not remember what date (Tr 77). In this text message, Petitioner asked him if there was any way he could earn $400 or $450 that day (Tr 77). The first time he learned that Petitioner was claiming a workers' compensation injury was on November 9, 2010 when a mailing was received and then a text message stating to be careful in the building with dust issues (Tr 77).

On cross-examination, Mr. Heil testified that in his text message, Petitioner did not ask for work; he asked if there was a way he could earn $450 (Tr 78). Mr. Heil did not remember when the text was received (Tr 79). It was before a second text from Petitioner was received in November 2010 which indicted he should be careful of grain dust (Tr 79). At the September 1, 2010 meeting, Petitioner said he had cancer. He did not say he had chest pains (Tr 80). Mr. Heil knew Petitioner had chest issues going back months before (Tr 80). Petitioner talked about biopsies and having to get tests done for the cancer (Tr 81). The flat is a big building. Petitioner referred to foreign material in that flat; foreign material would be a little piece of chip off a kernel of corn (Tr 82). Petitioner's job in July and August 2010 would be getting corn out of the building (Tr 82). The flat was built 5 or 6 years ago and grain was continuously brought in and out (Tr 82). Some of the grain in that building could have been 4 or 5 years old and some weeks or months old (Tr 83). Old grain would be at the sides and bottom of the flat (Tr 83). Light would come in through the open door and from the lights (Tr 84).

Mr. Heil indicated that on the Voluntary Leave Questionnaire, Petitioner noted he would take care of his health issues for the next few weeks to a month (Tr 84). It was his understanding that Petitioner would not be returning to work (Tr 84). Seasonal employment would be over by that time (Tr 85). In 2010, the harvest season ended October 1, 2010 (Tr 85). Some seasonal employees will stay longer if additional work is needed to be done (Tr 85). 2010 was probably the fastest harvest Respondent has ever had (Tr 86).

3. Matt Hinshaw testified that he is operations manager at Respondent and has been there for a little under 3 years (Tr 88). He did not directly work with Petitioner (Tr 88). He is in charge of supervision for all the grain elevators at Respondent (Tr 88). Petitioner worked from July 28, 2010 through August 31, 2010, his last day worked (Tr 88). Bin #18 is 200' diameter and the side wall is 63 feet tall and holds 2 million bushels of grain; at its peek, it is 90' tall (Tr 89). It has a large door where equipment tractors and Bobcats can enter and exit (Tr 89). The flat in Pontiac is 660' X 300' (Tr 89). Petitioner worked at the Pontiac location (Tr 90). Mr. Hinshaw has a working knowledge of what jobs are present there (Tr 90). Other jobs not involving grain dust include probing trucks as they come in and the person doing that is inside an

office; through a set of remotes, a sample is taken from the load (Tr 90). Another job is working the scales, running the computer system that weighs the trucks (Tr 91). Respondent makes an effort to accommodate injury restrictions (Tr 91). Petitioner did not approach Mr. Hinshaw at anytime and say he wanted to come back to Respondent and not in a grain heavy environment (Tr 91). Mark Heil informed him of the conversation he had with Petitioner (Tr 92).

On cross-examination, Mr. Hinshaw testified that truck probing is done with a hydraulic joy stick (Tr 92-93). It is a possibility that grain dust can fly in and out of the office when the door is opened or closed, the same amount of dust that is kicked up on a busy road (Tr 93). Operating the computer near the trains is not an inside job (Tr 93). Scaling trucks is an inside job (Tr 93). Mr. Hinshaw was aware Petitioner did not have any training on scaling and Respondent would have to train him (Tr 93). There is a slight exposure to grain dust now when loading trains if flipping the lid (Tr 94).

On re-direct examination, Mr. Hinshaw testified that train cars are not loaded every day and running the computer as light duty would not work out because it is not done that often; it could be once a week or once a month (Tr 94). The person running the computer is in an office next to the train (Tr 95).

4. Petitioner was recalled and testified that he would sometimes put on the time cards what he did on a day. Petitioner worked in flats every single day for 2 weeks straight and in and out for about another week with the tubes and back out to do something else on the elevator (Tr 99). Petitioner's time cards were admitted into evidence as Rx5.

5. In an e-mail to Karen White dated September 1, 2010, Rx7, Mr. Heil indicated, "Mark Tolbert is done working with pc. He came in and talked to me this morning."

A Voluntary Leave Questionnaire, Rx6, was completed by Mr. Heil and dated September 14, 2010. In this Questionnaire, Mr. Heil indicated that Petitioner's last day worked was August 31, 2010. Mr. Heil indicated that on September 1, 2010, "Mark told us that he had personal health issues that needed to be taken care of. We asked that he get an OK from doctor after he told us the doctor told him he needed to tell his employer of his health status. Mark then decided to leave work and take care of his health issues over the next few weeks to month." Regarding what steps Petitioner took to explain or resolve the situation, Mr. Heil indicated, "Came into our office to personally tell me that he needed to leave. He had dates set up that if he didn't pursue now would be pushed later into the year."

6. According to the records from OSF Saint James – John W. Albrecht Medical Center in Pontiac, Illinois, Px8, Petitioner was seen in the emergency room on September 21, 2010 for complaints of left chest pressure for the last 3 weeks. Petitioner also complained of shortness of breath and pain worsening with sitting. Petitioner reported constant pain for 3 weeks. It was noted that Petitioner, "Had similar episode of pain 2 years ago and had negative stress test."

The medical records from OSF Medical Group, Px1, indicate Dr. Norris that day ordered a chest x-ray and CT scan. The September 21, 2010 chest x-ray report indicates that the x-rays taken were compared to those taken on August 6, 2008 and other studies. The report indicates that the x-rays showed there was a new 13mm nodular opacity within the right midlung zone. In the September 21, 2010 CT scan report, the radiologist noted that the CT scan of the chest showed multiple non-calcified bilateral pulmonary nodules. Differential considerations included granulomatous disease or metastatic disease. Any of the nodules, in particular the two large nodules, could represent primary lung neoplasm. Multifocal lung neoplasm was considered much less likely.

On September 22, 2010, Dr. Norris noted that Petitioner was seen in the emergency room on September 21, 2010 for complaints of steady pain in the left chest for the last 3 weeks. Petitioner had also reported some shortness of breath which increased with activity. Petitioner described that it felt like pressure and a suction feeling in the left lower chest anterior lobe. Occasional right shoulder and back pain was noted and that he slept okay. Petitioner reported no chest pain with breathing and he rated the pain at 5-6/10. Dr. Norris' assessment was chest wall pain and lung nodule in the right lung. Dr. Norris called regarding results of CT scan and ordered a whole body CT scan. A percutaneous guided biopsy was noted. Dr. Norris prescribed medications.

A PET CT Tumor Imaging scan of the whole body excluding legs was performed on September 24, 2010. The report noted findings of a 1.7cm pulmonary nodule in the superior segment of the right lower lobe, a 1.2cm nodule in the posterior basilar segment of the right lower lobe and a 4mm nodule in the superior segment left lower lobe. The radiologist's impression of the PET scan was the two right lower lobe pulmonary nodules demonstrated low-grade metabolic activity compatible with benign etiology. The left lower lobe nodule was too small for accurate characterization. A follow-up CT scan in 6 to 9 months was recommended.

7. In a Certificate to Return to Work/School dated September 30, 2010, Px6, Mary Jo Krall, APN, CNP to Dr. Norris noted that Petitioner had been under care indefinitely for respiratory issues. Ms. Krall noted, "Unable to work around grain dust."

8. Petitioner was seen by PA Loren Marie on October 1, 2010 for a 2 month follow-up for a tube and sinus check. Petitioner had a long-standing history for eustachian tube dysfunction and PE tube placemnt. Petitioner complained of his ears bothering him off and on. He also reported that he went to the emergency room last week for chest pains and since then they found nodules in his lungs that may possibly be lung cancer. It was noted that Petitioner was scheduled for biopsy of the nodules.

9. On October 4, 2010, a cutting needle core biopsy with CT guidance of the right lower lobe lung nodule was performed. The pathology report indicated that a portion of necrotizing granuloma was observed, multinucleated giant cells were identified and chronic inflammatory

cells were also seen. GMS stain showed tiny yeasts morphologically consistent with Histplasma yeasts. AFB stain was negative.

10. On October 22, 2010, Dr. Norris noted that Petitioner presented for evaluation of acute pulmonary histoplasmosis with symptoms of DOE, shortness of breath, cough with phlegm, chest pain in the left chest, fatigue and weakness. Dr. Norris noted that Petitioner was to see pulmonologist Dr. Farah on November 9, 2010. Dr. Norris noted the following history: "States that back in late July through end of August was in a grain flat transferring and cleaning the flat. The corn was 6 years old and was the worst he has seen – lots of mold, bird droppings. Tons of pigeons and sparrows in the flat all the time." Following his examination, Dr. Norris diagnosed histoplasmosis. Dr. Norris prescribed medications and Petitioner was to follow-up with him in 4 months.

11. Petitioner saw Dr. Farah on November 9, 2010. In his office notes that date, Px3, Px1, Dr. Farah noted that Petitioner was diagnosed with a history of histoplasmosis. Dr. Farah noted the following history: "The patient was working around the bird feces and started to have chest pains and shortness of breath." Dr. Farah noted that the lung biopsy showed histoplasmosis. Petitioner reported he did smoke since age 15, one pack per day and now was cutting down. Petitioner reported he coughed twice daily with yellow and clear sputum production with occasional blood. Petitioner reported no fever, chills or night sweats and no weight loss. Dr. Farah's assessment was histoplasmosis and noted that this was a chronic infection. Dr. Farah noted that Petitioner was to continue on Itraconazole for now and would need 6 to 12 months of treatment depending on the disease process. Dr. Farah ordered a pulmonary function test, which was performed the following day.

12. In a letter to Respondent dated November 9, 2010, Px9, Petitioner's attorney indicated that his office had recently been retained by Petitioner to represent him for injuries he sustained as a result of a work injury. Petitioner's attorney indicated that it had come to light that Petitioner had been diagnosed with Histoplasmosis and that, "He has been advised by his physicians that he obtained this chronic pulmonary condition as a result of his work in cleaning out grain elevators." Petitioner's attorney requested Respondent turn over this matter to the workers' compensation insurance carrier for further evaluation and to have them contact him.

13. In a letter to Respondent dated November 11, 2010, Px2, Dr. Norris noted the following: "Mark is being treated for a lung infection that he likely got being around grain dust/dust in general as well as pigeon feces and or mold. I recommend Mark not work around these environmental exposures until his infection is adequately treated. Length of treatment is likely months and could be up to a year."

14. On November 12, 2010, Petitioner, through his attorney, filed an Application for Adjustment of Claim. A date of accident on or about October 4, 2010 was noted along with injury to man as a whole, lungs and chest.

15. In his January 19, 2011 report, Px4, Dr. Farah noted his November 9, 2010 office notes and diagnosis of histoplasmosis. Dr. Farah noted, "There is a significant history of exposure on the patient's occupational history. The patient was cleaning the dust out of grain elevators and was exposed to bird residue and this is known to be a significant risk factor for histoplasmosis." Dr. Farah noted the chest CT scan and PET scan results. Dr. Farah noted that the lung biopsy showed a necrotizing granuloma with multinucleated giant cells, chronic inflammatory changes and the stains showed morphology which was consistent with histoplasmosis. Dr. Farah opined that Petitioner had exposure in the grain elevator to bird residue which resulted in the exposure to histoplasmosis and development of chronic histoplasmosis lung disease. Dr. Farah noted he had advised Petitioner to quit smoking and Petitioner was started on Itraconazole treatment and that this would continue 6 to 12 months. Dr. Farah noted that a repeat CT scan was done in January 2011 and did not show significant change. Dr. Farah noted that Petitioner was seen for an unrelated matter by Dr. Kashyap for excessive sleeping and hypersomnia and was diagnosed with positional obstructive sleep apnea. Dr. Farah opined that this was unrelated to Petitioner's current condition. Petitioner was to continue Itraconazole treatments.

16. In a letter to Respondent dated January 28, 2011, Px7, Dr. Norris noted that Petitioner was still unable to work due to fungal lung infection that caused extreme fatigue, shortness of breath and pain. Dr. Norris noted Petitioner continued to follow-up with a pulmonary specialist and himself. Dr. Norris opined that recovery would likely take a long time and was unpredictable. Dr. Norris noted Petitioner would not be able to return to work at this time and would be re-evaluated in 60 days.

17. At Respondent's request, Petitioner saw Dr. Bruyntjens on March 11, 2011 for a §12 evaluation. In his report, Rx1, Dr. Bruyntjens noted Petitioner reported that in his working environment he developed a cough with shortness of breath. Dr. Bruyntjens noted the lung biopsy results. Dr. Bruyntjens noted that the pulmonary function test showed very mild airway obstruction, if at all. Dr. Bruyntjens noted that Petitioner's current condition was unremarkable, he had a near normal pulmonary function test and nodules on his CT scan with minimal symptoms. Dr. Bruyntjens opined, "The overwhelming majority of patients with histoplasmosis are either asymptomatic or have rapidly resolving, self limiting disease requiring no treatment or follow-up." Dr. Bruyntjens opined that it was probably true that Petitioner's current condition of ill-being was usually connected with his employment. Dr. Bruyntjens opined, "The organism is a soil-dwelling fungus that river banks are favorite roosting sites. When such sites are disturbed by construction activities, vast amounts of potentially infectious aerosois may be formed. In a typical patient the illness resembles influenza. The onset is abrupt, consisting of fever, chills and substernal chest discomfort. A harsh, nonproductive cough develops along with headache, arthralgias, and myalgias." Dr. Bruyntjens noted that normal hosts eventually recover 99% of the time. Dr. Bruyntjens opined it takes minimal exposure to acquire histoplasmosis, which is recognized as an extremely common and almost invariably benign infection. Dr. Bruyntjens opined that in this case, a large majority of pulmonary or infectious disease specialists would have elected not even to treat Petitioner. Dr. Bruyntjens opined, "The history of smoking with a

15IWCC0473

near normal pulmonary function test with exposure in a benign condition like histoplasmosis, is a concern due to the smoking not the histoplasmosis."

18. In a letter To Whom It May Concern dated March 14, 2011, Px7, Registered Nurse Shannon Garber noted that due to Petitioner's conditions and symptoms, he was to be excused from work duties at that time.

19. Respondent submitted a job description questionnaire and this was admitted into evidence as Rx2. Under the Section for Environment, it was noted that Petitioner was exposed to grain dust in some cases.

20. At the March 21, 2011 §19(b) arbitration hearing, a Request for Hearing form was admitted into evidence as Ax1. On the Request for Hearing form, Petitioner's attorney indicated that the medical bills had been paid by Public Aid and that there was a Public Aid Lien. No medical bills were submitted by Petitioner for admission into evidence. On the Request for Hearing form, the parties stipulated that Petitioner's average weekly wage was $489.96.

Pursuant to Appellate Court remand, the Commission finds Petitioner was temporarily totally disabled from September 30, 2010 through March 21, 2011, the date of the arbitration hearing, a period of 24-5/7 weeks, that the treatment rendered through the date of arbitration was reasonable and necessary and that Respondent is liable for the treatment rendered to Petitioner at OSF Saint James – John W. Albrecht Medical Center emergency room, treatment with Dr. Norris, treatment with OSF St. Joseph Medical Center and Dr. Farah and that Petitioner is entitled to prospective medical care.

Regarding extent of temporary total disability, the Commission finds that September 30, 2010 was the first date a medical provider indicated Petitioner was unable to work around grain dust due to respiratory issues. Petitioner testified he would have returned to work to any other position at Respondent that did not involve grain dust. Petitioner remained disabled through the date of arbitration on March 21, 2011. The Commission further finds that the treatment rendered to Petitioner was reasonable, necessary and causally related to Petitioner's conditions of ill-being, based on the medical records, and that Respondent is liable for such treatment. The Commission allows Petitioner to present the amount of claimed medical expenses and/or Public Aid Lien at a subsequent arbitration hearing. The Commission finds Petitioner is entitled to prospective medical care based on the records of Dr. Norris and Dr. Farrah and orders Respondent to authorize and pay for the treatment for Petitioner's conditions of ill-being.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $326.64 per week for a period of 24-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act 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.

15IWCC0473

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is allowed to present the amount of claimed medical expenses and/or Public Aid Lien at a subsequent arbitration hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care and orders Respondent to authorize and pay for further treatment for Petitioner's conditions of ill-being.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 19 2015
MB/maw
o05/27/15
43

Mario Basurto

Joshua D. Luskin

David L. Gore

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

TOLBERT, MARK
Employee/Petitioner

Case# **10WC043745**

15IWCC0473

PRAIRIE CENTRAL COOPERATIVE
Employer/Respondent

On 5/24/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0767 PETE SULLIVAN & ASSOC
LAURA L GRAY
124 S W ADAMS SUITE 340
PEORIA, IL 61602

0091 LAW OFFICE IZZO CAPUANI & SHIEL
TODD SEVERNS
135 S LASALLE SUITE 2950
CHICAGO, IL 60603

15IWCC0473

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)

Mark Tolbert
Employee/Petitioner

v.

Prairie Central Cooperative
Employer/Respondent

Case # 10 WC 043745

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 **Steve Mathis**, Arbitrator of the Commission, in the city of **Peoria, IL**, on **3/21/11**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches 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. [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. [ ] Were the 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, **10/4/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $; the average weekly wage was **$489.96**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

- Petitioner failed to prove she sustained accidental injuries which arose out of and in the course of her employment for Respondent.
- Petitioner failed to prove she provided timely notice of the alleged accident to Respondent.
- Petitioner failed to prove her current condition of ill-being is causally related to the alleged accident.
- All claims for compensation 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 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.

S7 Mathis
Signature of arbitrator

5-17-11
Date

MAY 24 2011

Was there an employee-employer relationship as of October 4, 2010? Was timely notice of the accident given to respondent?

Petitioner was no longer an employee of respondent on October 4, 2010, the date of accident listed on the Application for Adjustment of Claim. Mark Heil, general manager at Prairie Central Cooperative, testified on behalf of respondent. He testified that petitioner resigned his employment on September 1, 2010. Respondent also introduced Exhibit 6, Voluntary Leave Questionnaire, and Exhibit 7, an e-mail from Mark Heil to Karen White in the personnel department advising that petitioner's employment had ended on September 1, 2010 based on his conversation with petitioner. Mark Heil completed the Voluntary Leave Questionnaire on 9/20/10 summarizing the conversation he had with petitioner on 9/1/10. (RX 6). Section B: Reason for Leaving, reads:

> "Mark told us that he had personal health issues that needed to be taken care of. We asked that he get an ok from doctor after he told us the doctor told him he needed to tell his employer of his health status. Mark then decided to leave work and take care of his health issues of the next few weeks to a month." "He needed to take care of personal health related activities that would require him to make a decision as to continue to work or take care of health issues" as a reason for leaving." "Came into our office to personally tell me that he needed to leave. He had dates set up that if he didn't pursue now, would be pushed later into the year."

The only conversation that petitioner had with Mr. Heil was on September 1, 2010 in which petitioner confided that he had cancer, and he would no longer be working for respondent because of scheduled doctor appointments. At no time during that conversation did petitioner relate to Mr. Heil that his medical condition had anything to do with his work for respondent. Mr. Heil also testified that his first notice that petitioner was claiming a work related medical condition was upon receipt of a letter from petitioner's attorney on November 9, 2010. Petitioner treated with Dr. Norris for respiratory issues in September 2010, and an authorization was completed by Dr. Norris' office dated 9/30/10 that indicated that petitioner was unable to return to work around grain dust. (PX 6). Petitioner's last day of actual work for respondent was August 31, 2010. (RX 5). Respondent was required to be notified of a work injury at least by October 15, 2010; therefore, I find that notice to respondent was not received until November 9, 2010, beyond the 45-day requirement under Section 6(c) of the Act.

Did an accident occur that arose out of and in the course of petitioner's employment with respondent? What was the date of the accident? Is petitioner current condition of ill-being causally related to the injury?

Petitioner was a seasonal employee of respondent and worked for respondent from July 28, 2010 to August 31, 2010. Petitioner testified that he had worked previous season for respondent in 2009. Respondent submitted time cards (RX 5) and a job description (RX 2) which document the work performed by petitioner while employed with respondent for the 2010 season.

Prior to his employment for Respondent, Petitioner underwent a sleep study on April 26, 2010, which diagnosed positional obstructed sleep apnea. (RX 4). Prior to starting employment for respondent, petitioner treated with Dr. Kashyap on July 9, 2010. Past medical history documented on that report included chest pain, headaches, and dizziness. Petitioner also reported getting sleepy and tired during the daytime and would doze off when a passenger in a car. Petitioner testified that the pain in September 2010 was different from the prior chest pain because the latter pain was sharper. The doctor diagnosed hypersomnia in July 2010 before petitioner began employment for respondent for the 2010 season.

Petitioner treated at Pontiac Emergency Room on September 21, 2010. (PX 8). Petitioner complained of constant left chest pain for 3 weeks. Petitioner also complained of shortness of breath. Pain worsened with sitting up. It is also noted that petitioner had similar episode of pain 2 years (ago) and had negative stress test. (PX 8). Petitioner treated on November 9, 2010 with Dr. Farah. (PX 3). He provided a history of working around bird feces and started to have chest pain and shortness of breath. He underwent a lung biopsy in the hospital that found histoplasmosis. Dr. Farah noted that petitioner's exposure in the grain elevator to bird residue which was resulting in exposure to histoplasmosis and development of chronic histoplasmosis lung disease. (PX 4). The history given to Dr. Farah on November 9, 2010 indicated that petitioner did smoke for years since the age of 15 one pack per day and now he is cutting down on smoking. (PX 3). Petitioner's family doctor, Dr. Norris diagnosed a lung infection and stated that he likely got it being around grain dust/dust in general as well as pigeon feces and or mold. (PX 2). Petitioner subsequently underwent a pulmonary function test on November 10, 2010. (PX 1). The test noted very mild airway obstruction, and petitioner testified that he was advised by his treating doctors that the pulmonary function test findings were normal.

Dr. Bruyntjens from Quad City Pulmonary Consultants, P.L.C. provided an opinion report dated March 11, 2011. (RX 1). Dr. Bruyntjens opined that it is probably true that the histoplasmosis was connected to petitioner's employment. The doctor noted that the large majority of pulmonary or infectious disease specialists would have elected not even to treat the petitioner. The doctor stated that the history of smoking with a near normal pulmonary function test with exposure to benign condition like histoplasmosis, is a concern due to the smoking not the histoplasmosis. (RX1). The doctor also noted the onset of histoplasmosis is abrupt, consisting of fever, chills, and subternal chest discomfort. A harsh nonproductive cough develops along with headache, arthralgias, and myalgias (muscle/joint pain). Petitioner did not report any fever or chills in his testimony.

Based on the foregoing, I find that while petitioner may have been exposed to histoplasmosis during his short period of seasonal work for respondent, petitioner did not prove that his current condition of ill-being is causally related to a work injury.

Is petitioner entitled to any prospective medical care?

Dr. Farah provided an opinion that petitioner needed to continue with his Itraconazole treatment possibly between 6 and 12 months to address the chronic histoplasmosis lung disease. The doctor also strongly advised petitioner to quit smoking (PX 4). Dr. Norris, petitioner's primary care

doctor, estimated a length of treatment between a few months and up to a year and recommended that Petitioner not work around dust, feces or mold until the infection was cleared up.

Dr. Bruyntjens, a pulmonary specialist, opined that the large majority of pulmonary or infectious disease specialists would have elected not even to treat the petitioner. The doctor stated that the history of smoking with a near normal pulmonary function test with exposure to benign condition like histoplasmosis, is a concern due to the smoking not the histoplasmosis. (RX1). Dr. Bruyntjens did not recommend any treatment for the diagnosed histoplasmosis and indicated that regardless of initial symptoms, normal hosts with primary pulmonary histoplasmosis recover eventually more than 99% of the time. (RX 1). He noted that the overwhelming majority of patients with histoplasmosis are either asymptomatic or have rapidly resolving, self-limiting disease requiring no treatment or follow up.

I find that petitioner did not prove that future treatment was necessary as a result of the diagnosed histoplasmosis, nor did he prove that any ongoing treatment was related to the histoplasmosis as opposed to a preexisting condition or cancer as petitioner reported to Mark Heil on September 1, 2010.

Is petitioner entitled to any Temporary Total Disability benefits?

Dr. Norris, petitioner's primary care doctor, provided a letter dated January 28, 2011. The doctor opined that petitioner was unable to work due to a fungal lung infection that causes extreme fatigue, shortness of breath, and pain. He noted that the recovery was unpredictable and indicated that he would not be able to return to work at this time in grain areas and will be reevaluated in 60 days. (PX 7). Fatigue, shortness of breath, and chest pain are all symptoms that petitioner had in varying degrees before starting the 2010 season with respondent.

Petitioner testified that he did not resign his employment on September 1, 2010, and that he was willing to perform light duty after that date. However, this is contradicted by the testimony of respondent's witness, Mark Heil. Mr. Heil testified that petitioner voluntarily left employment with respondent on 9/1/10, and at no time, did petitioner request a position that was away from the grain dust areas. Both the general manager, Mark Heil, and the operations manager, Matt Hinshaw, testified that petitioner could have accommodated petitioner had he not resigned his position. They both described a particular job working the computer to load the train that was in an office and was similar to a video game running a joystick. This job was in an office away from the grain dust which was reportedly aggravating petitioner's symptoms. The testimony of Mark Heil was corroborated by Respondent's exhibits 6 and 7, the Voluntary Leave Questionnaire and an e-mail from Mark Heil to Karen White in the personnel department advising that petitioner's employment had ended on September 1, 2010 based on his conversation with petitioner.

I find that petitioner voluntarily resigned his seasonal position with respondent on September 1, 2010. By doing so, petitioner left respondent with no opportunity to offer a position away from the grain dust areas. Petitioner is not entitled to Temporary Total Disability benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark James Egan,

Petitioner,

vs.

NO. 11 WC 40046 &
14WC026079

City, Water, Light and Power

15IWCC0474

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical care, 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 November 14, 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: JUN 2 2 2015
SJM/sj
o-5/28/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

EGAN, MARK JAMES
Employee/Petitioner

Case# **11WC040046**

14WC026079

CITY WATER LIGHT AND POWER
Employer/Respondent

15IWCC0474

On 11/14/2014, 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:

1157 DELANO LAW OFFICES PC
PATRICK JAMES SMITH
1 S E OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62701

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
PO BOX 335
SPRINGFIELD, IL 62705

15IWCC0474

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARK JAMES EGAN,
Employee/Petitioner

v.

CITY WATER, LIGHT AND POWER,
Employer/Respondent

Case # **11** WC **40046**

Consolidated cases: **14 WC 26079**

An *Application for Adjustment 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 H. Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **10/14/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the dates of accident, **7/13/11 and 5/25/14**, 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*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident on 7/13/11.

In the year preceding the injuries, Petitioner earned **$46,995.50**; the average weekly wage was **$903.76**.

On the dates of accident, Petitioner was **51** years of age, ***married*** with **no** 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

Respondent shall pay reasonable and necessary medical services for petitioner's lumbar spine, as provided in Sections 8(a) and 8.2 of the Act through 10/14/14.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services for the L5-S1 TLIF recommended by Dr. Acapko-Satchivi, Dr. Payne, and Dr. Pineda, 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 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

11/7/14
Date

ICArbDec19(b)

NOV 14 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 51 year old Maintenance Equipment Operator (MEO), sustained an accidental injury to his low back on 7/13/11 (11 WC 40046) and 5/25/14 (14 WC 26079). Petitioner has been an MEO for respondent for 13 years. Petitioner testified that he performs multiple tasks during the day. Petitioner admitted that he had some prior low back problems prior to 7/13/11.

On 7/13/11 petitioner was working in the East Cotton Hill Park with a co-worker lifting a 55 gallon barrel of garbage on the back of a truck. As they were lifting the barrel onto the truck petitioner felt a sharp pain in his low back. (11 WC 40046)

Petitioner presented to Prompt Care on 7/13/11 with complaints of low back pain after lifting a 55 gallon barrel into a truck at work and felt sharp pains going across his lumbar area. He reported that he was currently using muscle relaxers and pain killers at nighttime only for ongoing back pain. He stated that he does not use them during the day. He stated that the pain that he was currently experiencing was more intense than what he had previously experienced. He reported that the pain was located in the central lumbar area, and he did not have any radicular pain, weakness, numbness, or tingling of the lower extremities. Petitioner was prescribed hydrocodone for pain. He was taken off work through 7/16/11.

On 7/15/11 petitioner presented to Dr. Western. Prior to this visit petitioner last saw Dr. Western on 5/23/11. In the year prior to 7/15/11 Dr. Western saw petitioner three additional times for back pain. Petitioner gave a history of lifting the 55 gallon barrel at work on 7/13/11 and experiencing sharp pains in his low back area. Petitioner gave a history of chronic back pain that did not radiate into his buttocks or down his legs. An examination revealed paralumbar muscles that were tender to palpation. Straight leg raise reproduced pain at about 35 to 40°, but stayed mostly in his back and into his buttocks region. Dr. Western prescribed Cymbalta and instructed petitioner to return in three weeks. He authorized petitioner off work until 7/19/11, when he could return to work with a 20 pound weight restriction.

On 7/15/11 petitioner was seen by Windie McKay, DC. He was there for a follow-up visit for acupuncture. He stated that he hurt his lower back again and was in pain. Dr. McKay performed acupuncture on petitioner. Petitioner underwent additional modalities on 8/2/11. She authorized petitioner off work until 8/29/11.

On 8/2/11 petitioner returned to Dr. Western with continuing complaints of lower back pain. Petitioner stated that he went back to work and respondent did not accommodate his restrictions. As such he stated that his back was getting steadily more and more painful. Petitioner indicated that he would like

to see Dr. Russell. Dr. Western referred petitioner to Dr. Russell. He also told him to stop the Cymbalta since it did not seem to be helping. He prescribed Paxil. Dr. Western authorized petitioner off work for three weeks.

On 8/26/11 petitioner returned to Dr. Western. He reported that his condition remained unchanged, if not worse. Again, Dr. Western referred petitioner to Dr. Russell. Petitioner reported that he had gotten some temporary relief from the chiropractic visits. Dr. Western continued petitioner on Paxil, and added Wellbutrin. He also discussed a referral to a physiatrist.

On 8/26/11 petitioner returned to Dr. McKay for follow-up concerning his back pain and migraines. He stated that his back was staying a little better after the last adjustment. Additional modalities were performed on petitioner. Dr. McKay restricted petitioner to half days work from 8/26/11 – 9/23/11 with a 20 pound work restriction during that period and afterwards.

On 9/20/11 petitioner presented to Dr. Russell. Petitioner reported constant low back pain since his injury about two months ago. Petitioner denied any radicular components at that time. He stated that he had undergone some therapy without much relief. Dr. Russell noted that petitioner had previous back issues for which he underwent an MRI scan that failed to show any significant compressive lesion. He also noted that petitioner has had no recent injections or therapy. Dr. Russell noted that petitioner has also had EMGs that failed to show any significant nerve compromise. Following an examination Dr. Russell was of the opinion that there was no clear evidence of radiculopathy. He noted some mild degenerative changes, but no significant compromise of the neural elements. He believed that petitioner was not a candidate for any operative intervention. He recommended that petitioner continue with the conservative approach, try some physical therapy, nonsteroidals, and core strengthening exercises. He was also of the opinion that petitioner may need to be involved in a work rehab program to try and build his endurance and get him back to his regular occupation. He referred petitioner back to Dr. Western.

On 10/7/11 petitioner followed up with Dr. Western. He reported that his pain was now in the left paralumbar area of his back radiating down into his left buttocks and his left leg. Petitioner stated that his current work involved driving a truck and it does not stay on the road. He stated that "it goes across the park and lots of bumping and hills, potholes, etc., and does not seem to help his back at all." Dr. Western prescribed Flexeril and ordered some x-rays. He asked petitioner to let him know of any other type of work restrictions that might allow him to do his job, and protect his back. X-rays of the lumbar spine showed no acute findings. On 10/10/11 petitioner returned to Dr. Western stating that his pain was getting worse and felt like a sharp ice pick in his back. He also complained of shooting pains in his legs.

Dr. Western was of the opinion that petitioner's pain complex was changing somewhat and was now definitely going down his left leg into his knee. Petitioner did not think he could go back to work in his current condition. Dr. Western noted that petitioner's best position was now sitting down and leaning forward some. He noted that this was different from before when petitioner would lay on his back, and raise his legs to be in the most comfortable position. Petitioner reported that standing is definitely worse after several minutes. He reported that after standing for several minutes the pain starts to go down into his left knee. Dr. Western noted that petitioner has had back pain for well over a year, but now his back pain has a new character to it in that it has a radicular component that is different. Dr. Western ordered an MRI of petitioner's lumbar spine. He also prescribed a short course of prednisone. Petitioner was authorized off work for an additional two weeks.

On 10/13/11 petitioner underwent an MRI of his lumbar spine. The impression was multilevel degenerative changes including interval new broad-based central disc protrusion at L4 – L5 superimposed on a chronic mild diffuse disc bulge. Also noted was interval new effacement of the descending L5 nerve roots bilaterally at the L4 – L5 level by the new disc protrusion.

On 10/18/11 petitioner underwent an EMG and nerve conduction study performed by Dr. Fortin. The findings were consistent with a left lumbosacral radiculopathy. Dr. Fortin assessed lower back pain likely associated with radiculopathy. He recommended a lumbar epidural steroid injection.

Petitioner returned to Dr. Western on 10/27/11. Petitioner's pain was notably better from the last time he was there. Petitioner stated that his pain was back to about baseline. He stated that it was not bad enough to get an injection. Since petitioner was improving Dr. Western gave him the option of repeating the course of prednisone in the future if it flares up again. He returned petitioner to work with restrictions on lifting over 50 pounds.

On 12/14/11 petitioner presented to Dr. Fortin. He noted that petitioner had failed a facet block as well as an LESI, and various medications. He noted that petitioner had an MRI that showed arthritis as well as disc bulging. Petitioner complained of low back pain with radiation to the legs. He stated that he had temporary relief from chiropractic adjustments, and acupuncture. He also stated a TENS unit and physical therapy did not help him. Dr. Fortin referred petitioner to neurology.

On 3/7/12 petitioner returned to Dr. Western. He reported that he was still having quite a bit of pain and stated that the myelogram was very uncomfortable. Dr. Western noted that the myelogram showed a tear. Dr. Western noted that Dr. Fortin recommended aqua therapy. Dr. Western noted that

when petitioner was hit in the head and neck with a big branch at work, this took some time to get over, but eventually it healed. He then noted that petitioner then hurt his back moving a log and has had problems since then. Petitioner reported that he felt he could occasionally, and from time to time, on a daily basis, lift 50 pounds and requested that he be allowed to return to work. Dr. Western felt that this was reasonable for petitioner to try.

On 5/8/12 petitioner underwent a Section 12 examination performed by Dr. Gunner Andersson, at the request of the respondent. He noted that petitioner had a prior history of back problems. He reviewed the medical records from Springfield Clinic prior to the accident on 7/13/11, as they relate to petitioner's history of chronic back problems. Petitioner gave a consistent history of the injury on 7/13/11. Petitioner complained of pain in the lower back. He denied any radiculopathy. He rated his pain at a 6–7/10. He stated that he takes Vicodin for his pain. Following a record review and examination Dr. Andersson was of the opinion that petitioner's degenerative changes preceded the alleged injury on 7/13/11. He compared the MRI from 7/23/10 to the MRI of 10/13/11 and noted no significant changes. He was of the opinion that petitioner does not have a specific surgical indication. He could not exclude that petitioner aggravated his pre-existing degenerative condition on 7/13/11, but was of the opinion that it is more likely that he actually strained his back based on the report of the nature of the accident.

In response to respondent's questions he opined that the petitioner's current diagnosis and symptoms did not originate from the injury on 7/13/11. He believed that they are related to petitioner's underlying degenerative condition in the lumbar spine which was documented a year earlier. He opined that there was nothing to suggest that petitioner's current symptomatology was related to his work injury. He was of the opinion that the electrophysiological changes noted on the EMG were soft and subjective. He was of the opinion that petitioner did not have any radiculopathy currently and had no neurologic symptoms whatsoever. He believed it would be reasonable to treat petitioner symptoms. He recommended active physical therapy by a licensed physical therapist. Dr. Andersson opined that at that time petitioner was not a surgical candidate. He further opined that petitioner should be able to return to full duty work. Since petitioner had been off work for a period of time he suggested a gradual work return with limitations of lifting of 20 pounds occasionally for the first four weeks after which petitioner can return to full duty work. He opined that petitioner reached maximum medical improvement with respect to the work injury on 7/13/11.

On 5/25/12 Dr. Western drafted a letter to "to whom it may concern". He reported that he had been treating petitioner for several years and several of his injuries arose out of work. After reviewing

respondent's Section 12 examination his concern was petitioner going back to work without any restrictions. He noted that he has documented throughout his chart in the past several years that some work activities definitely aggravate petitioner's back situation, including riding a tractor. Dr. Western noted that although he agreed that petitioner could probably return back to work, he did not believe petitioner would be able to return to work restriction free. He believed that a 20 pound weight restriction, and perhaps some limiting or eliminating such aggravating things as riding a tractor, might be a reasonable start to his return to work. Dr. Western was of the opinion that if petitioner's history is taken in its totality, one can see that if some of the factors were not caused directly by work they certainly were exacerbated at work.

On 6/13/12 petitioner returned to Dr. Western for evaluation. He felt that he did not have any choice but to go back to work with an FMLA status that when the back pain gets so severe he can no longer stand it that he will take time off intermittently to allow it to settle down. Dr. Western was of the opinion that there was a time when his back flared up and it has stayed flared up since then. Dr. Western prescribed a different muscle relaxer. Dr. Western returned petitioner to work on 6/22/12.

On 6/26/12 Dr. Western drafted another letter clarifying his letter dated 6/13/12. Dr. Western wrote that one can clearly see from at least his notes that petitioner has had back problems ever since his visit on 7/15/11 stemming from an injury within the previous two weeks. Dr. Western was of the opinion that petitioner has had an exacerbation of his back pain ever since that date. In summary, Dr. Western wrote that petitioner has had some chronic back and neck pains, but on the 7/15/11 visit he sustained an injury within the previous couple of weeks lifting a 55 gallon barrel drum and had an acute flareup of back pain that has not gone away since then. Dr. Western wrote that he would attribute the exacerbation of petitioner's back pain to that work incident.

On 8/20/12 petitioner followed up with Dr. Western for pain in his right leg that he described as shooting from the inside upper right leg down to the right foot and from the inside upper right leg up through the neck and into his whole head. He reported that it felt like an electric shock. Dr. Western assessed an abnormal MRI. He noted that he had offered petitioner surgery with a 50-50 chance of improvement. As a result petitioner declined surgery at that time. He stated that he had to work at least two more years before even thinking about retiring.

On 9/10/12 the evidence deposition of Dr. Andersson, orthopedic surgeon, was take in on behalf of the respondent. Dr. Andersson opined that petitioner's current condition of ill being as it relates to his low back is not related to the injury on 7/13/11 because petitioner had similar pain before the alleged

accident, and actually within six weeks of the accident had been advised to consider additional studies. He also noted that petitioner had an MRI the year before the alleged accident which was similar to the one obtained after the accident and did not have any evidence of radiculopathy. He opined that it was more probable than not that petitioner suffered a strain to his back as a result of the accident on 7/13/11.

On cross-examination Dr. Andersson opined that the treatment petitioner received from the doctors in Springfield was appropriate. Dr. Anderson testified that he could not exclude an aggravation of a pre-existing condition, but based on the pre-and post-MRI it was not very likely. He was of the opinion that petitioner had a temporary aggravation of his pre-existing condition and that caused a strain.

Petitioner followed-up with Dr. Fortin on 10/23/12 for his annual checkup. Petitioner complained of severe back pain. Dr. Fortin assessed lower back pain, lumbago and discogenic syndrome. He recommended a prednisone taper to see if they could stop his flare-up of pain. On 4/2/13 Dr. Fortin recommended that petitioner return to Dr. Western for a referral to a psychiatrist. He continued petitioner's narcotic medications.

On 12/6/12 the evidence deposition of Dr. Western, family practitioner, was taken on behalf of the petitioner. Dr. Western stated that the first time he saw petitioner was 11/29/05, and he had been treating petitioner for chronic back pain since 2010. Dr. Western opined that the injury on 7/13/11 was an aggravation of his pre-existing back condition. Dr. Western testified that petitioner was not a surgical candidate and he continued to treat him with conservative measures. Dr. Western opined that petitioner had undergone an MRI in 2010 and another one on 10/13/11. He opined that the difference between those MRI studies with regard to the L4 – L5 level was that the one that was performed on 10/13/11 had more of a disc bulge present that was new. He further opined that an EMG/NCV was done in 2010 and again in 2011 after the injury. The one that was done on 10/18/11 showed left lumbosacral radiculopathy, whereas there was no evidence for radiculopathy on the 2010 test. Dr. Western opined that petitioner suffered an aggravation of his pre-existing back condition as a result of the lifting incident on or about 7/13/11.

On cross-examination Dr. Western testified the last time he observed radiculopathy in petitioner's lower back emanating from his lower back was 10/7/11.

On 1/15/13 petitioner followed up with Dr. Acakpo-Satchivi for his L5 – S1 discogenic pain syndrome. He noted that petitioner had previously undergone a discogram demonstrating concordant pain. He stated that he had been seen by Dr. Payne for a second opinion and was also offered an L5–S1

TLIF with the understanding that the outcome of this particular surgery with this particular indication was less than certain. Petitioner stated that he was on the fence with regards to surgery. Petitioner told Dr. Acakpo-Satchivi that he had been assigned some of the more physically demanding duties at work and was told that he can return to work only if he has no restrictions, despite the fact that the Worker's Compensation physician who evaluated him felt that restrictions would be appropriate. Dr. Acakpo-Satchivi told petitioner that while he could not say with 100% certainty that his lumbar spine injury was a direct result of his work related activities, there was clearly a temporal concordance. Conversely he noted that discogenic pain syndromes can occur as a result of the expected degeneration of the spine with age and also due to certain genetic factors. He recommended that petitioner should be allowed restrictions in his work related activities given his ongoing pain complaints.

On 3/19/13 petitioner followed up with Dr. Acapko-Satchivi to discuss surgery. Details as well as risk and benefits of the L5 – S1 TLIF were discussed. Dr. Acakpo-Satchivi stated that he would be performing this procedure with Dr. Payne.

On 6/3/13 petitioner presented to the emergency room at St. John's Hospital after a large tree branch fell on him while working with a coworker to cut the branch down at work. He reported that the branch hit him on the top of the head. He complained that he had been dizzy since the incident that afternoon. He complained of headaches, neck pain, and low back pain. He also complained of elbow pain. Petitioner was assessed with a cervical spine strain, and minor head injury. Petitioner underwent a CT of the lumbar spine. The impression was T12-L1 spondylosis, and prominent herniation of the nucleus pulposus into the anterior aspect of the inferior endplate of T12, which was age indeterminate. No acute lumbar vertebral fracture or traumatic malalignment was noted.

On 6/5/13 petitioner followed up with Dr. Western. Petitioner gave a history of the incident on 6/3/13. He reported pain around his elbow and somewhat in his wrist. Dr. Western released petitioner to work with left arm duty only. He assessed sprains, contusion, and a mild concussion.

On 7/9/13 petitioner returned to Dr. Acakpo-Satchivi with ongoing complaints of lower back pain. He stated that he had talked to someone that had successfully tried a dorsal column stimulator. He asked if this was something he could consider in lieu of the surgery. Dr. Acakpo-Satchivi felt that it was a reasonable option to explore. He referred him to Dr. Pineda since he had no experience with this particular procedure.

On 8/12/13 petitioner presented to Dr. Pineda complaining of chronic back pain and pain in his legs. He stated that his back pain seemed to be the overriding issue. Following an examination Dr. Pineda was of the opinion that a fusion may be an option, but has potential for failure. He noted that another option was a spinal cord stimulator, that may or may not work. He stated that the spinal cord stimulator is not useful to control back pain, but is much better for leg pain. He recommended a trial. He referred petitioner to a pain center for the trial spinal cord stimulator.

On 9/17/13 petitioner returned to Dr. Acakpo-Satchivi. They discussed the L5-S1 TLIF. Petitioner expressed an understanding of the risks and wished to go forward with the surgery. This surgical authorization was denied by Health Link on 11/6/13. Petitioner appealed this decision.

On 10/9/13 petitioner underwent an MRI of the lumbar spine. The impression was chronic loss of disc height with chronic endplate deformity at T 12 – L1, and small broad-based noncompressive central disc protrusion at L4 – L5.

On 10/15/13 petitioner followed-up with Dr. Fortin. Following an examination Dr. Fortin assessed lower back pain and discogenic syndrome. He assessed low back pain syndrome with associated lumbar radiculopathy. He noted that petitioner was scheduled for lumbar surgery with Dr. Payne.

On 12/18/13 Dr. Fortin drafted a letter to "to whom it may concern". He wrote that petitioner was under his care for his discogenic low back pain syndrome with radiation to his legs. He wrote that he had consulted with Dr. Acakpo-Satchivi and Dr. Pineda and both offered an L5 – S1 TLIF to address petitioner's otherwise refractory pain syndrome. He wrote that this letter was a request for reconsideration of denial of surgery for petitioner's refractory pain. He wrote that petitioner had failed narcotics, chiropractic care, hydrotherapy, acupuncture, massage, physical therapy, amitriptyline, carisoprodol, cyclobenzaprine, Cymbalta, dexamethasone, gabapentin, hydrocodone, Fentanyl, ketorolac, Lyrica, naproxen, paroxetine, prednisone, Skelaxin, and trazodone. He further wrote that the MRI of petitioner's lumbosacral spine demonstrates endplate deformity at T12–L1, and non-compressive central disc protrusion at L4 – L5 with EMG that demonstrated left lumbosacral radiculopathy. He stated that he considered surgical intervention for his otherwise refractory pain syndrome a medical necessity and requested reconsideration for insurance authorization for the surgery.

Petitioner last followed up with Dr. Acakpo-Satchivi on 4/1/14. They discussed surgery. Petitioner also requested a referral to a different insurance carrier. An EMG of the lower extremities was recommended.

On 4/15/14 petitioner underwent an EMG/NCV. The impression was unremarkable nerve conduction study and EMG of both legs. On 4/21/14 petitioner followed up with Dr. Fortin. He continued to complain of low back pain which was partially improved with low dose fentanyl. He requested a higher dose. Petitioner testified that he has six months to retirement and did not know if he was going to make it because of his low back pain. Dr. Fortin examined petitioner and assessed lower back pain. He increased petitioner's fentanyl dosage. He instructed petitioner to follow-up in six months or earlier should there be any interval complaints.

On 5/25/14 petitioner presented to the emergency room after lifting two bags at work and experiencing increased pain in his low back (14 WC 26079). Petitioner underwent a CT of the lumbar spine without contrast. Mild facet degenerative changes were noted at L4 – L5. Also noted at the L4-L5 level was a minimal central disc protrusion without significant spinal canal stenosis. There was no evidence of nerve root compression at this level. At L5 – S1 a minimal disc bulge without significant spinal canal narrowing or evidence of nerve root compression was noted. Partial lumbarization of S1 was noted. Petitioner was prescribed Flexeril.

On 6/5/14 petitioner presented to Dr. Fortin following a visit to the ER after working and hurting his back when he picked up a couple things that were too heavy for him. Petitioner stated that he picked up two bags of material at his work that weighed 70 pounds each. After completing the lifting he reported increased pain in his lower back, and extreme difficulty walking. He also reported numbness and tingling. Petitioner testified that the Flexeril he was given at the emergency room was not helping. Petitioner rated his pain as a 7–8/10. He testified that when he sweats at work his Fentanyl patches do not stay in place. Dr. Fortin spoke to him regarding physical therapy. Petitioner indicated that he had tried physical therapy as well as aqua therapy and acupuncture, and none of these modalities were successful. He stated that he had recently changed insurance carriers and was hopeful that the new insurance would approve a request for back surgery. He stated that he was planning on retiring in October of this year and was just trying to make it from day-to-day until he could retire. Dr. Fortin renewed petitioner's hydrocodone and Fentanyl. Dr. Fortin instructed petitioner returned in November for his regularly scheduled drug testing.

Respondent offered into evidence medical records from Springfield Clinic for petitioner prior to the injury on 7/13/11. On 10/3/07 petitioner presented complaining of low back pain injury from lifting a big log on 10/1/07. Petitioner was given a 5 pound weight restriction with no bending for the next two days. Petitioner did not return until 4/30/08. At that time he stated that his low back was still bothering

him. He stated that he went to a chiropractor and it did not seem to help. He stated that he was concerned about the upcoming lawn mowing season where the lawn mower is quite bumpy. Petitioner's pain was mostly in his mid back. He denied radiation in his buttocks or down his legs. On 5/20/08 petitioner began a course of physical therapy. He reported that he has had low back pain for about 30 years, and it had been worse over the last couple months. He stated that he had been spending all day on a lawnmower and this jarring motion aggravated his back. He stated his last course of physical therapy was about 20 years ago. At its worst petitioner's pain was a 6-7/10. On 6/27/08 petitioner returned to Dr. Western complaining of some intermittent back pain. Dr. Western instructed him to continue the pain medicine for his back. On 7/17/09 petitioner complained of lower back pain for the past two years, with intermittent treatment. He stated that riding a tractor at work or mowing the lawn was most bothersome to him. He stated he was not interested in shots and did not want to go to physical therapy. Dr. Western prescribed Skelaxin. He also ordered x-rays of the lumbar spine. On 5/28/10 petitioner followed up with Dr. Western for complaints of back pain. He stated that his back pain is always there, and has not really gotten any better. Dr. Western recommended an MRI of the lumbar spine. He stated that petitioner has continued pain for over a year radiating into his buttocks. On 6/11/10 petitioner was released to light duty only through 6/23/10. On 6/16/10 Dr. Western noted that petitioner has chronic back pain and has failed physical therapy and chiropractic therapy. He noted that his request for an MRI was denied. On 7/6/10 petitioner was seen by Dr. Fortin for neurological consultation. Dr. Fortin assessed lumbago and cervicalgia. His impression was low back pain, nonradiating in nature. He also recommended amitriptyline, gabapentin, and an MRI of the lumbosacral spine.

On 7/23/10 petitioner underwent an MRI of the lumbar spine. The impression was small left paracentral disc protrusion impressing on the ventral thecal sac at T11 – T12, and mild multilevel degenerative changes without high grade canal or foramina stenosis. On 8/10/10 petitioner followed up with Dr. Fortin. He rated his pain at 7/10. He stated that he had work restrictions. Dr. Fortin assessed refractory low back pain with an element of facet syndrome. On 8/17/10 petitioner underwent a right L4 – L5 facet block. On 9/14/10 petitioner underwent an EMG/NCV. The impression was unremarkable nerve conduction study and EMG of the right leg and lumbar paraspinal muscles. There was no electrophysiologic evidence for neurogenic lesion including a right lumber radiculopathy, lumbosacral plexopathy or polyneuropathy.

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

Prior to the injury on 7/13/11 petitioner had been treating for a chronic low back condition from 10/30/07 through 8/10/10. There were no treatment records offered for the period 8/11/10 through 7/12/11. Prior to the injury on 7/13/11petitioner underwent physical therapy, chiropractic treatment, L4-L5 facet injection, EMGs that showed no radiculopathy, an MRI that showed a small left paracentral disc protrusion impressing on the ventral thecal sac at T11–T12, and mild multilevel degenerative changes without high grade canal or foramina stenosis, and some periods of light duty work.

Following the accident on 7/13/11 petitioner experienced and immediate increase in his low back pain and began treating for that pain. Although petitioner did not have any radiating pain complaints at that time, petitioner continued treating for his ongoing low back complaints and by 10/7/11 had complaints that included radiating pain to his left leg. Petitioner repeatedly reported that his pain following the accident on 7/13/11 was more intense than the pain before that and was ongoing. On 10/7/11 Dr. Western was of the opinion that petitioner's current back pain had a new radicular component that was different from the pain he experienced in the year before the accident on 7/13/11. An MRI of the lumbar spine performed 10/13/11 showed a new broad based central disc protrusion at L4-L5 superimposed on a chronic mild diffuse disc bulge, and an interval new effacement of the descending L5 nerve roots bilaterally at the L4-L5 level by the new disc protrusion. An EMG performed 10/18/11 also showed left lumbosacral radiculopathy that was not present before 7/13/11.

Following a course of prednisone, on 10/27/11 petitioner told Dr. Western that his pain was back to about baseline. However, Dr. Western continued petitioner on light duty work, restricting him from lifting over 50 pounds. By 12/4/11 petitioner was again complaining of low back pain with radiation to the legs. On 3/7/12 Dr. Western noted that the myelogram showed a tear.

On 5/8/12 Dr. Andersson examined petitioner on behalf of respondent. Petitioner had no complaints of radiculopathy at that time. Although Dr. Andersson was of the opinion that petitioner's degenerative changes preceded the alleged injury on 7/13/11, the MRI from 7/23/10 and 10/13/11 showed no significant changes, and the petitioner most likely strained his back, he also admitted that he could not exclude that petitioner aggravated his preexisting degenerative condition on 7/13/11. Dr. Andersson was also of the opinion that the EMG findings from 2010 were the same as the EMG findings from 2013. The arbitrator does not find Dr. Andersson's opinions the most persuasive given the fact that there clearly were new findings on MRI dated 10/13/11 that showed a new broad based central disc protrusion at L4-L5 superimposed on a chronic mild diffuse disc bulge, and an interval new effacement of the descending L5 nerve roots bilaterally at the L4-L5 level by the new disc

protrusion, and the EMG dated 10/18/13 that showed left lumbosacral radiculopathy when the EMG in 2010 showed no radiculopathy.

Dr. Western opined that petitioner exacerbated his preexisting back condition on 7/13/11 and it has remained exacerbated since that date. He based this opinion on the fact that the difference between the MRI in 2010 and 2013 was that the one in 2013 had more of a disc bulge present that was new, and the EMG done on 10/18/11 showed left lumbosacral radiculopathy that the one performed in 2010 did not.

When his complaints continued petitioner presented to Dr. Acakpo-Satchivi for his L5-S1 discogenic pain. Even though Dr. Acakpo-Satchivi could not say with 100% certainty that petitioner's lumbar spine injury was a direct result of his work related activities, he was of the opinion that there was clearly a temporal concordance. He believed petitioner could work with restrictions that he did not have before the 7/13/11 accident.

Just before the accident on 5/25/14 petitioner underwent a repeat EMG/NCV. The impression was unremarkable nerve conduction study and EMG of both legs. However, petitioner continued to complain of low back pain.

Following the accident on 5/25/14 petitioner complained of increased pain in his lower back and extreme difficulty walking. He underwent a CT scan of the lumbar spine that showed mild facet degenerative changes were noted at L4–L5. Also noted at the L4-L5 level was a minimal central disc protrusion without significant spinal canal stenosis. There was no evidence of nerve root compression at this level. At L5–S1 a minimal disc bulge without significant spinal canal narrowing or evidence of nerve root compression was noted. Partial lumbarization of S1 was noted.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner 's current condition of ill-being as it relates to his low back is causally related to the injuries he sustained on 7/13/11. The arbitrator bases this finding on the opinions of Dr. Western and finds that as a result of the accident on 7/13/11 the petitioner aggravated his preexisting degenerative lumbar spine condition. The arbitrator finds the opinions of Dr. Western more persuasive than those of Dr. Andersson given the fact that the EMG and MRI taken after the accident 7/13/11 showed new diagnostic findings that were consistent with petitioner's complaints and were not present on the MRI and EMG performed before the accident on 7/13/11. The arbitrator finds the accident on 5/25/14 was merely a temporary aggravation of the his preexisting condition. She bases this opinion on the fact that the diagnostic tests taken after the accident on 5/25/14 showed no new findings that were not seen on the diagnostic tests taken after the 7/13/11 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?

Having found the petitioner's current condition of ill-being as it relates to his lumbar spine condition is causally related to the injury he sustained on 7/13/11 and his condition after the injury on 5/25/14 was only a temporary exacerbation of his preexisting condition before that date, the arbitrator finds all treatment petitioner received for his lumbar spine from 7/13/11 through 10/14/14 was reasonable and necessary to cure or relieve petitioner from the effects of the injuries he sustained on 7/13/11 and 5/25/14.

Respondent shall pay reasonable and necessary medical services for petitioner's lumbar spine, as provided in Sections 8(a) and 8.2 of the Act through 10/14/14.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Prior to the accident on 7/13/11 surgery had never been recommended for petitioner. On 9/20/11 Dr. Russell opined that petitioner was not a candidate for any operative intervention. On 5/8/12 Dr. Andersson was of the opinion that petitioner did not have a specific surgical indication. On 8/20/12 Dr. Western noted that he had offered petitioner surgery with a 50-50 chance of improvement. Petitioner declined the recommendation for surgery at that time. However, during his deposition on 12/6/12 Dr. Western opined that petitioner was not a surgical candidate.

On 1/15/13 petitioner told Dr. Acakpo-Satchivi that he had been seen by Dr. Payne and was offered an L5-S1 TLIF with the understanding that the outcome of this particular surgery with this particular indication was less than certain. At that time petitioner was on the fence with regards to surgery.

On 7/9/13 petitioner asked Dr. Acapko-Satchivi if he could try a dorsal column stimulator in lieu of surgery. Dr. Acapko-Satchivi felt it was a reasonable option to explore. He sent him to Dr. Pineda.

On 8/12/13 Dr. Pineda examined petitioner and stated that a fusion may be an option, but has a potential for failure. He also stated that another option was a spinal cord stimulator, that may or may not work. He stated that it was not useful for back pain, but much better for leg pain. He referred petitioner to a pain center for a trial cord stimulator. Since petitioner's pain is primarily related to his low back and not his legs the arbitrator finds the spinal cord stimulator would not be reasonable and necessary at this time.

On 9/17/13 petitioner told Dr. Pineda he wanted to undergo the surgery. The surgery was denied by petitioner's health insurer. Dr. Fortin requested that the insurer reconsider based on the fact that petitioner had failed conservative treatment and the MRI demonstrated endplate deformity at T 12–L1, and non-compressive central disc protrusion at L4–L5 with EMG that demonstrated left lumbosacral radiculopathy. He also noted that he considered surgical intervention for petitioner's otherwise refractory pain syndrome a medical necessity.

Based on the above, as well as the credible record, the arbitrator finds that given petitioner's failure to receive any long-lasting relief from any conservative treatment over the three year period following his injury on 7/13/11, the arbitrator adopts the opinions of Dr. Pineda, Dr. Acakpo-Satchivi and Dr. Payne that surgery in the form of an L5-S1 TLIF is a reasonable option to cure or relieve petitioner from the effects of his injury on 7/13/11. Although surgery was not recommended by Dr. Andersson, Dr. Russell or Dr. Western, the arbitrator notes that these opinions were rendered over a year before those of Dr. Pineda, Dr. Acapko-Satchivi and Dr. Payne. The arbitrator further finds that although all doctors who are recommending this procedure agree that there is a potential for failure with this procedure, they also agree that there is also a potential for the surgery to relieve petitioner from effects of his low back pain syndrome, that to date has not resolved.

Respondent shall pay reasonable and necessary medical services for the L5-S1 TLIF recommended by Dr. Acapko-Satchivi, Dr. Payne, and Dr. Pineda, as provided in Sections 8(a) and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elaine Koliopoulos,

Petitioner,

vs.

NO. 08WC 43788

15IWCC0475

University of Chicago Physicians Group,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, permanent disability, nature and extent, temporary total disability, 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 May 20, 2014 is hereby affirmed and adopted.

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

DATED: JUN 2 2 2015
SJM/sj
o-6/4/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOLIOPOULOS, ELAINE
Employee/Petitioner

Case# **08WC043788**

15IWCC0475

UNIVERSITY OF CHICAGO PHYSICIANS GROUP
Employer/Respondent

On 5/20/2014, 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:

1357 RATHBUN CSEVENYAK & KOZOL
LUIS MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

1401 SCOPELITIS GARVIN LIGHT HANSON ET AL
GREGORY E AHERN
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

15IWCC0475

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

Elaine Koliopoulos
Employee/Petitioner

v.

University of Chicago Physicians Group
Employer/Respondent

Case # **08** WC **43788**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Wheaton**, 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. [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 _____

FINDINGS

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

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

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

Timely notice of the alleged accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$14,272.46**; the average weekly wage was **$475.75**.

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 ***is not liable for*** reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$all appropriate disability benefits paid via group disability** for other benefits, for a total credit of **$see above**.

Respondent would be entitled to a credit of **$8,748.80** under Section 8(j) of the Act; however, this is moot.

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 of Arbitrator

5/20/2014
Date

MAY 20 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELAINE KOLIOPOULOS,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 08 WC 43788
	)	
UNIVERSITY OF CHICAGO PHYSICIANS GROUP,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner, a right-hand-dominant woman born on 7/28/1943, began working for the respondent as a receptionist in November 2005. Her duties included answering the phone, greeting patients and computer usage. In 2007 she transferred to the billing department, calling patients and insurance companies, verifying coverage and entering information into the computer system. She worked five days per week, eight hours per day. The petitioner asserts repetitive trauma causing carpal tunnel syndrome with an effective accident date of September 28, 2007.

The medical records demonstrate that the petitioner sought treatment with Dr. Maria Lentzou, a primary care physician, on September 28, 2007. The petitioner treated for unrelated issues such as sinus issues and a diagnosis of a cerebral aneurysm, but also complained of bilateral hand numbness. She was provisionally diagnosed with bilateral carpal tunnel and referred for EMG testing. PX3.

On October 9, 2007, the petitioner saw Dr. Khanna. She reported a history of many years of intermittent numbness and tingling in the hands which had worsened on the right side over the prior six months. She denied a history of trauma or strain. Medical history was notable for high blood pressure, high cholesterol and osteoathritis, as well as prior history of smoking. EMG testing that day was significant for left-sided carpal tunnel syndrome; the right side could not be completed due to discomfort. PX2. At trial, the claimant disputed the history in these records. However, the Arbitrator notes other references to longstanding symptoms and accepts her medical records as accurate, and does not assess her testimony regarding this issue as credible.

The petitioner then sought treatment with Dr. Nikkel on October 27, 2007. She reported bilateral wrist complaints "for quite some time." Examination noted atrophy on the right side. Dr. Nikkel recommended wrist MRI studies. PX2. MRI studies of each wrist took place on November 1, 2007. Each was notable for extensive degenerative

arthritis. On December 1, 2007, Dr. Nikkel reviewed the MRI studies and discussed medical options with the petitioner; she elected to proceed with carpal tunnel release surgery bilaterally, which was scheduled. PX2.

The petitioner underwent left carpal tunnel release surgery on February 29, 2008. No complications were noted during the procedure. PX2.

On April 17, 2008, Dr. Nikkel saw the petitioner in follow-up. She noted good strength with no pain and improvements in numbness and tingling. She expressed a desire to proceed with the right wrist surgery, which was scheduled thereafter. PX2.

The petitioner underwent the right carpal tunnel release surgery on May 19, 2008. No complications were noted. PX2. On June 5, 2008, the petitioner's sutures were removed. She reported improvements in strength at that time and she was instructed to continue therapy. On July 23, 2008, she returned, noting some numbness in her fingers but overall was doing well. She was discharged to a home exercise program. Light duty was prescribed for the month of August. PX2.

On August 27, 2008, the petitioner returned with increased right hand complaints. Dr. Nikkel noted pain but no neuropathic complaints. He prescribed mandatory breaks each hour. She also complained of knee problems, not related to this issue. PX2.

On October 8, 2008, the petitioner presented, noting she was on a temporary leave from her job. He discussed a vocational shift, noting concerns that repetitive activity could result in recurrence of symptomology, but did not prescribe restrictions. He noted she was otherwise going to follow up with him regarding the left knee. PX2. The claimant retired from her job in late 2008 or early 2009, after the age of 65. She asserted ongoing symptoms in retirement but did not return to Dr. Nikkel.

The petitioner was seen by Dr. Vender for a Section 12 examination on November 11, 2010. She noted persistent symptoms and his examination noted atrophy in the hands. He noted she could have a new EMG due to persistent complaints but she had no desire to proceed with that option. He recommended splinting for the arthritis, but opined the work she had done would not contribute to the progression of either the arthritis or the carpal tunnel conditions. See RX1.

On June 11, 2012, Dr. Nikkel wrote a letter to the claimant's counsel, noting her history of treatment. He noted she had worked on computers. He opined that the treatment was necessary and appropriate and that she had returned to work in August of 2008, but was unaware if she was still working. See PX4.

OPINION AND ORDER

A claimant must prove by the preponderance of credible evidence all elements of a claim to receive compensation under the Act. See, e.g., *Orsini v. Industrial*

Commission, 117 Ill.2d 38, 44-45 (1987). Here, the petitioner is relying on a repetitive trauma theory. When performance of an employee's work involves constant or repetitive activity that gradually causes deterioration of or injury to a body part, the case may be compensable, provided it can be medically established the origin of the injury was the repetitive stressful activity. However, the claimant must prove the injury is related to the employment and not a result of the normal degenerative aging process; performing work over a period of years is not legally sufficient to prove that work is repetitive enough to cause an increased risk to the petitioner. See, e.g., *Peoria County Bellwood,* 115 Ill.2d 524 (1987); *Quaker Oats Co.* v. *Industrial Commission,* 414 Ill.2d 326 (1953).

When the question of medical causation is one specifically within the purview of experts, expert medical testimony is mandatory to show the claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478 (4th Dist. 1987). The causation of carpal tunnel syndrome via repetitive trauma has been deemed to fall in the area of requiring such expert testimony. *Johnson v. Industrial Commission*, 89 Ill.2d 438 (1982). In this case, however, this has not been done.

While there is general consensus that the claimant does suffer from carpal tunnel syndrome, the treating physicians did not provide an opinion specifying that the claimant's job activities worsened her actual medical condition or accelerated its progress. Moreover, the extent of the atrophy and the degenerative arthritis strongly suggests that the progress of the condition had been well established long before the petitioner took the position in the billing department. Moreover, the petitioner has non-work-related comorbidities commonly associated with the development of carpal tunnel syndrome, including a prior smoking history, hyperlipidemia, and high blood pressure. The only medical report that specifically comments on the nature of the causal relationship between her work and her medical condition is the report of Dr. Vender, and he concluded the job description as given to him by the claimant would not be contributory.

While the treatment incurred was reasonable to alleviate that condition, accident and causal relationship were not established. The evidence provided is legally insufficient to sustain a claim for benefits. Issues of notice, medical expenses, and disability are rendered moot by the above findings.

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Mertz,

Petitioner,

vs.

NO. 13 WC 13512

15IWCC0476

City of McHenry,

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 accident, temporary total 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 October 30, 2014 is hereby affirmed and adopted.

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

DATED: JUN 2 2 2015
SJM/sj
o-6/4/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

MERTZ, GARY
Employee/Petitioner

Case# **13WC013512**

CITY OF McHENRY
Employer/Respondent

15IWCC0476

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.

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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
FRANCIS M BRADY
120 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

☐ 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)

Gary Mertz
Employee/Petitioner

v.

City of McHenry
Employer/Respondent

Case # 13 WC 13512

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 **Woodstock**, on **October 1, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

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

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

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

K. ☒ 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?

FINDINGS

On the date of accident, **1/3/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,465.16**; the average weekly wage was **$1,124.33**. This AWW corrects by stipulation Arb. Ex.1 containing scrivener's error.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

THE ARBITRATOR FINDS AS A MATTER OF LAW AND FACT THE PETITIONER DID NOT SUSTAIN AN ACCIDENT IN THE COURSE AND SCOPE OF HIS EMPLOYMENT

THE ARBITRATOR FINDS AS A MATTER OF LAW AND FACT THE PETITIONER'S CURRENT CONDITION OF ILL BEING IN NOT CAUSALLY RELATED TO THE ALLEGED INCIDENT IN THE CASE AT BAR.

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

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

#01 George J. Andras Date 10/28/14

ICArbDec19(b)

OCT 30 2014

STATEMENT OF FACTS 13 WC 13512

On June 28, 2004, Gary Mertz, "Petitioner," received from the City of McHenry, "Respondent," its Personnel Policies and Procedures Manual; read its terms; and, acknowledged that, in fact, he was subject to them (Resp. Ex. 3, Tr. 77). Section 15 of that Manual provides that: "All city employees are expected to...(report) any injury, no matter how minor or insignificant immediately to (a) supervisor..." (Resp. Ex. 2, p. 32). Section 27.2 states that an employee must make a full written report of any job injury "no matter how minor or insignificant the injury may seem..." as soon as possible after its occurrence. Subparagraph (a) indicates Respondent "will provide reporting forms and the employee may obtain the form from his department head or City Administrator." (Resp. Ex. 2, p. 55). Subparagraph (b) notifies the injured employee that: "It is imperative that the (injury) report is filed in a timely fashion. (Respondent) is required to report any reports of employee of injuries or job-related illness to the State of Illinois within 48 hours after the accident" (Resp. Ex. 2, p. 55). Both Section 15 and Section 27 of the Manual make clear that failure to abide by the policy "may result in disciplinary action, up to and including immediate termination of employment" (Resp. Ex. 2, pp. 32, 55).

Some years later, Petitioner turned in the cab of the "Chevy one-ton truck..." he drove for Respondent to check "the box of the truck to make sure there was no debris or anything in there, any tools or anything..." (Tr. 9, 15). The compactness of the cab is depicted in Petitioner's Exhibits 1 and 2. In these quarters, he "swung (his) entire body to the right to look out the back of the window..." and his "left knee caught a trailer brake control lever...mounted on the dash of the steering column" (Tr. 15). The trauma involved in the impact was described variously by Petitioner as "caught"; "smacked"; "jammed" (Tr. 15-17, 38-39).

Elsewhere, he acknowledged that his knee impacted the lever with "pretty good force" (Tr. 39). The "inside part" of his left knee "ran into" the brake control lever (Tr. 15, 16).

Dr. Samuelson, Petitioner's treating orthopedist, testified that Petitioner told him the impact was significant, that he hit his knee really hard and felt immediate pain (Pet. Ex. 4, 16). Besides the pain, Petitioner was also experiencing stiffness in the knee (Pet. Ex. 4, pp. 15-16). But later on, the Petitioner qualified his version of the accident, particularly the severity of trauma. In trying to explain why he had not reported the injury, immediately, as he knew was required, Petitioner indicated : "A. Yes. I didn't think I was injured.

Q. But you knew you banged your knee?
A. I bumped my knee, I bumped my elbows, I do all types—bumped my shins. I don't think I am injured when that takes place" (Tr. 43, 77, 78).

In his Application for Adjustment of Claim and his testimony, Petitioner asserted that the incident with his left knee and the gear box occurred on January 3, 2013. But when he got care for the first time on January 25, 2013, he reported to Dr. Samuelson the date was January 4, 2013 (Tr. 70, Pet. Ex. 4, pp. 25-26). In fact, petitioner ultimately acknowledged both were approximate dates and, even just three weeks after the occurrence, he was not "quite sure when he hurt (his) knee...").

Though petitioner felt immediate knee pain, a pain he described as reaching at times the level of 7-8 on a 10 scale of intensity and which worsened with walking or bending his knee (Dr. Samuelson chart note of 1/25/13, Pet. Ex. 3, and Pet. Ex. 4, p. 16), he said nothing and finished out the workdays on January 3, 2013 and January 4, 2013; in fact, he continued at full duty through February 6, 2013 (Tr. 94).[1] This included 45 hours of overtime (Tr.75).

During that period, he did right-of-way cleanup requiring that he get in and out of the truck picking up roadside litter with a tool, and depositing it into a five-gallon bucket (Tr. 50).

He had to navigate uneven ground, requiring that he balance himself as he picked up debris and carried it to the truck (Tr. 51).

He also performed tree trimming requiring that he get in and out of his truck to drag branches that had been cut down, and insert them into a chipper machine (Tr. 14, 54, 55, 57). Petitioner acknowledged he was on his feet quite a bit and outside and that using the chipper was a physically hard job (Tr. 85, 87). Petitioner also checked grates to make sure they had not been "plugged up with debris, leaves, grass, sometimes snow, ice" (Tr. 58). He had a pitchfork and, when he would spy a blocked grate, he would exit his truck to clear the grate with the pitchfork, throwing the waste into the back of his truck from which it had to be placed into a dumpster (Tr. 58, 59). He was in and out of his truck clearing grates perhaps 20-24 times in an 8-hour shift (Tr. 65, 66). The jobs that Petitioner did throughout January and early February 2013 involved "bending over and twisting and turning..." (Tr. 49). "Twisting and turning..." meant "all the joints in (his) body..." (Tr. 49).

He put off orthopedic care until his 1/25/13 presentation to Dr. Samuelson, but Petitioner did, on 1/8/13, see a physician, Dr. Narang, his primary care physician for "a good seven years" (Tr. 12, Resp. Ex. 6, chart note of 1/8/13). Dr. Narang's chart note from that visit includes a section entitled "Review of Symptoms" with a subsection entitled "Musculoskeletal." In it, the doctor noted Petitioner was suffering low back pain but "no joint pain, joint swelling, neck pain, dorsal pain, bone pain, lumbar strain, muscle strain (unspecified site), limb pain, ankle sprain/strain, frequent leg cramps (or) rheumatoid arthritis, osteoarthritis, weakness, falls (or) limited movement or muscle aches" (Resp. Ex. 6, Dr. Narang's chart note of 1/8/13). In another section entitled "Physical Examination," Dr. Narang notes that regarding Petitioner's "musculoskeletal" system, there was no deformity or tenderness of joints" (Resp. Ex. 6, chart note of 1/8/13).

Petitioner said nothing to Dr. Narang regarding the episode at work involving his left knee nor indeed did he say anything about the pain in his left knee at all.[2]

When petitioner finally presented to Dr. Samuelson on January 25, 2013, he completed paperwork giving the doctor pertinent background (Tr. 22, 24, 67, 69-70; Pet. Ex. 3; Pet. Ex. 4, p. 6). Therein, Petitioner indicated his accident happened on "1/4/13 approx." (Pet. Ex. 3, Medical Intake Form completed by Petitioner). Upon examination, the doctor found Petitioner had full range of motion and full strength. There was slight effusion in the knee. There was no varus or valgus instability and drawer and Lachman's tests were negative. There was tenderness at the medial joint line and the medial femoral condyle area. There was mild pain with McMurray test but no click. Dr. Samuelson diagnosed "left knee contusion and effusion (with) possible intraarticular pathology" and prescribed a left knee MRI for Petitioner (Pet. Ex. 3, Dr. Samuelson's chart note of 1/25/13).

Petitioner had still not advised anyone at Respondent of his knee condition, let alone the fact that he thought he had sustained a work accident (Tr. 24, 71) (Tr. 25). Indeed, the first time he gave notice came on 2/1/14 when he met with his supervisor, Dale Moll (Tr. 24, 71).[3] Even then, he told Mr. Moll that he hurt his knee, had seen Dr. Samuelson, and needed personal time for an MRI (Resp. Ex. 4, Tr. 71).[4]

---

[2]Dr. Narung did diagnose on this date "internal derangement of knee, unspecified, and tear of medial cartilage or meniscus of bone, current," however, the doctor had been diagnosing that same condition consistently in multiple notes for petitioner since 2010. Petitioner explained though that he had never complained of his knees (left or right) to Dr. Narung and admitted he did not in fact complain to Dr. Narung on January 8, 2013 concerning his left knee. The first time Dr. Narung, Petitioner's long time personal physician, notes that Petitioner hurt his left knee at work was 4/17/14 when he recorded that Petitioner was going to have left knee arthroscopic surgery for medial meniscus repair…by Dr. Samuelson, (due to an) injury (which) happened on January 3 or 4, 2013 at work."

[3]Petitioner was also aware written notice was required immediately after the injury. But Petitioner submitted the necessary form only on 2/27/13. He blamed his failure to execute on Respondent indicating he was never offered the document to complete (Tr. 74). He admitted though he did not request one even though he seemed aware he need not wait on Respondent (Tr. 74).

[4] Under cross-examination, petitioner stated that he wanted personal time for the MRI because he was seeing a rodeo with his son on Saturday, February 2, 2013. The Arbitrator takes notice that February 4, 2013 was a Monday so the relevancy of petitioner's schedule on a Saturday is unclear (Tr. 72).

The MRI was performed on 2/4/13, revealing a subchondral collapse of the weight bearing surface of the medial femoral condyle with "signal intensity in the anterior horn of the lateral meniscus" but no "definite tear" (Pet. Ex. 3, report of MRI performed at Open Imaging MRI, McHenry County Orthopedics, on 2/4/13). Based on the MRI, Dr. Samuelson, diagnosed "left knee contusion and effusion with MRI findings of the medial femoral bone marrow edema with subchondral collapse" (Pet. Ex. 3, Samuelson chart note of 2/6/13). Dr. Samuelson testified that "subchrondral collapse" is a condition very similar to "osteochondritis dissecans" both involving "an area of damaged cartilage and bone...(at) the end of (Petitioner's) femur..." (Pet. Ex. 4, p. 6). While he testified that the condition was related to the January 2013 incident where Petitioner "hit his knee pretty hard" (Pet. Ex. 4, pp. 7,8,11, 17-18), the doctor also acknowledged that the condition can result from causes other than trauma (Pet. Ex. 4, p. 10).

Dr. Samuelson continued to treat Petitioner throughout 2013 and, in fact, saw him as recently as April 16, 2014 (Pet. Ex. 3 and Pet. Ex. 4, p. 11, 16-17, 28). By that time, the doctor had added a diagnosis of lateral meniscus tear to that of subchondral collapse. Dr. Samuelson believes that arthroscopic surgery is the correct palliative (treatment) ; specifically, he recommends a chondroplasty ("which is basically cleaning up bad cartilage") and debridement of the tear to the lateral meniscus cartilage (Pet. Ex. 4, p. 12).

Dr. Troy Karlsson performed a section 12 exam for Respondent on 12/3/13.(Resp. Ex. 7, p. 5). Dr. Karlsson earned his undergraduate degree in the Honors Biomedical Engineering Program at Northwestern University in 1984. He is a 1988 honors graduate of the College of Physicians and Surgeons, of Columbia University in New York City. He concluded a surgery internship at Washington University, St. Louis, Missouri, in 1989 and completed an orthopedic residency at that institution in 1993. He is board certified by the American Board of Orthopedic Surgeons.

Dr. Karlsson testified as to Petitioner's history:

> "A. ...He said he injured his left knee on January 4, 2013...working in street maintenance for the City of McHenry and...(while) in the driver's seat of the truck, he turned to look over his right shoulder to see if anything was in back of him, and his left knee struck a brake control lever in the square box that held it, around the dashboard of the vehicle" (Resp. Ex. 7, p. 6).

Though he suffered "pain right away," Petitioner did not seek treatment for a few weeks (Resp. Ex. 7, p. 6). Petitioner told Dr. Karlsson that the "inner side of the (left) knee just medial to the patella" had been hurting ever since the injury (Resp. Ex. 7, p. 7). After taking a history on 12/13/13, Dr. Karlsson went on to perform a physical exam which "was actually fairly normal, with no tenderness to palpation and normal motion and stability to it" (Resp. Ex. 7, p. 8). McMurray and Lachman signs were both negative without any indication of instability (Resp. Ex. 7, pp. 8-9). Petitioner had no "pain on palpation of the joint line (and) there was no abnormal give or stress of the knee, so no signs of ligament damage in the knee" (Resp. Ex. 7, p. 9). The doctor had a chance to examine the films of the February 4, 2013 MRI. They demonstrated to Dr. Karlsson "a normal ACL and PCL. On the medial or inner side of the knee, it did not look like he had cartilage or meniscus tear. There was high signal throughout the thigh bone or femoral condyle on that side...on the weight bearing surface, there was a one by one centimeter area flattening of the femoral condyle." The doctor saw no "fracture lines" (Resp. Ex. 7, pp. 8-10). The doctor went on to note that when he examined Petitioner on 12/13/13, there was no swelling in the left knee joint. Given the lack of effusion, the doctor concluded that Petitioner was not having a severe amount of irritation in his left knee. (Resp. Ex. 7, pp. 17-18). As a result of his involvement in the case on or about 12/13/13, Dr. Karlsson, like Dr. Samuelson, diagnosed Petitioner with "osteochondritis dissecans of the medial femoral condyle with some flattening" (Resp. Ex. 7, p. 10).

Dr. Karlsson clarified the meaning of his diagnosis:

> "A. Osteochondritis dissecans is a disease or problem with the cartilage and underlying bone. It can happen anywhere, but in this case, it is in the femur, which is one of the most common places to happen. When it does happen there, it is usually the medial femoral condyle. It is almost always in the same area that we see it, so there seems to be something with the blood supply to that area that makes it more prone to it.
>
> And you can have anything from just some blistering or loosening of the cartilage to the cartilage and the bone being detached or loose from the rest of the bone. And usually it is about this sort of size, a one to one-and-a-half centimeter area that gets involved" (Resp. Ex. 7, pp. 10-11).

As to whether this condition was caused or aggravated by the January 4, 2013 incident Petitioner described, Dr. Karlsson, indicated:

> "A. I did not feel it was caused or aggravated by that work injury for several reasons…
> "…one, just a natural history of osteochondritis dissecans, the majority of these are what we call idiopathic, meaning we don't have any specific thing to blame for it. It is usually an irregularity in the blood supply and why some people get it and others don't, we don't know. Less than half the people we can come up with a reason, and those are usually they have a connected tissue disorder such as rheumatoid arthritis.
> But most of the people we see with it we don't have a cause for it. So that's one part, as he seems to fit in with that, it is in the same area that we see with idiopathic osteochondritis dissecans of the medial femoral condyle" (Resp. Ex. 7, pp. 11-12).

While Dr. Karlsson acknowledged that osteochondritis dissecans can result from a traumatic injury, he was very specific that:

> "The trauma would be a very large force, such as falling from a height of 10 feet or more; a very strong blow to the knee such as a helmet and a football injury; a high velocity car injury, someone going 30, 40 miles an hour and suddenly stopping from hitting a wall and going forward in the dashboard; something with a very significant trauma, not the type of the trauma you get by turning and striking your knee against the control in a vehicle" (Resp. Ex. 7, pp. 12-13; 17-18).

Dr. Karlsson testified that the trauma Petitioner described was insufficient to cause, aggravate, or accelerate Petitioner's osteochondritis dissecans (Resp. Ex. 7, pp. 12-18).

Dr. Karlsson reviewed Dr. Samuelson's narrative of January 7, 2014, noting he still did not believe Petitioner's left knee pain was the result of any work injury inasmuch as the osteochondritis dissecans Petitioner suffered was idiopathic (Resp. Ex. 7, pp. 16-17).

Dr. Karlsson confirmed his belief that the trauma Petitioner described was insufficient to cause his conditions, or even to aggravate or advance them (Resp. Ex. 7, p. 18). He noted that the edema reflected in the MRI would be seen "in virtually every case of osteochondritis dissecans because there is more stress to the bone around it from the regular joint surfaces." The doctor noted that he had not "seen any cases of...osteochondritis dissecans where.." there was not some level of edema (Resp. Ex. 7, p. 18). The presence or absence of edema does not speak to the existence of a traumatic origin as an orthopedist would expect the swelling to be present in osteochondritis dissecans regardless of etiology (Resp. Ex. 7, p. 19).

Dr. Karlsson reviewed Dr. Samuelson's January 7, 2014 report and also looked at films from a second MRI of Petitioner's left knee, this one done 12/5/13 (Resp. Ex. 7, pp. 20-21). The films from the second MRI revealed edema throughout the medial femoral condyle and an area flattening of approximately one by one centimeter. The doctor noted that Petitioner's medial meniscus, ACL and PCL, were intact, though there was high signal in the anterior horn of the lateral meniscus that went to the joint surface (Resp. Ex. 7, p. 21). The doctor felt this was consistent with a tear but this finding had not been present on the prior MRI (i.e., February 4, 2013) (Resp. Ex. 7, p. 21). The radiologist interpreting the first MRI noted there was some signal intensity within the lateral meniscus but it did not go to the joint surface and there was no tear noted (Resp. Ex. 7, p. 22).

After reviewing the second MRI, Dr. Karlsson maintained his opinion that the January 2013 trauma Petitioner described did not cause or aggravate either Petitioner's chondromalacia or the tear of the lateral meniscus (Resp. Ex. 7, pp. 22-23). The doctor felt Petitioner most likely had some form of minor trauma after the first MRI but before the second (as low level as "twisting on a bent knee such as getting on or off a toilet, in or out of a car") (Pet. Ex. 7, p. 24).

The doctor noted Petitioner's complaints of pain were localized to the inner or front inner aspect of the knee (Resp. Ex. 7, pp. 24-25). In contrast, the doctor noted that Petitioner's meniscal tear was "lateral" meaning to the front outer side of the knee away from the midline and so outside the kneecap (Resp. Ex. 7, p. 25).

The doctor noted that "usually a tear is not as far removed from the site of the pain as was the case in Petitioner's presentation (Resp. Ex. 7, p. 25). The doctor concluded that if Petitioner "does have a tear, it's an asymptomatic tear, and it is not causing the discomfort that he has in his knee and I don't see any relationship to that meniscal tear and his work injury, if the tear even exists. We are not 100% sure it exists" (Resp. Ex. 7, pp. 25-26). The doctor did not feel that Petitioner's condition was even aggravated by any trauma he described given the lack of any symptoms or complaints on the outer side (Resp. Ex. 7, p. 26).

Dr. Karlsson went on to testify that on or about July 21, 2014, he examined records from Dr. Narang dated August 6, 2010 through April 17, 2014 (Resp. Ex. 7, pp. 26-28). The doctor noted that Petitioner had been seen just a few days after the trauma. Specifically, on January 8, 2013, he visited Dr. Narang for a regular check, but made no mention of any recent injury to the knee (Resp. Ex. 7, p. 27). Dr. Karlsson observed Dr. Narang's 1/8/13 chart note reflected no joint pain or joint swelling and no deformity or tenderness of the joints. The doctor emphasized that these findings were made "just five days after the date he alleges injuring his knee at work" (Resp. Ex. 7, p. 28).

He also noted that despite his failure to mention anything about the knee on January 8, 2013 to Dr. Narang, the history he (Dr. Karlsson) took indicated Petitioner had "immediate pain when he bumped his knee..." (Pet. Ex. 7, p. 28).

Finally, Dr. Karlsson scrutinized Dr. Samuelson's testimony in his evidence deposition of 7/8/14. The doctor concluded his testimony by stating Petitioner "has two diagnoses; osteochondritis dissecans and a lateral meniscus tear, or at least a possible lateral meniscus tear..."

The doctor felt that "most of his symptoms are likely coming from the osteochondritis dissecans based on where he is getting his symptoms. The lateral meniscal tear again is questionable. There is one MRI that shows it, one MRI that does not show it. He is not having any symptoms that are in that area" (Resp. Ex. 7, p. 29).

The doctor stated his "opinion...that the osteochondritis dissecans was pre-existing based on the collapse that he had at the time of the first MRI and the lack of any trauma that would be sufficient enough to cause a collapse or cause the depth of bone over a one by one centimeter area..." (Resp. Ex. 7, p. 29). The doctor saw "no relationship" between Petitioner's alleged injury and his ongoing symptoms and need for further care for his knee (Resp. Ex. 7, p. 29). On cross-examination, Dr. Karlsson testified that even Petitioner's complaints of knee pain were not related to any work accident given the first MRI revealing the collapse of the medial femoral condyle. The collapse was the cause of Petitioner's pain complaints "and not the contusion of his knee" (Resp. Ex. 7, p. 38).

He stated that the conditions in Petitioner's left knee were not caused by the incident Petitioner describes as occurring at work in his truck in January 2013 (Resp. Ex. 7, p. 29). The doctor confirmed his opinion that Petitioner's conditions were not even aggravated by any trauma that may have taken place (Resp. Ex. 7, p. 30).

Petitioner concluded that at all times material to his involvement in the matter, including the date of his testimony, Petitioner was at maximum medical improvement regarding any condition caused or aggravated by work and able to work full duty which he had been working for quite some time (Resp. Ex. 7, p. 30). Upon further persistent, insightful questioning by Petitioner's counsel, Dr. Karlsson clarified his opinion on lack of causation indicating that "there are too many things that go against it being causative. There is not enough force. He makes absolutely no mention (of it) to a doctor he has being seeing for years and he sees five days later just—it doesn't fit" (Resp. Ex., p. 41). The doctor's testimony further demonstrated that "turning and hitting your knee against an object doesn't cause osteochondritis dissecans or doesn't cause a collapse in the bone. I mean, that just does not—I don't see collapse in that with you know, 90-year-old ladies who turn and hit their knee. The bone doesn't get that weak even with a pre-existing osteochondritis dissecans where a single bump on it causes a collapse on it." The Arbitrator adopts the above findings of fact in support of the Award, infra. The Arbitrator adopts the medical opinions of Dr. Karlsson in case at bar.

CONCLUSIONS OF LAW 13 WC 13512

As to issue C, Whether the Petitioner Sustained an Accident in the Course and Scope of His Employment, the Arbitrator Finds as Follows:

Based upon the totality of the evidence the Arbitrator finds as a matter of law and fact that the Petitioner did not sustain an accident as alleged at bar in the course and scope of his employment.

As to issue F, Whether the Petitioner's Current Condition of Ill Being, If Any, is causally Connected to the Alleged Accident, the Arbitrator Finds as Follows:

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact the Petitioner's condition of ill being, if any is not related to the incident/alleged accident in the case at bar.

The Arbitrator adopts in this particular case the medical opinions of Dr. Karlsson as more persuasive on this issue that the opinion of Dr. Samuels.

Arbitrator George J. Andros #01 October 28, 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth Godoy,

Petitioner,

vs. NO. 11WC014673

MVP Workforce and ABF Labs,

15IWCC0477

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical care, notice, objections at trial and deposition of Dr. Ghanayem; joint and several liability, penalties and fees, permanent disability, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 29, 2014 is hereby affirmed and adopted.

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

DATED: JUN 2 2 2015
SJM/sj
o-6/4/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GODOY, ELIZABETH
Employee/Petitioner

Case# **11WC014673**

15IWCC0477

MVP WORKFORCE AND ABF LABS
Employer/Respondent

On 1/29/2014, 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 0.06% 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:

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15IWCC0477

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

Elizabeth Godoy
Employee/Petitioner

v.

MVP Workforce and ABF Labs
Employer/Respondent

Case # **11** WC **14673**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **11/4/2013**. 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 _____

15IWCC0477

FINDINGS

On **04/01/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**1,765.00**; the average weekly wage was $**249.25**

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* 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 $**1,717.09** for other benefits, for a total credit of $**1,717.09**.

No permanent benefits are due and owing.

There are *no* penalties or fees imposed upon the Respondent.

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

ORDER

All benefits are denied as Petitioner's accident did not arise out her employment.

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

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

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) necessity of medical bills; 4) payment of medical bills; 5) temporary total disability ("TTD"); 6) penalties; 7) attorney's fees; 8) joint and several liability; 9) the evidentiary deposition of Dr. Ghanayem; and 10) the nature and extent of Petitioner's injuries. *See,* AX1.

On April 1, 2011, Elizabeth Godoy ("Petitioner") was working at Visual Pak ("Respondent"). Petitioner was a temporary employee from Most Valuable Personnel ("MVP") and had been working at Visual Pak on assignment from MVP since March 30, 2011. Visual Pak bottles and packs small parcels of products, including clips and fragrances. Carlos Bezan, the supervisor at Visual Pak for over five years, testified that on April 1, 2011, Petitioner was working with fragrances and small clips and these products were approximately 4 inches by 4 inches and were described by Mr. Bezan as very light. Petitioner testified that she was working on an assembly line taking products from a table, putting them into a box. Mr. Bezan testified that these boxes were actually displays, which would come from a slow-moving conveyor belt. Mr. Bezan testified that the products were placed on the displays by teams of four workers who worked on an assembly line. *See,* Tr. pgs. 17-22.

Petitioner testified that she was given a pallet to stand on in order to perform her duties; without the pallet she would have be too short to do the work. Mr. Bezan stated that he specifically inspected each pallet, including the Petitioner's, as part of his duties as a supervisor. *See,* Tr. pgs. 79-87, 100-102.

On April 1, 2011, Petitioner's shift began at 3:00 p.m. and this was her third day of work at the facility. At approximately 9:15 p.m., Petitioner took a break for fifteen minutes and went to the kitchen area. Upon her return, the petitioner testified that she was working on an assembly line; rotating from left to right, picking up products repeatedly. She testified that once she grabbed the product, she would rotate to het right and place the product into a box. She testified that she performed this twisting and rotating motion 15-20 times per minute while working. She further stated that she developed pain in her neck and left shoulder and that she reported to her boss that the rapid twisting was causing her discomfort.

Petitioner was not moved from that work line. Shortly thereafter, she testified that she saw dark and fainted and recalled being picked up off the work floor. She recalled that immediately before, she was packing product. Petitioner stated she worked on top of a pallet about 7 inches tall because she could not reach the work line due to her height. She also stated she was authorized to use this pallet to complete her work. Petitioner stated she never received training to work on that line and was never reprimanded for standing on the pallet to work. Mr. Bezan testified there were no witnesses to the incident. *See,* Tr. pgs. 20, 33, 41, 82-83 & PX7, pg. 13.

Mr. Bezan testified that he remained with Petitioner in the cafeteria until he went back to the assembly line to verify that everything was in working order. Mr. Bezan stated that the assembly line Petitioner worked on that day was working properly. Petitioner testified that prior to her fainting, she

had asked her supervisor to removed her from this specific assembly line. However, the supervisor, Mr. Bezan, refuted this testimony and stated that Petitioner had never spoken with him about switching assembly lines. Following her initial syncopal episode, Petitioner was brought into the dining room in the facility; and after remaining in the dining room for a period, Petitioner testified that she suddenly and without warning, fainted again. *See,* Tr. pgs. 19, 41-42, 82-83.

Petitioner was taken to Vista Medical Center West in Waukegan, where she complained of pain in her neck. According to the medical records, Petitioner stated her back and left arm were hurting as a result of doing heavy work the past week prior to April 1, 2011. Petitioner was diagnosed with syncope and underwent a CT scan of her neck, which was read as "no definitive evidence for cervical spine fracture." The petitioner also underwent a scan of her left shoulder, which found no evidence of a traumatic injury or other such significant findings. Petitioner was discharged from Vista Medical Center, without work restrictions. *See,* PX5, pgs. 6-8, 24, 53.

On April 4, 2011, Petitioner, choose to present to Aldrin Carrion, D.C., for treatment. Petitioner told Mr. Carrion that prior to the alleged accident, she was having pain in her neck and left wrist. Petitioner also told Mr. Carrion that on April 1, 2011, shortly before her accident, she took a fifteen-minute break from her work duties and after returning from her break, she began to feel dizzy and fell to the floor, losing consciousness. Mr. Carrion's impression was a cervical sprain, cervical radiculopathy and cervical stiffness. Mr. Carrion ordered therapy for Petitioner three (3) times per week, for a period of three to four (3-4) weeks. Despite his alleged suspicion of a spinal problem, Mr. Carrion did not immediately order Petitioner to undergo any diagnostic tests. Petitioner subsequently underwent eighty-two (82) chiropractic sessions with Mr. Carrion, starting on April 4, 2011 and ending on November 10, 2011. Petitioner also testified that Mr. Carrion's records were incorrect. *See,* PX7, at 13-15 & Tr. pgs. 38, 68, 69.

On April 29, 2011, on the recommendation of Mr. Carrion, Petitioner had an EMG with Dr. Gregory Thurston. Petitioner complained of neck pain, left upper arm pain, numbness and tingling in the left posterior upper arm, and weakness of the left shoulder. Dr. Thurston noted that the petitioner's symptoms accumulated to a point and that her injuries had occurred over time. Dr. Thurston's impression was a left C7, C8 neuropathy/radiculopathy with distal axonopathy. *See,* PX11.

On May 26, 2011, Petitioner had a consultation with Dr. James Diesfeld. Dr. Diesfeld noted that on the day of the accident, Petitioner had fallen down and lost consciousness. On June 28, 2011, Dr. Diesfeld performed a trigger point injection in the right wrist and three trigger point injections in the upper back. *See,* PX8, pgs. 17-19.

On June 29, 2011, Petitioner had an examination by Dr. Alexander Ghanayem, M.D, at the request of Respondent. Dr. Ghanayem noted that "if the Petitioner sustained anything, it would have been a soft tissue sprain or strain of the back." Dr. Ghanayem noted that a brief course of chiropractic care or physical therapy, for approximately four weeks, would have been medically reasonable; and that no additional care beyond that, would be medically appropriate. He further stated that the petitioner was

at maximum medical improvement ("MMI") and could return to work, on a regular basis. *See,* RX1 pgs. 1-2.

On September 22, 2011, Petitioner had a cervical epidural steroid injection and three trigger point injections in the posterior cervical region, performed by Dr. Diesfeld. *See*, PX9, pg. 7.

On September 23, 2011, Petitioner had a neurosurgical consultation with Dr. Michel H. Malek. Petitioner told Dr. Malek that she placed two bottles of salad dressing, filling up six to seven bottles per minute at Visual Pak. Petitioner further stated that she had fallen backward and landed on her neck, arm, and right hand. Dr. Malek stated that his diagnosis was a cervical musculoligamentous sprain and left cervical radiculopathy. *See,* PX10 pg. 38.

On November 18, 2011, Petitioner had a follow-up examination with Dr. Malek, who indicated that Petitioner had reached MMI and she was discharged from therapy.

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

The claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial 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 under the Workers' Compensation Act, she must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. *See, Hansel & Gretel Day Care Center v. Industrial 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).

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).

It is established law that at hearing, it is the employee's burden to establish the elements of her 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).

A workers compensation claimant bears the burden of proving that an accident arose out of his/her employment. *See, Builders Square, Inc. v. Industrial Commission*, 339 Ill.App.3d 1006, 1010 (3rd Dist. 2003). "[A] fall originating from an internal and personal condition of the employee is deemed 'idiopathic." The "arising out of" requirement is not satisfied when the fall is deemed idiopathic.

In *Builders Square*, the petitioner was removing items from boxes at work when she suddenly went rigid, staggered backwards and fell to the ground. Petitioner later died from the fall. There was no object on the floor or defect in the floor that contributed to Petitioner's fall. Doctors retained by Respondent Builders Square opined that Petitioner's fall was the likely result of Petitioner's prior medical condition, cardiac arrhythmia, and concluded that Petitioner's fall was idiopathic in nature. The Commission, and later the Appellate Court of the Third District of Illinois, agreed with Respondent's doctors and deemed that Petitioner's accident was idiopathic. Thus, the accident did not arise out of Petitioner's employment.

Similar to *Builders Square*, the petitioner in this matter, fell to the floor without warning, and allegedly injured her neck, shoulder, and arm. Petitioner testified that she had been suffering from severe pain due to twisting her body in a repetitive motion as part of her job on the assembly line. Specifically, Petitioner testified that she suddenly "saw dark" and fell to the floor. Prior to her sudden fall, Petitioner had taken a break, for fifteen minutes, in the kitchen area. Additionally there was also no defect at her work area that contributed to the fall.

In *Horath v. Industrial Commission*, 96 Ill.2d 349, 356 (1983), the Court denied benefits and disregarded the medical opinions of those doctors that relied upon that petitioner's conflicting versions of the accident, in forming their diagnoses. In *Horath*, the claimant testified that he injured himself while he was assisting co-workers in handling a steel form. The claimant specifically testified that he injured his back, neck, left arm and left leg when wind blew the steel form causing the rope positioned across the claimant's back to thrust him forward and pin him against a stack of steel bars. The claimant further testified that he did not feel any pain until the following day. This testimony was at odds with medical records admitted into evidence. According to claimant's medical records, he had given different histories of the accident, at one time alleging that the accident occurred while he was lifting some heavy lumber and another time while stacking wooden forms. The medical records also recounted that the claimant had told one of his doctors that he had experienced immediate pain and had to be helped home by his coworkers.

The Court concluded that the medical evidence relied upon by the claimant, was "based upon the description of the accident and the injury he gave at the hearing," and were contradicted by other, more credible, evidence and the Commission correctly found the petitioner's credibility to be suspect in its denial of benefits to the petitioner.

Additionally, the credibility of a petitioner becomes paramount when the alleged incident is not witnessed. In *Orkin Exterminating Co., Inc. v. Indus. Comm'n*, 172 Ill. App. 3d 753, 526 N.E.2d 861 (1988), the Court held that proving that an unwitnessed accident arose out of and in the course of employment, depended upon the petitioner's testimony regarding the accident's circumstances and therefore upon his credibility. In *Orkin*, the Court denied compensation when the petitioner's credibility was contradicted by numerous elements in the evidence. The Court based its decision on the petitioner's lack of credibility due to the accident not being witnessed, and concluded that the petitioner had failed to prove that an accident occurred that arose out of and in the course of the petitioner's employment.

In this matter, Petitioner's histories of her alleged accident on April 1, 2011, varied each time she described the sequence of events and therefore her credibility is at issue. Initially at Mr. Carrion's office, Petitioner claimed that as a result of the rapid back and forth movement from her job duties, she began to feel to dizzy and light-headed. Shortly thereafter, Petitioner claims that her vision went dark and she fell to the floor. Petitioner described this version to Mr. Carrion, just three days after the accident on April 4, 2011. In a later version of the event, which she told to Dr. Malek, Petitioner stated that she stood on an unstable platform, subsequently lost her balance, and fell to the floor. Petitioner failed to mention she had become dizzy to Dr. Malek or to Dr. Ghanayem. When asked about the discrepancy between the two stories, Petitioner testified that Mr. Carrion's records, taken three days after the accident, were simply wrong. She further testified that she had no idea what dizziness felt like despite having previously described this feeling to Mr. Carrion at her initial examination. Further confounding the veracity of Petitioner's report to Dr. Malek is the fact that she told Dr. Malek that she was working with salad dressing bottles, not fragrance clips.

Petitioner's story also varied as to the presence of pain prior to April 1, 2011. Initially, at Vista Medical Center West, she stated that the week leading up the accident she suffered from back and left arm pain. Three days later, on April 4, 2011, she told Dr. Carrion that, prior to the accident, it was her neck and left wrist that caused her pain. Petitioner later testified that her back was never in pain and it was only her neck, shoulder, and arm. Additionally, the amount of time that she was in pain prior to the accident varied as well. According to the Vista Medical Center West records, she suffered from pain for the week prior to April 1, 2011. In her later visit with Dr. Thurston on April 29, 2011, Petitioner told him that she had developed neck, shoulder and arm pain, which over time, had led to the symptoms of which she complained. Dr. Thurston further stated that on the date of the injury the symptoms accumulated to a point that the petitioner decided to report the injury. As stated above, Petitioner had only been working at facility for three days.

Further, Petitioner is not credible on her alleged loss of consciousness. In her initial examination with Mr. Carrion, Petitioner stated she had lost consciousness. In her later visitations with Dr. Malek, Petitioner also stated that she fell to the floor losing consciousness. However, this changed in her examination with Dr. Ghanayem when she stated that she did not lose consciousness when she fell to

the floor. Petitioner stated that she had turned fast, lost her balance and fell backward without a loss of consciousness.

Similar to *Horath*, each treating physician relied upon the version of Petitioner's accident and injuries in constructing their medical opinion. The medical records and Petitioner's testimony demonstrate a conflicting version of events with conflicting and changing injuries. Therefore, pursuant to *Horath*, the Arbitrator disregards the conclusions of Petitioner's doctors as they are based on inaccurate or incomplete information. Furthermore, Petitioner's lack of credibility casts doubt on the veracity of her version of the accident testified to at hearing.

Petitioner has failed to prove, by a preponderance of the evidence, that an accident arose out of and in the course of her employment. Having determined that Petitioner has failed to prove an accident, Petitioner's claim for benefits is hereby denied. All other issues are moot and therefore will not be addressed.

15IWCC0477

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11WC14673
SIGNATURE PAGE

Signature of Arbitrator

January 29, 2014
Date of Decision

JAN 29 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Mansell,

Petitioner,

vs. NO. 04WC028670

15IWCC0478

Jack Murphy Chemical Co.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 11, 2014 is hereby affirmed and adopted.

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

DATED: JUN 2 2 2015
SJM/sj
o-6/4/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MANSELL, JOSEPH
Employee/Petitioner

Case# **04WC028670**

JACK MURPHY CHEMICAL CO
Employer/Respondent

15IWCC0478

On 6/11/2014, 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:

2221 VRDOLYAK LAW GROUP LLC
MEGAN WAGNER
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60610

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

15IWCC0478

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

Joseph Mansell,
Employee/Petitioner

v.

Jack Murphy Chemical Co.,
Employer/Respondent

Case # **04** WC **28670**

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 **2/19/14**. 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. [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 [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 _____

15IWCC0478

FINDINGS

On **8/9/01**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** suffer an accidental exposure that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$31,820.04**; the average weekly wage was **$611.92**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**. (See Arb.Ex.#1).

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

ORDER

The Arbitrator finds that Petitioner suffered an occupational exposure that arose out of and in the course of his employment on or about August 9, 2001, but that Petitioner failed to prove by a preponderance of the credible evidence that his current conditions of ill-being with respect to his liver function abnormalities, variously diagnosed as nonalcoholic steatohepatitis (NASH), fatty or elevated liver enzymes and/or hepatomegaly, as well as Barrett's esophagus, inflammatory bowel disease (Crohn's disease) and type II diabetes are causally related to said exposure. Accordingly, Petitioner's claim for compensation is hereby denied.

No benefits are awarded.

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

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

Signature of Arbitrator

6/6/14
Date

JUN 11 2014

STATEMENT OF FACTS:

Petitioner, a 42 year old chemical inspector/chemist, testified that he had worked for Respondent for approximately 10 years as of the date of the alleged accident on August 9, 2001. His job duties included inspecting the movement of petroleum products and laboratory testing. He performed his job at different work stations including barges, railroad cars, tank trucks, different facilities, and different terminals. Petitioner testified that the terminal is very large, with a docking location where barges enter, as well as storage tanks, railroad transfer areas, and a scale house where trucks enter. The terminal is owned by IMTT (International Matrix Tank Terminal). Respondent rents space within the terminal from IMTT. Petitioner testified that IMTT would have control over the areas where he would be sampling or testing chemicals.

Petitioner testified that he stopped working at Respondent on or about August 9, 2001, the date of the alleged accident. He testified that he believed he was terminated from his position in that he was told if he can't do the job not to come back. He indicated that he had asked for a job change, and his request was refused. When asked whether his old job was still available, however, Petitioner indicated that he was not sure. Petitioner testified that he had worked for Respondent for approximately 10 years and that he had worked in the petrol industry all his life since the age of 18.

Petitioner testified that while working for Respondent, he was provided with safety gear including boots, gloves, safety glasses and a hard hat. He was not provided with any type of breathing mask. He testified that IMTT employees wore respirators in regulated areas. Petitioner testified that while employed by Respondent, he worked with chemicals including ethylene chloride, perchloroethylene, ethylene dichloride, solvent 1 trichloroethylene dioxin and dioxin free, styrene, ethylene glycol, acetone and toluene. He worked with most of the chemicals on a daily basis, performing sampling and inspections. Petitioner testified that IMTT had a manual on how to handle the chemicals. Petitioner testified that he performed chemical analysis in two laboratories, a main large lab and a smaller lab. The main lab had a wall mount ventilation system. The smaller lab did not. Petitioner testified that he requested his employer purchase a laboratory fume hood.

Petitioner testified that on the date of alleged accident, August 9, 2001, he began having right flank pain. He claimed that he had never felt that pain before and that he went to the doctor when he started feeling said pain. He also indicted that he believed it was about four days before he could get in to see his doctor.

However, the records of Primary Health Associates reveal that Petitioner visited his primary care physician, Dr. Amit Joshi, on August 8, 2001, the day before the alleged accident, with complaints of right flank pain in the kidney area for three or four weeks. (PX1). It appears that blood work was ordered at that time as well as a renal ultrasound if the pain persists. (PX1). Petitioner then returned to see Dr. Joshi on August 13, 2001. (PX1). However, Dr. Joshi's handwritten notes for that date and subsequent visits are difficult if not impossible to decipher. (PX1).

An ultrasound was performed on Petitioner's liver and kidneys at Palos Community Hospital on August 15, 2001 which demonstrated fatty infiltration of the liver and a small kidney cyst. Petitioner testified that Dr. Joshi recommended renal and liver sonograms, and restricted him from work.

Petitioner testified that he was examined by Dr. Vincent Muscarello at Southwest Center for Gastroenterology on October 10, 2001. (PX2). Dr. Muscarello noted that Petitioner had treated with Dr. Joshi and had undergone testing for hepatitis, including an ultrasonography. He requested his employer assign him a new position. Dr. Muscarello noted that when the employer refused, Petitioner quit his job. Dr. Muscarello stated that the right-sided back pain with radiation to the flank and lower right quadrant was not typical for pain caused by an

enlarged liver. He noted Petitioner's liver function abnormalities were "very modest." Based on that, and the fact that Petitioner had no enlargement of the liver on exam, Dr. Muscarello doubted this was the source of Petitioner's pain. Instead, he noted Petitioner was active in swimming and running and that the pain could have been radicular or due to a lumbosacral strain. Dr. Muscarello recommended Petitioner undergo a liver CT. However, Petitioner refused to undergo same. Dr. Muscarello further noted that the elevated liver function test could be "purely a phenomenon of exogenous obesity, given the patient's height and weight." In addition, Dr. Muscarello could not rule out that the abnormalities could have been caused by chemical exposure, but also noted possible causes including hepatitis C, autoimmune hepatitis, hemochromatosis, and Wilson's disease. (PX2). Dr. Muscarello noted that Petitioner was "somewhat loathe to pursue further workup" and that "his main focus is justification for quitting his employment on the theory that chemical exposure caused liver disease." Dr. Muscarello stated that although he could not exclude the possibility of long-term chemical exposure causing the liver function abnormalities, he doubted the "cause of the pain as being related to liver disease." He also noted that Petitioner did not want to undergo the further workup needed to ascertain same. Dr. Muscarello recommended Petitioner undergo blood work. (PX2).

Petitioner testified that he followed up with Dr. Joshi on October 17, 2001.

In a letter addressed "TO WHOM IT MAY CONCERN" and dated October 18, 2001 Dr. Joshi noted that Petitioner initially presented "… with a concern of right flank pain for over three weeks. A workup to elicit the cause of this pain was pursued. He was found to have elevated liver enzymes and diffuse fatty infiltration on an ultrasound of his liver. The patient expressed concern that his exposure to possibly harmful chemicals at his workplace may have caused this development of abnormalities. At that time I referred the patient to a gastroenterologist who recommended a further workup. At this time it is difficult to exclude the possibility of chemical exposure causing his symptoms and liver function abnormalities." (PX1). Dr. Joshi went on to state that "[i]deally, a completion of his laboratory workup would be more helpful in settling the matter at hand. Additionally, perhaps an evaluation by an environmental physician may be of assistance." (PX1).

Petitioner testified that he followed up with Dr. Joshi on November 19, 2001 and also visited Dr. Michael W. Heniff on November 26, 2001. In a "Progress Note" dated November 26, 2001, Dr. Heniff noted that Petitioner was a ten (10) year smoker of approximately ¾ of a pack a day before quitting in 1995 who "…works in a chemical plant with exposure to acetone, ethylene glycol, methanol, and a number of other hydrocarbons, none of which he has had a significant exposure to from what I can gather. The patient has worked at this job for the past 10 years or so." (PX1). Dr. Heniff went on to state that Petitioner had had chest pain in the right lower rib area since August of 2001and that he "… had a work up done and saw Dr. Muscarello because of some elevated liver function tests. Ultrasound at that time showed a fatty liver and the patient is unsure what Dr. Muscarello told him but told him that he did not have any significant pathology. Apparently he was worked up for hemochromatosis and there was no need felt for a biopsy for what the patient tells me. Presently, I am getting the records from Dr. Muscarello's office to see if this is in fact the case. I did find an ultrasound which only showed diffuse fatty infiltration of the liver and a cyst in the right lower pole of his kidney…" (PX1). The Arbitrator notes that this progress note of Dr. Heniff appears to be incomplete, given that it consists of a single page and contains only the above history and no discussion of physical findings on examination much less an assessment. (PX1).

In a letter addressed "TO WHOM IT MAY CONCERN" and dated December 14, 2001, Dr. Joshi noted Petitioner had seen a gastroenterologist and a pulmonologist "… who have both confirmed that the patient does have abnormal liver function tests. Both physicians agree that the etiology of this elevation of the liver function tests is obscure. At this point it is not clear whether exposure to chemicals at work is a likely cause of this problem. However, I do believe that it is preferable for the patient to avoid further contact with chemicals as he

does have marked elevation of his liver enzymes. In concurrence with the pulmonologist and the gastroenterologist I feel that it is advisable for the patient to avoid exposure to various chemicals that could possibly worsen his liver function tests." (PX1).

Petitioner testified that he next treated with Dr. Joshi on April 24, 2002 at which time he was diagnosed with non-alcoholic steatohepatitis and a liver biopsy was recommended. (PX1).

Petitioner next treated approximately ten (10) months later on February 1, 2003 with Dr. Van Thiel at Loyola University Medical Center who recommended a liver CT and ultrasound, blood work and a sleep study. Petitioner underwent a liver CT on March 5, 2003 which demonstrated an enlarged liver with fatty infiltration. Petitioner subsequently underwent a liver biopsy on April 22, 2003 per Dr. Van Thiel which demonstrated minimal normal inflammation, mild periportal fibrosis stage 2 consistent with steatohepatitis. (PX3).

On May 2, 2003 Petitioner underwent a colonoscopy. (PX3). The operative diagnosis was "4 polyps removed, moderate internal hemorrhoids, sigmoid colon diverticulosis." (PX3).

Petitioner followed up with Dr. Van Thiel on June 2, 2003 at which time the assessment was mild/moderate reflux esophagitis, Crohn's disease, diabetes and fatty liver. (PX3).

Petitioner underwent a CT of the abdomen and pelvis on October 18, 2003. The indication was to follow-up for Crohn's disease. The impression was persistent mild hepatomegaly, with interval resolution of fatty infiltration of the liver. (PX3)

Petitioner testified he treated with Dr. Van Thiel on February 27, 2004 at which time it was recommended that he continue a low fat diet and exercise. (PX3).

Petitioner testified he next treated with Dr. Joshi on April 19, 2004 and was diagnosed with NASH, Crohn's disease and type II diabetes. (PX1).

Petitioner testified that on June 14, 2004, Dr. Joshi went over the results from Dr. Van Thiel and recommended a repeat CT scan. Petitioner was also referred to a nephrologist. (PX1).

On October 21, 2004, Petitioner presented to Dr. Oyama at Southwest Nephrology. At that time Dr. Oyama performed an evaluation and noted right flank pain but found no renal abnormality. (PX1). Dr. Oyama also noted that Petitioner had right flank pain which began 6-8 months prior. Following his examination and review of the records, Dr. Oyama's assessment was right flank and low back discomfort of unspecified etiology, normal kidney function and an apparent simple cyst of a renal ultrasound of 2001. (PX1). Dr. Oyama noted that it did not appear that the patient demonstrated any renal abnormalities of concern and that he did not believe that his primary complaint of discomfort of the right side was renal in origin. (PX1). As a result, Dr. Oyama had no recommendation for further assessment of his renal status, but would suggest an ENT examination for his hoarseness and continued concerns about his throat. (PX1).

Petitioner testified that he saw Dr. Joshi for a check up on March 2, 2005 and underwent an ultrasound of the liver and spleen at Palos Community Hospital on March 9, 2005, or approximately 3-1/2 years after he stopped working for Respondent. The ultrasound demonstrated increased echogenicity of the liver suggestive of diffuse parenchymal disease or fatty infiltration, otherwise unremarkable. (PX1).

Petitioner was subsequently examined by Dr. Gavron of Southwest Head and Neck Surgical Associates on April 29, 2005, who recommended speech therapy for hoarseness which he attributed to GERD. (PX1). Medical records also indicate that Petitioner admitted to a ten (10 year history of smoking, though he told Dr. Oyama he stopped smoking in 1988 and told Dr. Heniff he quit in 1995. (PX1).

Petitioner testified that he was next examined by Dr. Joshi on October 1, 2007, or over 2 years later. Records indicate he presented for increased uncontrolled blood sugar. (PX1).

Petitioner next treated with Dr. Muscarello on June 10, 2008, approximately 8 months later. (PX2). Dr. Muscarello stated that Petitioner had a reported history of methylene chloride exposure, and was skeptical that Petitioner should return to work in the petro chemical industry. He also stated that this was the only case of methylene chloride exposure he had seen in clinical practice. (PX2). Dr. Muscarello noted that Petitioner "apparently has a history of Crohn's disease although he is firmly denying this and reporting that he does not believe he has the problem at all." (PX2). Dr. Muscarello recommended a colonoscopy and an MRI of the liver. However, he noted that Petitioner was "admit (sic) that he does not want another colonoscopy, that he would not submit for a serum antibody test for ASCA antibodies, and does not want to obtain the old records regarding this particular issue." (PX2). Petitioner testified on he had stopped taking medication for Crohn's disease because he thought he no longer needed it.

Petitioner testified that he followed up with Dr. Joshi in July 2008 and asked Dr. Joshi whether he could return to the petrol chemical industry. Petitioner testified that Dr. Joshi did not release him to return to the petrol chemical industry at that time.

In a letter addressed "To Whom It May Concern" dated July 23, 2008, Dr. Joshi noted that Dr. Muscarello had indicated that "… he would not recommend Mr. Mansell returning to the petro chemical industry based on his prior responses and issues with liver dysfunction." (PX1). Dr. Joshi went on to state that Petitioner "… presented to my office seeking an opinion and I merely advised him that I would concur with Dr. Muscarello's opinion based on the workup that he has in the past … In a final analysis, I feel that Joe would be best advised not to return to petro chemicals. We do not have a definitive test indicating that he has had an injury to his liver from exposure. However, prudency would dictate that he not return to that field of employment…" (PX1).

On March 24, 2010, or almost nine (9) years after the claimed date of accident, Petitioner presented to Dr. Orris of Occupational Health Services Institute. Dr. Orris testified by way of evidence deposition on March 2, 2011. (PX4). By way of employment history, Dr. Orris noted that from the age of 18 to age 25 Petitioner had worked for a petroleum company cleaning up a laboratory and that from age 25 to age 44 he worked for Respondent as an inspector. (PX4, p.7). Dr. Orris noted that by way of history this latter job involved the collection of chemicals, including hydrocarbon solvents, without the benefit of a respirator or other personal protective equipment. (PX4, p.7). Specifically, Dr. Orris recorded that Petitioner claimed to have been exposed through his entire shift to aromatic hydrocarbons, methylene chloride and ethylene dichloride. (PX4, p.8). Dr. Orris indicated that in October of 2001 Petitioner was found to have mildly elevated liver enzymes and fatty infiltration of the liver with some hepatomegaly, but that after leaving his job in the spring of 2003 (sic) the fatty infiltration had essentially resolved and the hepatomegaly had been reduced. (PX4, p.8). Dr. Orris testified that his impression at the time of this initial visit was chemically induced nonalcoholic steatohepatitis, based on the previous biopsy, history and physical examination, as well as Barrett's esophagus, inflammatory bowel disease and diabetes type II. (PX4, p.10). Petitioner returned to Dr. Orris in follow up on June 23, 2010 at which time the latter reviewed additional records brought by the patient. (PX4, p.11). When asked his opinion as to the cause of the fatty infiltration of the liver, Dr. Orris indicated that he believed "… it's multi-factorial. The Diabetes Mellitus Type II, of course, predisposes and is a cause of fatty infiltration of the liver. In addition, his

prolonged and chronic exposure to the hydrocarbons at work were a cause of the liver inflammation, fatty infiltration, and hepatitis." (PX4, p.11). Dr. Orris also noted that removal from exposure and the fact that Petitioner was on Metformin for his diabetes "… would have reduced the likelihood of his developing this and would be considered treatment for the fatty infiltration, the inflammation, and the hepatitis." (PX4, p.12).

Dr. Orris indicated that the cause of the hepatomegaly, or enlargement of the liver, as well as elevated liver enzymes was "… secondary to the fatty infiltration and the inflammation, the hepatitis that had developed due to these exposures and the diabetes." (PX4, pp.12-13). With respect to the Barrett's esophagus, Dr. Orris stated that it "… will develop in a number of situations. Chronic irritation is one of the causes, and the swallowing of hydrocarbons, secondary to their inhalation in the setting that he described at work in which he was working with these materials on an open basis, could have contributed to this Barrett's esophagus, but I am less sure of the etiology in relationship with the hydrocarbons in this situation." (PX4, p.13). Likewise, with regard to the inflammatory bowel disease, Dr. Orris indicated that "… hydrocarbons can inflame the GI tract. You inhale them, basically, but then you combine them with the water in your mouth, the saliva in your mouth, you swallow them, and these became irritating to the GI tract at the esophageal level. So the Barrett's esophagus could well have been stimulated by this, lower down in the GI tract as well, inflaming an inflammatory bowel disease." (PX4, pp.13-14). Finally, with respect to the type II diabetes, Dr. Orris noted that "[c]hlorinated hydrocarbons are known to be associated, but whether they were in this situation, I wouldn't be able to say on a more likely than not basis." (PX4, p.14). Dr. Orris was also of the opinion that Petitioner should not go back to this employment and exposure given that "… he will redevelop the same thing again. This is a direct toxic effect of the exposure, and that's the problem." (PX4, p.14).

On cross examination, Dr. Orris conceded that he had only seen Petitioner on two occasions and that Mr. Mansell was asymptomatic at that time. Dr. Orris also agreed that his opinions were completely based on Petitioner's descriptions of his exposure. (PX4, p.23). Dr. Orris testified that he did not review any time weighted average studies, that he did not have any evidence independent of Petitioner's report regarding what chemicals were present in the workplace and did not review any MSDS sheets on any chemicals related to Petitioner's alleged exposure at work. (PX4, pp.24-25). In addition, Dr. Orris acknowledged that he was not aware of the number of samples Petitioner handled over the course of a day and was also not aware of how much time Mr. Mansell spent in the lab versus outside the lab. (PX4, pp. 27-28). Dr. Orris also agreed that Crohn's disease, diabetes, NASH and obesity can cause elevated liver enzymes. (PX4, pp.35-37). Dr. Orris testified that the fatty infiltration spectrum is one of the most common diseases of the liver in the United States (PX4, p.43). Furthermore, Dr. Orris testified that type II diabetes and Crohn's disease, both of which Petitioner was diagnosed with, can cause elevated liver enzymes and fatty liver. (PX4, p. 49-50). In addition, Dr. Orris testified that Petitioner told Dr. Muscarello he quit taking his medication for Crohn's disease, and that cessation of medication can cause liver inflammation. (PX4, pp. 54-55). Dr. Orris also indicated that Petitioner's medical records indicated he was borderline clinically obese. (PX4, pp. 56-57). Dr. Orris testified that based on liver ultrasounds from 2005, Petitioner had fatty infiltration of his liver at least 2 years after he had stopped working for Respondent (PX4, p. 61). Dr. Orris also agreed that Petitioner had undergone extensive testing at Loyola Medical Center on April 22, 2003 and was discharged to full duty work without restrictions at that time. (PX4, p. 69).

Petitioner testified that based on Dr. Orris' recommendations, he refused to take a job in the chemical industry. He indicated that following his employment with Respondent he applied for unemployment, worked at Stelzer Water and Sewer earning about $15.00/hour, then worked for a limo service where he earned $32,000 in his best year, then worked as a taxi manager before acquiring his current job as a substitute teacher where he earned approximately $13,000 in 2013. Petitioner testified that he found these jobs on his own and that he never had to leave a job for physical reasons.

Petitioner underwent a vocational assessment with Kari Stafseth on October 14, 2011. (PX5). Ms. Stafseth testified that Petitioner informed her that he earned $32 per hour working for his cousin at Stelzer Water and Sewer. (PX5, p.7). Ms. Stafseth also related that Petitioner told her that he earned $32,000 per year working for Southwest Limo Service from 2005 to 2009. (PX5, p.8).

Petitioner testified he was not diagnosed with NASH, diabetes or fatty liver before 2001. In addition, Petitioner indicated that he has not had any exposure to any of the previously mentioned chemicals since he left Respondent's employ. He also noted that he currently does not have any problems with his Crohn's disease, although he noted that it took a couple of years.

WITH RESPECT TO ISSUES (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, AND (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that on August 9, 2001 he started having right flank pain. He provided no information as to any particular activity he may have been performing at that time or what he may have been doing earlier in the day in order to explain the onset of his pain. Therefore, there is no evidence to support a finding that Petitioner's claimed injuries were the result of a specific, identifiable accident on the day in question. Instead, it would appear that Petitioner's theory of recovery is that his injuries were the result of occupational exposure.

§1(d) of the Occupational Diseases Act states that "… the term '[o]ccupational [d]isease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists…" 820 ILCS 310/1(d).

§1(f) of the Occupational Diseases Act states that "[n]o compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease …" 820 ILCS 310/1(f).

§1(e) of the Occupational Diseases Act states that "'[d]isablement' means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment; and 'disability' means the state of being so incapacitated." 820 ILCS 310/1(e).

Petitioner testified that as of the last date of the alleged exposure on August 9, 2001 he had worked for Respondent for about ten (10) years and that he had worked in the petrol industry since the age of 18. He stated that his job as a chemical inspector/chemist for Respondent entailed the inspection of petroleum products being transported via railroad cars, barges, tank trucks, and the like. He indicated that the terminal was owned by IMTT and included a docking place for barges, storage tanks and a steel hut for trucks. He noted that

Respondent rented space from IMTT. Petitioner testified that in addition to his inspection duties he would perform tests in one of two laboratories – a main one that had a ventilator system and a smaller one that did not. Petitioner did not testify as to the amount of time he spent either inspecting railroad cars, etc. or working in either of the two labs.

Petitioner noted that Respondent provided him with boots, gloves, safety glasses and a hard hat. He indicated that he was not given any type of breathing mask even though IMTT employees were provided same and were required to wear them in certain areas, including areas Petitioner visited. Petitioner did not testify as to the actual amount of time he spent in these particular areas on a daily basis.

Petitioner testified that during his employment with Respondent he sometimes worked more than but never less than 40 hours per week. He also indicated that as part of his job he handled the following chemicals: ethylene chloride, perchloroethylene, trichloroethylene, solvent 1 trichlorethylene (one with dioxin and one that was dioxin-free), styrene, ethylene glycol and acetone toluene. Petitioner indicated that he would handle each of these chemicals every day he worked, with the exception of the acetone toluene. Petitioner also noted that he had not worked with these chemicals before his employment with Respondent, except for the acetone. Petitioner did not testify as to the frequency with which he handled a particular chemical, or the manner in which he would perform this activity. In addition, Petitioner offered no material safety data sheets or the like that would set forth the hazardous nature and possible side-effects of the chemicals in question.

Petitioner did offer into evidence an article entitled "Potential Health Effect of Occupational Chlorinated Solvent Exposure" (PX9) as well as a U.S. Department of Labor Occupational Safety and Health Administration (OSHA) "Citation and Notification of Penalty" for Murphy Chemical Inspection Co. issued January 30, 2002 and reflecting inspection dates from December 11, 2001 through January 18, 2002. (PX8). This report was issued in response to a complaint filed by Petitioner. The report cited Respondent for not providing an adequate eye wash station; failing to set forth in writing the employer's hazard assessment for personal protective equipment; failing to develop and implement a written respiratory protection program; failure to conduct initial exposure monitoring to methylene chloride; failing to develop, implement and maintain a written hazard communication program for employees working with hazardous chemicals, including but not limited to methylene chloride, tetrachlorethylene and other chemicals; and failure to provide employees with information and training on hazardous chemicals, including but not limited to methylene chloride, tetrachlorethylene and other chemicals. (PX8). Furthermore, in response to a formal complaint by Petitioner, it was noted that OSHA had conducted an inspection of Respondent's operation and found that "[e]mployees sampling storage tanks, trucks, barges, and/or railroad cars are overexposed to chemicals. The chemicals the employees are overexposed to include Methylene Chloride and Perchloroethylene (Tetrachloroethylene)." (PX8).

A separate OSHA letter dated February 11, 2002 noted that air sampling at Murphy Chemical Inspection Co. on January 17, 2002 showed methylene chloride results of 14.00P (parts per million), or below OSHA permissible levels of 25.0P, and "0.00P" or no detectable levels of perchloroethylene. (PX8).

Respondent argues that Petitioner failed to prove that he was exposed to unsafe levels of hazardous chemicals, based in part on the above OSHA air sampling analysis, as well as the limited nature of Petitioner's testimony as his actual daily exposure. However, such considerations are not relevant to the present inquiry. Instead, the Illinois Supreme Court has held that proof of hazardous exposure is "conclusively established" and not subject to challenge by the employer when the worker proves employment in an occupation in which the hazard exists. See *Freeman United Coal Mining Co. v. Industrial Commission*, 188 Ill.2d 243, 720 N.E.2d 1063, 1065-1066, 242 Ill.Dec. 108 (1999). Along these lines, the *Freeman* court specifically noted that the worker is not required to provide any proof of the amount, time or duration of exposure and rejected the employer's argument that a

claimant must establish a medically significant exposure on his or her last day of work. *Freeman*, 720 N.E.2d at 1065, 1066.

Accordingly, based on the fact that Petitioner was employed in an occupation where a known hazard exists, as evidenced by the aforementioned OSHA report and by Petitioner's credible testimony as to the type of chemicals he handled, the Arbitrator finds that Petitioner "conclusively established" that he suffered an occupational exposure that arose out of and in the course of his employment on or about August 9, 2001.

The question then becomes whether Petitioner proved by a preponderance of the credible evidence that a causal relationship exists between said exposure and the claimed occupational diseases.

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

An occupational disease is compensable if it is 'a causative factor' in the resulting disability or condition of ill-being even if other nonoccupational factors contribute to the condition. *Old Ben Coal Co. v. Industrial Commission*, 217 Ill.App.3d 70, 576 N.E.2d 890, 899, 159 Ill.Dec. 967 (5th Dist. 1991). Along these lines, the burden rests on the claimant to establish that he is suffering from a condition of ill-being caused by or related to his employment, and a mere possibility that a claimant may have become afflicted with a condition of ill-being in the course of his employment is not sufficient to support an award of compensation. See *Weekley v. Industrial Commission*, 245 Ill.App.3d 863, 615 N.E.2d 59, 185 Ill.Dec. 764 (1993).

A finding of a causal relation may be based on a medical expert's opinion that an accident "could have" or "might have" caused an injury. *Mason & Dixon Lines, Inc. v. Industrial Commission*, 99 Ill.2d 174, 457 N.E.2d 1222, 1226, 75 Ill.Dec. 663 (1983). A finding of causation will not be overturned merely because the disease may have been caused by nonoccupational exposures. *Revere Copper & Brass, Inc. v. Industrial Commission*, 97 Ill.2d 388, 454 N.E.2d 657, 660, 73 Ill.Dec. 560 (1983). Likewise, a finding negating causation will not be rejected because the evidence shows the disease could have been contracted from an occupational exposure. *Sperling v. Industrial Commission*, 129 Ill.2d 416, 544 N.E.2d 290, 293, 135 Ill.Dec. 794 (1989). However, a chain of events suggesting causal connection can suffice even if the etiology of the disease is unknown. *Certi-Serve, Inc. v. Industrial Commission*, 101 Ill.2d 236, 461 N.E.2d 954, 958-959, 78 Ill.Dec. 120 (1984).

In the present case, Petitioner is alleging that as a result of his occupational exposure he acquired or developed liver function abnormalities -- variously diagnosed as nonalcoholic steatophepatitis (NASH), hepatomegaly, liver enzyme elevation and/or fatty liver infiltration -- in addition to Barrett's esophagus, inflammatory bowel disease (Crohn's) and type II diabetes. However, given the myriad of symptoms, bewildering set of records and varied medical opinions, determining what conditions Petitioner may actually be suffering from is not as simple a task as it may sound. Indeed, the evidence seems to amount to more of an amalgamation of symptoms and test results in search of a diagnosis than anything else. The initial studies revealed that immediately following his last date of exposure Petitioner exhibited elevated liver enzymes and fatty liver infiltrates. Treating physician Dr. Joshi was perplexed enough to refer Petitioner to a gastroenterologist and a pulmonologist to evaluate what he termed "liver function abnormalities." After ruling out a host of other possibilities, Dr. Joshi appears to have settled upon a diagnosis of nonalcoholic steatohepatitis (NASH), or inflammation of the liver caused by a build-up of fat. (PX1).

Dr. Muscarello seemed similarly uncertain, diagnosing right-sided back pain with radiation to the flank and right lower quadrant as well as elevated liver function tests at the time of his initial examination, and later

noting that Petitioner "... apparently has a history of Crohn's disease although he is firmly denying this and reporting that he does not believe he has the problem at all." (PX2).

Yet another physician, Dr. Oyama noted an assessment of right flank and low back discomfort of unspecified etiology, normal kidney function and an apparent simple cyst noted on a renal ultrasound. (PX1).

Dr. Van Thiel, in his handwritten note dated June 2, 2003, appears to offer a diagnosis that includes Crohn's disease in addition to mild/moderate reflex esophagitis, diabetes and fatty liver. (PX3).

Finally, there is Dr. Orris, who saw Petitioner on only two occasions, almost nine (9) years after the last date of exposure, and whose referral source is unclear. Dr. Orris did not treat Petitioner and made no treatment recommendations other than to advise Mr. Mansell to refrain from returning to his former employment. Dr. Orris offered a primary diagnosis of "chemically induced nonalcoholic steatohepatitis, which included the fatty infiltration of the liver, hepatomegaly, and some inflammation ..." as well as "... Barrett's esophagus and inflammatory bowel disease, as well as diabetes, although we did not look at those specifically ..." (PX4, p.10).

With respect to the alleged conditions of Barrett's esophagus and Crohn's, the Arbitrator notes that the record is less than clear as to how and when these diagnoses were made. As already noted, Dr. Orris conceded that he did not specifically look at those conditions, and as a result admittedly was "... less sure of the etiology in relationship with the hydrocarbons in this situation..." (PX4, p.13). Likewise, the record appears to contain second hand references to both conditions by the various treating and consulting physicians. Out of all of these physicians, the one most likely to have been in a position to make such a diagnosis would have been Dr. Van Thiel at Loyola Medical Center, who noted in his handwritten (and difficult to decipher) notes his assessment that Petitioner was suffering from mild/moderate reflux esophagitis, Crohn's disease, diabetes and fatty liver. (PX3). Unfortunately, Dr. Van Thiel referenced no basis for these diagnoses, much less offer an opinion as to whether or not they were causally related to the occupational exposure in question. Furthermore, the colonoscopy report dated May 2, 2003, which one would think would provide such a basis, only refers to the removal of 4 polyps, moderate internal hemorrhoids and sigmoid colon diverticulosis and makes no reference to a finding of Crohn's, or even the need to rule it out. (PX3). Interestingly enough, the only other reference to Crohn's can be found in the records of Dr. Muscarello, who noted that Petitioner adamantly denied that he had the condition and refused treatment for same.

Likewise, one has to question the diagnosis of Barrett's esophagus given that the ear, nose and throat specialist who examined Petitioner with respect to these complaints on April 29, 2005, Dr. Gavron at Southwest Head and Neck Surgical Associates, only recommended that Petitioner undergo speech therapy for hoarseness, which he attributed to GERD. (PX1).

In any event, even assuming that Petitioner does in fact suffer from both Crohn's disease and Barrett's esophagus, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that said conditions had their origin in a risk connected with the employment, particularly in light of the fact that approximately two to three years had elapsed since the last date of exposure before there was even the slightest indication that Petitioner was suffering from either of these conditions. Furthermore, no medical opinion was offered into evidence, other than that of Dr. Orris, that would directly link these two conditions to the exposure, and as already noted Dr. Orris himself candidly admitted that he "... did not look at those [conditions] specifically ..." and was therefore "... less sure of the etiology in relationship with the hydrocarbons in this situation..." (PX4, pp.10,13). (See issue "F", infra).

Furthermore, there is absolutely no evidence to support a finding that Petitioner's type II diabetes had it's origin in or was aggravated by the workplace exposure. Indeed, even Dr. Orris did not weigh in with an opinion along these lines, other than to note that diabetes, along with Crohn's disease and obesity, can cause elevated liver enzymes and fatty liver. (PX4, pp.35-37,49-50).

With respect to the remaining conditions, all dealing with liver function abnormalities, including nonalcoholic steatophepatitis (or "NASH", inflammation of the liver caused by a build-up of fat), hepatomegaly (or enlargement of the liver), liver enzyme elevation and/or fatty liver infiltrates, the record shows that only one physician offered an opinion in support of Petitioner's claim – namely, Dr. Orris. Indeed, as previously noted, neither Dr. Joshi nor Dr. Muscarello offered clear opinions to the effect that the above conditions were causally related to the occupational exposure in question. Indeed, Dr. Joshi noted that both the consulting physicians he had referred Petitioner to "... agree that the etiology of this elevation of the liver function tests is obscure..." and that "... it is not clear whether exposure to chemicals at work is a likely cause of this problem..." (PX1). Likewise, Dr. Muscarello, who conceded that Petitioner's was the only case of methylene chloride exposure he had seen in clinical practice, ultimately declined to affirmatively link Petitioner's conditions to the exposure, noting that the liver function abnormalities were "very modest" and that he doubted it would have caused Petitioner's right flank pain. (PX2). Similarly, Drs. Van Thiel, Gavron and Oyama offered no opinions along these lines.

Instead, we are asked to decide this issue of causation based solely on the opinion of Dr. Orris, who saw Petitioner on only two occasions and who offered no treatment in this matter. Dr. Orris opined that the cause of the fatty infiltration of the liver was "... multi-factorial. The Diabetes Mellitus Type II, of course, predisposes and is a cause of fatty infiltration of the liver. In addition, his prolonged and chronic exposure to the hydrocarbons at work were a cause of the liver inflammation, fatty infiltration, and hepatitis." (PX4, p.11). Dr. Orris also noted that removal from exposure and the fact that Petitioner was on Metformin for his diabetes "... would have reduced the likelihood of his developing this and would be considered treatment for the fatty infiltration, the inflammation, and the hepatitis." (PX4, p.12). Furthermore, Dr. Orris indicated that the cause of the hepatomegaly, or enlargement of the liver, as well as elevated liver enzymes was "... secondary to the fatty infiltration and the inflammation, the hepatitis that had developed due to these exposures and the diabetes." (PX4, pp.12-13).

However, Dr. Orris' opinion in this regard appears to be based on an inaccurate history involving the cessation of the workplace exposure. To wit, Dr. Orris testified that Petitioner "... left his job in the spring of 2003, and by October, the liver enzyme elevation, as well as the fatty infiltration, had essentially resolved, and the heptomegaly, the increased liver, had been reduced." (PX4, p.8). Thus, Dr. Orris' opinion appears to be premised on the fact that once Petitioner was removed from the workplace exposure, his symptoms immediately abated. This, of course, was not the case, given that Petitioner's last date of exposure was on August 9, 2001, not the spring of 2003, and a CT scan of the abdomen and pelvis performed more than two (2) years later, on October 18, 2003, revealed persistent mild hepatomegaly with interval resolution of fatty infiltration of the liver. (PX3). Later still, an ultrasound of the liver performed on March 9, 2005 demonstrated increased echogenicity of the liver suggestive of diffuse parenchymal disease or fatty infiltration. (PX1). Thus, it would appear that Dr. Orris' attempt to relate Petitioner's liver condition to the workplace exposure by pointing to the resolution of the findings immediately after removal from the source hazard is misplaced.

Therefore, 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 is causally related to the alleged accident on August 9, 2001. More to the point, the Arbitrator finds the opinion of Dr. Orris to be unpersuasive along these lines. The Arbitrator notes that Dr. Orris' opinion is not being discounted for the

reason that other potential causes exist for the liver function abnormalities in question. Instead, the Arbitrator views this matter simply as a failure of proof in that the only opinion offered in support of a finding of causation in this matter, Dr. Orris, was based on a significant misunderstanding as to the duration and cessation of the workplace exposure. Accordingly, Petitioner's claim for compensation is hereby denied.

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

Based on the 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 medical expenses pursuant to §8(a) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, 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 temporary total disability benefits pursuant to §8(b) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, 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 permanent partial disability benefits. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

The parties filled out and signed a Request for Hearing wherein the parties stipulated that no benefits in the form of TTD, TPD, maintenance or non-occupational indemnity disability benefits had been paid on account of this injury. (See Arb.Ex.#1, item 9). Furthermore, Respondent noted that it was not seeking credit under §8(j) for medical expenses that may have been paid through its group medical plan. (See Arb.Ex.#1, item 7). Respondent did dispute, however, Petitioner's claim that it was liable for a Laborers Health & Welfare Fund Lien in the amount of $22,228.97. (See Arb.Ex.#1, item 7). In light of the denial of benefits in this matter, however, this dispute is now moot.

Petitioner also submitted into evidence a "Release of All Claims" evidencing the settlement of a third party claim filed on behalf of Petitioner, Joseph Mansell, against International-Matex Tank Terminals, IMTT-Lemont and Murphy Chemical Inspection, Inc. in the amount of $15,000.00. (PX16). In its proposed findings, Respondent is requesting a §5(b) credit in the amount of $11,250.00 as a result of this settlement. However, the Release itself does not spell out the amount of any such §5(b) lien. Furthermore, the "Release" itself states that "[i]t is further understood that the present settlement and RELEASE OF ALL CLAIMS shall in no way affect any claim for workers' compensation disability benefits associated with the incident." (PX16). Therefore, given the fact that the "Release" does not appear to specifically address, much less quantify the amount of such a lien, the Arbitrator finds that he is not in a position to allow such a credit and declines Respondent request for same.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Rivera,
Petitioner,

vs. No: 12 WC 04190

15IWCC0479

County of Lake,
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 and nature and extent of permanent disability, and being advised of the facts and law, modifies the Arbitrator's award of permanent disability and otherwise affirms and adopts the July 24, 2014 Decision of Arbitrator Andros, which is attached hereto and made a part hereof.

The Arbitrator found that Petitioner, a 64 year old special investigator for the Lake County State's Attorney's Office, sustained injury to his right leg on December 29, 2011 when he slipped and fell on ice at his home, but concluded the claimant was a travelling employee and was loading his State vehicle with work equipment at the time of the injury, and had therefore demonstrated that he was within the course and scope of his employment; as such, the Arbitrator found accident to have been successfully demonstrated. The Commission observes and relies on current case law in affirming the Arbitrator's finding that Petitioner sustained accidental injuries on December 29, 2011 to his right leg and knee that arose out of and in the course of his employment with Respondent.

15IWCC0479

The Arbitrator found Petitioner sustained a rupture of his right quadriceps tendon in the December 29, 2011 accident which required an open repair, irrigation and closure the same day. Petitioner was able to return to light duty work following surgery on January 24, 2012. By May 17, 2012, Dr. Mayer noted that Petitioner continued to improve and could cease physical therapy. Dr. Mayer released Petitioner to return to work full duty and released Petitioner from care on July 12, 2012. Petitioner testified at hearing that he remained apprehensive about his overall knee activity and noted difficulty with stairs and jogging due to pain in the knee, as well as weakness and achiness in the leg with extensive walking or standing.

The Arbitrator found the accident caused a 35% loss of use of the Petitioner's right leg, pursuant to Section 8(e) of the Act. The Petitioner successfully returned to work full duty in July 2012 for Respondent as a Special Investigator. Petitioner testified he changed jobs thereafter and is employed by the Lake County Sheriff Department as the Director of Homeland Security and Internal Affairs. The Commission views the evidence as to the residual effects of the claimant's injury differently and reduces the Arbitrator's award to 27.5% loss of use of the right leg, pursuant to Section 8(e) of the Act.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the July 24, 2014 Decision of the Arbitrator is modified with regard to the issue of permanent partial disability, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $902.33/week for a period of 4 weeks, commencing December 29, 2011 through January 24, 2012, being the period of temporary total disability from work under Section 8(b) of the Act. Respondent shall receive credit for benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical expenses of $34,109.85, as provided in Sections 8(a) and 8.2 of the Act. Respondent is to receive credit for expenses paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for a period of 59.125 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the 27.5% loss of use of the right leg.

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.

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

DATED: JUN 2 2 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/22/15
jdl/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RIVERA, JOSEPH M
Employee/Petitioner

Case# **12WC004190**

COUNTY OF LAKE
Employer/Respondent

15IWCC0479

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:

0152 LINN CAMPE & RIZZO LTD
JOHN J RIZZO
215 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

0238 WOLFE & JACOBSON LTD
PETER W JACOBSON
25 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOSEPH M. RIVERA
Employee/Petitioner

v.

COUNTY OF LAKE
Employer/Respondent

Case # 12 WC 4190

Consolidated cases: _____

15IWCC0479

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **May 28, 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 29, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,382.00**; the average weekly wage was **$1,353.50**.

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner & his attorney temporary total disability benefits of $902.33 per week for 4 weeks, commencing December 29, 2011 through January 24, 2012, provided in Section 8(b) of the Act.

Respondent shall pay to the Petitioner & his attorney the amount of $34,109.85 for reasonable and necessary medical services of as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner & his attorney permanent partial disability benefits of $695.78 for 75.25 weeks because the accidental work injury caused the Petitioner to sustain 35% loss of use of the right leg, as provided in Section 8(e) of the Act.

Respondent shall pay the Petitioner compensation that has accrued from December 29, 2011 through the present, and shall pay the remainder of the award 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.

/s/ George J Andros

Signature of Arbitrator

July 23, 2014

Date

JUL 24 2014

FINDINGS OF FACT 12 WC 4190

The 64 year old Petitioner was employed by the Respondent as a Special Investigator in the State's Attorney's office. Among his various duties, He was required to serve summons and warrants on individuals in their homes and other places in the community. Petitioner was provided a vehicle which he would drive home each evening and keep at his residence. He would routinely start his work day from home, meet with other members of the Lake County Sheriff's Office to serve warrants and summons. Petitioner spends most of his day traveling around the county serving said warrants and summons.

The Petitioner testified that on December 29, 2011 he was preparing to leave his house to serve a summons to an individual in Highland Park. He testified that he was to go directly to Highland Park as his first stop of the day to deliver warrants and summons. He was not scheduled to be at the office that day as he was going to be traveling in his Respondent issued vehicle performing his work duties. After serving various summonses in Highland Park and elsewhere, he was scheduled to meet officers of the Lake County Sheriff's Office for other activities.

Petitioner testified that his wife went out to their attached garage where her vehicle was parked. She told Petitioner that there was snow and/or ice outside and that he should give himself additional travel time for work.

Petitioner's wife testified that her car was parked in the attached garage and that Petitioner's company vehicle was parked in the driveway off to the side. She identified her vehicle and the parking arrangement in photographs. (Px 1) Mrs. Rivera testified that she was scheduled to pick up her daughter in Lombard; she left the house while Petitioner was still at home preparing his materials to begin his work day. She did not have any problem existing the driveway as her car was parking in the garage, without snow or ice, and she was "backed" into the garage so she could pull straight out.

Petitioner testified that after his wife left he exited the house to start his company vehicle and move it to the center of the driveway to facilitate loading his work materials as well as warm the car. He stated that his vehicle slid sideways momentarily because of the icy driveway. He did chip some ice near his car wheel and threw some salt down to help move the vehicle. At that point he went back into the house to gather his work equipment and materials.

Petitioner testified that he made his first trip out to the company vehicle when he carried out his briefcase, laptop computer, some extra bullets and a flashlight and placed them in the car. He indicated that he went back into the house to get his "police radio" that is kept in the house overnight for charging which must then be installed in vehicle. He exited the house with his police radio and a file folder containing all the paperwork (warrants, summons, etc) for the day's work. He got to the vehicle and installed his radio and placed the file folder on the seat of the car. He then went to the rear of the vehicle to obtain his ballistics vest and was going back into the house. Petitioner testified that he normally puts on his bullet-proof vest and retrieves his service weapon from the house only when his completely ready to leave for the day's work. It is the last duty he performs before his final exit/entry to vehicle as he travels.

Petitioner testified that on this third (3rd) trip back into the house, after loading his briefcase and laptop and file folder, installing his police radio and retrieving his ballistics vest, he slipped on the ice in his driveway landing on his right knee near the stairs to enter the house. Petitioner identified the location of his fall on the photo in PX1.

Petitioner testified that he was in immediate pain and could not get up from the driveway. He stated that he had to crawl up the stairs and into the house. He was the only person home at the time since his wife had left to meet up with their daughter in Lombard.

Petitioner testified that he called his wife's cell phone to tell her that he had fallen. The phone records of AT&T reflect a call from Petitioner's residence to his wife's cell phone at 9:37:29am. (Px 15) Petitioner testified that he asked his wife to come back home and that he was going to call 911. Petitioner then proceeded to call 911. The Fox Lake Fire Protection District records reflect a call from Petitioner's residence at 9:38:52am. (Px 16) Those same records from Fox Lake F.P.D. state that the 911 caller was the injured patient, 1st party. (Px 16) Mrs. Rivera testified that the emergency squad was at the house when she arrived back at the home. Petitioner was transport via ambulance to Condell Medical Center. His ER diagnosis was a ruptured right quadriceps tendon. He was immediately referred for care to an orthopedic surgeon, Dr. John Mayer. He was admitted then underwent open surgery to repair the ruptured quadriceps tendon. (Px 17)

After discharge from Condell MC, Petitioner continued his treatment with Dr. Mayer. (Px 18) Following his initial post-op visit, Petitioner requested a light duty release to return to desk duties, sedentary work as soon as possible. Dr. Mayer allowed Petitioner to return to desk duty as of January 24, 2012. (Px 18) Petitioner participated in physical therapy from February 6, 2012 through May 3, 2012 at the direction of Dr. Mayer which was conducted at Greenleaf Physical Therapy. Ultimately he was released from care and to full duty work as of July 12, 2012. (Px 18)

Petitioner testified that remains apprehensive about his overall knee activity. He stated that it remains somewhat weak and he had difficulty going up and down stairs. His leg gets tired quickly and he is unable to do some of the things he normally did before the accident. Petitioner testified that he normally was a jogger for exercise. After the accident he is relegated to walking on a treadmill for exercise because jogging causes his pain around the knee. He testified that he does notice a sore aching pain when he does a lot of walking or standing.

Since this accident, Petitioner testified that he has switched his job and is no longer working as a special investigator for the Lake County State's Attorney's Office. He is presently working for the Lake County Sheriff's Office as the Director of Homeland Security and an Internal Affairs Officer. (Px 2) This job requires less moving around, travel and less getting in/out of his county vehicle.

CONCLUSIONS OF LAW:

(C) Accident:

Respondent disputed Petitioner's accident based upon the statements and testimony of Ms. Terry White. Ms. White testified that she was the Chief Deputy for Administrative Services. She testified that she received a call from Petitioner on the morning of the accident. She indicated that Petitioner called her from the hospital. She stated that Petitioner told her he slipped at his house after moving his car and that he needed surgery. She did not recall Petitioner saying anything about loading his car with supplies. She stated that Petitioner did not indicate anything to her at that time about workers compensation. Ms. White testified that she understood Petitioner was moving his car so that Petitioner's wife could get her car out.

Petitioner testified that his wife had left for the morning. His wife so testified underscoring the pre-wedding activity that day. The Arbitrator relies upon her testimony noting the benchmark of shopping for a wedding dress as likely refreshing her memory as the temporal events of that specific morning. Petitioner testified that he was loading his work vehicle with equipment and materials. He had made two (2) trips with various items including his briefcase, laptop, police radio, file folders and other items. Petitioner testified that he slipped on ice as he was going back into his home to install his ballistics vest and retrieve his service weapon.

The credibility of the witnesses is an element to be determined by the Arbitrator. In addition, the Arbitrator must view additional evidence to evaluate whether other elements support any particular testimony.

Petitioner is deemed an exceptionally credible witness based upon the content of his testimony, his demeanor, his direct responsiveness to questions plus his replies during an insightful, probing cross examination.. Dating back almost thirty (30) years, Petitioner has held various positions of trust and authority including positions requiring top secret clearance within the Federal government. Petitioner has worked as a law enforcement officer, internal affairs investigator for various local law enforcement entities. In addition, Petitioner spent twenty (20) years with the U.S. Department of Justice including roles as Supervisory Special Agent. (PX 2) Petitioner testified that he has held positions of integrity and his character has never been questioned.

Respondent's witness, Ms. Terry White, has spent seventeen (17) years, the last eight (8) as a Chief Deputy in the Lake County State's Attorney Office. While she is certainly a person with integrity with extremely responsible position, her testimony was focused on a brief phone call with Petitioner while his was in the hospital prior to surgery. She does not recall having discussed any specifics with Petitioner at that time. Her testimony was that she recalled Petitioner saying that he slipped helping get his wife's car out of the driveway.

There are various elements of evidence that support Petitioner's testimony. Those same elements by a preponderance of the evidence rise to the level of deeming the testimony/recollection and accuracy of the details of the Petitioner and his spouse at their own home working with their own vehicles that morning as most accurate. Thus, the testimony of the Petitioner's recollection and the wife's recollection are deemed the findings of fact at bar. The likelihood of perhaps an understandable mis-summary of an urgent call from a hospital does not create an impeachment or a strong inconsistency to bely the testimony of this dedicated public servant.

Showing outstanding trial preparation, the records of AT&T (Px 15) show that Petitioner called his wife's cell phone at 9:37:29am. If Petitioner slipped moving his car so that his wife could get out of the driveway, his wife would still be at home. She would have been there to assist him. Mrs. Rivera testified that she was at Route 12 and Route 134, nearly 5 miles away, en route to her daughter's house when she got a call from Petitioner that he had fallen.

The records of Fox Lake Fire Protection District (Px 16) reflect that the 911 call was received at 9:38:52am. Critically,, the records show that Petitioner was the person making to call to 911 as the injured patient, 1st party. (Px16) If Petitioner was moving his car for his wife to get her car out of the driveway when he fell, it is most logical and likely that Mrs. Rivera would have been at home to assist him. Moreover, she would have made the call to 911, not Petitioner.

The Arbitrator finds Petitioner's testimony credible that he would need to make several trips to his county issued vehicle. It is certainly foreseeable that a traveling employee, like Petitioner that has a county vehicle at his home, would not be able to carry all of his essential materials and equipment. It is reasonably foreseeable that Petitioner would take his briefcase, laptop other items out to his car and then return to install his police radio that must be charged overnight in the house. In addition, Petitioner's testimony that he prepares his ballistics vest and retrieves his service weapons as a last action before leaving completely credible and by inference, a matter of safety protocol in the handling of firearms.

The Arbitrator finds that the evidence presented in the AT&T records and the Fox Lake Fire Protection District support the Petitioner and Mrs. Lesleigh Rivera's testimony that she was not at home when Petitioner fell in the driveway.

While it is the Arbitrator totally respects the testimony of Ms. White, its context is her conversation with Petitioner was made while he was in the emergency room awaiting surgery. Petitioner could not be expected to provide every specific detail and step of his morning in such a situation. Petitioner's purpose of making the call to Ms. White at that time was to advise her that he could not carrier out his daily work duties and to notify the office that he was in the hospital. When Ms. White asked Petitioner to make a written report of the accident, Petitioner completed the Form 45 with information detailing that he was injured loading work equipment in the squad car. (Rx1)

Based upon the totality of the evidence, the Arbitrator finds as a conclusion of law and fact Petitioner sustained accident injuries that arose out of and in the course of his employment with the Respondent on December 29, 2011 causing injuries to his right leg and knee.

(K) Temporary Total Disability Benefits:

The Arbitrator's findings with regarding to (C) Accident above are incorporated herein.

The Respondent disputed its obligation to pay temporary total disability benefits based upon their challenge to the existence of a work related accident. Respondent disputed liability based only on their contention that Petitioner did not sustain a compensable work accident.

There is no dispute as to the dates Petitioner was temporarily and totally disabled. The Petitioner was temporarily and totally disabled from December 29, 2011 through January 24, 2012; a period of four (4) weeks.

Based upon the totality of the evidence, finds that Petitioner is entitled to temporary total disability benefits for the stipulated time period.

Accordingly, the Respondent shall pay the Petitioner temporary total disability benefits of $902.33 per week for 4 weeks, from December 29, 2011 through January 24, 2012, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the Petitioner, the disabling condition was temporary and had not reached a permanent condition, pursuant to Section 19(b) of the Act.

(J) Medical Benefits:

The Arbitrator's findings with regarding to (C) Accident above are incorporated herein. Petitioner submitted medical expenses totaling $34,109.85 in Petitioner's exhibits 3 through 14. Respondent objected on liability issues.

Petitioner's exhibits included (3) Greenleaf Orthopedic - $8,442.00, (4) Condell MC - $21,903.00, (5) Lake County Radiology - $ 82.00, (6) Lake County Radiology - $36.00, (7) Advanced Inpatient Consultants - $369.00, (8) Midwest Diagnostic Pathology - $68.00, (9) Midwest Diagnostic Pathology - $33.00, (10) Thomas & Thomas - $35.00, (11) IHC Libertyville ER Physicians - $700.00, (12) Lake County Anesthesia - $1,377.00, (13) Fox Lake Fire Protection District - $1,000.00 and (14) Amazon brace reimbursement - $64.85.

Based upon the totality of the evidence finds as a matter of fact and conclusion of law Petitioner is entitled to medical benefits for all charges submitted in Petitioner's exhibits 3 through 14.

The Respondent shall pay to the Petitioner & his attorney the amount of the reasonable and necessary medical services of $34,109.85, as provided in Sections 8(a) and 8.2 of the Act.

(L) Nature and Extent:

The Arbitrator's findings with regarding to (C) Accident above are incorporated herein.

Petitioner sustained a rupture of his right quadriceps tendon in the work accident of December 29, 2011. Petitioner underwent surgery on that same date at Condell MC with Dr. John Mayer to repair the ruptured tendon. He participated in physical therapy from February 2012 through May 2012.Petitioner was restriction from all work until January 24, 2012 and restricted to desk duties until July 12, 2012. Petitioner testified that remains apprehensive about his overall knee activity. He stated that it remains somewhat weak and he had difficulty going up and down stairs. His leg gets tired quickly and he is unable to do some of the things he normally did before the accident. He normally was a jogger.Pos accident he is relegated to walking on a treadmill for exercise because jogging causes his pain around the knee. He notices a sore aching pain when he does a lot of walking or standing.

Dr. Mayer rcorded Petitioner complained of feelings of hesitancy and stiffness after prolonged sitting. He also noted Petitioner's complaints about stairs. Dr. Mayer stated that Petitioner could continue to work on strengthening since Petitioner noticed weakness in the right leg. The doctors records in detail correlated to the Petitioner's testimony.

Based upon the totality of the evidence , Respondent shall pay to Petitioner his attorney & the sum of $695.78 per week for a further period of 75.25 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 35% permanent loss of use of the right leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LUIS DE JESUS,

Petitioner,

15IWCC0480

vs.

Nos.: 08 WC 24578, 08 WC 43933, & 08 WC 53383

UNIFIRST,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

1. Petitioner worked for Respondent as a route sales representative in which he picked up soiled uniforms and delivered laundered uniforms.

2. Petitioner alleged three separate work-related accidents. He testified on May 27, 2008, he was "picking up some meat frocks" weighing between 50 and 75 pounds when he felt a pop in his lower back. He reported the accident and Respondent sent him to Concentra for treatment. There he had physical therapy. Petitioner testified that helped his pain somewhat and that he returned to work around September 4, 2008.

3. Petitioner further testified on September 28, 2008, he was trying to get a ramp weighing about 50 lbs out of the truck. He had to tug hard because it was stuck. He felt a pop in his low back again. He also felt a tingling sensation in his left arm and his fingers were numb. He was again sent to Concentra for treatment. During his treatment after this injury he did not report any complaints regarding his left arm until October 28, 2008.

4. Petitioner was returned to work on November 24, 2008. He testified that on December 3, 2008, he was manually lifting a tub of dirty uniforms and mats weighing about 100 lbs into the truck because he did not have a ramp that day. He felt bad sharp pains in his back. His elbow was numb, and he could hardly feel his fingers. He was again sent to Concentra. There he was examined by Dr. Khan who noted that Petitioner did not exhibit any Waddell signs.

5. Petitioner testified that after his third accident, Respondent did not offer him employment. In fact, Petitioner testified that he had not worked anywhere since December 3, 2008.

6. Petitioner was examined by Dr. Slack for an evaluation pursuant to Section 12 of the Act at the request of his own lawyer. Dr. Slack noted a new MRI taken on March 3, 2009, showed a small disc herniation at L5-S1, and a larger herniation at L1-2. He noted that the L5-S1 herniation was present in an MRI taken after the first accident on May 27, 2008, but L1-2 herniation was not shown in the earlier MRI. Dr. Slack concluded that the L5-S1 herniation was consistent with the mechanism of injury described in the initial accident and the L1-2 herniation was consistent with the reported second or third accident. He recommended conservative treatment and surgical intervention at L1-2 should be considered if the conservative treatment did not relieve Petitioner's symptoms.

7. At Respondent's request, Petitioner was seen by Dr. Singh for Section 12 medical examinations on three occasions in 2008 and 2009. On all three examinations, Petitioner reported 7-10/10 pain and Dr. Singh noted normal neurological examinations. Petitioner also exhibited "several nonorganic/Waddell findings, including hyperexaggeration of symptoms with percussion of his lumbar spine, pain with simulated axial loading, pain with simulated axial rotation, symptom magnification as well as distracted straight leg raise." Dr. Singh did not consider the pathology identified in the MRIs to be significant and opined Petitioner suffered only soft tissue injuries. He also noted disc herniations at L1-2 are almost universally asymptomatic and if it causes sufficient compression abutting the end of the spinal cord, "you can have diffuse leg pain; bowel, bladder weakness; profound weakness in the lower extremities." Petitioner exhibited no such symptoms.

8. On April 3, 2009, Dr. Freedberg performed left ulnar nerve transposition surgery, which Petitioner considered successful.

9. On September 3, 2009, Dr. Fernandez performed a review of Petitioner's medical records. He concluded that Petitioner's cubital tunnel syndrome was not related to his work accidents. He explained that "had any of those events been a contributory or aggravating effect or causal effect to the underlying cubital tunnel syndrome, he would have had immediate onset of symptoms or numbness and pain from the medial elbow which would have resulted in the patient complaining and/or documentation of those complaints. Not only was this not documented by the Concentra Medical Clinics, it was not documented by Dr. Freedberg's initial examination or therapy reports." In addition, there is "no mechanism of injury which would have explained a causal relationship or an aggravating effect from those dates."

10. On July 14, 2009, Petitioner came under the care of Dr. McNally for his lumbar spine condition. On October 23, 2009, a provocative discogram was taken for the diagnoses of lumbar discogenic pain, lumbosacral radiculopathy, and lumbar facet syndrome. The discogram was positive for concordant pain only at L5-S1.

11. On January 4, 2010, Dr. McNally performed L5-S1 laminectomy with posterior fusion and interbody instrumentation. It appears that Petitioner was referred to both Dr. Freedberg and Dr. McNally by his lawyer.

12. Petitioner continued to complain of debilitating pain after surgery. He had extensive treatment for his reported pain including three epidural steroid injections, implantation of a spinal cord stimulator, and ongoing and continuing approximate monthly visits to a pain management doctor who managed his narcotic medication.

13. Petitioner testified he believed his injury prevented him from bowling and riding a bike. He did not remember riding a bike in 2011 and being hit by a car. He then answered "probably, yes" when asked whether he remembered being treated at an emergency room after running into a car while on a bicycle. He then testified he did not remember being on a bicycle at the time of the motor vehicle accident. He also did not recall telling the staff at the emergency room that he had no back pain at that time.

14. The records from Norwegian American Hospital indicated that on November 25, 2011, Petitioner presented to the emergency department complaining of left shoulder, elbow, and ankle pain after being struck by a car while on a bicycle. He denied back pain at that time.

15. Petitioner testified at arbitration that currently he had a lot of pain "almost every day" and has to take Dilaudid and Morphine four to five times a day. He uses his stimulator every day as well. He has good days and bad days. On good days his back pain is 3/10 and on bad days it is 8/10. His leg pain is 3-4/10. He does not move around as much as he used to and has limited activities. When he engages in activities that would require a lot of walking, he uses a power chair. His ability to walk is limited because of the pain in his back and numbness in his right leg. He rarely sleeps and typically he has to wait for 20 minutes after taking his medication in the morning before he can get out of bed. Then he gets his children ready for school and drives them there. He has a Jeep 4X4 because it is easier to get into and out of. About four days in a week he is "pretty much in bed in pain, taking meds all day and trying to alleviate the pain." On those days he does not drive his children to school. He can "hardly ever" do physical activities with his children.

16. Petitioner was the subject of extensive covert surveillance. The surveillance basically began on February 6, 2013. Petitioner is seen walking extensively without any apparent difficulty. He is videotaped on several occasions through October 2, 2013. He is seen arriving at a place of business called AIM Collision Center. He often stayed through throughout the day. He is seen emptying garbage and moving vehicles. He is mostly seen while outside the garage during apparent cigarette breaks.

17. Petitioner testified in rebuttal after the surveillance videos were entered into evidence. He stated that he was familiar with the AIM facility but never worked there. He has a friend and brother-in-law who sublease from AIM. He never worked on any vehicle at AIM but did look under the hood of the car which belonged to his sister-in-law to check the oil. He would empty garbage in a dumpster if it was lying around and they were painting in the booth. That was not his job. He does not work for them because he is "not stable." He is not certified to paint or work as a mechanic. He wished he could physically work as a car restorer, but he cannot.

The Arbitrator found that Petitioner sustained his burden of proving all three of the alleged accidents. He also found that Petitioner proved that these accidents caused his condition of ill-being of his lumbar spine and awarded all medical expenses associated with treatment of his lower back. However, the Arbitrator also found that Petitioner did not prove that his cubital tunnel syndrome was caused by the work accident and denied compensation and medical expenses associated with that condition. The Commission agrees with these findings of the Arbitrator.

First, on the issue of accidents, Respondent has not disputed that Petitioner gave proper notice. Therefore, Petitioner promptly reported these incidents and sought medical attention immediately. Second, regarding causation of the lumbar condition, the MRI showed pathology at L5-S1 after the initial accident, and at L1-2 pathology after the third accident. In addition, the discogram showed concordant pain at L5-S1. Third regarding the issue of causation to the elbow condition, the Commission notes the month-long delay from the date of the alleged injury (second accident) in reporting any symptoms regarding an elbow condition. That delay was critical in Dr. Fernandez' opinion that Petitioner's cubital tunnel syndrome was not related to his work accidents. The Commission finds the opinion of Dr. Fernandez persuasive.

The Arbitrator awarded Petitioner 240&6/7 weeks of temporary total disability benefits. The awards regarding the first two accidents were based simply on the dates Petitioner was taken off work by Concentra and the dates he returned to work after those injuries. The Commission affirms those awards. Regarding the third accident, the Arbitrator terminated temporary total disability benefits as of February 6, 2013 when surveillance video which showed "him walking normally and for extended periods with no limping, bending over fully without hesitation, entering AIMS Collision in the early hours and leaving in the late evening on many occasions, leaving AIMS with soiled, dirty clothing, locking and unlocking locks on a dumpster, entering a vehicle with little apparent difficulty or hesitation and standing for over 30 minutes." The Arbitrator continued, "petitioner is not believable or truthful. He has magnified symptoms and is not candid about his relationship with AIM Collision."

The Commission agrees with the Arbitrator's apparent conclusion that there is little doubt that Petitioner was actually working at AIMS, in direct contradiction to his sworn testimony. The Commission is reluctant to countenance the Arbitrator's award of 240&6/7 weeks in temporary total disability benefits. The record is clear that on November 25, 2011, Petitioner was injured while riding a bicycle. Therefore, he was clearly not as disabled as he alleged at that time and the Commission finds that November 25, 2011 is an appropriate date to terminate temporary total disability and awards benefits from December 4, 2008 to November 25, 2011.

The Arbitrator also awarded Petitioner 200 weeks of permanent partial disability benefits representing 40% loss of the person-as-a-whole. He did not provide a detailed explanation for the bases for this award. In light of Petitioner's repeated prevarication and rampant symptom magnification, the Commission finds the 40% loss of the person-as-a-whole award to be excessive. Because of Petitioner's untruthfulness, it is impossible for the Commission to rely on any of his subjective reports of pain and continuing impairment. In addition, even though Petitioner may have suffered an injury to his spine at L1-2, Dr. Singh noted that such pathology is almost universally asymptomatic and the lack of concordant pain seems to bear that out in Petitioner's case. Therefore, in looking at the entire records before the Commission, we reduce the permanent partial disability award to 125 weeks representing 25% loss of the person-as-a-whole, which is a relatively standard award for a claimant with one-level fusion surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $518.91 per week for a period of 125&5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $467.02 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to petitioner to the extent of 25% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the expenses associated with treatment of Petitioner's condition of ill-being of the lumbar spine pursuant to §8(a) and pursuant to the applicable medical fee schedule under to Section 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 proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUN 2 2 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-4/21/15
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DE JESUS, LOUIS
Employee/Petitioner

Case# **08WC024578**

08WC053383
08WC043933

UNIFIRST
Employer/Respondent

15IWCC0480

On 3/6/2014, 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 0.08% 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:

4783 HETHERINGTON KARPEL BOBBER ET AL
PETER C BOBBER
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
DANIEL CODY
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

15IWCC0480

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

LOUIS DE JESUS
Employee/Petitioner

Case #08 WC 24578
08 WC 43933
08 WC 53383

v.

UNIFIRST
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 18, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Choice of doctors?

O. ☒ Vocational rehabilitation?

FINDINGS

- On May 27, 2008, September 26, 2008, and December 3, 2008, the respondent was operating under and subject to the provisions of the Act.

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

- Timely notice of accidents was given to the respondent.

- In the year preceding the injuries, the petitioner earned $39,696.93; the average weekly wage was $778.37.

- At the time of injuries, the petitioner was 28 and 29 years of age and married with four children under 18.

- The parties agreed that the respondent paid $7,159.02 in temporary total disability benefits for claim #08 WC 24578 and $3,631.17 in temporary total disability benefits for claim #08 WC 43933.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $518.91/week for 240-6/7 weeks, from May 28, 2008, through September 3, 2008, September 27, 2008, through November 25, 2008, through February 6, 2013, which is the period of temporary total disability for which compensation is payable.

- The respondent shall pay the petitioner the sum of $467.02/week for a further period of 200 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 40% loss of use of the man as a whole.

- The respondent shall pay the petitioner compensation that has accrued from May 27, 2008, through February 18, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his lumbar spine was reasonable and necessary and is awarded. The medical care rendered the petitioner for his left elbow is not causally related to the injuries and is denied. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for vocational rehabilitation 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.

Robert E. Williams

Signature of Arbitrator

March 6, 2014
Date

MAR 6 - 2014

FINDINGS OF FACTS:

On May 27, 2008, the petitioner, a route sales representative, received urgent care at Concentra Medical Centers for a sudden onset of moderate right low back and right thigh pain going down to his knee while lifting a large, heavy, wet load of uniforms at work earlier that day. The incident is the subject matter of claim #08 WC 24578. X-rays of his lumbar and sacral spine were negative. Physical therapy, activity modification and medication were started. He reported continued but improved symptoms the next day at Concentra and also complained of some left groin pain.

The petitioner saw Dr. Igor Russo at Advanced Physical Medicine on the 29th and reported low back, right thigh, left groin and left leg pain. Dr. Russo noted that x-rays were negative for gross osseous pathology. He placed the petitioner on a total disability status and started chiropractic modalities. There was little change in symptoms reported at follow-ups on June 4th, 6th, 11th, and 13th. Chiropractic modalities and the total disability status were continued. The petitioner reported a slight improvement on the 16th. He received care at Suburban Orthopaedics on June 24th. It was noted that an MRI on June 17th revealed mild degenerative bulging at L5-S1 and no focal disc herniation. The diagnosis was bilateral lumbar radiculopathy and L5-S1 bulging disc, which was reiterated by Dr. Howard Freedberg at two follow-ups through August 19th. Slight incremental improvements were noted at twelve follow-ups through July 18th. Physical therapy was started on July 22nd and provided through August 30th, at which time the petitioner reported to the therapist that he was returning to work. On September 2nd, the petitioner reported to the therapist that his low back pain went to 8/10 after working that

required a pain pill for sleeping. The therapist noted complaints of continued low back pain at the last follow-up on September 13th.

On September 26, 2008, the petitioner received urgent care at Concentra for lumbosacral pain and right leg radiation after pulling a ramp out of his truck. The incident is the subject matter of claim #08 WC 43933. The recommendation was modified activity, medication and icing for the assessment of a lumbosacral strain. Physical therapy was started on September 29th. The petitioner returned to Suburban Orthopaedics on October 7th with complaints of right lower back pain from tailbone to middle back and on-and-off shooting pain in both legs. The diagnosis was again bilateral lumbar radiculopathy and L5-S1 bulging disc and the recommendation was no work. On October 28th, the petitioner reported numbness in his fourth and fifth fingers of his left hand for one week, improved leg pain, sharp stabbing pain in the bottom of his feet and severe, sleep-interfering back pain. The additional diagnosis of left cubital tunnel/cervical radiculopathy was made and an ulnar gutter splint was provided. The petitioner reported no improvement on November 18th. EMG/NCVs on November 24th were abnormal with evidence of moderate left ulnar neuropathy across the elbow, mild bilateral median mononeuropathy across his wrists and moderately severe right L4-5 radiculopathy. The petitioner returned to work on November 25th. The petitioner reported no change in his condition on December 2nd and agreed to ulnar surgery.

On December 3, 2008, the petitioner received urgent care at Concentra for lower lumbar pain with bilateral radiation and bilateral arm pain after putting a tub of products into his truck. The incident is the subject matter of claim #08 WC 53383. The petitioner followed up at Concentra on December 4th and reported seeking emergency care for pain

medication on December 3rd. He was placed on sitting-work only and referred to Dr. Heller for lumbar injections. Dr. Heller at Occspecialists evaluated the petitioner on December 19th and recommended work conditioning for his lumbar spine. Physical therapy was initiated on December 23rd. The petitioner complained of fluctuating back pain and hand pain to Dr. Freedberg on January 6 and 29, 2009. Dr. Charles Slack of Midwest Orthopaedics recommended an MRI after a Section 12 examination of the petitioner on February 5th. An MRI on March 10th revealed a new central disc protrusion at L1-2 resulting in moderate central spinal stenosis. Dr. Slack opined on March 31st that the herniation at L1-2 was consistent with severe back pain and leg numbness reported by the petitioner on September 26 and December 3, 2008. Dr. Freedberg performed a left ulnar nerve transposition on April 3rd. The doctor started physical therapy on April 9th.

Dr. Thomas McNally at Suburban Orthopaedics examined the petitioner's lumbar spine on July 14, 2009, and recommended pain management for a lumbar condition. Dr. Slack opined on September 3rd that there would have been immediate onset of cubital tunnel symptoms of numbness, tingling and pain from the medial elbow after an injury. A discogram by Dr. Jain on October 23rd was reported positive for concordant pain at L5-S1. On November 10th, the petitioner reported to Dr. McNally receiving three sets of lumbar injections with no improvement. An MRI on December 30th revealed a slightly increased mild to moderate disc protrusion at L1-2 and an unchanged small disc protrusion at L5-S1.

Dr. McNally performed a L5-S1 laminectomy with bilateral facetectomies and foraminotomies with decompression and L5-S1 posterolateral spinal and posterior lumbar interbody fusions with carbon fiber cages on January 4, 2010. At follow-ups, the

petitioner reported some improvement in his leg pain but continued back pain and leg numbness. The petitioner started care with Dr. Lipov at Advanced Pain Centers on March 18, 2010. He received lumbar facet injections on April 23rd, a lumbar medial branch injection at L3, 4 and 5 on May 3rd. Dr. Freedberg recommended different pain management care on August 24th. Dr. Slavin of UIC evaluated the petitioner on November 22nd and recommended an MRI. He opined on December 13th that the MRI revealed good alignment and complete decompression of L5-S1.

Dr. McNally opined on January 11, 2011, that there was no need for further surgery. A CT scan on February 4th revealed no evidence of a fracture or loosening of the transpedicular screws. Dr. Ivanov opined on February 4th that there was no indication for neurosurgical procedures since his thecal sac and neuroforaminas were well decompressed. The petitioner elected to be evaluated by Dr. Burra of Hinsdale Orthopaedics on March 22nd, who opined that the petitioner's lumbar and left arm condition problems were caused by his work injuries, no further medical care was necessary and all treatment had been reasonable and necessary. An MRI of his lumbar and thoracic spines on June 11th revealed a patent spinal canal at the operative level, diffuse lumbar spondylosis at T12 through L5 and no evidence of high grade spinal canal or neural foramina stenosis. The petitioner received facet injections at L3 through S1 and an epidural injection at L4-5 on June 13th and 27th and July 13th.

The petitioner had an epidural injection at T11-12 on January 19, 2012. At his last visit with Dr. Freedberg on April 24, 2012, the petitioner reported continued low back pain in his waist area with numbness down his legs to his feet. An MRI the same day revealed unremarkable post-surgical changes at L4-S1 and stable degenerative diseases in

the other levels. The petitioner received placement of a dorsal column stimulator on May 29th. On January 9, 2013, the petitioner reported severe aching back pain with intermittent bilateral radiation to feet to Dr. Lipov and on November 19th, he reported an 80% improvement of pain.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained accidents on May 27, September 26 and December 3, 2008, arising out of and in the course of his employment with the respondent. The petitioner initially injured his lower back on May 27, 2008, while lifting and carrying in the performance of his work duties. He reinjured or aggravated his low back on September 26 and December 3, 2008.

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

The medical care rendered the petitioner for his lumbar spine was reasonable and necessary and is awarded. The medical care rendered the petitioner for his left elbow is not causally related to the injuries and is denied.

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

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his low back is causally related to the work injuries. The petitioner failed to prove that his current condition of ill-being with his left elbow is causally related to the work injuries. The petitioner did not report an injury or trauma to his left elbow when he sought care at Concentra after re-injuring his back on September 26, 2008. Moreover, on October 28, 2008, the petitioner reported that the

numbness in his fourth and fifth fingers of his left hand began one week earlier, which was almost a month after his back injury on September 26, 2008.

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

Due to the work injuries, the petitioner was taken off of work by his doctor and is entitled to temporary total disability benefits from May 28, 2008, through September 3, 2008, September 27, 2008, through November 25, 2008, through February 6, 2013, the date of the first surveillance video. The respondent shall pay the petitioner temporary total disability benefits of $518.91/week for 240-6/7 weeks, from May 28, 2008, through September 3, 2008, September 27, 2008, through November 25, 2008, through February 6, 2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to establish that he is entitled to a Section 8(d)1 award. The petitioner's request for a wage differential is denied. Surveillance videos of the petitioner from February 6, 2013, through October 2, 2013, show him walking normally and for extended periods with no limping, bending over fully without hesitation, picking up objects, lifting and empting large containers into dumpsters, entering Aims Collision in the early hours and leaving in late evening on many occasions, leaving Aims with soiled, dirty clothing, locking and unlocking locks on a dumpster, entering and exiting a vehicle with little apparent difficulty or hesitation and standing over thirty minutes. The petitioner is not believable or truthful. He has magnified his symptoms and condition and is not candid about his relationship with Aims Collison. Whether the petitioner has sustained a loss in his earning capacity cannot be determined in light of his dishonesty.

The respondent shall pay the petitioner the sum of $467.02/week for a further period of 200 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 40% loss of use of the man as a whole.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to establish that he is entitled to vocational rehabilitation. The petitioner has not been truthful about his condition and denied being able to perform any gainful work. The petitioner's commitment and candor is necessary for vocational training to succeed. The petitioner's request for vocational rehabilitation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Alvarez,
Petitioner,

vs.

No: 11 WC 29912

15IWCC0481

Scrub, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes claim 11 WC 29912 was heard in consolidation with claim 12 WC 26299 before Arbitrator Cronin on May 23, 2013. A separate decision is issued for claim 12 WC 26299.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 1, 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: JUN 22 2015

Joshua D. Luskin

o-04/21/15
jdl/adc
68

Ruth W. White

Charles J. DeVriendt

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

ALVAREZ, MARIA
Employee/Petitioner

Case# **11WC029912**

12WC026299

15IWCC0481

SCRUB INC
Employer/Respondent

On 5/1/2014, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
MICHAEL A ROM
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
TAMMY PAQUETTE
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)

Maria Alvarez
Employee/Petitioner

v.

Scrub, Inc.
Employer/Respondent

Case # 11 WC 29912

Consolidated cases: 12 WC 26299

15IWCC0481

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **May 23, 2013, September 18, 2013 and September 23, 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 _____

15IWCC0481

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 not*** sustain an accident that arose out of and in the course of employment.

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

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **60** 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 **$0.00** 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 **$3,795.00** under Section 8(j) of the Act, for both cases **11 WC 29912** and **12 WC 26299** combined.

ORDER

No benefits are awarded as Petitioner failed to prove that on October 27, 2010, she sustained accidental injuries arising out of and in the course of her employment by Respondent and further failed to prove that her current condition of ill-being of her right shoulder is causally related to work activities of October 27, 2010.

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

April 30, 2014
Date

ICArbDec19(b)

MAY - 1 2014

Maria Alvarez

v.

Case # 11 WC 29912
Consolidated w/ **12 WC 26299**

Scrub, Inc.

15IWCC0481

Statement of Facts:

Petitioner's Testimony

In 2005, Petitioner was hired by Respondent to work as a custodian/janitor at O'Hare International Airport. Over the course of five years for Respondent, Petitioner has worked five days a week, eight hours a day with two fifteen-minute breaks and a half-hour lunch break. In October 2010, she started work at 2:00 p.m. and ended at 10:30 p.m. Her job duties consisted of cleaning bathrooms, which included the floors, sinks, mirrors, toilets and walls, and emptying garbage. Petitioner testified that she also cleaned glass and window frames and polished metal. She used soap, water, buckets, rags, sponges, poles, brushes and mops. When asked on direct examination to estimate the percentage of the workday that she spent doing overhead work with her arms stretched out, Petitioner responded that she spent almost the whole day doing this type of work.

In October 2010, she noticed that her right arm and shoulder started to hurt.

On October 27, 2010, at approximately 9:00 a.m., she had a conversation with Juan Carlos, who, for the previous three years had been in charge of her shift. He was the lead worker. During this conversation, she told Juan Carlos that she was having difficulty mopping and that her right arm hurt a lot. It had snowed that day and she had to do a good deal of mopping around the doors. Juan Carlos told her in that conversation that she should mop slowly, but that she must do the mopping.

Prior to October 2010, she never had problems with or treatment to her right arm. Petitioner has vertigo and treated at Union Health Service. On October 27, 2010, she complained of right arm pain. Petitioner further testified that before October 27, 2010, her arm hurt, but she never sought medical treatment for it. She initially treated with various physicians at Union Health Services. She was eventually referred to Dr. Ira Kornblatt for treatment of her right shoulder.

Dr. Kornblatt recommended physical therapy and injections and placed her on light-duty work. On July 11, 2011, Dr. Kornblatt recommended surgery for her right shoulder. Such surgery has not been performed.

She later saw Dr. Brian Neal, at the request of the insurance company.

On March 5, 2012, she returned to Dr. Kornblatt in a lot of pain.

On March 1, 2012, her supervisor, Maria Rios, sent her to extract glue from a wall. The glue was inside a picture frame that hung on the wall in the baggage claim area. At 9:00 p.m. on March 1, 2012, when her supervisor checked on her, she told Ms. Rios that she injured her shoulder some more and that she cannot tolerate the pain. She told the supervisor that she tried to remove the glue but that it did not come off, and that she felt "stronger pain" in her right arm. She continued to work that day.

At trial, Petitioner demonstrated the method she used in an attempt to remove the glue. She had to work on a surface that was six feet high. She started to scrub and scrub and the glue would not come out. She used a "metal sponge" or scrubber.

On March 2, 2012, she spoke to Maria Rios again. She told Ms. Rios that she cannot work with her right arm the way it is, and asked Ms. Rios to make out a report.

Ms. Rios would not make out a report and told Petitioner that she has had this problem for years and has previously complained of it.

When she next saw Dr. Kornblatt, the doctor gave her a three-pound lifting restriction. She tried to work, but Ms. Rios did not want her to work. Ms. Rios instructed her to return to her doctor and bring back another note.

On March 26, 2012, she worked one hour and forty-five minutes. She was sent to clean bathrooms with a lot of mirrors. It was very crowded. She was cleaning sinks and metal. Petitioner was complaining of arm pain. Maria Rios entered the bathroom and told Petitioner that if she is experiencing a lot of pain, she must go home. Ms. Rios directed her to go to the doctor and to get a slip.

Petitioner has not worked for Respondent or anyone else since that date and has not sought work within her three-pound lifting restriction.

Approximately once a month, she faxed off-work slips to Respondent. Whenever she saw Dr. Kornblatt, she would fax a slip to work. She would fax the slips to the Polish lady, Theresa, who is the "highest" one at Scrub, Inc.

Petitioner's right shoulder continues to hurt. She has received injections for the shoulder, but the doctor will not give her any more injections. She has received other medical treatment, but nothing for her right arm. Dr. Kornblatt is still recommending shoulder surgery and it is her desire to undergo such surgery because her shoulder hurts a lot and she cannot do anything.

On cross-examination, Petitioner testified that she has worked as a custodian for seven years. Before Scrub, she worked as a custodian for Total, and then for Kimco.

Prior to Total and Kimco, she worked two years and eight months at a company named Ohmite where she assembled parts. Ohmite closed its doors.

While at Kimco, she cleaned walls, mopped and performed other custodial duties at O'Hare Airport. The walls at O'Hare are higher than the walls in the hearing room. She had to use a pole with a brush on it and dipped it in a bucket of soap and water. She had to use one brush to wash and another to dry the walls.

Petitioner explained how she held the pole. Petitioner testified that she grabbed the pole with her left hand and stretched her right arm up the pole toward the brush. At times she stretched her left hand up the pole, but on this particular occasion, when she had to apply force, she stretched her right hand up the pole toward the brush. When she cleaned the bathrooms, she polished the metal with her right hand, but when she is tired, she uses her left hand to do this work. Over the course of a workday, she spends more than 50% of the time performing work at a "high" level, that is, overhead as opposed to waist level. She belongs to a union, Local 1, and the union has work rules.

Petitioner further testified that she had an accident on October 27, 2010, while she was cleaning walls and windows and mopping the salt on the floor from the snow. On that day, she had a conversation with Juan Carlos. No one else was present for the conversation. Such conversation took place near the Terminal 1 doors on the ticketing side. At that time, she voiced complaints, but no report was completed.

Respondent's Counsel then showed Petitioner Respondent's Exhibit #1, which is the Application for Adjustment of Claim. Petitioner testified that such document did bear her signature. When Respondent's Counsel directed Petitioner's attention to the date entered in the field beside "Date of accident," Petitioner testified that there must be some

mistake and that the date should read "10/27/10." Petitioner testified that she signed a paper that indicated 10/27/10, but maybe she did not notice it. Petitioner testified that she knew she hurt herself on 10/27/10. Petitioner testified that when she went to see the doctor that Scrub sent her to, she told him that she hurt herself on 10/27/10.

Petitioner testified that she saw Dr. Kornblatt on many occasions and that she told him she had hurt herself on 10/27/10 and continued to report such date as her date of injury. She did tell Dr. Kornblatt that her right arm had been hurting for at least six months. She claimed that she had an accident on a single day because that was the day her arm hurt the worst.

Petitioner agreed with Respondent's Counsel that on March 1, 2012, she was scrubbing glue off a wall on which the highest point of the glue was 6 feet and the lowest point of the glue was 3 - 3-1/2 feet. She used her right arm and hand and worked with a liquid for 1-1/2 hours to remove the glue from the wall. Her right arm always hurt, but it hurt the most that day.

She had a conversation with Maria Rios on March 1, 2012 at 9:45 p.m. after she had been working on the glue. She told Ms. Rios that day that she tried to remove the glue with the sponge Rios had given her, but that her arm hurt more than ever. Petitioner testified that Ms. Rios told her to "leave it" and that we will give it a try on another day. When she had this conversation with Maria Rios, there was an unidentified man close by who observed Petitioner crying and may or may not have heard the conversation. Petitioner wanted Maria Rios to make out a report at that time, because she wanted to let Respondent know she was injured and that the task she was performing "hurt the most."

Petitioner agreed with Respondent's Counsel that she had seen Dr. Kornblatt and that he had given her restrictions of no overhead work and no lifting over 15 pounds . The only work modification that Respondent made was that they did not have her dump any garbage. Trash is collected outside the bathrooms. Tending to the trash was one of Petitioner's duties. On one occasion, when Maria Rios directed her to empty the garbage, Petitioner responded that the garbage was too heavy to lift.

Only the men who work at Scrub, Inc., lifted the heavy bottles of water near the ticketing area.

Petitioner testified that she cleaned bathrooms at the direction of Maria Rios. She emptied small bags of garbage in the bathrooms and large bags of garbage near the gates. She has to lift each bag out of the trash receptacle, raise it up high, tie a knot in each of the filled bags and put a new bag in each receptacle. There is a high gondola into which the full garbage bags must go. There are also dumpsters. The gondolas and dumpsters are then taken to the street for pick up.

Petitioner testified that she last lifted the large garbage bags in 2011 and that Maria Rios pulled her off that job because she could not do it anymore.

Petitioner lives in an apartment with her son. Her son helps her with cleaning the apartment.

She has vertigo and that has felt dizzy when she has cleaned the walls, but has never fallen as a result of the vertigo/dizziness.

Petitioner injured her left wrist in the 1990's, but has not sustained any injuries as a result of a motor vehicle, bus or train accident.

Petitioner last saw Dr. Kornblatt in August or September 2013.

Petitioner was aware that Scrub, Inc., lost the contract to clean O'Hare Airport. Petitioner has not approached the new cleaning company at O'Hare and has not asked them for a job. Petitioner has not gone back to Scrub, Inc., and asked for a job.

Petitioner testified that she was not sure if Dr. Kornblatt recommended shoulder surgery before or after she filed a claim and got a lawyer. Petitioner testified that it was when her arm started to hurt a lot that she decided to file a claim.

Petitioner testified that in December 2012, she started to experience sciatic nerve pain down to her knee. In January 2013, she applied for SSDI due to the condition of her hip and sciatic nerve. Social Security sent her to a lady doctor to be examined. Petitioner was approved for SSDI by Social Security in April 2013. Petitioner has been receiving SSDI due to her hip and sciatic nerve. She now walks with a limp. She cannot look for work because she is already disabled.

Petitioner testified that she never passed out from vertigo.

When asked about an incident on February 27, 2012 at which time she complained of a headache and a fainting episode, Petitioner recalled the incident.

Petitioner denied that on May 27, 2008, she fell on her right hand at home.

Petitioner testified that on May 11, 2009, she only complained of right shoulder pain.

Petitioner agreed with Respondent's Counsel that on November 29, 2010, she complained of shoulder pain that she has had for six months.

Petitioner testified that if the July 11, 2011 records indicate that she wanted to make this into a workers' compensation claim, such records might or could be correct.

Petitioner testified that she filed a workers' compensation claim approximately one month after Dr. Kornblatt prescribed shoulder surgery.

Petitioner agreed that she was sent to a physical rehabilitation clinic on May 6, 2011. Petitioner testified that when she gave a history to the physical therapy evaluator, that she was truthful and honest.

Respondent's Counsel asked Petitioner if the history recorded by the physical therapy evaluator that day - - that Petitioner experienced a gradual onset of right shoulder pain with no mechanism of injury - - might or could be correct. Petitioner responded: "No."

On redirect examination, Petitioner agreed with Petitioner's Counsel that she came under the care of Dr. Kornblatt at Union Health Service and that she went there because that is where Respondent sends their employees for medical treatment. Petitioner testified that she has no personal relationship with Dr. Kornblatt and that she does not know him outside of the work injury.

Petitioner testified that she does not know which bills go through group insurance and which bills go through workers' compensation insurance.

Petitioner testified that the Application for Adjustment of Claim form is in English and that she does not read much English.

Petitioner testified that she had a prior attorney, Glen Betancourt, and that Mr. Betancourt spoke with Petitioner and filed a claim for her.

Petitioner testified that when she first started noticing things with her shoulder, she did not know what repetitive trauma was.

Petitioner agreed with Petitioner's Counsel that in May 2009, she was working full duty. When asked, with regard to the May 2009 treating record discussed on cross-examination, if she lost any time from work due to those complaints, Petitioner testified: "Not that I can remember."

Petitioner agreed with Petitioner's Counsel that opposing counsel had asked her if she wanted to make this into a workers' compensation case. Petitioner testified that Dr. Kornblatt agreed that this was a workers' compensation claim.

Petitioner testified that she went to the emergency room for treatment for her back and sciatica. Then, Social Security sent her to be examined by Dr. Rochelle Hawkins on March 29, 2013, to have her back, and not her shoulder, examined. Petitioner testified that in March and April of 2013, she treated for her back, and not her shoulder, at the Howard Brown Health Center because she did not have any money to pay for treatment.

On re-cross examination, Petitioner agreed with Respondent's Counsel that opposing counsel asked her about Dr. Kornblatt's opinion with regard to her right shoulder, and also asked if Dr. Kornblatt's opinion was based on Petitioner's job duties.

When Respondent's Counsel asked Petitioner - - you never gave Dr. Kornblatt a written job description - - you just told him what you did - - Petitioner responded in the affirmative.

Maria Rios' Testimony

Ms. Maria Rios (a.k.a. Maria Mercedes Garcia) testified on behalf of Respondent. She testified that she has worked for Scrub, Inc., for three years and was Petitioner's supervisor. Ms. Rios testified that Petitioner was a janitor who duties included cleaning

the toilets, sinks and mirrors in the public bathrooms. Ms. Rios further testified that Petitioner was instructed to clean the mirrors to chest height, that is, she was to wipe the mirrors only half-way up where splash marks may have occurred. Any cleaning higher up than that on the mirrors or walls - - "risky cleaning" - - would be performed by the third shift when O'Hare Airport was essentially empty. Ms. Rios further testified that on March 1, 2012, she asked Petitioner's lead person to have Petitioner remove glue from a wall that was at chest level. Ms. Rios testified that she herself is 5'3" tall and noted that the glue was at *her* chest level. Ms. Rios testified that Maria Alvarez told her that she was not going to remove the glue because her arm was hurting her, and later told Rios that her hand was also hurting her. Ms. Rios testified that she inspected the wall and noted that the glue had not been washed off.

On cross-examination, Ms. Rios reiterated that Petitioner was only required to clean the lower halves of the bathroom mirrors when they had gotten wet. Petitioner was also required to clean the rest of the bathrooms, including the floors. Ms. Rios testified that there is a written description of Petitioner's job duties but that Rios did not have this with her at the time she gave her testimony. Ms. Rios also testified that Petitioner was given a company training materials, but that Rios did not have this with her at the time she gave her testimony. Ms. Rios testified that she became Petitioner's supervisor in the summer of 2011.

Ms. Rios testified that on March 1, 2012, she became aware that Petitioner's arm was hurting her - - she received notice of an arm problem. Ms. Rios stated that one time when Petitioner was cleaning the floor, she refused to pick up the garbage. Ms. Rios told her that if she has a problem with her arm, she should see a doctor. On March 1, 2012,

Ms. Rios testified, Rios told Petitioner to see a doctor. However, it was not until she complained about having to pick up the garbage that she went and got a doctor's note. Ms. Rios testified that Juan Carlos was Petitioner's lead at that time.

Ms. Rios testified that an accident report was filed with her complaints, and that such accident report was sent to the main office. Respondent did not produce the accident report.

Ms. Rios testified that Petitioner was reprimanded because she refused to do her job, but that Rios did not recall the date or even the year of such reprimand.

Ms. Rios testified that although she checked all the areas that that her charges cleaned, she did not work side-by-side with Maria Alvarez. Ms. Rios testified that she only saw Petitioner at opening and closing times because everyone is very busy during the second shift. When Petitioner's Counsel asked Ms. Rios if it is possible that Petitioner performed overhead work, Rios responded: "That I don't know." Ms. Rios testified that she never asked Petitioner to do any work higher than her chest or her chin. Ms. Rios testified that when her charges perform overhead cleaning, they use rags or sticks with sponges on the end of them. Ms. Rios reiterated that the third-shift cleaners do the overhead work; these people use the sticks with the sponges. Ms. Rios testified that the second-shift cleaners only clean halfway up and that she has never observed these cleaners do above chest-level work. Ms. Rios testified that the glue on the wall was at chest level. Such glue held a sign or a poster on the wall.

Maria Alvarez in Rebuttal

In rebuttal, Maria Alvarez testified that she heard the testimony of Maria Rios and that Ms. Rios' testimony that Petitioner was not required to perform overhead work but was only required to wash part of the mirror and part of the wall was not accurate. Petitioner reiterated that she was required to wash the entire mirror and wall. Petitioner testified that she used a stick with a sponge and that it is not true that that the third shift was required to do the "high" work. Petitioner testified that she and her co-workers had to wash the walls; that was required of them.

Pertinent Medical Records

The May 11, 2009, Progress Notes from Union Health Service state the following: "This 58 yr old female presents for HA L side of head past 3 months and R neck, shoulder and arm discomfort for longer." After conducting a physical examination in which he found the musculoskeletal system to be "negative" and the neck to be "supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender," the physician made the following assessment: "Headache: 784.0." (PX #1)

The October 27, 2010, Progress Notes from Union Health Service state the following: "S: This 59 yr old female presents for a follow-up visit. Current symptoms complained of: Returns after long interval relating daily ongoing **headaches** described as sharp **left temporal region pain with occasional nausea** no emesis and little response to tylenol or other otc RX or prior RX for Fioricet. Has had MRI and **Optho** evaluation and was advised Optho f/u will reschedule. Discussed headache diary to keep and record and

bring will assess further with **Neurology** consult and schedule **Labs screen PPX Mammogram and GYN screens.** Has had shoulder pain right with restriction of motion present recent weeks." (PX #1)

The November 22, 2010, Progress Notes from Union Health Service state the following: "S: This 59 yr old female presents for an unscheduled visit. Current symptoms: complaint of: History of current illness symptoms: Feeling very vertiginous for 2 days. No headache and no focal neurological symptoms or signs. Needs some pain meds for the right shoulder which she says continues to bother her." (PX #1)

The November 29, 2010, handwritten, Progress Notes from Union Health Service state the following: "Dropin ... pt. states that she was here last week for same complaint & given 1 week off of work but reports that she need more time off work. c/o vertigo x 1 week. Also, reports R shoulder pain x 6 months c̄ current pain level @ 7/10 after taking Motrin. Describes pain as sharp c̄ limited ROM of RUE." (PX #1)

The February 25, 2011, Progress Notes from Union Health Services state: "PHYSICAL EXAM: ... Musculoskeletal: **Severe restriction abduction right shoulder with tenderness to palpation.**" (PX #1)

The April 16, 2011, X-Ray report from Union Health Service states: "INDICATION: Pain. Limitation of movement. COMPARISON: None. FINDINGS: Routine films of the shoulder demonstrate degenerative disease involving the shoulder

joint and acromioclavicular joint. There is no evidence of fracture or dislocation. No destructive bony lesion is identified. The soft tissues appear normal. IMPRESSION: Osteoarthritis." (PX #1)

The May 16, 2011, Accelerated Rehabilitation Centers Initial Evaluation states: "**HISTORY:** Ms. Alvarez is a 60-year-old Cleaning Person, who reports a gradual onset of (R) shoulder and arm pain, which began about 6 months ago. She states that she does not have a mechanism of injury. She denies neck pain, numbness or tingling in her arms or other discomfort throughout her body. She reports to have difficulty with dressing, reaching overhead, and lifting objects. The patient reports a pain score of 8 out of 10 . . . **FUNCTIONAL/PHYSICAL DEFICITS INCLUDE:** . . .

ROM:	(R)	(L)
Shoulder flexion	80°	180°
Abduction	95°	180°
IR	L5	T7 . . .

Special Tests: There is positive impingement sign, positive speeds test for RUE, negative Hoffmann's test, negative upper quadrant screen for cervical involvement . . . **ASSESSMENT:** The findings are consistent with the diagnosis of (R) shoulder impingement involving rotator cuff and biceps tendons. The rehab potential for the patient is good." (PX #1)

The June 15, 2011, Progress Note from Accelerated Rehabilitation Centers states: "**SUBJECTIVE**: Ms. Alvarez reports decreased pain at her shoulder with exception to

continued anterior shoulder/biceps tendon pain. She states she continues to have most difficulty mopping at work." (PX #1)

The June 20, 2011, Progress Notes from Union Health Service state:

"This is a 60-year-old female who I last saw on 5/9/11 at which time I gave her a steroid injection and a course of therapy. She is feeling somewhat better, but still has significant discomfort. On examination she has well-maintained range of motion of the cervical spine, full painless range of motion of the left shoulder and the right shoulder has minor loss of motion at the extremes of motion. Impingement sign is equivocal. Strength is satisfactory ... IMPRESSION: Rotator cuff tendinitis, possible tear. I have ordered an MRI scan and she will return to see me in 2 weeks." (PX #1)

In the June 27, 2011, **MRI SHOULDER RT WO CON**, the radiologist offers the following impression:

1. Moderate tendinopathy the (sic) distal supraspinatus and adjacent infraspinatus tendons with partial thickness undersurface tear of the mid fibers of the distal supraspinatus at its insertion. The patient has an elongated acromiale and with (sic) narrowing of the subacromial space at the level of the greater tuberosity.
2. Moderate tendinopathy of the upper subscapularis with partial thickness undersurface tear near the rotator interval.
3. Abnormal signal within the horizontal and upper vertical portions of the lung to the biceps tendon indicating at least tendinopathy and possibly a longitudinal split of the horizontal portion of the tendon. (PX #1)

The July 11, 2011, Progress Notes from Union Health Service states:

"This is a 60-year-old female who has ongoing pain involving the right shoulder. She believes that this is due to her work activities. She has been doing heavy lifting and overhead activities, lifting heavy garbage. She would like to try to make this into a workman's compensation case . . . I believe she is a candidate for surgical treatment. She does, however, have to first straighten out whether this is going to be done through workman's compensation or through her regular medical insurance . . . I did have a full discussion with her with Pacific interpreter." (PX #1)

Also on July 11, 2011, Dr. Kornblatt wrote a "To Whom It May Concern" letter and stated that Petitioner will continue to have treatment and needs to be on light duty with no overhead activities and lifting limited to 15 pounds. (PX #1)

On October 17, 2011, at the request of Respondent, and pursuant to Section 12 of the Act, Petitioner submitted to an examination by M. Bryan Neal, M.D., an orthopedic surgeon who is affiliated with Arlington Orthopedic & Hand Surgery Specialists, Ltd. Dr. Neal reviewed the medical records and took a history from Petitioner. To assist Dr. Neal, he used a Spanish interpreter named Francisca Grijalava. Dr. Neal reviewed what her self-reported job duties and descriptions were as a janitor. She indicated that she will use a dust pan to pick up trash and that she will clean mirrors and sinks. She cleans toilets and the plastic around toilets. She will mop and pick up garbage. She will clean walls and also does various cleaning "projects." This is janitorial-type work that is done at O'Hare International Airport.

Dr. Neal conducted an examination of Petitioner. He wrote that Petitioner reports a height of 5'1" and a weight of 130 pounds; Dr. Neal wrote that these figures appeared accurate. Dr. Neal noted that Petitioner has been in the United States for 39 years.

After examining Petitioner, Dr. Neal diagnosed Petitioner with right shoulder pain secondary to impingement syndrome. Dr. Neal found that Petitioner's subjective complaints correlate with the objective findings.

Dr. Neal offered, *inter alia*, the following additional opinions:

1. Concerning whether the diagnosis (right shoulder impingement syndrome) is "solely the direct result of the work incident in question," Dr. Neal points out that there is absolutely no single incident, occurrence or work injury; the examinee admitted so in a forthcoming manner and on the form she filled out upon presentation to his office. In response to the question "How did your injury occur?" she wrote: "repetitive work, it wasn't a specific work accident." Therefore, Dr. Neal opined that Petitioner's right shoulder condition is not the result of any work incident or event.
2. Dr. Neal further opined there is no direct causal relationship between her current condition and her occupational activities. She has worked for many years at the same job without symptoms. In addition, x-rays obtained in his office on the date of the examination and the previous MRI revealed degenerative changes of the acromioclavicular joint, degenerative changes, spurring, and anatomic abnormalities which predispose her to impingement of the rotator cuff and bursa

in the subacromial space. Dr. Neal believed that it is the subacromial degenerative changes that are the root or direct cause of her current right shoulder condition.

Dr. Neal also opined that Petitioner is capable of performing full-duty work, that the treatment and diagnostic testing that Petitioner has undergone has been reasonable and necessary and that he anticipates Petitioner will not reach maximum medical improvement before four months since he believed she will elect to undergo additional treatment. Dr. Neal recommended a repeat subacromial corticosteroid injection and anti-inflammatory medications. If Petitioner does not find additional relief, she may be a surgical candidate. (RX #2)

The March 3, 2012, Progress Notes from Union Health Service state the following:

"S: This 60 years old (sic) female presents for an unscheduled visit.

Current symptoms: complaint of: R shoulder pain

History of current illness symptoms: Pt with >1 yr hx of R shoulder pain which is followed by ortho. She has been dx'd with Rotator cuff tendonitis/impingement. She reports she has been through PT without significant improvement and is waiting for R shoulder arthroscopic surgery. 3 days ago she was at work, she was told to clean a wall. She had received a note from doctor stating no overhead activity. She reports worsening pain since. She is taking Advil 200 mg 2 tabs only . . .

Physical exam:

General: Well appearing, well nourished in no distress. Oriented x 3, normal mood and

affect.

Musculoskeletal: R arm active abduction to 60 degrees. + impingement on R." (PX #1)

The March 5, 2012, Progress Notes from Union Health Service state the following:

"S: This 60 years old female (sic) presents with Right shoulder pain

A: This is a 60-year-old female who re-injured her right shoulder last Thursday when she was walking a wall (sic) in spite of the fact that she had been given a prescription for light duty work. She presented here to the clinic on Saturday with increased pain of her right shoulder. They gave her ibuprofen for the pain.

PHYSICAL EXAMINATION: . . . The right shoulder has a very painful range of motion. Impingement sign is positive . . .

OPINION: The patient has pre-existing rotator cuff impingement with partial thickness tear that has been reinjured.

TREATMENT: After appropriate discussion the right shoulder was prepped in the usual manner and the subacromial space was injected with 1 cc of Lidocaine and 40 m of Kenalog.

RECOMMENDATION: We will keep her off work. She is to use ice, symptomatic measures, and home exercise program. I will re-evaluate her on 3/20/12." (PX #1)

The March 20, 2012, a "To Whom It May Concern" letter, authored by Dr. Kornblatt and on Union Health Service letterhead, states the following:

"MARIA ALVAREZ has been under the care of UNION HEALTH SERVICE, INC. and may return to work as of March 27 2012. Light duty, no overhead lifting 3 lbs (sic) with

right upper extremities or mopping, next medical evaluation is scheduled for June 18, 2012." (PX #1)

In a narrative report dated July 9, 2012, Ira B. Kornblatt, M.D., Petitioner's treating orthopedic surgeon who is affiliated with Illinois Bone & Joint Institute, offered the following opinion:

"The patient has rotator cuff involving the right shoulder (sic). This is likely a combination of degenerative process in addition to permanent aggravation due to her job activities. In addition, there was a specific injury in March 2012 where she developed increased pain about the right shoulder. As such, it is likely that her present complaints and disability are a result of her job-related activities. She is in need of an outpatient, arthroscopic surgical procedure."

In the body of the report, Dr. Kornblatt wrote: "It should be noted that the patient believed that her injury was due to heavy lifting and overhead activities on her job." (PX #2)

The July 30, 2012, Progress Notes of Union Health Service state:

"This is a 61-year-old female here for follow up. She is still dealing with her attorney regarding the workers' compensation claim. I actually did write a report to the attorney backing up her claim. In the meantime, they will not let her work with restrictions. She continues to have ongoing shoulder with secondary neck pain. She is to continue an independent exercise program and I will see her back in 5 weeks time. We will keep her off work.

Work related/medical disability exam by treating physician: 99455

Cervicalgia/neck pain: 723.1

Shoulder (region) pain: 719.41" (PX #1)

The September 4, 2012, a "To Whom It May Concern" letter, authored by Dr. Kornblatt and printed on Union Health Service letterhead, states the following:

"MARIA ALVAREZ has been under the care of UNION HEALTH SERVICE, INC. PATIENT IS DISABLED." (PX #1)

Conclusions of Law:

In support of the Arbitrator's decision relating to issues (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", (E) "Was timely notice of the accident given to Respondent?" and (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator makes the following findings of fact and conclusions of law:

An employee who alleges an injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process. Peoria County Belwood Nursing Home v. Indus. Comm'n, 505 N.E.2d 1026, 106 Ill. Dec. 235 (1987)

In Durand v. Indus. Comm'n, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006), the Supreme Court held:

"The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee. See *General Electric Co. v. Industrial Comm'n*, 190 Ill. App. 3d 847, 857, 546 N.E.2d 987, 137 Ill. Dec. 874 (1989). However, because repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. See *Oscar Mayer*, 176 Ill. App. 3d at 610."

Petitioner provided unrebutted testimony that on October 27, 2010, she complained to the lead worker, Juan Carlos, that she had difficulty mopping and that her

right arm hurt. Petitioner explained that it had snowed that day and she had to do a good deal of mopping around the doors.

Yet, when Petitioner visited Union Health Service on October 27, 2010, her primary complaint was of daily, ongoing headaches. The physician prescribed a neurology consultation and a follow-up appointment with the ophthalmologist. He also directed her to keep a headache diary. Petitioner also complained of right shoulder pain with a restriction of motion that has been present in recent weeks. For her shoulder, the physician prescribed 10 days of Naproxen and to add Omeprazole for protection. The physician diagnosed Petitioner with a headache and tendinitis. In the Progress Notes for that date, the physician made no mention of shoulder pain caused by, aggravated by or even accompanied by Petitioner's performance of a work activity. In fact, the physician made no mention of work and did not give Petitioner any work restrictions.

Petitioner then returned to Union Health Service on November 22, 2010 at which time she voiced complaints relative to her vertigo. She also requested pain medication for her shoulder but again made no allegation of a work injury. (PX #1)

The Arbitrator notes the records reveal that when Petitioner was seen at Union Health Service on November 29, 2010, she complained of right shoulder pain for six months. (PX #1)

The medical records also reveal that on April 6, 2011, Petitioner underwent an x-ray of her right shoulder that the radiologist interpreted as osteoarthritis of the shoulder. (PX #1)

On May 6, 2011, Petitioner was seen at Accelerated Rehabilitation Center and advised that she had experienced a gradual onset of pain in her right shoulder for over 6 months with no mechanism of injury. (PX #1)

On June 15, 2011, when Petitioner was seen at Accelerated Rehabilitation Center, the therapist wrote: "She states she continues to have most difficulty mopping at work." (PX #1)

The June 27, 2011, right shoulder MRI was interpreted as showing, *inter alia* moderate tendinopathy of the supraspinatus, infraspinatus and subscapularis with a partial thickness undersurface tear of the distal supraspinatus at its insertion as well as an undersurface tear near the rotator cuff interval. (PX #1)

It was not until July 11, 2011, when Dr. Kornblatt opined that she was a surgical candidate, that Petitioner indicated "[s]he would like to try to make this into a workman's compensation case." (PX 1)

The Arbitrator finds it suspicious that Petitioner told her doctor that she would like to try to make this into a workers' compensation case.

In his causation opinion, Dr. Kornblatt opined: "This is likely a combination of degenerative process in addition to permanent aggravation due to her job activities." Dr. Kornblatt also wrote: "It should be noted that the patient believed that her injury was due to heavy lifting and overhead activities on her job." (PX #2) Yet, Dr. Kornblatt made no mention of October 27, 2010.

Dr. Neal opined that there is no direct causal relationship between her current condition and her occupational activities. He noted that she has worked for many years at the same job without symptoms. In addition, x-rays obtained in his office on the date of

the examination and the previous MRI revealed degenerative changes of the acromioclavicular joint, degenerative changes, spurring, and anatomic abnormalities which predispose her to impingement of the rotator cuff and bursa in the subacromial space. Dr. Neal believed that it was the subacromial degenerative changes that are the root or direct cause of her current right shoulder condition.

Neither Dr. Kornblatt nor Dr. Neal reviewed Petitioner's written job description before rendering a causation opinion.

Finally, Petitioner filed the initial Application for Adjustment of Claim for case #11 WC 29912 on August 5, 2011. In such Application, she alleged a date of accident of November 24, 2011, which would have been more than three months *after* the Application was filed. (RX #1) This Application was later amended to reflect an October 27, 2010 date of loss. (PX #11) However, such Amended Application was not filed until November 2, 2012. Despite the fact that Petitioner testified that the exact date on which she was injured was October 27, 2010 (the date on she testified her arm "hurt the worst"), it was not until more than a year after she filed the initial Application that she realized the date on which her arm hurt the worst.

Based on a preponderance of the evidence, the Arbitrator finds that Petitioner failed to prove that she sustained an accident on October 27, 2010 and that her current condition of ill-being of her right shoulder is causally related to any work activities on October 27, 2010. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Alvarez,
Petitioner,

vs. No: 12 WC 26299

Scrub, Inc.,
Respondent.

15IWCC0482

DECISION AND OPINION ON REVIEW

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

The Commission notes claim 12 WC 26299 was heard in consolidation with claim 11 WC 29912 before Arbitrator Cronin on May 23, 2013. A separate decision is issued for claim 11 WC 29912.

Arbitrator Cronin found that Petitioner proved she sustained an accident that arose out of and in the course of employment on March 1, 2012 and also proved her current condition of ill-being is causally related to that accident. The Arbitrator awarded Petitioner medical expenses and temporary total disability benefits and ordered Respondent to authorize and pay for reasonable, necessary and related medical treatment that Dr. Kornblatt presrcribed, specifically, surgery to Petitioner's right shoulder.

After considering the entire record, and for the reasons set forth below, the Commission reverses the May 23, 2013 decision of the Arbitrator. Petitioner failed to prove she sustained an accident that arose out of and in the course of her employment on March 1, 2013. All benefits are denied.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On March 1, 2012, Petitioner was employed by Respondent as a custodian at O'Hare Airport. Petitioner alleged that on that date, her supervisor had sent her to clean walls and extract glue from the walls of the facitily.

2. Prior to March 1, 2012, Petitioner had been seeking medical treatment for her right shoulder for an alleged work injury on October 27, 2010, the subject of claim 11 WC 29912.

3. Petitioner testified that her supervisor, Maria Rios, came to see her at 9:00 pm on March 1, 2012, and Petitioner indicated to Ms. Rios that she had injured her right arm while scrubbing very hard to loosen glue off the wall at a hight of approximately six feet. Petitioner testified she stands 5'1" tall.

4. Petitioner's supervisor, Ms. Rios, testified at hearing that she had given Petitioner a special project to scrub glue from the walls on March 1, 2012. Ms. Rios testified that she stands 5'3" tall and the glue was at her chest level. Ms. Rios further testified that when she went to check on Petitioner's progress, none of the glue had been removed from the wall, and it did not appear Petitioner had even attepted to remove the glue.

5. Ms. Rios testified that Petitioner did complain of right arm pain on March 1, 2012 after allegedly scrubbing the wall. Petitioner testified that Ms. Rios told her they would try to remove the glue another day.

6. Petitioner had last treated with Dr. Kornblatt for her prior right shoulder complaints on November 7, 2011. At that time, the doctor noted that Petitioner was awaiting approval for surgery through workers' compensation and had compalitns of increased pain. Petitioner was given a steroid injection and continued on light duty work restrictions of no lifting over ten pounds and no overhead activities.

7. Petitioner returned to Dr. Kornblatt on March 5, 2012, at which point she complained of right shoulder pain after reinjuring her shoulder at work when cleaning a wall in spite of her light duty restrictions. Dr. Kornblatt opined Petitioner suffered from pre-existing rotator cuff impingment with partial thickness tear that had been reinjured. He administered a steroid injection and took Petitioner off work through March 20, 2012.

8. On March 20, 2012, Petitioner returned to Dr. Kornblatt and was given a three pound lifting restriction. Petitioner testified she attempted to return to work under these restrictions but alleged after an hour and a half on the job, she was sent home due to complaints of her arm hurting.

9. Petitioner continued to treat with Dr. Kornblatt, and on July 9, 2012, he authored a note stating Petitioner believed her injury was due to the heavy lifting and overhead activities of her job. It was Dr. Kornblatt's opinion that Petitioner required arthroscopic surgery on her right shoulder.

15IWCC0482

Petiotner bears the burden of proving every element of his claim by a preponderance of the evidence. *Hutson v. Industrial Comm'n.*, 223 Ill. App. 3d 706, 585 N.E.2d 1208 (1992). The burden of proof is on a claimant to establish the elements of his righ to compensation, and unless the evidence considered in its entirely supports a finding that the injury resulted from a cause connected with the employment there is no right to recover. *Revere Paint & Varnish Corp. v. Industrial Comm'n.*, 41 Ill. 2d 59, 242 N.E.2d 1 (1968).

The Commission finds Petitioner failed to prove she sustained an accident that arose out of and in the course of her employment on March 1, 2012 by a preponderance of the evidence. The totality of the evidence in the record reveals Petitioner had a longstanding history of complaints in the right shouder prior to the alleged date of accident. In addition to the medical records, Respondent presented Ms. Rios, whom the Commission finds to be a credible witness. Ms. Rios testified she did instruct Petitioner to remove glue from a wall on March 1, 2012, but that the task did not require Petitioner to reach overhead. Further, when Ms. Rios checked on Petitioner's progress, there was no indication that she had even attempted to remove the glue from the wall.

As the Commission finds Petitioner failed to establish she sustained a compensable work accident on March 1, 2012, Petitioner's claim for compensation under the Act is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 1, 2014 is hereby reversed.

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

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

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

DATED: JUN 2 2 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/21/15
jdl/adc
68

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

ALVAREZ, MARIA
Employee/Petitioner

Case# **12WC026299**

11WC029912

SCRUB INC
Employer/Respondent

15IWCC0482

On 5/1/2014, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
MICHAEL A ROM
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
TAMMY PAQUETE
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)

Maria Alvarez
Employee/Petitioner

v.

Scrub, Inc.
Employer/Respondent

Case # **12** WC **26299**

Consolidated cases: **11 WC 29912**

15IWCC0482

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **5/23/13, 9/18/13 and 9/23/13**. 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **March 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 $**31,200.00**; the average weekly wage was $**600.00**.

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.

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 $**3,795.00** under Section 8(j) of the Act, for both cases **11 WC 29912** and **12 WC 26299** combined.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $**400.00** per week for **81-1/7** weeks commencing on **March 5, 2012** through **September 23, 2013** as provided in Section 8(b) of the Act.

- Respondent shall pay for the reasonable and necessary medical services incurred by the Petitioner in the amount of $**380.77**, pursuant to Section 8(a) and subject to Section 8.2 of the Act and Section 8(j).

- Respondent shall authorize and pay for the reasonable, necessary and related medical treatment that Dr. Ira Kornblatt has prescribed, specifically, surgery to Petitioner's right shoulder, pursuant to Section 8(a) and subject to Section 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

April 30, 2014
Date

ICArbDec19(b)

MAY - 1 2014

Maria Alvarez

v.

Case # 12 WC 26299
Consolidated w/ **11 WC 29912**

Scrub, Inc.

15IWCC0482

Statement of Facts:

Petitioner's Testimony

In 2005, Petitioner was hired by Respondent to work as a custodian/janitor at O'Hare International Airport. Over the course of five years for Respondent, Petitioner has worked five days a week, eight hours a day with two fifteen-minute breaks and a half-hour lunch break. In October 2010, she started work at 2:00 p.m. and ended at 10:30 p.m. Her job duties consisted of cleaning bathrooms, which included the floors, sinks, mirrors, toilets and walls, and emptying garbage. Petitioner testified that she also cleaned glass and window frames and polished metal. She used soap, water, buckets, rags, sponges, poles, brushes and mops. When asked on direct examination to estimate the percentage of the workday that she spent doing overhead work with her arms stretched out, Petitioner responded that she spent almost the whole day doing this type of work.

In October 2010, she noticed that her right arm and shoulder started to hurt.

On October 27, 2010, at approximately 9:00 a.m., she had a conversation with Juan Carlos, who, for the previous three years had been in charge of her shift. He was the lead worker. During this conversation, she told Juan Carlos that she was having difficulty mopping and that her right arm hurt a lot. It had snowed that day and she had to do a good deal of mopping around the doors. Juan Carlos told her in that conversation that she should mop slowly, but that she must do the mopping.

Prior to October 2010, she never had problems with or treatment to her right arm. Petitioner has vertigo and treated at Union Health Service. On October 27, 2010, she complained of right arm pain. Petitioner further testified that before October 27, 2010, her arm hurt, but she never sought medical treatment for it. She initially treated with various physicians at Union Health Services. She was eventually referred to Dr. Ira Kornblatt for treatment of her right shoulder.

Dr. Kornblatt recommended physical therapy and injections and placed her on light-duty work. On July 11, 2011, Dr. Kornblatt recommended surgery for her right shoulder. Such surgery has not been performed.

She later saw Dr. Brian Neal, at the request of the insurance company.

On March 5, 2012, she returned to Dr. Kornblatt in a lot of pain.

On March 1, 2012, her supervisor, Maria Rios, sent her to extract glue from a wall. The glue was inside a picture frame that hung on the wall in the baggage claim area. At 9:00 p.m. on March 1, 2012, when her supervisor checked on her, she told Ms. Rios that she injured her shoulder some more and that she cannot tolerate the pain. She told the supervisor that she tried to remove the glue but that it did not come off, and that she felt "stronger pain" in her right arm. She continued to work that day.

At trial, Petitioner demonstrated the method she used in an attempt to remove the glue. She had to work on a surface that was six feet high. She started to scrub and scrub and the glue would not come out. She used a "metal sponge" or scrubber.

On March 2, 2012, she spoke to Maria Rios again. She told Ms. Rios that she cannot work with her right arm the way it is, and asked Ms. Rios to make out a report.

Ms. Rios would not make out a report and told Petitioner that she has had this problem for years and has previously complained of it.

When she next saw Dr. Kornblatt, the doctor gave her a three-pound lifting restriction. She tried to work, but Ms. Rios did not want her to work. Ms. Rios instructed her to return to her doctor and bring back another note.

On March 26, 2012, she worked one hour and forty-five minutes. She was sent to clean bathrooms with a lot of mirrors. It was very crowded. She was cleaning sinks and metal. Petitioner was complaining of arm pain. Maria Rios entered the bathroom and told Petitioner that if she is experiencing a lot of pain, she must go home. Ms. Rios directed her to go to the doctor and to get a slip.

Petitioner has not worked for Respondent or anyone else since that date and has not sought work within her three-pound lifting restriction.

Approximately once a month, she faxed off-work slips to Respondent. Whenever she saw Dr. Kornblatt, she would fax a slip to work. She would fax the slips to the Polish lady, Theresa, who is the "highest" one at Scrub, Inc.

Petitioner's right shoulder continues to hurt. She has received injections for the shoulder, but the doctor will not give her any more injections. She has received other medical treatment, but nothing for her right arm. Dr. Kornblatt is still recommending shoulder surgery and it is her desire to undergo such surgery because her shoulder hurts a lot and she cannot do anything.

On cross-examination, Petitioner testified that she has worked as a custodian for seven years. Before Scrub, she worked as a custodian for Total, and then for Kimco.

Prior to Total and Kimco, she worked two years and eight months at a company named Ohmite where she assembled parts. Ohmite closed its doors.

While at Kimco, she cleaned walls, mopped and performed other custodial duties at O'Hare Airport. The walls at O'Hare are higher than the walls in the hearing room. She had to use a pole with a brush on it and dipped it in a bucket of soap and water. She had to use one brush to wash and another to dry the walls.

Petitioner explained how she held the pole. Petitioner testified that she grabbed the pole with her left hand and stretched her right arm up the pole toward the brush. At times she stretched her left hand up the pole, but on this particular occasion, when she had to apply force, she stretched her right hand up the pole toward the brush. When she cleaned the bathrooms, she polished the metal with her right hand, but when she is tired, she uses her left hand to do this work. Over the course of a workday, she spends more than 50% of the time performing work at a "high" level, that is, overhead as opposed to waist level. She belongs to a union, Local 1, and the union has work rules.

Petitioner further testified that she had an accident on October 27, 2010, while she was cleaning walls and windows and mopping the salt on the floor from the snow. On that day, she had a conversation with Juan Carlos. No one else was present for the conversation. Such conversation took place near the Terminal 1 doors on the ticketing side. At that time, she voiced complaints, but no report was completed.

Respondent's Counsel then showed Petitioner Respondent's Exhibit #1, which is the Application for Adjustment of Claim. Petitioner testified that such document did bear her signature. When Respondent's Counsel directed Petitioner's attention to the date entered in the field beside "Date of accident," Petitioner testified that there must be some

mistake and that the date should read "10/27/10." Petitioner testified that she signed a paper that indicated 10/27/10, but maybe she did not notice it. Petitioner testified that she knew she hurt herself on 10/27/10. Petitioner testified that when she went to see the doctor that Scrub sent her to, she told him that she hurt herself on 10/27/10.

Petitioner testified that she saw Dr. Kornblatt on many occasions and that she told him she had hurt herself on 10/27/10 and continued to report such date as her date of injury. She did tell Dr. Kornblatt that her right arm had been hurting for at least six months. She claimed that she had an accident on a single day because that was the day her arm hurt the worst.

Petitioner agreed with Respondent's Counsel that on March 1, 2012, she was scrubbing glue off a wall on which the highest point of the glue was 6 feet and the lowest point of the glue was 3 - 3-1/2 feet. She used her right arm and hand and worked with a liquid for 1-1/2 hours to remove the glue from the wall. Her right arm always hurt, but it hurt the most that day.

She had a conversation with Maria Rios on March 1, 2012 at 9:45 p.m. after she had been working on the glue. She told Ms. Rios that day that she tried to remove the glue with the sponge Rios had given her, but that her arm hurt more than ever. Petitioner testified that Ms. Rios told her to "leave it" and that we will give it a try on another day. When she had this conversation with Maria Rios, there was an unidentified man close by who observed Petitioner crying and may or may not have heard the conversation. Petitioner wanted Maria Rios to make out a report at that time, because she wanted to let Respondent know she was injured and that the task she was performing "hurt the most."

Petitioner agreed with Respondent's Counsel that she had seen Dr. Kornblatt and that he had given her restrictions of no overhead work and no lifting over 15 pounds . The only work modification that Respondent made was that they did not have her dump any garbage. Trash is collected outside the bathrooms. Tending to the trash was one of Petitioner's duties. On one occasion, when Maria Rios directed her to empty the garbage, Petitioner responded that the garbage was too heavy to lift.

Only the men who work at Scrub, Inc., lifted the heavy bottles of water near the ticketing area.

Petitioner testified that she cleaned bathrooms at the direction of Maria Rios. She emptied small bags of garbage in the bathrooms and large bags of garbage near the gates. She has to lift each bag out of the trash receptacle, raise it up high, tie a knot in each of the filled bags and put a new bag in each receptacle. There is a high gondola into which the full garbage bags must go. There are also dumpsters. The gondolas and dumpsters are then taken to the street for pick up.

Petitioner testified that she last lifted the large garbage bags in 2011 and that Maria Rios pulled her off that job because she could not do it anymore.

Petitioner lives in an apartment with her son. Her son helps her with cleaning the apartment.

She has vertigo and that has felt dizzy when she has cleaned the walls, but has never fallen as a result of the vertigo/dizziness.

Petitioner injured her left wrist in the 1990's, but has not sustained any injuries as a result of a motor vehicle, bus or train accident.

Petitioner last saw Dr. Kornblatt in August or September 2013.

Petitioner was aware that Scrub, Inc., lost the contract to clean O'Hare Airport. Petitioner has not approached the new cleaning company at O'Hare and has not asked them for a job. Petitioner has not gone back to Scrub, Inc., and asked for a job.

Petitioner testified that she was not sure if Dr. Kornblatt recommended shoulder surgery before or after she filed a claim and got a lawyer. Petitioner testified that it was when her arm started to hurt a lot that she decided to file a claim.

Petitioner testified that in December 2012, she started to experience sciatic nerve pain down to her knee. In January 2013, she applied for SSDI due to the condition of her hip and sciatic nerve. Social Security sent her to a lady doctor to be examined. Petitioner was approved for SSDI by Social Security in April 2013. Petitioner has been receiving SSDI due to her hip and sciatic nerve. She now walks with a limp. She cannot look for work because she is already disabled.

Petitioner testified that she never passed out from vertigo.

When asked about an incident on February 27, 2012 at which time she complained of a headache and a fainting episode, Petitioner recalled the incident.

Petitioner denied that on May 27, 2008, she fell on her right hand at home.

Petitioner testified that on May 11, 2009, she only complained of right shoulder pain.

Petitioner agreed with Respondent's Counsel that on November 29, 2010, she complained of shoulder pain that she has had for six months.

Petitioner testified that if the July 11, 2011 records indicate that she wanted to make this into a workers' compensation claim, such records might or could be correct.

Petitioner testified that she filed a workers' compensation claim approximately one month after Dr. Kornblatt prescribed shoulder surgery.

Petitioner agreed that she was sent to a physical rehabilitation clinic on May 6, 2011. Petitioner testified that when she gave a history to the physical therapy evaluator, that she was truthful and honest.

Respondent's Counsel asked Petitioner if the history recorded by the physical therapy evaluator that day - - that Petitioner experienced a gradual onset of right shoulder pain with no mechanism of injury - - might or could be correct. Petitioner responded: "No."

On redirect examination, Petitioner agreed with Petitioner's Counsel that she came under the care of Dr. Kornblatt at Union Health Service and that she went there because that is where Respondent sends their employees for medical treatment. Petitioner testified that she has no personal relationship with Dr. Kornblatt and that she does not know him outside of the work injury.

Petitioner testified that she does not know which bills go through group insurance and which bills go through workers' compensation insurance.

Petitioner testified that the Application for Adjustment of Claim form is in English and that she does not read much English.

Petitioner testified that she had a prior attorney, Glen Betancourt, and that Mr. Betancourt spoke with Petitioner and filed a claim for her.

Petitioner testified that when she first started noticing things with her shoulder, she did not know what repetitive trauma was.

Petitioner agreed with Petitioner's Counsel that in May 2009, she was working full duty. When asked, with regard to the May 2009 treating record discussed on cross-examination, if she lost any time from work due to those complaints, Petitioner testified: "Not that I can remember."

Petitioner agreed with Petitioner's Counsel that opposing counsel had asked her if she wanted to make this into a workers' compensation case. Petitioner testified that Dr. Kornblatt agreed that this was a workers' compensation claim.

Petitioner testified that she went to the emergency room for treatment for her back and sciatica. Then, Social Security sent her to be examined by Dr. Rochelle Hawkins on March 29, 2013, to have her back, and not her shoulder, examined. Petitioner testified that in March and April of 2013, she treated for her back, and not her shoulder, at the Howard Brown Health Center because she did not have any money to pay for treatment.

On re-cross examination, Petitioner agreed with Respondent's Counsel that opposing counsel asked her about Dr. Kornblatt's opinion with regard to her right shoulder, and also asked if Dr. Kornblatt's opinion was based on Petitioner's job duties.

When Respondent's Counsel asked Petitioner - - you never gave Dr. Kornblatt a written job description - - you just told him what you did - - Petitioner responded in the affirmative.

Maria Rios' Testimony

Ms. Maria Rios (a.k.a. Maria Mercedes Garcia) testified on behalf of Respondent. She testified that she has worked for Scrub, Inc., for three years and was Petitioner's supervisor. Ms. Rios testified that Petitioner was a janitor who duties included cleaning

the toilets, sinks and mirrors in the public bathrooms. Ms. Rios further testified that Petitioner was instructed to clean the mirrors to chest height, that is, she was to wipe the mirrors only half-way up where splash marks may have occurred. Any cleaning higher up than that on the mirrors or walls - - "risky cleaning" - - would be performed by the third shift when O'Hare Airport was essentially empty. Ms. Rios further testified that on March 1, 2012, she asked Petitioner's lead person to have Petitioner remove glue from a wall that was at chest level. Ms. Rios testified that she herself is 5'3" tall and noted that the glue was at *her* chest level. Ms. Rios testified that Maria Alvarez told her that she was not going to remove the glue because her arm was hurting her, and later told Rios that her hand was also hurting her. Ms. Rios testified that she inspected the wall and noted that the glue had not been washed off.

On cross-examination, Ms. Rios reiterated that Petitioner was only required to clean the lower halves of the bathroom mirrors when they had gotten wet. Petitioner was also required to clean the rest of the bathrooms, including the floors. Ms. Rios testified that there is a written description of Petitioner's job duties but that Rios did not have this with her at the time she gave her testimony. Ms. Rios also testified that Petitioner was given a company training materials, but that Rios did not have this with her at the time she gave her testimony. Ms. Rios testified that she became Petitioner's supervisor in the summer of 2011.

Ms. Rios testified that on March 1, 2012, she became aware that Petitioner's arm was hurting her - - she received notice of an arm problem. Ms. Rios stated that one time when Petitioner was cleaning the floor, she refused to pick up the garbage. Ms. Rios told her that if she has a problem with her arm, she should see a doctor. On March 1, 2012,

Ms. Rios testified, Rios told Petitioner to see a doctor. However, it was not until she complained about having to pick up the garbage that she went and got a doctor's note. Ms. Rios testified that Juan Carlos was Petitioner's lead at that time.

Ms. Rios testified that an accident report was filed with her complaints, and that such accident report was sent to the main office. Respondent did not produce the accident report.

Ms. Rios testified that Petitioner was reprimanded because she refused to do her job, but that Rios did not recall the date or even the year of such reprimand.

Ms. Rios testified that although she checked all the areas that that her charges cleaned, she did not work side-by-side with Maria Alvarez. Ms. Rios testified that she only saw Petitioner at opening and closing times because everyone is very busy during the second shift. When Petitioner's Counsel asked Ms. Rios if it is possible that Petitioner performed overhead work, Rios responded: "That I don't know." Ms. Rios testified that she never asked Petitioner to do any work higher than her chest or her chin. Ms. Rios testified that when her charges perform overhead cleaning, they use rags or sticks with sponges on the end of them. Ms. Rios reiterated that the third-shift cleaners do the overhead work; these people use the sticks with the sponges. Ms. Rios testified that the second-shift cleaners only clean halfway up and that she has never observed these cleaners do above chest-level work. Ms. Rios testified that the glue on the wall was at chest level. Such glue held a sign or a poster on the wall.

Maria Alvarez in Rebuttal

In rebuttal, Maria Alvarez testified that she heard the testimony of Maria Rios and that Ms. Rios' testimony that Petitioner was not required to perform overhead work but was only required to wash part of the mirror and part of the wall was not accurate. Petitioner reiterated that she was required to wash the entire mirror and wall. Petitioner testified that she used a stick with a sponge and that it is not true that that the third shift was required to do the "high" work. Petitioner testified that she and her co-workers had to wash the walls; that was required of them.

Pertinent Medical Records

The May 11, 2009, Progress Notes from Union Health Service state the following: "This 58 yr old female presents for HA L side of head past 3 months and R neck, shoulder and arm discomfort for longer." After conducting a physical examination in which he found the musculoskeletal system to be "negative" and the neck to be "supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender," the physician made the following assessment: "Headache: 784.0." (PX #1)

The October 27, 2010, Progress Notes from Union Health Service state the following: "S: This 59 yr old female presents for a follow-up visit. Current symptoms complained of: Returns after long interval relating daily ongoing **headaches** described as sharp **left temporal region pain with occasional nausea** no emesis and little response to tylenol or other otc RX or prior RX for Fioricet. Has had MRI and **Optho** evaluation and was advised Optho f/u will reschedule. Discussed headache diary to keep and record and

bring will assess further with **Neurology** consult and schedule **Labs screen PPX Mammogram and GYN screens**. Has had shoulder pain right with restriction of motion present recent weeks." (PX #1)

The November 22, 2010, Progress Notes from Union Health Service state the following: "S: This 59 yr old female presents for an unscheduled visit. Current symptoms: complaint of: History of current illness symptoms: Feeling very vertiginous for 2 days. No headache and no focal neurological symptoms or signs. Needs some pain meds for the right shoulder which she says continues to bother her." (PX #1)

The November 29, 2010, handwritten, Progress Notes from Union Health Service state the following: "Dropin ... pt. states that she was here last week for same complaint & given 1 week off of work but reports that she need more time off work. c/o vertigo x 1 week. Also, reports R shoulder pain x 6 months c̄ current pain level @ 7/10 after taking Motrin. Describes pain as sharp c̄ limited ROM of RUE." (PX #1)

The February 25, 2011, Progress Notes from Union Health Services state: "PHYSICAL EXAM: ... Musculoskeletal: **Severe restriction abduction right shoulder with tenderness to palpation.**" (PX #1)

The April 16, 2011, X-Ray report from Union Health Service states: "INDICATION: Pain. Limitation of movement. COMPARISON: None. FINDINGS: Routine films of the shoulder demonstrate degenerative disease involving the shoulder

joint and acromioclavicular joint. There is no evidence of fracture or dislocation. No destructive bony lesion is identified. The soft tissues appear normal. IMPRESSION: Osteoarthritis." (PX #1)

The May 16, 2011, Accelerated Rehabilitation Centers Initial Evaluation states: "**HISTORY:** Ms. Alvarez is a 60-year-old Cleaning Person, who reports a gradual onset of (R) shoulder and arm pain, which began about 6 months ago. She states that she does not have a mechanism of injury. She denies neck pain, numbness or tingling in her arms or other discomfort throughout her body. She reports to have difficulty with dressing, reaching overhead, and lifting objects. The patient reports a pain score of 8 out of 10 . . . **FUNCTIONAL/PHYSICAL DEFICITS INCLUDE:** . . .

ROM:	(R)	(L)
Shoulder flexion	80°	180°
Abduction	95°	180°
IR	L5	T7 . . .

Special Tests: There is positive impingement sign, positive speeds test for RUE, negative Hoffmann's test, negative upper quadrant screen for cervical involvement . . . **ASSESSMENT:** The findings are consistent with the diagnosis of (R) shoulder impingement involving rotator cuff and biceps tendons. The rehab potential for the patient is good." (PX #1)

The June 15, 2011, Progress Note from Accelerated Rehabilitation Centers states: "**SUBJECTIVE:** Ms. Alvarez reports decreased pain at her shoulder with exception to

continued anterior shoulder/biceps tendon pain. She states she continues to have most difficulty mopping at work." (PX #1)

The June 20, 2011, Progress Notes from Union Health Service state:

"This is a 60-year-old female who I last saw on 5/9/11 at which time I gave her a steroid injection and a course of therapy. She is feeling somewhat better, but still has significant discomfort. On examination she has well-maintained range of motion of the cervical spine, full painless range of motion of the left shoulder and the right shoulder has minor loss of motion at the extremes of motion. Impingement sign is equivocal. Strength is satisfactory … IMPRESSION: Rotator cuff tendinitis, possible tear. I have ordered an MRI scan and she will return to see me in 2 weeks." (PX #1)

In the June 27, 2011, **MRI SHOULDER RT WO CON**, the radiologist offers the following impression:

1. Moderate tendinopathy the (sic) distal supraspinatus and adjacent infraspinatus tendons with partial thickness undersurface tear of the mid fibers of the distal supraspinatus at its insertion. The patient has an elongated acromiale and with (sic) narrowing of the subacromial space at the level of the greater tuberosity.
2. Moderate tendinopathy of the upper subscapularis with partial thickness undersurface tear near the rotator interval.
3. Abnormal signal within the horizontal and upper vertical portions of the lung to the biceps tendon indicating at least tendinopathy and possibly a longitudinal split of the horizontal portion of the tendon. (PX #1)

The July 11, 2011, Progress Notes from Union Health Service states:

"This is a 60-year-old female who has ongoing pain involving the right shoulder. She believes that this is due to her work activities. She has been doing heavy lifting and overhead activities, lifting heavy garbage. She would like to try to make this into a workman's compensation case . . . I believe she is a candidate for surgical treatment. She does, however, have to first straighten out whether this is going to be done through workman's compensation or through her regular medical insurance . . . I did have a full discussion with her with Pacific interpreter." (PX #1)

Also on July 11, 2011, Dr. Kornblatt wrote a "To Whom It May Concern" letter and stated that Petitioner will continue to have treatment and needs to be on light duty with no overhead activities and lifting limited to 15 pounds. (PX #1)

On October 17, 2011, at the request of Respondent, and pursuant to Section 12 of the Act, Petitioner submitted to an examination by M. Bryan Neal, M.D., an orthopedic surgeon who is affiliated with Arlington Orthopedic & Hand Surgery Specialists, Ltd. Dr. Neal reviewed the medical records and took a history from Petitioner. To assist Dr. Neal, he used a Spanish interpreter named Francisca Grijalava. Dr. Neal reviewed what her self-reported job duties and descriptions were as a janitor. She indicated that she will use a dust pan to pick up trash and that she will clean mirrors and sinks. She cleans toilets and the plastic around toilets. She will mop and pick up garbage. She will clean walls and also does various cleaning "projects." This is janitorial-type work that is done at O'Hare International Airport.

Dr. Neal conducted an examination of Petitioner. He wrote that Petitioner reports a height of 5'1" and a weight of 130 pounds; Dr. Neal wrote that these figures appeared accurate. Dr. Neal noted that Petitioner has been in the United States for 39 years.

After examining Petitioner, Dr. Neal diagnosed Petitioner with right shoulder pain secondary to impingement syndrome. Dr. Neal found that Petitioner's subjective complaints correlate with the objective findings.

Dr. Neal offered, *inter alia*, the following additional opinions:

1. Concerning whether the diagnosis (right shoulder impingement syndrome) is "solely the direct result of the work incident in question," Dr. Neal points out that there is absolutely no single incident, occurrence or work injury; the examinee admitted so in a forthcoming manner and on the form she filled out upon presentation to his office. In response to the question "How did your injury occur?" she wrote: "repetitive work, it wasn't a specific work accident." Therefore, Dr. Neal opined that Petitioner's right shoulder condition is not the result of any work incident or event.
2. Dr. Neal further opined there is no direct causal relationship between her current condition and her occupational activities. She has worked for many years at the same job without symptoms. In addition, x-rays obtained in his office on the date of the examination and the previous MRI revealed degenerative changes of the acromioclavicular joint, degenerative changes, spurring, and anatomic abnormalities which predispose her to impingement of the rotator cuff and bursa

in the subacromial space. Dr. Neal believed that it is the subacromial degenerative changes that are the root or direct cause of her current right shoulder condition.

Dr. Neal also opined that Petitioner is capable of performing full-duty work, that the treatment and diagnostic testing that Petitioner has undergone has been reasonable and necessary and that he anticipates Petitioner will not reach maximum medical improvement before four months since he believed she will elect to undergo additional treatment. Dr. Neal recommended a repeat subacromial corticosteroid injection and anti-inflammatory medications. If Petitioner does not find additional relief, she may be a surgical candidate. (RX #2)

The March 3, 2012, Progress Notes from Union Health Service state the following:

"S: This 60 years old (sic) female presents for an unscheduled visit.

Current symptoms: complaint of: R shoulder pain

History of current illness symptoms: Pt with >1 yr hx of R shoulder pain which is followed by ortho. She has been dx'd with Rotator cuff tendonitis/impingement. She reports she has been through PT without significant improvement and is waiting for R shoulder arthroscopic surgery. 3 days ago she was at work, she was told to clean a wall. She had received a note from doctor stating no overhead activity. She reports worsening pain since. She is taking Advil 200 mg 2 tabs only . . .

Physical exam:

General: Well appearing, well nourished in no distress. Oriented x 3, normal mood and

affect.

Musculoskeletal: R arm active abduction to 60 degrees. + impingement on R." (PX #1)

The March 5, 2012, Progress Notes from Union Health Service state the following:

"S: This 60 years old female (sic) presents with Right shoulder pain

A: This is a 60-year-old female who re-injured her right shoulder last Thursday when she was walking a wall (sic) in spite of the fact that she had been given a prescription for light duty work. She presented here to the clinic on Saturday with increased pain of her right shoulder. They gave her ibuprofen for the pain.

PHYSICAL EXAMINATION: . . . The right shoulder has a very painful range of motion. Impingement sign is positive . . .

OPINION: The patient has pre-existing rotator cuff impingement with partial thickness tear that has been reinjured.

TREATMENT: After appropriate discussion the right shoulder was prepped in the usual manner and the subacromial space was injected with 1 cc of Lidocaine and 40 m of Kenalog.

RECOMMENDATION: We will keep her off work. She is to use ice, symptomatic measures, and home exercise program. I will re-evaluate her on 3/20/12." (PX #1)

The March 20, 2012, a "To Whom It May Concern" letter, authored by Dr. Kornblatt and on Union Health Service letterhead, states the following:

"MARIA ALVAREZ has been under the care of UNION HEALTH SERVICE, INC. and may return to work as of March 27 2012. Light duty, no overhead lifting 3 lbs (sic) with

right upper extremities or mopping, next medical evaluation is scheduled for June 18, 2012." (PX #1)

In a narrative report dated July 9, 2012, Ira B. Kornblatt, M.D., Petitioner's treating orthopedic surgeon who is affiliated with Illinois Bone & Joint Institute, offered the following opinion:

"The patient has rotator cuff involving the right shoulder (sic). This is likely a combination of degenerative process in addition to permanent aggravation due to her job activities. In addition, there was a specific injury in March 2012 where she developed increased pain about the right shoulder. As such, it is likely that her present complaints and disability are a result of her job-related activities. She is in need of an outpatient, arthroscopic surgical procedure."

In the body of the report, Dr. Kornblatt wrote: "It should be noted that the patient believed that her injury was due to heavy lifting and overhead activities on her job." (PX #2)

The July 30, 2012, Progress Notes of Union Health Service state:

"This is a 61-year-old female here for follow up. She is still dealing with her attorney regarding the workers' compensation claim. I actually did write a report to the attorney backing up her claim. In the meantime, they will not let her work with restrictions. She continues to have ongoing shoulder with secondary neck pain. She is to continue an independent exercise program and I will see her back in 5 weeks time. We will keep her off work.

Work related/medical disability exam by treating physician: 99455

Cervicalgia/neck pain: 723.1

Shoulder (region) pain: 719.41" (PX #1)

The September 4, 2012, a "To Whom It May Concern" letter, authored by Dr. Kornblatt and printed on Union Health Service letterhead, states the following:

"MARIA ALVAREZ has been under the care of UNION HEALTH SERVICE, INC. PATIENT IS DISABLED." (PX #1)

Conclusions of Law:

In support of the Arbitrator's decision relating to issues (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", (E) "Was timely notice of the accident given to Respondent?" and (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator concludes:

In the Application for Adjustment of Claim for case #11 WC 29912, Petitioner alleged an accident to her right arm as a result of repetitive trauma. (PX #11)

In the Application for Adjustment of Claim for case #12 WC 26299, Petitioner alleged an accident to her right arm as a result of scrubbing glue off a wall.

Petitioner testified that on March 1, 2012, Respondent asked her to perform an activity that exceeded her restriction of no overhead work: scrubbing glue off a wall. Petitioner testified that the patch of glue was from 3-1/2 to 6 feet high.

Dr. Neal recorded that Petitioner was 5'1'' tall.

Petitioner testified that she used her right arm and hand and worked with a liquid for 1-1/2 hours to remove the glue from the wall. She further testified that her right arm always hurt, but it hurt the most that day. She testified she had a conversation with Maria Rios on March 1, 2012 at 9:45 p.m. after she had been working on the glue. She told Ms. Rios that day that she tried to remove the glue with the sponge Rios had given her, but that her arm hurt more than ever. Petitioner testified that Ms. Rios told her to "leave it" and that we will give it a try on another day.

Petitioner sought treatment two days later at Union Health Service where she reported that she has been through PT without significant improvement and was waiting for R shoulder arthroscopic surgery, that 3 days ago she was at work and was told to clean a wall, that she had received a note from a doctor stating no overhead activity and

that she reports worsening pain since that time. The doctor also wrote she was taking Advil 200 mg 2 tabs only . . . Upon examination, the doctor found Petitioner to be well appearing, well nourished, in no distress . . . right arm abduction to 60° and positive impingement. On March 5, 2012, Dr. Kornblatt injected Petitioner's right shoulder and took her off work.

Maria Rios testified that on March 1, 2012, she asked Petitioner's lead person to have Petitioner remove glue from a wall that was at chest level. Ms. Rios testified that she herself is 5'3" tall and noted that the glue was at *her* chest level. Ms. Rios testified that Maria Alvarez told her that she was not going to remove the glue because her arm was hurting her, and later told Rios that her hand was also hurting her. Ms. Rios testified that she inspected the wall and noted that the glue had not been washed off. Furthermore, Ms. Rios testified, it appeared as though Petitioner had not even attempted to remove the glue.

On cross-examination, Ms. Rios testified that on March 1, 2012, she became aware that Petitioner's arm was hurting her - - she received notice of an arm problem. On March 1, 2012, Ms. Rios testified, she told Petitioner to see a doctor. In addition, Ms. Rios testified that an accident report was filed with her complaints, and that such accident report was sent to the main office.

Respondent did not produce the accident report.

No evidence was presented that Respondent closes the O'Hare bathrooms for cleaning, which adds credibility to Ms. Rios' testimony that the "risky cleaning" of the walls by employees maneuvering poles fitted with brushes is performed by the third shift when the airport is essentially empty. The Arbitrator reasons that with so many

passengers around over the course of the second shift, Respondent would not expose them to risky cleaning that involved the use of poles and brushes.

Petitioner even admitted that when she went back to work for 1 hour and 45 minutes on March 26, 2012, it was very crowded.

The Arbitrator notes instances in which Petitioner's credibility is called into question.

First, at the time of the September 18, 2013 trial, when questioned with regard to her past history of vertigo, Petitioner testified that she had never passed out from it. That being said, the medical records from Union Health dated February 27, 2012 reveal that she was seen with complaints of a headache and a fainting episode the day before for which an ambulance had to be called. (PX #1) Petitioner did admit to this fact on cross-examination.

Next, Petitioner denied that on May 27, 2008, she fell at home and injured her right hand, despite documentation of such injury in the Union Health Service records. Due to that fall, Petitioner sought treatment there for complaints of right hand/finger pain and actually required x-rays and follow-up visits for her complaints. Petitioner testified that such medical records would be wrong if they reflected those things. (PX #1)

Then, on July 11, 2011, Dr. Kornblatt wrote: "She would like to try to make this into a workman's compensation case."

The Arbitrator finds it suspect that Petitioner told her doctor that she wanted to try to make this into a workers' compensation case on the same date that Dr. Kornblatt determined she was a surgical candidate. Approximately three months later, on October 17, 2011, Dr. Neal examined Petitioner and wrote that there was absolutely no single

incident, occurrence or work injury and, therefore, Petitioner's right shoulder condition is not the result of any work incident or event. Five months after that, on March 1, 2012, Petitioner alleged a single, traumatic work injury to her right shoulder.

On direct examination, Petitioner estimated that she spent almost the whole day performing overhead work with her arms outstretched.

On cross-examination, Petitioner testified that over the course of a workday, she spent more than 50% of the time performing work at a "high" level, that is, overhead as opposed to waist level.

The Arbitrator recognizes that Petitioner is 5'1" tall. Yet, her job involved mopping the floors, cleaning the toilets, cleaning the sinks, cleaning the mirrors, polishing the metal work and emptying the garbage.

The Arbitrator finds that with regard to the high cleaning of the walls with a pole and brush, the Arbitrator finds Ms. Rios' testimony to be more convincing.

Petitioner has several unrelated medical conditions for which she has treated, including chronic headaches, vertigo and back/sciatic nerve pain. Petitioner testified that in December 2012, she began to experience back/sciatic nerve pain. Because of this back/sciatic nerve condition, she applied for SSDI in January 2013 and was granted SSDI in April 2013.

Notwithstanding evidence to the contrary, the Arbitrator concludes that by a mere preponderance of the evidence, Petitioner sustained an accident on March 1, 2012. The Arbitrator further concludes that Petitioner's current condition of ill-being of her right shoulder is causally related to the March 1, 2012 accident. Petitioner gave timely notice of such accident to Maria Rios.

The Arbitrator notes that Dr. Neal examined Petitioner on one occasion: October 17, 2011. He did not conduct a subsequent records review. Consequently, Dr. Neal offered no causation opinion as it relates to the March 1, 2012 incident.

Moreover, the Arbitrator finds it interesting that Dr. Neal, in his October 17, 2011 report, released Petitioner to return to full-duty work, yet recommended a repeat subacromial corticosteroid injection and anti-inflammatory medications, and further opined that if Petitioner did not experience additional relief, she may be a surgical candidate. So, Dr. Neal found Petitioner's shoulder bad enough to possibly require surgery, but not bad enough to at least be placed on light-duty work. The Arbitrator notes that Petitioner's job of janitor/custodian is not a sedentary job.

The June 15, 2011, Progress Note from Accelerated Rehabilitation Centers states: "**SUBJECTIVE**: Ms. Alvarez reports decreased pain at her shoulder with exception to continued anterior shoulder/biceps tendon pain. She states she continues to have most difficulty mopping at work."

On July 9, 2012, Dr. Ira Kornblatt wrote: "The patient has rotator cuff involving the right shoulder (sic). This is likely a combination of degenerative process in addition to permanent aggravation due to her job activities. In addition, there was a specific injury in March 2012 where she developed increased pain about the right shoulder. As such, it is likely that her present complaints and disability are a result of her job-related activities. She is in need of an outpatient, arthroscopic surgical procedure." In the body of the report, Dr. Kornblatt wrote: "It should be noted that the patient believed that her injury was due to heavy lifting and overhead activities on her job."

On July 30, 2012, Dr. Kornblatt wrote: "I actually did write a report to the attorney backing up her claim."

Neither Dr. Neal nor Dr. Kornblatt found Petitioner to be symptom magnifying or malingering.

In support of his conclusion, the Arbitrator cites Sisbro v. Indus. Comm'n, 797 N.E.2d 665, 278 Ill. Dec. 70 (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. Generally, these will be factual questions to be resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a preexisting condition, and, thereby, caused the disability, the Commission's award of compensation must be confirmed."

On March 1, 2012, Petitioner was 60 years old, 5'1" tall and 131 pounds. Dr. Neal opined, *inter alia*, that Petitioner has anatomic abnormalities which predispose her to impingement of the rotator cuff and bursa in the subacromial space.

It is axiomatic that employers take their employees as they find them. Baggett v. Indus. Comm'n, 201 Ill. 2d at 199 (2002)

In support of the Arbitrator's decision relating to issue (L) "What temporary benefits are in dispute? (TTD), " the Arbitrator concludes:

Petitioner testified that she continued to work after seeking medical attention on October 27, 2010. It was only after the specific incident of removing glue from the wall on March 1, 2012 that Petitioner was placed on a light-duty restriction of no lifting over 3 pounds, which Respondent did not accommodate.

The Arbitrator awards all lost time under case # 12 WC 26299.

Based on the above, the Arbitrator finds that Respondent shall pay Petitioner temporary total disability benefits of $400.00 per week for 81-1/7 weeks, from March 5, 2012 through September 23, 2013 as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of Petitioner, such disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

In support of the Arbitrator's decisions relating to issues (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?" and (K) "Is the Petitioner entitled to any prospective medical care?", the Arbitrator concludes:

Petitioner's Exhibits 7-10 consist of medical bills in the total amount of $6,011.46. These bills represent treatment to Petitioner's right shoulder condition. As the Arbitrator has found Petitioner's current condition of ill-being of her right shoulder causally related to the March 1, 2012 accident only, the Arbitrator finds that Petitioner is entitled to have and receive from Respondent the sum of $380.77 (minus any amounts for which Respondent has credit under section 8(j) for which Respondent will hold Petitioner harmless), pursuant to Section 8(a) and subject to Section 8.2 of the Act..

Furthermore, the Arbitrator orders Respondent to authorize and pay for the reasonable, necessary and related treatment that Dr. Ira Kornblatt has prescribed, specifically, the surgical procedure for Petitioner's right shoulder, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul Fritz,

Petitioner,

vs. NO. 12WC040343

Village of Lansing,

15IWCC0483

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

DATED: JUN 23 2015
SJM/sj
o-6/4/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

15IWCC0483

FRITZ, PAUL
Employee/Petitioner

Case# **12WC040343**

VILLAGE OF LANSING
Employer/Respondent

On 4/24/2014, 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:

0247 HANNIGAN & BOTHA LTD
RICHARD HANNIGAN
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

1401 SCOPELITIS GARVIN LIGHT & ET AL
GREGORY E AHERN
30 W MONROE ST SUITE 600
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

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Paul Fritz
Employee/Petitioner

v.

Village of Lansing
Employer/Respondent

Case # **12** WC **40343**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **3/18/2014**. 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, **5/2/2012**, 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 **$60,476.00**; the average weekly wage was **$1,163.00**.

On the date of accident, Petitioner was **43** 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 **$14,509.53** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$14,509.53**.

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

ORDER

The Respondent shall pay Petitioner temporary total disability benefits of $775.33/week for 18-5/7 weeks, from 7/16/2012 through 10/23/2012 and 11/2/2012 through 12/2/2012, as provided in Section 8(b) of the Act.

The Respondent shall pay $3,315.20 for medical services, as provided in Section 8(a) of the Act.

The Respondent is hereby ordered to authorize the fusion surgery as recommended by Petitioner's treating doctors and any reasonable and necessary rehabilitative services needed thereafter.

Respondent shall be given a credit of $14,509.53 for temporary total disability paid to Petitioner.

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.

15IWCC0483

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) medical bills; and 3) prospective medical treatment. *See,* AX1.

At the time of the petitioner's injury, he was 42 years of age and had worked for the respondent for approximately twenty-three (23) years. During this period, before the stipulated injury of May 2, 2012, the petitioner had never had any treatment to his low back or any low back pain. On May 2, 2012, he was pulling boxes up some stairs when he heard a pop in his low back and felt pain in that area.

He was referred, by his employer, to Ingalls Family Care Center ("Ingalls"); where he was seen on May 4, 2012. He gave a consistent history of his injury on May 2, 2012, and was advised to use warm moist compresses and take ibuprofen every eight hours. He returned to Ingalls on May 7, 2012, and was advised to begin range of motion exercises and Flexeril was added to his medication. He was placed on restricted duty and according to the petitioner, the respondent provided him with work within his restrictions. X-rays of the lumbar spine were also prescribed. PX1.

Those x-rays were performed on May 10, 2012 and read to show spondylolysis at L5, with mild anterorlisthesis of L5 on S1. Ingalls changed the petitioner's medication to Tramadol, continued his restrictions and prescribed physical therapy. Ingalls began physical therapy on May 14, 2012 and on May 17, 2012, noted that the petitioner's pain low back pain was mainly on the left side and shot around his back, but did not radiate into the leg. There is intermittent pain in the middle part of his back, which radiated around the interior chest. PX1 pgs.48-49.

On May 31, 2012, Ingalls prescribed a hold on physical therapy and an MRI of the lumbar spine was performed on June 8, 2012, at Franciscan Physicians Hospital. It was read to show a very mild grade 1 spondylolisthesis of L5, anteriorly upon S1 with bilateral L5 spondylolysis; and multi-level moderate spondylolisthesis, with predominately right-sided findings. There was also a possible annular tear at T12-S1 and L4-5. PX2, pgs.7-8.

On June 19, 2012, the doctor at Ingalls went over the MRI with the petitioner and recommended a back specialist. The petitioner testified that the insurance adjuster, Marilyn, advised him to see Dr. Anwar, who he saw on June 24, 2012. The doctor noted a consistent history of the work-related injury and prescribed medication and a five (5) pound lifting restriction. He also prescribed transforaminal injections, which were performed on May 2, 2012; from the T12 level through the L5 level, on the right side.

On July 11, 2012, Dr. Anwar noted a ten to twenty percent (10 to 20%) reduction in the petitioner's low back pain and prescribed another series of injections, which were performed on July 18, 2012; again from T12 through L5. PX1, pg. 20; PX2, pgs.10-18.

The respondent ceased to provide the petitioner with light duty work and it is agreed that he then lost time from July 16, 2012 through October 23, 2012; and from November 3, 2012 through December 3, 2012.

On July 25, 2012, Dr. Anwar prescribed another series of injections; however, the petitioner became wary of this treatment and presented to Dr. Kondamuri on August 2, 2012. Dr. Kondamuri recorded a consistent history of his work injury and the doctor's records reflect an impression that the petitioner's status was post lumbar strain, following work-related injury, that occurred on May 2, 2012. The doctor also noted probable aggravation of pre-existing lumbar spondylosis; possible new onset of disc protrusions; and new onset of facet joint arthropathy and myofascial pain syndrome. PX2, pg. 41.

He then prescribed Tramadol and a thoracic MRI; and wanted to review Dr. Anwar's records. Dr. Kondamuri also prescribed a medial branch block bilaterally at L3 through L5; which was performed on August 9, 2012. It was repeated on August 16, 2012 and August 20, 2012. Dr. Kondamuri prescribed a rhizotomy of the L3 through L5 medial branch nerves; which was performed on August 30, 2012; and repeated on September 27, 2012. PX2, pgs.16-41.

On October 11, 2012, Dr. Kondamuri noted that the facet-mediated pain was significantly improved, but would later note, on November 1, 2012, that there was no improvement. He then prescribed a facet joint injection. The thoracic MRI was performed on October 15, 2012 and was read to note multi-level, discogenic, degenerative changes in the thoracic spine.

On November 1, 2012, Dr. Kondamuri felt that the petitioner was at maximum medical improvement ("MMI") from a pain management perspective. He could not recommend any other procedures that would significantly change the petitioner's condition, between then and the next 12 months. He had no explanation as to why the pain was as bad as it was, aside from the possibility that it was functional pain or related to secondary gain. The doctor then indicated that would it be reasonable for the petitioner to obtain a second opinion from a neurosurgeon. Dr. Kondamuri agreed that Dr. Amine would be an appropriate spine doctor and made the referral.

The respondent had the petitioner evaluated pursuant to Section 12 of the Act, by Dr. Jay Levin. Dr. Levin opined that the body mechanics of the described accident did not support the likelihood of any major injury to the lumbar spine and went on to state that the petitioner did not suffer any injury from the alleged occurrence on May 2, 2012. In a subsequent report dated April 25, 2013, Dr. Levin was quite adamant in his disagreement regarding the diagnosis and treatment recommendations of Drs. Amine and Ghanayem. RX1.

Dr. Ghanayem evaluated the petitioner on November 7, 2012, per his attorney's request. Dr. Ghanayem is a board-certified, orthopedic surgeon, teaching spinal surgery to residents and medical students at Stritch School of Medicine. He examined the petitioner, reviewed the treating medical records; and reviewed the flexion extension radiographs and reports, taken on November 2012, from

Dr. Levin's office. Dr. Ghanayem believed that the x-rays revealed a 2mm slip in the neutral posture at L5-S1 and when the patient flexed forward, he subluxed to about 9 or 10mm at L5–S1. One of the neutral x-rays obtained by Dr. Levin was truncated at the lumbosacral junction, however, the flexion and neutral views were easy to read; and there is gross instabilities seen upon forward flexion.

Dr. Ghanayem opined that the petitioner was misdiagnosed and he has L5–S1 spondylolisthesis, which is unstable and correlates with his low-back pain. It is the doctor's opinion that Petitioner's work injury aggravated this condition. According to Dr. Ghanayem, the injections performed by Dr. Anwar were not appropriate and Petitioner would benefit from a lumbar fusion at L5-S1. He opined that the petitioner should work at the light duty level only. PX5 & 6.

On November 8, 2012, upon referral by Dr. Kondamuri, the petitioner was seen by Dr. Amine. Dr. Amine also noted the injury of May 2, 2012, while the petitioner was pulling a dolly upward over the steps and he felt a sharp pain in his back; and that he has had that pain ever since. He reviewed the petitioner's treatment and his findings on the MRI were consistent with Dr. Ghanayem's; and his impression was chronic low back pain syndrome. He stated there were two options for treatment: 1) a fusion from T-10 through S1; or 2) a fusion at L5–S1. He also recommended that the petitioner change jobs. It is the petitioner's desire to have a fusion at L5–S1 with either Dr. Amine or Dr. Ghanayem. PX4.

CONCLUSIONS OF LAW

F. Is the Petitioner's current condition of ill-being causally 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).

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 Supreme Court of Illinois has stated on numerous occasions that one need not even present medical evidence in order to prove causal connection. *International Harvester v Industrial Commission* 93 Ill. 2d 59, 442 N.E.2d 908, 66 Ill.Dec. 347 the Supreme Court held:

> "This court has held that medical evidence is not an essential ingredient to support the conclusion of the Industrial Commission that an industrial accident caused the disability. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. (Martin Young Enterprises, Inc. v. Industrial Com. (1972), 51 Ill.2d 149, 155, 281 N.E.2d 305.) In Union Starch & Refining Co. v. Industrial Com. (1967), 37 Ill.2d 139, 144, 224 N.E.2d 856, this court said, "We know of no case requiring a doctor's testimony to establish causation and the

> extent of disability, especially where, as here, the record contains the company doctor's report and hospital records showing findings of the employee's personal physician which are consistent with the employee's testimony." When the claimant's version of the accident is uncontradicted and his testimony unimpeached, his recital of the facts surrounding the accident may be sufficient to sustain an award. *Thrall Car Manufacturing Co. v. Industrial Comm'n.*, 64 Ill.2d 459, 463, 1 Ill.Dec. 328, 356 N.E.2d 516 (1976)."

In workers' compensation proceedings, proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. *Waldorf v. Industrial Commission*, 303 Ill. App. 3d 477, 708 NE 2d 476 (1999). As should be noted in the instant case, the chain of events herein indicate that the petitioner was able to perform his job without lost time or complaint, prior to his work injury and after the work injury he was ultimately unable to perform his job. His symptoms beginning immediately post injury and continue, to date.

The Arbitrator finds that prior to May 2, 2012, the petitioner enjoyed good health regarding his low back. He had no treatment for low back pain and there is nothing in the record to contradict the petitioner's testimony of an asymptomatic condition, regarding his low back. Since the date of accident, the petitioner has experienced low back pain. Based upon the facts as presented in this case, the petitioner's unrebutted testimony, and the medical evidence, it is the conclusion of the Arbitrator that the petitioner has proven, by a preponderance of the evidence, that his current condition of ill-being, regarding the low back, is causally related to the May 2, 2012 work accident.

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

The Arbitrator notes that Dr. Kondamuri is a pain specialist and not an orthopedic surgeon. And while this physician found the petitioner be at MMI, Drs. Amine's and Ghanayem's opinions are more persuasive. The Arbitrator has also considered the opinions of Dr. Levin and taking the evidence as a whole, it is the Arbitrator's finding that the prescription for the fusion at L5-S1 is reasonable, necessary and related to the May 2, 2012 accident.

It is the conclusion of the Arbitrator that the lumbar MRI of June 8, 2012 prescribed by Ingalls, was reasonable, necessary and related to the injury of May 2, 2012. The medical bill from Dr. Amine of November 9, 2012 is reasonable, necessary and related to the petitioner's injury of May 2, 2012. The respondent is ordered to pay these two bills, pursuant to the medical fee schedule, or the negotiated rate, whichever is less.

15IWCC0483

K. Is Petitioner entitled to prospective medical care?

In findings that the Petitioner has proven that his present condition of ill-being is related to his work accident, the Arbitrator also concludes that the petitioner is entitled to the prospective care recommended by Drs. Amine and Ghanayem, i.e. a fusion at L5-S1. The respondent is hereby ordered to authorize and pay for said surgery and any and all reasonable and necessary rehabilitative care.

L. What temporary benefits are in dispute?

The respondent shall pay the petitioner temporary total disability benefits of $775.33/week for 18-5/7 weeks, from 7/16/2012 through 10/23/2012 and 11/2/2012 through 12/2/2012, 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.

15IWCC0483

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC40343
SIGNATURE PAGE

Signature of Arbitrator

April 24, 2014
Date of Decision

APR 24 2014

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Allan D. Ohlau,
Petitioner,

15IWCC0484

vs.

NO: 12 WC 38839

Power Maintenance Corp.,
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, permanent disability, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 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: JUN 23 2015
O6/9/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OHLAU, ALLAN D
Employee/Petitioner

Case# **12WC038839**

15IWCC0484

POWER MAINTENANCE CORP
Employer/Respondent

On 8/11/2014, 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

1109 GAROFALO SCHREIBER & STORM CHTD
CRAIG SCARPELLI
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

15IWCC0484

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

ALLAN D. OHLAU
Employee/Petitioner
v.
POWER MAINTENANCE CORP.
Employer/Respondent

Case # 12 WC 38839

An *Application for Adjustment 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 **Belleville**, on **May 28, 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 **September 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 **$126,053.20**; the average weekly wage was **$2,424.10**.

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 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 **$3,848.25** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $3,848.25 for medical benefits that have been paid (as noted above), and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,295.47/week for 28 4/7 weeks, commencing November 3, 2012 through May 22, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

07/24/2014
Date

AUG 11 2014

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

15IWCC0484

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ALLAN D. OHLAU
Employee/Petitioner

v.

Case # 12 WC 38839

POWER MAINTENANCE CORP.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Allan Ohlau, testified he was currently 65 years of age and was employed by Respondent, Power Maintenance Corp., on September 25, 2012. Petitioner further testified he suffered an injury at work on this date around 7:00 p.m., when he was constructing a scaffold. Petitioner described he was coming off the roof to assist his co-worker and when he climbed off the roof onto the scaffold his right shoulder "snapped," and he felt tremendous pain. Petitioner described his right arm was extended as he was descending the roof and his shoulder did not pivot correctly.

Petitioner further testified he waited until about 7:30 p.m. to report the injury because his crew was about finished with the scaffold. He then proceeded to the break room. Petitioner told his foreman of the injury, who in turn took Petitioner to the safety manager, Larry Wright. Petitioner stated he did not perform any work between the moment where his shoulder "popped" and when he left with Mr. Wright for the emergency room at Red Bud Regional Hospital. The emergency room records indicate Petitioner was triaged at 8:51 p.m. and reported he had right shoulder pain which developed when he "was stepping down scaffolding and heard a 'pop' in his R shoulder." (Petitioner's Exhibit (PX) 1, p. 5). Petitioner testified he underwent x-ray examination and was discharged from the emergency room with instructions to seek further medical treatment. (See also PX 1).

Petitioner then presented to Belleville Memorial Hospital the following day to see Physician's Assistant (PA) Andy Colon. Petitioner provided a history of injury to PA Colon, stating he was climbing down scaffolding about three feet off the ground, trying to balance the toe with his right hand above and behind his head when he slipped. He tried to grip to stop from falling and felt a "pop" and cracking sensation in his right shoulder. (PX 2, p. 3). PA Colon referred Petitioner for MRI examination. (See PX 3). Following the MRI, Dr. Colon referred Petitioner to orthopedics for further evaluation and because of the findings on MRI. (PX 2, p. 5).

Petitioner was then referred to Dr. George Paletta. Dr. Paletta first treated Petitioner on November 2, 2012, taking a history of the injury on September 25, 2012 that was consistent with Petitioner's testimony of the injury at trial, as well as the emergency room history. (PX 4, p. 2). Following Dr. Paletta's physical examination and review of the MRI, he opined that Petitioner's current right shoulder condition is causally related to the work incident that occurred on September 25, 2012. (PX 4, p. 3). Dr. Paletta recommended surgery, and performed the following

surgical interventions on December 11, 2012: right shoulder exam under anesthesia; right shoulder diagnostic athroscopy; right shoulder arthroscopy with extensive debridement of labrum; right shoulder arthroscopy with biceps tenodesis; right shoulder arthroscopy with rotator cuff repair; and right shoulder arthroscopy with subacromial decompression, bursectomy, and acromioplasty. (PX 4, p. 15).

Petitioner continued to follow-up with Dr. Paletta over the next several months. Petitioner underwent four months of physical therapy following surgery. Petitioner acknowledged being released from further medical treatment by Dr. Paletta on May 22, 2013. On this date, Dr. Paletta noted that overall Petitioner was well and should improve, but that Petitioner did not feel like the strength was at 100%. Dr. Paletta released Petitioner without restrictions but encouraged him to continue his home exercise program. (PX 4, p. 8).

Petitioner testified that no physician allowed him to return to work from November 3, 2012 until his release by Dr. Paletta on May 22, 2013. Further, Petitioner stated his employer did not call him back to work at any time between November 3, 2012 and May 22, 2013. Petitioner further stated that his employer never called him to offer him light-duty work for the period of November 3, 2012 through May 22, 2013.

Since being released, Petitioner noted he has a building in Steeleville which he needed to finish, and it was very difficult for him to do so. He could not drive a nail up over his head and in order for him to run screws in, he had to get both hands behind the drill. Petitioner testified he does not feel he has the range of motion as before the accident. Since his release, Petitioner now uses two hands when engaging in his hobby of fishing, and has difficulty playing catch with a baseball. Petitioner has coached baseball for many years. Petitioner testified that he had never had any major trauma or injury to his right shoulder prior to September 25, 2012.

On October 16, 2012, Petitioner was evaluated by Dr. Joseph Williams at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). Dr. Williams diagnosed Petitioner with mild bursitis, osteoarthritis, and chronic rotator cuff changes. Dr. Williams felt all conditions were pre-existing and unrelated to the work injury from September 2012. (RX 1).

Respondent also admitted into evidence an MRI Review from Dr. Sidney Jain performed on February 22, 2014. Dr. Jain concluded the MRI demonstrated chronic pre-existing rotator cuff pathology. Dr. Jain noted "although it can be difficult to differentiate mild acute rotator cuff injuries superimposed on pre-existing chronic pathology… the imaging findings do not favor a consequence of [Petitioner's] described acute injury." (RX 2).

Petitioner admitted a report from Dr. Paletta into evidence which was dated April 7, 2014. The report indicated Dr. Paletta had reviewed Dr. Jain's report and made mention of Dr. Jain's finding of Grade III chondromalacia of the humeral head and Grade II chondromalacia of the glenoid process . (PX 7, pp. 1-2). Dr. Paletta also referred to his own reading of the MRI on November 2, 2012, which included significant thinning and tendinopathy of the rotator cuff, with a small focal full thickness tear of the cuff that suggested acute on chronic injury. Dr. Paletta then noted that, during surgery, he found no evidence of degenerative joint disease or chondromalacia to support Dr. Jain's impression of Grade III chondromalacia of the humeral head and Grade II chondromalacia of the glenoid process. Dr. Paletta wrote: "[i]n fact, I documented that the humeral head and glenoid articular surface were intact without any evidence of chondral abnormality or degenerative changes." Dr. Paletta further noted the intraoperative findings confirmed his impression and suggested his interpretation of the MRI scan was much more accurate than that of Dr. Jain. Dr. Paletta wrote: "[t]hese intraoperative findings, combined with the acute mechanism of injury, clearly support the opinion that his pattern of pathology represents an acute on chronic tear." (PX 7, p. 2).

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 concludes Petitioner sustained an accident that arose out of and in the course of his employment by Respondent. Petitioner's testimony was credible and un-rebutted. The medical records were entirely consistent with the description of the injury by Petitioner at trial. Petitioner was a credible witness, who testified in an open and forthcoming manner. He appeared to be endeavoring to give the full truth during his testimony. Petitioner sustained his burden of proof with respect to this issue.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the injury of September 25, 2012. The Arbitrator notes again that Petitioner's testimony was credible and unrebutted. The Arbitrator further notes a consistent description of injury is documented in the medical records, including the emergency room visit no more than one hour following the injury. Petitioner's un-rebutted testimony indicates he is 65 years old and has never suffered an injury to his right shoulder prior to September 25, 2012. The Arbitrator relies upon the opinion of Dr. Paletta, Petitioner's treating physician. Dr. Paletta's opinion is more persuasive than those of Dr. Williams and Dr. Jain. Dr. Williams' diagnosis is not accurate in light of the surgical findings of Dr. Paletta. Dr. Jain's findings on MRI are not consistent with the surgical findings of Dr. Paletta. Dr. Paletta's findings from the pre-operative MRI, which Dr. Jain reviewed, are consistent with the later findings during surgery. Further, Petitioner gave open, direct and forthcoming testimony during both direct and cross-examination, and great weight is placed upon Petitioner's credibility regarding having never had a prior injury to his right shoulder until September 25, 2012.

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

The Arbitrator concludes that the medical services that were provided to Petitioner were reasonable and necessary. Respondent has not paid all appropriate charges for all reasonable and necessary medical services. The Arbitrator concludes Respondent shall be liable for the medical bills based upon the conclusions regarding accident and causal connection. Accordingly, Respondent shall pay the medical bills contained in Petitioner's Exhibit 6, subject to Sections 8(a) and 8.2 of the Act. The parties stipulated that Respondent has paid $3,848.25 in medical bills to date for which it shall receive a credit pursuant to Section 8(j) of the Act.

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

The Arbitrator concludes that Petitioner is entitled to temporary total disability (TTD) benefits for the period of November 3, 2012 through May 22, 2013. The undisputed testimony of Petitioner shows he was authorized off of work for this period. Although he possibly could have worked light-duty, Petitioner testified he was never called back to work by his employer and never told of any light-duty work being available despite the employer knowing his restrictions for the period of November 3, 2012 through May 22, 2013. Respondent seems to have disputed liability for TTD benefits only. Based upon the Arbitrator's conclusions regarding accident and causal connection, the Arbitrator hereby concludes Respondent shall pay Petitioner TTD benefits of $1,295.47/week for a period of 28 4/7 weeks.

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. 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.

Concerning Section 8.1b(b)(ii) of the Act (Petitioner's occupation), Petitioner is a laborer. Petitioner's credible testimony indicated his job involved performing manual construction labor. Further, Petitioner testified he has difficulty hammering overhead and must use two hands following his injury to drill in screws. Accordingly, the Arbitrator concludes that Petitioner's permanent disability will be larger based on this regard than an individual who performs lighter work. 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 63 years old on the date of accident. The Arbitrator considers Petitioner to be a somewhat older individual and concludes that Petitioner's disability will likely be less extensive than that of a younger individual because he will likely have to work and live with the disability for a lesser period of time than that of a younger person. Some weight is placed on this factor when determining the permanency award.

Concerning Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), there is no alleged future earning capacity in question, and no weight is therefore given in this regard.

With regard to Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), Petitioner's treating medical records indicate that Petitioner's right shoulder injury was treated with surgery and is now healed. The surgery consisted of the following: right shoulder exam under anesthesia; right shoulder diagnostic athroscopy; right shoulder arthroscopy with extensive debridement of labrum; right shoulder arthroscopy with biceps tenodesis; right shoulder arthroscopy with rotator cuff repair; and right shoulder arthroscopy with subacromial decompression, bursectomy, and acromioplasty. Petitioner does not feel he has full range of motion with playing catch with a baseball and with hammering overhead. As noted above, Petitioner was a credible witness, and the Arbitrator takes notice of said credibility when assessing Petitioner's complaints regarding disability. Accordingly, great weight is given to the foregoing 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 12.5% loss of use to the person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Bellitto,

Petitioner,

vs.

NO: 08 WC 08160

Monterey Coal Company,

Respondent,

15IWCC0485

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, causal connection, permanent partial disability, legal error, evidentiary error, section 1(d)-(f) and 19(d) of the occupational disease act 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 17, 2014 is hereby affirmed and adopted.

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

DATED: JUN 2 5 2015

MB/mam
o:4/30/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELLITTO, STEVEN
Employee/Petitioner

Case# **08WC008160**

15IWCC0485

MONTEREY COAL COMPANY
Employer/Respondent

On 10/17/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0332 LIVINGSTONE MUELLER ET AL
L R MUELLER
P O BOX 335
SPRINGFIELD, IL 62705

15IWCC0485

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Bellitto
Employee/Petitioner

v.

Monterey Coal Company
Employer/Respondent

Case # 08 WC 08160

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on August 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 28, 2007, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is not causally related to the alleged occupational disease.

In the year preceding the injury, Petitioner earned $52,824.93; the average weekly wage was $1,015.86.

On the date of accident, Petitioner was 50 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

October 10, 2014
Date

OCT 17 2014

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart arising out of and in the course of his employment for Respondent. The Application alleged a date of last exposure of December 28, 2007, and that Petitioner sustained the occupational disease as a result of inhalation of coal dust, rock dust, fumes and vapors for a period in excess of 22 years.

Petitioner testified that he began working for Respondent on December 1, 1980, and that he worked as an underground coal miner for approximately 23 3/4 years. Petitioner's last day of work for Respondent was December 28, 2007 (the date of last exposure alleged in the Application) which was also the date the mine closed. Petitioner was laid off by Respondent for two periods of time, from June, 1986, to February, 1987, and again from December, 1994, to August, 1999. During the latter period of time, Petitioner attended Vatterott college in St. Louis where he received computer training. After Petitioner received computer training, he worked for Edison Brothers for a few years at a desk inputting computer data. When Edison went bankrupt, Petitioner worked for May Company for approximately six months doing the same type of job he performed while working for Edison until the time he was recalled to work by Respondent.

Subsequent to the mine closing in December, 2007, Petitioner went to truck driving school and obtained a CDL. Petitioner worked for a brief period of time at Global Brass but was laid off. In January, 2009, Petitioner started working for Beverly Farms as a bus driver. Petitioner described the bus as being one that could hold 15 passengers and Petitioner's job consisted primarily of transporting wheelchair bound people to/from medical appointments and activities. Petitioner continues to work at this job at the time the case was tried and stated that he was paid $8.53 per hour and that he worked a 40 hour workweek. If Petitioner had been able to continue to work in the mine, he would have made $27.64 per hour.

Petitioner testified regarding his work history prior to being employed by Respondent. While Petitioner was in high school, he worked as an attendant at a gas station, a job he continued to hold following his high school graduation. He also worked for a very brief period of time at a foundry.

In regard to his work for Respondent, Petitioner testified that he worked as a laborer for approximately 15 years; a roof bolter for approximately five years; and that he also worked as a shuttle car operator.

As a laborer, Petitioner would perform a wide variety of duties and did a lot of shoveling coal on a belt. He would also work as a roof bolter or shuttle car operator on an as needed basis. While working as a laborer, Petitioner was exposed to a significant amount of coal dust.

When Petitioner worked as a roof bolter, he would operate a machine that drilled holes in the roof of the mine to support it. This required the use of roof bolting glue which caused Petitioner to be exposed to roof bolting glue fumes as well as coal dust.

When Petitioner worked as a shuttle car operator, he drove a "buggy" behind the machine that would dig the coal out and load it into the "buggy." Petitioner would then drive the shuttle car back and forth picking up and delivering the coal. This also caused Petitioner to be exposed to coal dust as well as diesel fumes.

Petitioner testified that he began to experience shortness of breath in the 1990s when he was a laborer shoveling coal on the belt. He continued to experience shortness of breath when he worked as a roof bolter. Over time, Petitioner stated that his breathing problems gradually worsened and, since last day he worked in the mine, they have continued to worsen.

Petitioner began smoking cigarettes when he was 16 years old and continued until he was 35 to 40 years old. During that time, Petitioner smoked about one pack of cigarettes per day.

Dr. Stanley Sidwell was Petitioner's family physician from May, 1987, through October, 2007, and records for treatment provided by Dr. Sidwell for that period were received into evidence at trial (Petitioner's Exhibit 11). During that period of time, Dr. Sidwell treated Petitioner for a variety of problems including sinusitis, respiratory infections, congestion, drainage, etc. While Petitioner was treated for these various symptoms, Dr. Sidwell noted that on examination Petitioner did not exhibit shortness of breath on a significant number of occasions, from December, 1990, through October, 2007 (Petitioner's Exhibit 11; pp 11-88).

Dr. Sidwell ordered a chest x-ray of Petitioner on March 3, 2005, and it revealed no radiographic evidence of pulmonary disease. Dr. Sidwell also had pulmonary function tests performed on August 22, 2005, which revealed a moderately severe resistive ventilatory defect with abnormal gas transfer; however, the report also noted that Petitioner was 5'6" and weighed 261 pounds with a body mass index that was quite elevated (Petitioner's Exhibit 11; pp 64, 78).

At the direction of his attorney, Petitioner was examined by Dr. Glennon Paul, an internist, on May 28, 2008. At that time, Petitioner informed Dr. Paul that he had shortness of breath and coughing for the preceding 10 years. Dr. Paul had pulmonary function tests performed which were normal; however, they did show an 11% fall in the FEV after inhalation of methacholine suggestive of bronchitis. A chest x-ray showed multiple small nodules with some fibrosis. Dr. Paul opined Petitioner had coal workers' pneumoconiosis complicated by bronchitis (Petitioner's Exhibit 1; Deposition Exhibit 2).

Dr. Paul was deposed on March 30, 2009, and his deposition testimony was received into evidence at trial. Dr. Paul's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner had coal workers' pneumoconiosis related to Petitioner's exposure to coal dust and chronic bronchitis related to Petitioner's cigarette smoking and exposure to coal dust (Petitioner's Exhibit 1; p 13).

Dr. Jon Wagnon became Petitioner's family physician when Dr. Sidwell retired and saw Petitioner for the first time on November 3, 2010. Dr. Wagnon's medical records were received into evidence at trial; however, the records were limited to the treatment provided by Dr. Wagnon to Petitioner from January 1, 2012, to October 31, 2012 (Petitioner's Exhibit 9). Dr. Wagnon was deposed on August 1, 2012, and his deposition testimony was received into

evidence at trial. When he was deposed, Dr. Wagnon opined that Petitioner had chronic bronchitis, black lung and asthma, caused or aggravated by Petitioner's exposure as an underground coal miner for 22 years (Petitioner's Exhibit 2; pp 7-8).

Petitioner had chest x-rays performed on January 15, 2008, and January 13, 2011, which were subsequently read by B-readers. On January 24, 2008, Dr. Jonathan Abrahams reviewed the x-ray of January 15, 2008, and opined that it revealed parenchymal abnormalities consistent with pneumoconiosis and a 1/0 profusion (Petitioner's Exhibit 6). Dr. Henry Smith reviewed the x-ray taken on January 13, 2011, and opined that it revealed parenchymal abnormalities consistent with pneumoconiosis and a 1/0 profusion (Petitioner's Exhibit 4). Dr. Ralph Shipley reviewed the x-ray of January 13, 2011, and opined that it showed no evidence of abnormalities consistent with pneumoconiosis (Respondent's Exhibit 2). Dr. Robert Tarver also reviewed the x-ray of January 13, 2011, and opined that it revealed no abnormalities consistent with pneumoconiosis (Respondent's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Peter Tuteur, a pulmonary specialist, on January 13, 2011. In connection with his examination of Petitioner, Dr. Tuteur ordered a chest x-ray and pulmonary function tests. At the time of his examination of Petitioner, Petitioner was not taking any breathing medication on a regular basis and was not being treated for any breathing issues. Dr. Tuteur's findings on clinical examination were normal without any indication of lung disease. The x-rays as well as the pulmonary function tests were also normal. It was noted that Petitioner had a reduced ERV consistent with Petitioner's obesity. Dr. Tuteur opined that Petitioner did not have coal workers' pneumoconiosis or any other mine dust related disease. He noted Petitioner had other respiratory issues but none that were caused or aggravated by inhalation of coal mine dust (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Tuteur was deposed on February 7, 2013, and his deposition testimony was received into evidence at trial. Dr. Tuteur's deposition testimony was consistent with his narrative medical report and he reaffirmed his opinions that Petitioner did not have pneumoconiosis or any disease related to exposure to coal mine dust. He also further stated that Petitioner did not have chronic bronchitis, emphysema or chronic obstructive pulmonary disease but that the primary cause of these conditions was cigarette smoking. He opined Petitioner was capable of being employed as a coal miner (Respondent's Exhibit 1; pp 6-11).

Petitioner was treated at Alton Memorial Hospital for pneumonia in November/December, 2012. X-rays taken on November 29, 2012, revealed a small left pleural effusion but were otherwise clear (Petitioner's Exhibit 12; p 102). An x-ray taken on December 18, 2012, revealed a mild bibasilar atelectasis but no focal confluent infiltrates (Petitioner's Exhibit 12; p 4).

At the direction of his attorney, Petitioner was evaluated by Delores Gonzalez, a vocational expert, on February 20, 2013. Gonzalez obtained a work history from Petitioner, administered various tests and reviewed medical records provided to her. Gonzalez opined that Petitioner had a significant wage loss and that he would not be able to make what he made while working in the mines (Petitioner's Exhibit 8).

Gonzalez was deposed on May 15, 2013, and her deposition testimony was received into evidence at trial. Her testimony was consistent with her report and she reaffirmed her opinion that Petitioner sustained a significant wage loss. She agreed that if credence were given to the opinions of Dr. Tuteur and Dr. Shipley, Petitioner could return to work in the mine. She further opined that if credence were given to the opinions of Dr. Paul and Dr. Smith, Petitioner would not be able to return to work in the mine (Petitioner's Exhibit 3; pp 14-16).

At trial, Petitioner testified that his breathing difficulties have continued to worsen since he left the mine. Petitioner stated he gets short of breath after walking approximately 100 yards and he can only climb about 10 steps before he has to rest. Petitioner does have a number of other health conditions including high blood pressure as well as previously undergoing two back surgeries.

Petitioner had two witnesses testify on his behalf at trial, Reggie Ruyle and Jim Chronister. Ruyle testified that he worked for Respondent for 33 years and with Petitioner for eight of those years. He stated that he observed Petitioner's breathing problems became worse as Petitioner continued to work in the mine. Chronister worked for Respondent for 31 years and worked in proximity to Petitioner at various times. He also testified that he observed Petitioner having problems breathing, moving about more slowly, sweating, etc. He was, and remains, a social acquaintance of the Petitioner.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment for Respondent that manifested itself on December 28, 2007.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified he began to experience shortness of breath in the 1990s and that this condition got progressively worse from that time on. The records of Petitioner's family physician, Dr. Sidwell, do not support this and, in fact, there are numerous entries in those records where Petitioner did not exhibit shortness of breath.

While Dr. Wagnon opined that Petitioner had chronic bronchitis, black lung and asthma caused or aggravated by Petitioner's exposure, he gave little or no specifics as to the basis for these diagnoses. While Dr. Paul opined that Petitioner had pneumoconiosis related to Petitioner's exposure to coal dust and chronic bronchitis related to Petitioner's cigarette smoking and exposure to coal dust, this opinion was based, at least in part, on Petitioner's having been short of breath for the preceding 10 years. As previously stated herein, this history of being short of breath is not supported by Dr. Sidwell's treatment records.

When Dr. Tuteur examined Petitioner, Petitioner was not under any treatment for a breathing problem, the pulmonary function tests were normal and Dr. Tuteur opined that Petitioner did not have coal workers' pneumoconiosis.

The Arbitrator finds the opinion of Dr. Tuteur to be more persuasive.

In regard to disputed issue (L) the Arbitrator makes no conclusion of law because this issue is rendered moot.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVEN LASCODY,

Petitioner,

15IWCC0486

vs.

NO: 13 WC 33787

GIUFFRE BUICK AND VOLVO,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

1. Petitioner testified he worked for Respondent since July of 2001. He has basically worked as a mechanic all of his working life. His duties include any type of car repair other than body work.

2. Petitioner testified he is right-handed. He injured his right arm about five years ago when he tore the lower bicep. Thereafter, he became more dependent on his left arm, which "became the more dominant arm."

3. On December 10, 2012, he was lifting a "relatively heavy tire," 80-100 lbs. He felt a pop in his left arm. He had never injured his left arm previously. He reported his accident immediately and Respondent sent him to Midwest Occupational Health Associates ("MOHA"). They put work restrictions on him. He returned to MOHA a week later and was then referred to Dr. Wolters, an orthopedist also at MOHA.

4. Dr. Wolters ordered an MRI, which showed extensive rotator cuff pathology, complete tear of the biceps tendon, intra-articular loose bodies in the joint space, delamination of the anterior superior labral cartilage, full thickness tear of the supraspinatus with additional intrasubstance tendinosis and partial tear extending for 3.6 mm without significant retraction, mild to moderate supraspinatus atrophy, and partial tear of the infraspinatus as well as myotendinous disruption bordering the humeral neck between the infraspinatus and teres.

5. After reviewing the MRI, Dr. Wolters diagnosed acute left rotator cuff tear, left acute proximal biceps tear, and asymptomatic left AC joint arthritis with possible intraarticular loose bodies. Dr. Wolters recommended surgery.

6. On February 4, 2013, Dr. Wolters preformed left shoulder arthroscopic rotator cuff repair, subacromial decompression and open subpectoral biceps tendonosis, for acute rotator cuff tear, partial thickness proximal biceps tendon tear with significant tendinopathy, shoulder impingement, and type IV SLAP tear.

7. After the surgery, Petitioner noticed that his arm was reddening. It "was starting to get the purply weirdness" to the skin. He returned to Dr. Wolters on March 8, 2013. Dr. Wolters thought that Petitioner likely "pulled through his biceps tendon repair." He recommended revision surgery ASAP.

8. On March 18, 2013, Dr. Wolters performed revision proximal biceps tenodesis for re-rupture of the proximal biceps tendon at the musculotendinous junction.

9. Petitioner testified he continued to treat with Dr. Wolters until July 24, 2013, when he released Petitioner to "full duty," but "with a 50-lb or something restriction limit."

10. Dr. Wolters' records indicate that on June 5, 2013, he increased Petitioner restrictions to 50 pounds lifting. On July 24, 2013, he found that Petitioner had 4/5 strength in his left shoulder, declared him at maximum medical improvement, released him to full duty work, and released him from treatment.

11. Petitioner testified he was currently working full duty. However, he has difficulty with some aspects of his job. He has less strength in his left arm. When he puts stress on this arm he gets a "red hot burn in the arm" and itching. Petitioner is required to perform overhead work. That also causes the red hot burn and itching.

12. Petitioner further testified he no longer lifts the heavy tires weighing up to over 150 pounds, because it is not "doable;" "it's like somebody's sticking a red hot poker up into the left biceps kind of deal." He can feel the burning sensation lifting as little as 15-20 pounds. He has to change tires using his right arm only. It now takes longer for him to perform his various jobs as a mechanic. He is paid based on the billing for a particular job and not the actual time it takes him. Therefore, he makes less money than he did previously.

13. Petitioner also owns a farm he inherited from his father. He testified he can no longer lift bales of feed for the cattle he raises. He has to carry only a single bucket of feed with his right arm. He has to have a lot of people doing jobs for him; he's "not the same guy." Anything can bring on the searing pain. Petitioner exhibited his arms. The parties agreed that there was a difference on the appearance of the arms where the biceps attach to the shoulders.

14. Dr. Bowers a family practitioner at MOHA, examined Petitioner and provided an impairment rating pursuant to AMA Guides. Dr. Bowers testified by deposition that in preparing his impairment rating he used the rotator cuff tear which had a higher impairment rating than either biceps condition or the SLAP tear. Use of the condition that would result in the highest impairment rating is required under the Guides. He rated Petitioner's impairment as 7% of the left arm and 4% of the person as a whole.

Nature and extent of Petitioner's permanent disability was the only issue arbitrated and the only issue before the Commission. The Arbitrator awarded Petitioner 12.5% loss of the person as a whole noting that while Petitioner showed that he earned less money than he did prior to the accident, he did not prove a loss of earning potential. The Commission does not entirely agree with that assessment of the Arbitrator. Petitioner has worked as a mechanic his entire working career. He testified that it was standard practice for mechanics to be paid based on the billing for specific services and not the time it takes for him to complete the task. In addition, he can no longer work at the same pace as he did prior to the accident and that as a result he completes fewer tasks and therefore earns less money. Petitioner was declared at MMI and therefore will not be expected to get any better. Therefore, the Commission concludes that Petitioner did present evidence to a diminution of earning potential.

The Commission notes that Petitioner works in a very heavy physical demand level occupation. As such his physical impairment will be more profound than it would be if he worked in a less physically demanding job. In that regard, while Dr. Wolters declared Petitioner at maximum medical improvement and released him to work without restrictions as of July 24, 2013, at that time he also acknowledged that he still had limited strength in his left shoulder. In addition, Petitioner testified that he had substantial difficulty performing many of his regular work duties and simply cannot perform some of them at all. These continuing difficulties suggest a greater level of impairment.

Finally, regarding the AMA impairment rating, the AMA Guides itself specifies that impairment does not equate to disability. The Workers' Compensation Act requires that the Commission take the AMA impairment rating into consideration in arriving at a permanent partial disability award, but that rating is only one of the factors to be considered. Furthermore, while the AMA Guides may require that an impairment rating be based on the single condition associated with the greatest level of impairment that does not mean that the Commission cannot take into consideration other conditions of ill being in determining a permanent partial disability award. Here, besides the rotator cuff tear Petitioner also tore a biceps tendon twice. He had three distinct surgical procedures. In looking at the record as a whole, the Commission finds a permanent partial disability award of loss of 17.5% of the person as a whole appropriate and modifies the Decision of the Arbitrator accordingly.

15IWCC0486

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $562.57 per week for a period of 87.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused Petitioner's loss of 17.5% of the use of the person as a whole.

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

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

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

DATED: JUN 2 6 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-6/9/15
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LASCODY, STEVEN
Employee/Petitioner

Case# **13WC033787**

GIUFFRE BUICK AND VOLVO
Employer/Respondent

15IWCC0486

On 11/5/2014, 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 0.06% 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:

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

2871 LAW OFFICES OF PATRICIA M CARAGHER
MARY FLANAGAN-DEAN
1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

15IWCC0486

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
NATURE AND EXTENT ONLY

STEVEN LASCODY,
Employee/Petitioner

v.

GUIFFRE BUICK AND VOLVO,
Employer/Respondent

Case # **13** WC **33787**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **10/16/14**. By stipulation, the parties agree:

On the date of accident, **12/10/12**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$48,756.24**, and the average weekly wage was **$937.62**.

At the time of injury, Petitioner was **51** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$14,019.66** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$14,019.66**.

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 **$562.57**/week for a further period of **62.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **petitioner a 12.5% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act**.

Respondent shall pay Petitioner compensation that has accrued from **12/10/12** through **10/16/14**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

11/1/14
Date

NOV 5 - 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT AND CONCLUSION OF LAW:

Petitioner, a 51 year old auto mechanic, sustained an accidental injury to his left arm that arose out of and in the course of his employment by respondent on 12/10/12. Respondent is right hand dominant. He testified that he had injured his right arm in 2008 when he sustained a right bicep tear. Since then petitioner testified that he has used his left arm more. As an auto mechanic petitioner testified that he does everything but body work on cars.

Petitioner testified that respondent no longer has a dealership that sells new Volvo and Buick lines, and is only a used car lot where and respondent is selling off the remaining used cars, of which only 20 are left. Petitioner is the only mechanic left working there and does whatever maintenance needs to be done on these cars. Petitioner testified that the respondent will be closing the dealership soon, but he does not know when.

Petitioner has a high school education. After graduating from high school he worked as a security guard, ran an auto parts outlet for Lincoln, and worked as a heavy truck mechanic. He testified that he has been a mechanic basically his whole life.

On 12/10/12 petitioner grabbed a heavy tire, weighing 80-100 pounds, with his left arm off the floor, and felt a pop in his left arm. Petitioner presented for treatment to MOHA that same day. He was assessed with a strain of the left bicep. He was placed on light duty. On 12/17/12 petitioner returned to MOHA and was examined by Dr. Clem. He reported that his arm was about the same and he was having quite a bit of pain in the bicep area. He also reported having a numb and tingling feeling going down the inside part of his arm all the way from the top into his left little finger. He stated that he could not push or pull with his left arm. Following an examination Dr. Clem recommended that a tendon rupture be ruled out. He referred petitioner to Dr. Wolters. Petitioner was continued on light duty.

On 12/17/12 petitioner presented to Dr. Wolters. Petitioner reported that he had suffered a biceps tendon tear in his right arm four years ago which he had repaired and that he was doing well, but does utilize his left arm more as a result of the previous injury. Dr. Wolters examined petitioner and assessed a suspected biceps tendon tear of the long head. Dr. Wolters ordered an MRI of the left shoulder.

Petitioner underwent an MRI of the left shoulder on 1/3/13 that showed a rotator cuff tear and biceps tendon tear. Dr. Wolters assessed a left acute rotator cuff tear; a left acute proximal biceps rupture; left shoulder acromioclavicular joint arthritis that was asymptomatic; and possible intra-articular loose bodies of the left shoulder. Dr. Wolters recommended a left shoulder arthroscopic rotator cuff repair, subacromial decompression, and open subpectoral biceps tenodesis.

On 2/4/13 petitioner underwent a left shoulder arthroscopic rotator cuff repair, subacromial decompression and opened subpectoral biceps tenodesis. This procedure was performed by Dr. Wolters. Petitioner's postoperative diagnosis was left shoulder acute rotator cuff tear; left shoulder partial thickness proximal biceps tendon tear with significant tendinopathy; left shoulder impingement; and type IV SLAP tear. Petitioner followed up postoperatively with Dr. Wolters. This treatment included a course of physical therapy.

On 3/4/13 petitioner presented to Dr. Sharma complaining of burning pain and numbness, and tingling down his left arm. He stated that for the past two days he had been having increased pain in the biceps of the left arm with burning sensation and increased sensitivity, as well as a cold feeling. Dr. Sharma returned petitioner to Dr. Wolters for further assessment and evaluation. He told petitioner to continue wearing his sling with only limited and gentle range of motion.

Petitioner followed up with Dr. Wolters postoperatively on 3/8/13. On that date Dr. Wolters was of the opinion that it looked like petitioner had pulled through his biceps tendon repair. He recommended revision open subpectoral biceps tenodesis. On 3/18/13 petitioner underwent a revision left shoulder proximal biceps tenodesis. This procedure was performed by Dr. Wolters. Petitioner's postoperative diagnosis was rupture of the proximal biceps tendon at the musculotendinous junction. Petitioner followed up postoperatively with Dr. Wolters. This treatment included physical therapy.

Petitioner followed up with Dr. Wolters on 3/26/13, 4/17/13, 5/8/13, 6/5/13 and 7/24/13. On 6/5/13 petitioner reported to Dr. Wolters that he was doing very well, and was following his light duty restrictions. He reported that he had altered how he does things at work which had helped tremendously. He stated that he was experiencing no pain at work, but occasionally get some pain in his elbow on the medial aspect. An examination revealed full range of motion of the left shoulder, strength at 4/5 in the supra and infraspinatus and deltoid, and biceps strength in about 4+/5 on the left. Dr. Wolters discontinued therapy and gave petitioner 50 pound weight restriction.

On 7/24/13 petitioner last saw Dr. Wolters. At that time petitioner had essentially no pain. He stated that he had been working full duty for the last month without any problems. He noted that there was some cosmetic deformity of his left biceps, but he had no pain or loss of range of motion or dysfunction. He reported no numbness or tingling into his hands. An examination revealed 180° of forward flexion bilaterally, no pain with internal or external rotation bilaterally, 5+/5 strength of the supraspinatus and deltoid bilaterally, 4+/5 strength of his infraspinatus on the left side compared to 5/5 on the right side, a mild deformity of the left proximal biceps compared to the right, and strength of 5/5

bilaterally in the biceps. Dr. Wolters released petitioner at maximum medical improvement with no restrictions. He instructed him to return as necessary.

On 6/3/14 Dr. Jeff Brewer, a family practitioner, performed an AMA Rating on petitioner. Dr. Brewer reviewed petitioner's medical records and examined petitioner. Petitioner's current symptoms included pain and weakness in the left shoulder. Dr. Brewer had petitioner complete a QuickDASH with a score of 73. On physical examination he noted that petitioner was able to flex both shoulders to 160°; abduction was 150° on the left and 160° on the right; adduction was 45° bilaterally; external rotation was 70° on the left and 80° on the right; and internal rotation was 70° on the left and 80° on the right. Additionally, Dr. Brewer noted a soft tissue defect along the proximal anteromedial arm consistent with biceps tendon rupture/repair. His strength on the left was 4+/5, and on the right was 5/5. Dr. Brewer's diagnoses were worn left rotator cuff tendon, status post repair, proximal biceps tendon tear, status post repair times two, and Type IV SLAP tear. Utilizing the American Medical Association's "The Guides to the Evaluation of Permanent Impairment, Sixth Edition, Second Printing", Dr. Brewer came up with a 4% whole person impairment. He testified that this was the highest rating that could have been given based on petitioner's diagnosis.

Petitioner completed a Quick DASH for Dr. Brewer. He indicated that he had mild difficulty using a knife to cut food; moderate difficulty opening a tight or new jar; severe difficulty doing heavy household chores and carrying a shopping bag or briefcase; and unable to wash his back or perform recreational activities that require force or impact. Petitioner indicated that during the past week his arm interfered with his normal social activities quite a bit, limited his work or other regular daily activities very much; caused severe symptoms in his arm; extreme tingling in his arm; and caused moderate difficulty sleeping because of the pain in his arm. Dr. Brewer found the information petitioner provided on this form consistent with his physical exam.

Currently petitioner testified that he has difficulty doing his job as it relates to putting in rack and pinion. He testified that when picking up and putting stress and on his arm when pulling or tugging he feels a red-hot burning/itching where the biceps muscle was repaired. Petitioner testified that the left bicep looks different than the right bicep where the bicep and shoulder attach. Petitioner testified that when he does overhead work under car on a rack, the reaching up pulling and tugging causes a red-hot burning. Petitioner testified that he no longer picks up heavy tires. When he does he feels like a red-hot poker was put in his bicep. Petitioner testified that he can pick up 15 to 20 pounds before feeling the sensation. Petitioner testified that he primarily uses his right arm when he lifts and moves tires around.

Petitioner testified that tasks now take longer to complete than it did before the accident. He stated that he is paid by the amount of time the task should take, not the actual time it takes him to do it. Petitioner reported that he has pain almost all the time, and experiences loss of strength in his left arm.

Petitioner has a farm. He can no longer bale for the cows without the searing pain occurring in his left bicep. Petitioner defers work to his neighbor farmers for baling and his sons to do his chores, i.e. throwing hay bales to the hogs. Petitioner's farm is 700 acres. He breeds cattle, has 14 to 15 pigs, 60 chickens, seven dogs, and rabbits. Petitioner does have tillable acres that are done by other farmers.

Since being released by Dr. Wolters on 7/24/13 petitioner has not attempted to return back to see Dr. Wolters because of his current complaints, nor has he sought treatment from any other healthcare provider, despite being told by Dr. Wolters to return as needed.

As a result of the injury petitioner sustained on 12/10/12 the arbitrator finds the petitioner sustained a 12.5% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act. Pursuant to Section 8.1b of the Act the arbitrator, in determining the level of permanent partial disability, bases her decision 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.

With respect to (i) the reported level of impairment pursuant to subsection (a) the respondent offered into evidence an impairment rating from Dr. Brewer of a 4% whole person impairment.

With respect to (ii) the occupation of the injured employee, the petitioner was an auto mechanic at the time of the injury. After being returned to full duty work without restrictions on 7/24/13 petitioner returned to his regular duty job as a mechanic for respondent, and was still working in that capacity as of the trial date. At trial petitioner testified that he makes less money now because it takes longer to do specific tasks. He testified that since he is paid for a job based on the time allotted for that job, and it now takes longer to do certain jobs, he completes less jobs in a given day, and therefore makes less money. Petitioner did not offer any time sheets or wage records to support this claim.

With respect to (iii) the age of the employee, the petitioner was 51 years old on 12/10/12. Petitioner is now around 53 years old.

With respect to (iv) the petitioner's future earning capacity, petitioner is still working in his full duty capacity for respondent as an auto mechanic, 15 months after he was released to full duty work without restrictions. Petitioner testified that he is currently doing maintenance on the approximately 20 cars respondent still has on its lot. Petitioner testified that respondent has lost its new line of Buick and Volvo cars. Petitioner testified that he was told the dealership where he works will be closing, but he did not know when. Petitioner provided no credible evidence to support a finding that his future earning capacity will be diminished.

With respect to (v) evidence of disability corroborated by the treating medical records, the arbitrator looks to the records of Dr. Wolters and Dr. Brewer. When petitioner last followed-up with Dr. Wolters on 7/24/13 he reported essentially no pain. He also reported that he had been working for the last month without any problems. Dr. Wolters noted some cosmetic deformity of the left bicep, and petitioner reported that he had no pain, loss of range of motion, or dysfunction. Petitioner reported no numbness or tingling into his hands. An examination revealed a slight decrease in the strength of the infraspinatus on the left, and a mild deformity of the left proximal biceps as compared to the right.

On 6/3/14 petitioner presented to Dr. Brewers for an AMA impairment rating. Petitioner reported pain and weakness in his left shoulder. Petitioner's Quick DASH score was 73, and Dr. Brewer found those complaints consistent with his physical examination. An examination revealed decreased abduction, external rotation, internal rotation, and strength of the left arm. Dr. Brewer also noted a soft tissue defect along the proximal anteromedial arm consistent with biceps tendon rupture/repair.

Petitioner testified to various subjective complaints not corroborated by the medical records. These include a red hot burning sensation in the left bicep when putting stress on his left bicep. This complaint is corroborated in the presurgery medical records, but not postoperatively. Petitioner also reported that performing his job takes longer postoperatively than before the injury. Again, this is not corroborated by the treating medical records. Despite these ongoing complaints petitioner has not followed up with Dr. Wolters or any other health care provider since he last followed-up with Dr. Wolters on 7/24/13.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 12.5% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act.

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

Michael Appleberg,
Petitioner,

15IWCC0487

vs.

NO: 12 WC 36393

Victoria Lane, LLC. and Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent and being advised of the facts and law, 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 2, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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.

15IWCC0487

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,300.00. 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:
o6/10/15
RWW/rm
046

JUN 2 6 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

APPLEBERG, MICHAEL
Employee/Petitioner

Case# **12WC036393**

15IWCC0487

VICTORIA LANE LLC AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 7/2/2014, 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 0.06% 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:

0247 HANNIGAN & BOTHA LTD
PATRICK CZUPRYNSKI
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

VICTORIA LANE LLC
43 W FERN CT
UNIT 225D
PALATINE, IL 60067

3201 ASSISTANT ATTORNEY GENERAL
MONICA KIEHL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

15IWCC0487

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Appleberg
Employee/Petitioner

v.

Victoria Lane, LLC. and Illinois State Treasurer as ex-oficio custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **12** WC **36393**

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 **Ottawa**, 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 **Adequate notice to employer? Is Injured Worker Benefit Fund liable?**

FINDINGS

On **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 $____ the average weekly wage was **$1,000.00**.

On the date of accident, Petitioner was **37** years of age, ***separated*** 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 **$0.00** 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 to the Petitioner reasonable, related and necessary of medical services of $1,877.74, as provided in Section 8(a) of the Illinois Workers' Compensation Act ("Act").

Respondent shall pay Petitioner permanent partial disability benefits of $600.00/week for 25 weeks, because the injury sustained caused 5% loss of use of the person as a whole under 8(d)(2) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $666.66/week for 5 weeks for the time period of October 10, 2012 through November 13, 2012.

Respondent, Victoria Lane, LLC., shall pay Petitioner $11,605.54 in penalties pursuant to 19(k) of the Act, $10,000.00 Pursuant to 19(l) of the act and $2,321.10 pursuant to Section 16 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund permitted and allowed under Section 4(d) of this Act, except for the Penalties awarded against the Respondent, Victoria Lane, LLC, under section 19(k), 19(l) or 16(a) of the Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing to the Petitioner pursuant to Section 5(b) and 4(d) of the Act. Respondent/Employer/Officer/Owner shall reimburse the injured benefit fund for any compensation obligations Respondent/Employer/Officer/Owner that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

6/25/14
Date

JUL 2 - 2014

15IWCC0487

Findings of Fact

This matter was pursued under the Illinois Workers' Compensation Act by Petitioner, Michael Appleberg, against Respondent-Employer, Victoria Lane, LLC (herein "Victoria Lane"). Petitioner also sought relief from the Injured Workers' Benefit Fund because Victoria Lane did not maintain workers' compensation insurance. (Petitioner's Exhibit "Px." 16). This case was previously set for trial numerous times and continued for a specially set trial date in Ottawa. A trial was held on May 29, 2014 in Ottawa. Petitioner notified the employer Victoria Lane of the trial by certified mail. No one appeared on behalf of Victoria Lane at any of the arbitration proceedings. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings.

Petitioner testified that he was 37 years old, separated, and with two dependent children on the date of the accident. He testified that he worked for Victoria Lane for 6 days prior to the accident. He found the position for Victoria Lane through the website "Craigslist," and interviewed with Victoria and Erik Hansen, the owners of Victoria Lane, before being hired. Petitioner stated that he was hired to eventually become a supervisor of construction projects completed by Victoria Lane. Petitioner testified that there were 6 employees at Victoria Lane and its business was general home construction. Petitioner testified that at the time of the accident, his job duties included framing doors and other home construction activities. Petitioner testified that he would receive his job assignments in the morning from Eric Hansen and would then drive himself to the jobsites. Petitioner testified that he would use power tools, such as a circular saw, air compressed nail gun, air compressor and gas generator in additional to hand tools while working for Victoria Lane. Petitioner used his own truck, nail gun and circular saw, but used the company's gas powered generator and air compressor to complete his tasks. Petitioner testified that he was an hourly employee earning $25.00 per hour, paid in cash and personal check, and worked approximately eight hours per day.

On October 9, 2012, while working at a jobsite in Joliet, Illinois, Petitioner was walking along a steel beam, lost his footing and fell approximately eight feet onto concrete. Petitioner hit his head and injured his low back, upper back and upper right side, but continued working the rest of the day in pain. (Px. 1 at 23). In the early morning of October 10, 2012, Petitioner experienced severe stiffness and pain throughout his low back and buttocks and decided to go to the emergency room. Petitioner presented to the emergency room at Mercy Walworth Medical Center where he indicated a consistent history of injury. (Px. 1 at 15). Dr. Kavanaugh examined and treated the Petitioner. (Id.) X-rays of the sacrum and lumbar spine were unremarkable. (Px. 1 at 20). The treating doctor diagnosed Petitioner with a back contusion and prescribed no work for four days, pain medication and anti-inflammatories. (Px. 1 at 16). On October 11, 2014, Petitioner returned to Dr. Kavanaugh's office (Px. 1 at 31). Petitioner reported that on October 9, 2012 he had lost consciousness, had since developed a lump on his head and had right side pain. (Id.) Petitioner was diagnosed with an injury resulting from a fall from height, back contusion, chest wall contusion head trauma and coccyx contusion. (Id.) On October 12, 2012, Petitioner had continued complaints of back pain, lost of consciousness with a lump on his head. (Px. 1 at 33). Pain medications were continued. (Id.)

On October 15, 2012, Petitioner presented for follow up to Mercy Medical. (Px. 1 at 34). Petitioner reported that he fell from a beam eight feet high onto concrete and was unclear about exactly what happened as he had some memory loss after the incident. (Id.) Petitioner reported head pain, headache and slurred speech the day after the accident, however, those symptoms had since resolved. (Id.) Additionally, Petitioner reported

15IWCC0487

continued low back pain with radiation into his legs bilaterally. (Id.) Work restrictions were prescribed (Id.) Petitioner testified the restrictions were not accommodated by the employer.

On October 19, 2012, Petitioner followed up for treatment and reported some improvement in his low back and leg pain. (Px. 1 at 43). Petitioner reported right side chest wall pain, low back pain, tailbone and right groin pain. (Id.) Pain medications and work restrictions were continued, Petitioner was requested to follow up in one week. (Px. 1 at 44). Petitioner testified the work restrictions were not accommodated by the employer. On follow up with the doctor's office on October 26, 2012, the Petitioner reported a consistent work accident with improved symptoms, however, pain continued in his right upper quadrant and occasional right leg and groin pain. (Px. 1 at 52). A referral to Dr. Grzeskowiak for evaluation was given along with continued work restrictions. These restrictions were not accommodated by the employer.

On October 30, 2012, Petitioner saw Dr. Grzeskowiak. Petitioner reported improvement, but the groin and leg pain continued to occur with prolonged standing or walking and continued right sided thoracic back pain. (Px. 1 at 58). Petitioner believed the work restrictions could be more lenient, however, the physician assistant continued the current work restrictions and no lifting greater than 20 pounds. (Px. 1 at 59, 63). Dr. Grzeskowiak notes that the injury was reported to the Employer, Victoria Lane and diagnosed Petitioner with upper back pain on right side, injury resulting from fall from height, back contusion, groin strain, chest wall contusion. (Px. 1 at 59). Upper right back pain complaints continued upon follow up with Dr. Grzeskowiak on November 6, 2012. (Px. 1 at 66). The Doctor prescribes naproxen and no lifting greater than 30 pounds. (Id.) On November 13, 2012, Dr. Grzeskowiak discharged the Petitioner back to work as healed with no disability. (Px. 1 at 69).

At hearing, Petitioner testified to good health generally prior to October 9, 2012 which included regular exercise and no back pain complaints. Petitioner testified that he has a high school education. Petitioner testified that he currently experiences reduced range of motion, pain and stiffness in his low back which can radiate from time to time in his upper right back - stretching does help alleviate these symptoms. Petitioner testified he is no longer able to run 50 miles a month, like he used to nor able to ride a bike for long durations. Petitioner testified he can only run up to 4 miles a week. Petitioner testified that he has not returned to treatment with Dr. Greskowiak or any other doctor for his continued back pain, due to lack of insurance coverage. Petitioner testified that the injury has affected his future earning capacity as he is not able to do the same line of work he used to due to the low back pain. Petitioner testified he received no payment of medical or temporary total disability benefits from the Employer.

Conclusions of Law

1. The Arbitrator finds that Victoria Lane's business and activities were sufficient to subject Victoria Lane to the automatic coverage provision of Section 3(1), 3(2), 3(8) and 3(15) of the Illinois Workers' Compensation Act. The Petitioner testified and the records reflect that the employer, Victoria Lane' business was general home construction which included framing of homes. Petitioner testified that as a part of his employment, he used an employer-provided gas powered generator and air compressor and used his own circular saw, nail gun and other hand held tools.

2. The Arbitrator finds that Petitioner has met his burden of proving that an employee employer relationship existed on October 9, 2012. The unrebutted testimony of the Petitioner established an employee employer

15IWCC0487

relationship between Victoria Lane, LLC and Petitioner at the time of the accident. Petitioner testified that he worked for Victoria Lane, Inc. for six days prior to the October 9, 2012 accident. Petitioner further testified that he was interviewed and hired by the owners Victoria and Eric Hansen; was paid an hourly rate of $25.00 per hour and worked eight hours per day. Further, Petitioner testified that he reported to the owners to receive his job assignments every morning and used some equipment provided by Victoria Lane to perform his job duties.

3. The Arbitrator finds that the evidence establishes Petitioner suffered an accident that arose out of and in the course of his employment with Victoria Lane on October 9, 2012. The unrebutted testimony of the Petitioner and the medical records admitted into evidence establish that the October 9, 2012 accident arose out of and in the course of Petitioner's employment with Victoria Lane. Petitioner testified that on the morning of October 9, 2012, he was working for Victoria Lane at a jobsite in Joliet, Illinois when he fell approximately 8 feet, landing on the concrete.

4. With regard to the issue of notice, the Arbitrator finds that the petitioner has proven that he gave notice of this injury to the Respondent within 45 days of the October 9, 2012, accident. The unrebutted testimony and evidence presented by the Petitioner establishes timely notice of the accident to the owner of Victoria Lane. Although disputed by the State of Illinois, no evidence rebutting the assertion of adequate notice was provided at hearing. On October 30, November 6 and November 13, 2012, Dr. Grzeskowiak states in his records that the "injury was reported to the employer, Victoria Lane." (Px. 1 at 63 and 66). Further, on November 5, 2012, Victoria Hansen contacted Petitioner's attorney and stated Victoria Lane did not have workers' compensation insurance. (Px. 5 at 2). No evidence was presented rebutting Petitioner's assertion and evidence that adequate notice was given to Victoria Lane.

5. The Arbitrator finds that the Petitioner has met his burden of proof with regard to the issue of causation. The medical evidence coupled with the unrebutted and credible testimony of the Petitioner established that his current condition of ill-being, namely: loss of range of motion, pain and stiffness, of his low back and occasional pain radiating into the right upper back is causally related to the October 9, 2012 accident. Petitioner testified to general good health prior to October 9, 2012 and that since the accident, he experiences loss of range of motion, pain and stiffness, of his low back and occasional pain radiating into the right upper back.

6. With regard to the issue of earnings, the Arbitrator finds the evidence establishes an average weekly wage of $1,000.00. The Petitioner testified he was a six day employee of Victoria Lane and at the time of the accident he was earning a salary of $25.00 per hour and working approximately 8 hours per day. Petitioner's testimony was both credible and unrebutted.

7. The Arbitrator finds Petitioner was 37 years old on the date of the accident and that he was separated with two dependent children at the time of accident. This finding is supported by Petitioner's credible and unrebutted testimony on these issues.

8. Based upon the testimony of the Petitioner and the Petitioner's exhibits, the Arbitrator finds that the services rendered to the Petitioner for treatment between October 10, 2012 and November 13, 2012 was medically reasonable, necessary and related to Petitioner's work injury. The Petitioner testified he sought treatment for his back pain complaints from October 10, 2012 through November 13, 2012 with Dr. Kavanaugh's and Dr. Grzeskowiak's offices. Petitioner was treated at the Mercy Walworth Medical Center in Lake Geneva, WI. On October 10, 2012, X-rays were taken of Petitioner's back and coccyx. (Px. 1 at 21). On November 13, 2012

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Dr. Grzeskowiak discharged Petitioner from care. (Px. 1 at 69). Petitioner testified he received no payment of benefits from the Respondent. Victoria Lane. Petitioner presented a medical bill with an outstanding amount from Mercy Health System for $1,877.74 (Px. 2) The Arbitrator finds that the Respondent, shall pay this medical bill pursuant to the fee schedule or negotiated rate, whichever is less, pursuant to the Illinois Workers' Compensation Act.

9 The Arbitrator finds that Petitioner was temporary and totally disabled due to the work injury from October 10, 2012 through his date of discharge by Dr. Grzeskowiak on November 13, 2012 and is entitled to 5 weeks of Total Temporary Disability benefits. Petitioner testified and provided exhibits showing work restrictions from October 10, 2012 through November 13, 2012, which were never accommodated by Victoria Lane. Petitioner testified that there were no jobs available at Victoria Lane within the restrictions provided by the Doctors.

10. Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator first notes that no AMA impairment rating evaluation was performed and no AMA impairment rating report was presented at hearing. Petitioner testified that he recently became unemployed due to moving to another state, but has a high school education and is trained as a foreman. Petitioner testified the injury has affected his future earning capacity as he no longer can perform his regular line of work in construction due to the work injury. Petitioner was 37 on the date of the accident. The medical records provide that Petitioner suffered head trauma, loss of consciousness, groin strain, back contusion, coccyx contusion and chest wall contusion due the eight foot fall on October 9, 2012. He had continued complaints of pain from October 10, 2012 through November 6, 2012 and was discharged from care on November 13, 2012. Petitioner testified that since November 13, 2013 he has had continued complaints of pain, but has not sought medical treatment since that time in relation to the October 9, 2012 accident.

Based upon the factors enumerated in 8.1(b) of the act, the Arbitrator awards 5% loss of use of the person as a whole pursuant to 8(d)(2) of the Act for the October 9, 2012 work injury.

11. With regard to the issue of penalties and attorney fees, the Arbitrator finds that an award of penalties and attorneys fees against Victoria Lane is warranted in this case. Petitioner filed a petition for penalties with the Illinois Workers' Compensation Commission on November 14, 2012. (Px. 3). Victoria Lane was notified of the work accident within forty five days of the accident and also has communicated with Petitioner's Attorney regarding no workers' compensation coverage on November 5, 2012 and attempted to negotiate settlement on April 11, 2013. (Px. 1 at 63, 69, 66 and Px. 5 and Px. 6). However, no payment of benefits has been made by Victoria Lane to the petitioner for the medical expenses incurred nor for the time he has lost due to the accident. The Arbitrator finds that the Victoria Lane has failed to provide an explanation as to why it has made no payment of benefits to the Petitioner since the work-related accident of October 9, 2012. Over 85 weeks has passed since the date of accident and trial before this Arbitrator and no payment of benefit has been made. Accordingly, the Arbitrator finds that there has been an unreasonable and vexatious delay of payment and awards penalties in the amount of $11,605.54 pursuant to 19(k) of the Act, $10,000.00 Pursuant to 19(l) of the

15IWCC0487

act and $2,321.10 pursuant to Section 16 of the Act against the Respondent, Victoria Lane.

12. With regard to the issue of whether the Respondent, Victoria Lane was provided sufficient notice of trial, the Arbitrator finds that Petitioner has provided sufficient notice of the hearing to Respondent. Section 7030.20 of the "Rules Governing Practice Before the Workers' Compensation Commission," establish the practice for setting a case for trial:

...If any party fails without good cause to appear, the Arbitrator will hear the motion for trial date ex-parte and if the Arbitrator determines the matter ready for trial will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify opposing party of the trial date.

The Respondent, Victoria Lane, was given adequate notice of this matter and trial occurring on May 29, 2014. Petitioner's Exhibit 12 provides a "LLC File Detail Report" from the Secretary of State of Illinois, printed on December 31, 2013. This report shows Victoria Lane as an active company and has a principal office at 43 West Fern Ct, Unit 225D, Palatine, Illinois 60067. On June 18, 2013, Petitioner's Attorney sent a request for hearing for July 11, 2013, via certified mail to Victoria Lane, which was received by Victoria Lane. (Px. 7). On August 6, 2013, Petitioner sent Victoria Lane a request for hearing via certified mail for hearing on October 3, 2013. (Px. 8). On October 3, 2013, the matter was set for trial on October 10, 2013 and Petitioner sent notice to Victoria Lane. (Px. 9). Victoria Lane did not appear and the matter was continued. December 10, 2013, Petitioner sent a request for hearing to Victoria Lane via certified mail for January 2, 2014. (Px. 10). The matter was set for trial on January 14, 2014 and Petitioner sent notice via certified mail to Victoria Lane. (Px. 11). Victoria Lane did not appear on January 14, 2014 and the matter was specially set for February 26, 2014 in Ottawa, IL; notice to Victoria Lane was accordingly given. (Px. 13). The matter did not go to trial on February 26, 2014. On March 6, 2014, Petitioner sent a request for hearing to Victoria Lane, certified mail, for April 1, 2014. (Px. 14). The matter was set for trial on April 15, 2014 and notice was given to Victoria Lane accordingly. (Px. 15). On April 15, 2014, Victoria Lane failed to appear and the parties present, Petitioner and the State of Illinois, held an ex-parte hearing. At the ex-parte hearing, the Petitioner and State of Illinois agreed to a specially set trial date of May 29, 2014 in Ottawa, IL and notice was sent to Victoria Lane via certified mail. (Px. 17). Attorney for the Injured Workers' Benefit Fund was also provided notice of the hearing and trial dates above and is included as a part of Petitioner's exhibits. (Px. 7, 8, 9, 10, 11, 13, 14, 15, 17). The attorney for the Fund appeared on behalf of the Fund at all hearings.

13. The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter and the Petitioner proved by the preponderance of the evidence that Victoria Lane, LLC did not have workers' compensation coverage at the time of the accident. (Px. 16). The Treasurer was represented by the Illinois Attorney General. Hence, this award is hereby entered against the Fund permitted and allowed under Section 4(d) of this Act, except for the Penalties pursuant to Sections 19(k), 19(l), 16(a) or 16, awarded against the Respondent, Victoria Lane, under section "M." In the event Victoria Lane fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing to the Petitioner pursuant to Section 5(b) and 4(d) of the Act. Victoria Lane shall reimburse the injured benefit fund for any compensation obligations that are paid to the Petitioner from the Injured Workers' Benefit Fund.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nealy Flamm,
Petitioner,

15IWCC0488

vs.

NO: 10 WC 43263

Tamms Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 October 20, 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.

DATED:
o6/10/15
RWW/rm
046

JUN 2 6 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0488

FLAMM, NEALY
Employee/Petitioner

Case# **10WC043263**

TAMMS CORRECTIONAL CENTER
Employer/Respondent

On 10/20/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
MICHELLE RICH
#6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
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

OCT 20 2014

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

15IWCC0488

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)

Nealy Flamm
Employee/Petitioner

v.

Tamms Correctional Center
Employer/Respondent

Case # **10** WC **43263**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **August 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **October 8, 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 not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$56,973.00**; the average weekly wage was **$1,095.63**.

On the date of accident, Petitioner was **38** 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 $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

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

ORDER

Petitioner failed to prove he sustained an accident on October 8, 2010 that arose out of and in the course of her employment or that her current condition of ill-being is causally related to said accident. 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.

Edward Lee
Signature of Arbitrator

10/16/14
Date

ICArbDec19(b)

OCT 20 2014

15IWCC0488

FINDINGS OF FACT

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. Petitioner alleged that she sustained injuries to her bilateral hands and right arm as a result of repetitive duties while working for Tamms Correctional Center. Petitioner has alleged the date of accident as October 8, 2010. This is a repetitive trauma claim and the issues in dispute are notice, accident, causation, medical bills, and prospective medical.

Petitioner was 38 years old on October 12, 2010 which is her alleged manifestation date for her repetitive trauma claim. Petitioner testified that she has worked as a Correctional Officer since October 2, 1995. Petitioner testified that she worked at Menard CC from October 2, 1995 until 2006. Petitioner testified she began working at Tamms CC in 2006 until January 2013 when she transferred to Vienna CC.

On October 2, 2010, Petitioner presented to her primary care physician, Dr. Pamela Hunter, with complaints of chest pain, gastroesophageal reflux disease, and with right wrist pain that radiated into the right elbow. In respect to her wrist pain, Petitioner described it as aching. She provided no incident of injury to Dr. Hunter, nor were there any aggravating factors. Petitioner also had complaints of difficulty going to sleep, and numbness and tingling into the arms. Petitioner reported that she had tried to use over the counter ibuprofen, but that the same had no provided any relief of the symptoms. Dr. Hunter referred Petitioner to Dr. Fakhre Alam for a nerve conduction study.

Petitioner underwent an electromyography/nerve conduction study with Dr. Alam, a neurologist at SI Neurology & Sleep Medicine, on October 8, 2010. The nerve conduction study revealed mild bilateral carpal tunnel syndrome, and mild right ulnar neruopathy at elbow, but no evidence of cervical radiculopathy on either side.

On October 20, 2010, a phone message report was generated by Dr. Hunter to Petitioner advising that she could be referred to an orthopedic surgeon for further evaluation. It further noted that Dr. Hunter did not realize that this was a workers' compensation claim. On October 22, 2010, Petitioner advised Dr. Hunter that she was being referred to an orthopedic surgeon in Chesterfield by her lawyer, and that her first appointment was on November 3, 2010.
At the referral of her attorney, Tom Rich, on November 3, 2010, Petitioner presented to Dr. David Brown, an orthopedic surgeon of The Orthopedic Center of St. Louis. On the New Patient Questionnaire, Petitioner noted that she had experienced carpal tunnel symptoms for over 2 years. She also noted that she had undergone 2 nerve conduction studies, one in January 2008, and the most recent one performed by Dr. Alam on October 8, 2010. She further noted that her hobbies included gardening and crafting.

During examination, Petitioner presented for evaluation and treatment of both upper extremities. She reported to Dr. Brown that she had worked for Tamms Correctional Center since 1995, and that she worked eight ours a day, 37 ½ hours per week. She described her job as having to turn keys throughout the day, cuffing and uncuffing inmates and working on the

computer. She specifically reported that she constantly pushes buttons, sometimes 2000 buttons a day to open and close doors. Petitioner provided a history of two to three years of progressive pain, numbness and tingling in both her hands, worse on the right than the left. Physical examination by Dr. Brown revealed a good active range of motion of both elbows, both wrists and all digits of both hands. She had a mildly positive Tinel's sign over the ulnar nerve at the right cubital tunnel, negative on the left. Direct compression tests induced some discomfort over the right and left cubital tunnels. Direct compression test/Phalen's test was positive bilaterally. Dr. Brown diagnosed Petitioner with bilateral carpal tunnel syndrome and right cubital tunnel syndrome. He prescribed splints for Petitioner to wear at night, as well as pads to wear over both elbows. Dr. Brown opined that based on her job description as a correctional officer, combined with her lack of medical problems that would put her at risk for a peripheral compression neuropathy, that he did believer her work would be considered in part an aggravating factor in her carpal and cubital tunnel syndrome.

On December 13, 2010, Petitioner followed up with Dr. Brown. She reported no improvement in her symptoms. On examination, she had a positive Tinel's sign over the ulnar nerve at the right cubital tunnel. Direct compression test/elbow flexion test was positive. She had a negative Tinel's and direct compression test over the left cubital tunnel. Elbow flexion test was negative on the left. She had a negative Tinel's over both carpal tunnels. Direct compression test/Phalen's test was positive bilaterally. As conservative treatment had failed. Dr. Brown recommended surgical intervention.

On February 7, 2012 Dr. Anthony Sudekum performed a records review of Petitioner's records at Respondent's request. Dr. Sudekum testified via evidence deposition on April 30, 2012 with regard to his findings for Petitioner's bilateral arms. (RX 10) Dr. Sudekum testified that he reviewed the medical records from Drs. Hunter, Alam, and Brown, as well as the Workers' Compensation Employee's Notice of Injury, Employer's First Report of Injury, Supervisor's Report of Injury or Illness, Illinois Form 45, a Staff Assignment History, a CMS position description, a job description written by Petitioner dated November 3, 2010, a job site analysis, and a repetitive movement report prepared by Major Homer Markel. Dr. Sudekum testified that he has personally toured some of the Illinois Department of Corrections facilities, including Menard Correctional Center, Centralia Correctional Center, and Big Muddy Correctional Center. Dr. Sudekum testified that while touring these facilities he performed certain job duties of a correctional officer, specifically bar rapping, opening and closing the sliding doors, opening and closing the chuckholes, opening and closing housing unit doors, and operating the hand crank for the lock downs.

Dr. Sudekum opined with a reasonable degree of medical certainty that Petitioner's job duties at Tamms Correctional Center did not cause or aggravate carpal or cubital tunnel syndrome or affect her need to undergo treatment for those conditions. Dr. Sudekum testified that the basis for his opinion was that the work Petitioner did at Tamms did not rise to the level of the type of forces and stresses in terms of the frequency and duration and type of activities that would serve to cause or aggravate the pathology that's associated with carpal and cubital tunnel syndrome.

Dr. Sudekum opined with a reasonable degree of medical certainty that Petitioner's job duties at Menard Correctional Center did not cause or aggravate carpal or cubital tunnel syndrome or affect her need to undergo treatment for those conditions. Dr. Sudekum testified that his opinion was based on a lack of any record of any symptoms about when the onset of her symptoms began. Dr. Sudekum testified that he did not feel like the job of correctional officer at Menard would be implicated in the development of a condition years after stopping that type of work at Menard.

Dr. Brown testified via evidence deposition on April 29, 2014. (PX6) Dr. Brown testified that Petitioner presented with a two to three year history of progressive pain, numbness and tingling in both her hands, right greater than left. Dr. Brown testified that Petitioner presented with a four page written description which talked about her first 11 years as a correctional officer at Menard, and then the last four years she had worked at Tamms. Dr. Brown testified that when she went to Tamms she started to push more buttons but she was still opening and closing doors, turning keys, and that she estimated about 256 times per day. Dr. Brown testified that he believed the accumulation of 15 years of performing those activities would be considered an aggravating factor in those conditions. Dr. Brown further testified that he believed her entire job history for the State of Illinois is relevant in making his causation opinion.

Dr. Brown testified that Petitioner was first diagnosed in January 2008 with carpal tunnel syndrome. Dr. Brown testified that Petitioner told him she had a nerve conduction study which showed carpal tunnel syndrome in January 2008. Dr. Brown admitted on cross-examination he had not reviewed the study.

Dr. Brown testified that he reviewed a job analysis from Corvel which was performed on December 20, 2010, a repetitive motion study, DVD, and Dr. Anthony Sudekum's records review, and Dr. Sudekum's deposition. However, Dr. Brown admitted he did not have this information when forming his initial opinion regarding the causal relationship of Petitioner's condition to his work.

On cross-examination Dr. Brown testified that Petitioner filled out a patient intake questionnaire prior to seeing Dr. Brown. Dr. Brown testified that Petitioner stated in her questionnaire that she was being seen for a work related injury, that she was represented by an attorney, and that she might be involved in litigation. Dr. Brown testified that he was not aware of the Petitioner being advised she had a work related condition by another physician prior to filling out his questionnaire.

On cross-examination Dr. Brown admitted that Petitioner had not discussed the job activities of cleaning, laundry, or mail with him. Dr. Brown also admitted that Petitioner did not discuss with him how often she was cuffing/uncuffing inmates, nor did she describe the activity of wing checks and the frequency of them. Dr. Brown testified that Petitioner did not discuss with him the activity of lifting. Dr. Brown further testified that Petitioner never discussed with him what job posts she held at Menard or how often she had to turn Folger Adams keys.

On cross-examination Dr. Brown testified that he did not believe button pushing or typing would be considered a risk factor for her condition.

On direct examination Dr. Brown testified that Dr. Sudekum had not reviewed the repetitive movement report authored by Major Homer Markel. On cross-examination Dr. Brown admitted Dr. Sudekum stated in his deposition that he had the repetitive movement report, but Dr. Brown claimed that Dr. Sudekum did not understand the report because Dr. Sudekum talked about the number of buttons pushed in the report and Dr. Brown stated the report had nothing to do with pushing buttons that it was about keying.

Petitioner testified that she worked at Menard CC from October 2, 1995 until 2006 as a correctional officer. Petitioner testified that at Menard she used Folger Adams keys to gain entry into the cells. Petitioner testified that the locks worked "for the most part" and that "sometimes you'll get an occasional lock that doesn't work, and you have to put a work order in or call a locksmith to fix them." Petitioner testified that she did bar rapping while at Menard, but was never assigned as a gallery officer all the time but did bar rap on occasion. Petitioner testified that the activity of bar rapping vibrates your hands. Petitioner testified that she was more of a "door officer" where she would open all the doors with a Folger Adams key. Petitioner testified that while performing these activities her arms and hands would get tired after a while, and she would take some Tylenol and go about her business.

Petitioner testified on cross-examination that there are no chuckholes on the regular cell doors, and that if she was working in a regular cell house she would not have been opening chuckholes. Petitioner testified on cross-examination regarding the handwritten job description she gave to Dr. Brown. Petitioner testified that she worked in the armory at the MSU and she would have to push buttons to open all the doors and hand out keys and that she did not use Folger Adams keys or bar rap in that position. Petitioner testified that she worked the day shift and midnight shift. Petitioner agreed that she pushed less buttons on the midnight shift, she estimated that she would push 150 buttons on the midnight shift. Petitioner estimated that when working the day shift she would push 600 – 900 buttons.

Petitioner testified that she also worked in the account office at Menard, and that the job entailed computer work, phone calls, and writing. She would also have to control the back door, side doors, and another door to get to the double bay area. Petitioner admitted that when working in the account office she would not have to bar rap. Petitioner admitted that she worked in the visiting room while at Menard. Petitioner testified that this required computer work, phone work, and keys to open the doors. Petitioner testified she would not have to bar rap while working in the visiting room. Petitioner testified that at Menard "we didn't have to cuff and uncuff a whole lot of inmates at Menard".

Petitioner testified that she transferred to Tamms in 2006 and worked there as a correctional officer until January 2013 when Tamms closed. Petitioner testified that inmate services are given through a chuckhole, which is opened with a Folger Adams key. Petitioner testified that inamtes are cuffed and uncuffed through the chuckhole. Petitioner described the process and stated that the inmate would back into the chuckhole, the officers would cuff them, they would open the door, the inmate would step back, officers would kneel and cuff his feet.

Petitioner testified that mail, medication, laundry, and literature were delivered through the chuckhole.

Petitioner admitted on cross-examination that mail was delivered on the 3 – 11 pm shift, and so when she was working day shift she would not have distributed mail. Petitioner later testified that, with the exception of six months spent on midnights, she worked day shift at Tamms.

On cross-examination Petitioner agreed that Tamms was a new facility, especially in comparison to Menard. Petitioner admitted that movement of Tamms inmates were done through the control pod. Petitioner testified that an officer still had to open chuckholes to get the inmates out for them to move, but admitted, when questioned further, that there was a difference between restricted movement and unrestricted movement of inmates. Petitioner testified that during unrestricted movement an inmate is allowed to leave their cell without being strip searched and allowed to walk themselves, without being handcuffed, to the yard or shower.

Petitioner testified that Tamms is a super max facility and that the inmates are not allowed out of their cells except to go to the shower, to go to the library, to get medical treatment, or to go to the yard. Petitioner testified that to pass food trays she would have to open the chuckhole with one hand, unlock with the other and then pass the food tray. Petitioner testified on cross-examination that as a pod officer she would have been responsible for one feed per shift and two officers would hand out the food trays.

Petitioner testified that there were six wings in a pod and there were ten cells to a wing, totaling 60 cells in a pod. Petitioner stated that the cells were not always fully occupied, that there could be anywhere from 40 – 50 inmates on a unit at a time with only one inmate per cell.

Petitioner testified on cross-examination that the pods were rarely at full capacity, so if there was a problem with a lock or a chuckhole an inmate could be moved to a different cell. She also testified that there was a full time locksmith working at Tamms who could repair the locks.

Petitioner testified on direct examination that a wing check is something that's done every 30 minutes. An officer would go around and check doors and make sure they weren't tampered with. Petitioner testified she would tug on chuckholes and make sure that they were still secure. Petitioner further testified that she would pull on the doors as well as the chuckholes.

Petitioner testified on cross-examination that she tugged on chuckholes and pulled on doors, and when she was a control officer she observed others doing the same. Petitioner agreed that there is a light in the control room that indicates whether the door is locked or not. Petitioner also agreed that the purpose of a wing check is to check on the status of the inmate to make sure they were not hurting themselves.

Petitioner testified on direct examination that she worked as a control officer, and a control officer would run all the doors by pushing buttons. Petitioner testified that she would use

her thumb and pinky the most to open doors for people. Petitioner testified that if you have to do a wing check every 30 minutes "you're talking 96 times doing that" and that did not include feeds or nurse rounds. Petitioner testified that she could not give a number of how many buttons she pushed. Petitioner testified that during her tenure at Tamms she pushed "probably a million" buttons. Petitioner testified that the buttons were easy to operate but that it was tedious.

Petitioner was questioned on cross-examination about the repetitive movement study performed by Major Markel. (RX7) Petitioner agreed that it was possible that a pod control officer could push a door button 525 times on average on the 7 – 3pm shift. She also felt that it could be more. Petitioner was asked about the number of buttons she told Dr. Brown she pushed. Petitioner was asked if she could explain the discrepancy between telling Dr. Brown she pushed 2,000 buttons a day and then later in her handwritten job description she stated she pushed buttons 2,540 times per week. Petitioner replied "No, I cannot".

Petitioner admitted on cross-examination that when she worked in control she was only opening doors, that she was not passing out inmate services, like medication and laundry, through the chuckhole.

On cross-examination Petitioner was questioned about her staff assignment history from April 2009 until February 2011. (RX11) Petitioner testified that for a brief period of time she worked the midnight shift, maybe for six months, and the rest of her time at Tamms was on the day shift. Petitioner admitted that she had worked in all the positions that are listed in her staff assignment history, but stated even though it indicated she was assigned to a position she could have been moved to another position at any time.

Petitioner testified on cross that when she worked as a wing/control officer she could potentially work as a wing officer for half the shift and then switch to a control officer for the other half, it would depend on what the other person wanted to do.

Petitioner testified on cross that she had worked as a roving patrol officer, which required her to drive a van around the facility on smooth blacktop.

Petitioner testified that a shakedown was performed on the majority of inmates once a month and a Level E, or high extreme, inmate would get shook down once a week. Petitioner testified that if there were 60 people in a pod two people would get shook down that day.

Petitioner admitted on cross-examination that depending on the job post she was at she might not do shakedowns. Petitioner admitted she could have gone weeks without performing a shakedown. Petitioner stated that when she was assigned to the armory she couldn't shake down anything.

Petitioner testified correctional officers clean the pods, clean the toilets, clean the windows, sweep, mop, moving trash. Petitioner testified on cross-examination that correctional officers were supposed to clean every day. Petitioner testified it could take anywhere from fifteen minutes to one and a half hours.

Petitioner also testified that she worked at the Minimum Security Unit at Tamms during the "end of her tour" at Tamms. Petitioner estimated that she spent a year and a half there consecutively. Petitioner admitted that there were no Folger Adams keys, bar rapping, or cuffing/uncuffing inmates at the MSU.

Petitioner testified that there is no bar rapping at Tamms.

Petitioner testified that she is currently 5'2 and weighs 170 lbs and that her weight fluctuates a little bit.

Petitioner testified that in 2008 she had an EMG and nerve conduction study to rule out diabetic neuropathy, and that she did not receive any treatment for carpal and/or cubital tunnel syndrome in 2008. Petitioner testified that she did not receive any splints, medicine, or recommendation for surgery. Petitioner testified that she was not placed on diabetic medication because she was not diabetic.

Petitioner was questioned about her 2008 nerve conduction study on cross-examination. Petitioner testified that the reason she underwent the study was because she had numbness in her hands. Petitioner stated that if Dr. Brown testified that Petitioner had a test done in 2008 which showed carpal tunnel syndrome that he would be inaccurate. Petitioner testified that she believed he had an inaccurate understanding of her medical history.

Petitioner testified that she did not have any hobbies and did not ride a motorcycle. Petitioner admitted on cross-examination that she told Dr. Brown that she had hobbies of crafts and gardening. She testified that crafts would probably be along the lines of scrap booking but that she does not do that anymore. Petitioner testified that gardening included taking care of her yard and planting flowers, and that she would probably spend a couple hours a week doing that in 2010. On cross examination Petitioner admitted that she has a small business that she began in October 2013 which is called the Yellow Rose Boutique. Petitioner testified that she makes gift baskets and puts them together. Petitioner testified that she works there on her two days off a week for eight hours a day.

Petitioner testified that during the performance of her job duties she was having severe pain in her right arm and numbness in her fingers, her pinky and thumb. Petitioner said she first saw Dr. Hunter-Reach on October 1, 2010 and was referred to Dr. Alam for a nerve conduction study. Petitioner testified that she was referred to Dr. Brown by her attorney Mr. Rich. Petitioner testified that Dr. Brown recommended surgery and she would like to have surgery.

Petitioner testified on cross-examination that Dr. Alam told her that her condition was work related.

Petitioner testified that she transferred to Vienna CC in January 2013. Petitioner testified that she worked at Vienna as a correctional officer and she had been working in the placement assignment office. Petitioner testified that in that position she did typing, phone calling, and writing. She agreed that she was not cuffing/uncuffing inmates or using Folger Adams keys.

Petitioner testified that inmates have their own keys at Vienna and inmate movement is done by mass movement.

Petitioner testified that in the last week she had begun working as a correctional counselor doing a lot of typing, computer work, writing, and seeing inmates. Petitioner testified that she still has the same symptoms, pain in her thumb, pinky, and elbow more on the right because it's her dominant hand.

Petitioner's counsel called Homer Markel to testify during Petitioner's case in chief. Mr. Markel testified that he is retired from the Department of Corrections and that he retired from Tamms as a Major shift commander. Mr. Markel testified that the Petitioner worked for him when he was her shift commander, and that he would assign her duties if she was assigned to the shift he was on. Mr. Markel also testified that he had worked at Menard for 10 years, from November 1985 to April 1995.

Mr. Markel testified that he disagreed with Petitioner's testimony that laundry was done every day, he testified that laundry was done by the laundry officer every day but that each pod had laundry one day per week. Mr. Markel also disagreed with Petitioner's testimony that when she did wing checks she was required to pull on the cell doors and chuckholes. Mr. Markel stated it was not a requirement, and there were indicator lights in the pod control that showed whether the cell door was open or closed. Mr. Markel testified that the wing checks were to check on the safety of the inmate and do a visual inspection of the cell. Mr. Markel testified that he had observed Petitioner's work as her supervisor, and he saw and remembered her doing wing checks but he did not see her pull on cell doors. Mr. Markel agreed that officers were supposed to clean on a daily basis but they did not actually do so.

Respondent's counsel called Mr. Jason Hall to testify. Mr. Hall testified that he is currently employed by the Department of Corrections, Vienna Correctional Center. Mr. Hall testified that he worked at Tamms CC 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. Mr. Hall testified that as an Administrative Assistant II he would handle labor issues, staffing issues, supervise personnel, legal issues, and disciplinary issues for staff. Mr. Hall testified that he knew the Petitioner from his tenure at Tamms.

Mr. Hall testified that pulling on doors and pulling on chuckholes was not part of the post description for a pod officer. Mr. Hall testified that he did not know any correctional officer who had performed those activities, he did not ever see any other correctional officer do them, and he personally did not pull on cell doors or chuckholes when he did wing checks as a correctional officer at Tamms. Mr. Hall further testified that when he returned to Tamms as an Administrative Assistant II he did not ever see any other correctional officer pull on a door or chuckhole during a wing check.

Mr. Hall also testified that laundry was not done every day in every cell house. Mr. Hall testified that with regards to cleaning duties, day shift was more active and a lot of the cleaning duties were pushed to the second and third shift because there was less inmate movement.

Mr. Hall testified that the facility had a full time locksmith, and that if there were any issues with the locks or chuckholes replacement parts and repairs were readily accessible. Mr. Hall did not recall any major malfunctions or any issues with any of them. Mr. Hall testified that there was a routine maintenance schedule that was maintained by the locksmith per policy. Mr. Hall testified that very few chuckholes stuck and "at a moments notice he came down and addressed it".

Respondent's counsel recalled Mr. Markel in their case in chief. Mr. Markel testified that he had heard Mr. Hall's testimony with regards to the condition of the locks and the chuckholes and he agreed with Mr. Hall's testimony.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove she sustained an accident on October 8, 2010 that arose out of her employment. Petitioner further failed to prove that her current condition of ill-being in her bilateral hands and right elbow is causally connected to her alleged incident of October 8, 2010.

Petitioner failed to prove that her current condition of ill-being with regard to her bilateral wrists and right elbow is a result of her work-related duties as a correctional officer at Tamms Correctional Center. The job description given to Dr. Brown was not an accurate representation of Petitioner's job or duties. Dr. Sudekum's knowledge of the job duties of a correctional officer at Tamms is more extensive than Dr. Brown's and is given greater weight. Not only had Dr. Sudekum reviewed Petitioner's medical records, but he also obtained an accurate description of Petitioner's job duties before rendering his opinion.

Dr. Brown's opinion is not credible. An examination of the record and deposition of Dr. Brown shows that any causal opinion is based on inaccurate information. Dr. Brown testified that Dr. Sudekum did not understand the repetitive movement report because Dr. Sudekum talked about the number of buttons pushed in the report and Dr. Brown stated the report had nothing to do with pushing buttons that it was about keying. However, a review of Respondent's Exhibit 7 proves that the first page of the report is devoted to the frequency of button pushing.

Dr. Brown also based his opinion on the belief that Petitioner turned keys, locked/unlocked doors, cuffed and uncuffed inmates, and pulled on doors during wing checks throughout the day. Petitioner did not testify to this at trial. Additionally, Dr. Brown did not know the frequency, intensity, or duration of Petitioner's job duties. 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 23.

Petitioner's claim for compensation is denied. All other issues are moot. No benefits are awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Mickelson,
Petitioner,

vs. No: 13 WC 24529

15IWCC0489

Superior Carriers,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the sole issue of the nature and extent of permanent disability, and being advised of the facts and law, modifies the Arbitrator's award of permanent partial disability, and otherwise affirms and adopts the December 17, 2014 Decision of Arbitrator Robert Williams, which is attached hereto and made a part hereof.

Petitioner, a 49 year old tanker/semi-truck driver for Respondent, suffered a work-related injury to his right shoulder on April 18, 2012. A May 4, 2012 MRI showed a large rotator cuff tear with medial cuff retraction of the entire supraspinatus and infraspinatus tendons. Dr. Jones of Oak Orthopedics surgically repaired Petitioner's right rotator cuff, infraspinatus, and supraspinatus tendons and performed an acromioplasty on May 23, 2012. Petitioner began post-operative physical therapy on June 13, 2012 and was returned to work on September 5, 2012 at the medium physical demand level, which was consistent with his employment as truck driver. On September 28, 2014, Dr. Jones discharged Petitioner from care and noted that he had returned to work full duty and was doing well.

Respondent did not dispute accident or causal connection and paid all temporary total disability and medical expenses prior to hearing. The sole disputed issue was the nature and extent of the permanent partial disability resulting from Petitioner's work accident.

Arbitrator Williams followed Section 8.1b of the Act in weighing each of the five listed considerations:

1. AMA rating: The impairment rating was 4% of the person as a whole.

2. Occupation: There was no evidence as to the impact of the injury on Petitioner's pursuit of his occupation. However, Petitioner was able to return to work at the medium physical capability level, and that was consistent with his occupation as truck driver.

3. Age: There was no evidence presented as to the effect of Petitioner's age at the time of injury. Petitioner was 49 at the time of the accident.

4. Future earning capacity: There was no evidence presented as to the impact of the injury on Petitioner's future earning capacity. He was able to return to his previous occupation, so the Commission can infer that the injury did not seriously impact his future earning capacity.

5. Evidence of disability corroborated by medical records: Petitioner testified that he suffered increased stiffness and fatigue with longer hours, pain on the top of his shoulder which increased when he raised his arm, and reduced range of motion. The Arbitrator noted that the records of Petitioner's treating physician do not fully corroborate his complaints, and the Commission notes that Dr. Jones' September 28, 2012 office note reports that Petitioner had made a good transition to his workplace and had no pain complaints.

After weighing these factors, Arbitrator Williams concluded that Petitioner had proved a 7% loss of use of the person as a whole for his right shoulder injury.

On appeal, Petitioner argued he was entitled to a more generous permanent partial disability award, noting that his rotator cuff, supraspinatus and infraspinatus tendons were all torn and retracted. Dr. Jones noted that he could repair only 75% of the tendon. Dr. Phillips, Respondent's Section 12 examiner, found a reduced range of motion, pain and tenderness around the AC joint, crepitus, and myofascial pain around the shoulder blade and clavicle. Petitioner testified that his job duties require him to work 70 hours per week, driving, climbing on a tanker, and inspecting the truck and hoses.

The Commission notes there is no question that Petitioner suffered a significant rotator cuff tear which required surgical intervention. However, after his surgery, physical therapy and work hardening, he was able to return to his physically demanding job without restrictions. The Commission further notes that Petitioner testified to pain at 7-8/10 when doing heavy overhead lifting and 4/10 when at rest, yet he never returned to Dr. Jones for pain management and never sought relief from other physicians after Dr. Jones released him from care in September 2012.

After considering the entire record, and for the reasons set forth above, and taking into consideration the Section 8.1b findings as enumerated by the Arbitrator, the Commission views the Petitioner's permanent disability somewhat differently than the Arbitrator. The Commission hereby increases the permanency award to 12.5% loss of use of the person as a whole, pursuant to Section 8(d)2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the December 17, 2014 Decision of the Arbitrator is modified with regard to the award of permanent partial disability, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $679.03/week for a period of 62.5 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 12.5% loss of use of the person as a whole.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $42,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 2 6 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-05/19/15
jdl/dak
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MICKELSON, DAVID
Employee/Petitioner

Case# **13WC024529**

SUPERIOR CARRIERS
Employer/Respondent

15IWCC0489

On 12/17/2014, 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 0.11% 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:

0347 MARSZALEK AND MARSZALEK
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1596 LAW OFFICES MEACHUM & STARCK
DEBORAH A BENZING
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CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

DAVID MICHELSON
Employee/Petitioner

Case #13 WC 24529

v.

SUPERIOR CARRIERS
Employer/Respondent

15IWCC0489

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on December 15, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On April 18, 2012, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $58,848.92; the average weekly wage was $1,131.71.
- At the time of injury, the petitioner was 49 years of age, married with one child under 18.
- The parties agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner.
- The parties agreed that the respondent paid $13,688.24 in temporary total disability benefits.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 18-1/7 weeks from April 21, 2012, through August 26, 2012.

ORDER:

- The respondent shall pay the petitioner the sum of $679.03/week for a further period of 35 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 7% loss use of the man as a whole for his right shoulder injury.

- The respondent shall pay the petitioner compensation that has accrued from April 18, 2012, through December 15, 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.

Robert E. Williams

Signature of Arbitrator

December 17, 2014

Date

DEC 17 2014

FINDINGS OF FACTS:

The petitioner, a tanker semi-truck driver, injured his right arm on April 18, 2012. An MRI of his right shoulder on May 4th revealed a large rotator cuff tear with medial cuff retraction of the entire supraspinatus and infraspinatus tendons. The petitioner started care with Dr. Eddie Jones at Oak Orthopedics on May 10th, whose assessment was a complete tear of his right rotator cuff. Dr. Jones preformed a rotator cuff tear repair, infraspinatus and supraspinatus tendons repairs and an acromioplasty on May 23rd. Physical therapy was started on June 13th. At the petitioner's last follow-up on September 28th, Dr. Jones noted forward flexion to 160 degrees, external rotation to 30 degrees versus 45 degrees with his left arm, internal rotation to L1, good strength with resisted abduction and weakened resistance to external rotation. The doctor also noted that the petitioner had returned to work full duty without any pain or complaints and was doing fine.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The AMA impairment rating is 4% of the whole body. There is no evidence concerning the impact of the petitioner's injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(ii) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of increased stiffness with longer hours and as he becomes more tired. He has pain on the top of his shoulder which increases with raising his arm. The range of motion of his shoulder is reduced, especially with touching his back. The treating medical records do not fully corroborate the petitioner's complaints.

The respondent shall pay the petitioner the sum of $679.03/week for a further period of 35 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 7% loss use of the man as a whole for his right shoulder injury.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

State of Illinois,
Illinois Workers' Compensation Commission,
Petitioner,

vs.

Case No. 14 INC 00060

Giuseppe A. Di Prizio, individually and as president of
MGD Cement Construction, Inc., a dissolved corp.,
Respondent.

15IWCC0490

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

On February 3, 2015, Commissioner Donohoo entered a default judgment against Respondent Giuseppe DiPrizio, individually and as president of MCD Cement Construction, for violation of Section 4(a) of the Illinois Workers' Compensation Act. Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the office of the Illinois Attorney General, against the above-captioned Respondent, seeking a determination of the amount of civil penalties to be awarded for Respondent's violation of Section 4(a) of the Act. Proper and timely notice was provided to Respondent and a hearing was held before Commissioner Luskin in Chicago, Illinois on March 18, 2015. Respondent Giuseppe A. DiPrizio, individually and as president of MGD Cement Construction, a dissolved corporation, appeared *pro se*.

Petitioner seeks penalties for Respondent's knowing and willful lack of workers' compensation insurance coverage from January 4, 2006 to March 14, 2014. At the non-compliance hearing, Respondent DiPrizio testified that his company had dissolved in 2009, although he did not recall the exact date, and he was certain that the business performed no work in 2008. The business was incorporated in 2006, and Respondent DiPrizio admitted at hearing that his company never carried workers' compensation insurance from the time of incorporation in 2006 through its dissolution in 2009.

Ruben Espinosa, an employee of Respondent, alleged that he was injured in a work-related accident on June 2, 2008. Espinosa's claim was filed with the Illinois Workers' Compensation Commission, and the Injured Workers' Benefit Fund was named as a Respondent

15IWCC0450

in Case No. 08 WC 042405. On May 23, 2013, Arbitrator Carolyn Doherty entered her decision, finding that the claimant had failed to prove that and employer-employee relationship existed on the date of the alleged work accident. The Arbitrator therefore denied all benefits. On November 25, 2013, the Commission reversed the Arbitrator's Decision, found the claimant's claim compensable, and awarded him $38,006.89 for medical expenses, 3-2/7 weeks of temporary total disability at $380.00 per week, and a total of 38.98 weeks at $342.00 per week in permanent partial disability benefits, for a total award of $52,588.25.

In the non-compliance case against Respondent, Frank Capuzi, chief investigator for the Commission, testified that he had not yet evaluated the amount the Commission would seek for Respondent's violation of Section 4(d) of the Act. However, Inspector Capuzi stated that the minimum amount sought for the violation would be the amount awarded by the Commission to the injured worker, Espinosa, or $52,588.25. This amount includes no fines, not the $500.00 per day for each day of non-coverage nor the savings of premium for the period of non-coverage.

At the time of hearing, MGD Cement Construction had dissolved.

After considering the entire record, the Commission finds that Respondent knowingly and willfully violated Section 4(d) of the Act and Section 7100.100 of the Rules Governing Practice before the Illinois Workers' Compensation Commission from January 4, 2006 through December 31, 2009. The Commission finds that, as a result of Respondent's non-compliance, he shall be held liable and pay a fine of $52,588.25, pursuant to Section 4(d) of the Act and Section 7100.100(b)(1)(2) of the Rules.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, Giuseppe A. DiPrizio, pay to the Illinois Workers' Compensation Commission the sum of $52,588.25, as provided in Section 4 of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,700.00. 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: JUN 29 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

jdl/dak
r-03/18/14
68

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUBEN ESPINOSA,

Petitioner,

vs.

NO: 08 WC 42405

MGD CEMENT CONSTRUCTION, INC., and the ILLINOIS STATE TREASURER as EX-OFFICIO CUSTODIAN of the INJURED WORKERS' BENEFIT FUND

Respondent,

13IWCC1005

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employment, accident, medical expenses, temporary total disability, nature and extent, average weekly wage, and penalties/fees, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of employment and awards benefits related to this claim but attaches the Decision for the purpose of the Findings of Fact which is attached hereto and made a part hereof but with the modifications noted below.

Although we note that there were inconsistencies and discrepancies in the testimony of both parties, the Commission views the evidence differently regarding the credibility of Petitioner versus that of Mike Diprizio, President of Respondent. Petitioner testified that he worked for Respondent in 2006, 2007, and 2008. He submitted into evidence paycheck stubs and a W2 form from 2007. (Px12 and Px13). From January to about May 2008, he was waiting for Mr. Diprizio to call him to work. (T.34). Petitioner initially testified that he started working for Respondent during the second week of May 2008 (T.8) but later stated that he also worked in the beginning of April (T.37). Petitioner testified that he did not receive a W2 for 2006 or 2008 (T.63) and he did not bring his pay stubs for April and May 2008 to the hearing. (T.37).

Petitioner testified that he was working with Mr. Diprizio on the date of accident, June 2, 2008. Petitioner was a laborer and driver whose responsibility was to drive a truck transporting wood and other employees. He testified that he got to Respondent's yard at 7:00a.m. along with other employees. He waited a few minutes until Mr. Diprizio arrived and told them that there was no work at the time because the job site was not ready. Petitioner testified that Mr. Diprizio left him and another employee, Manuel, to cut wood with a machine into stakes to be used at the job site, which were duties that Petitioner had performed on previous occasions as well.

Mr. Diprizio admitted that Petitioner worked for Respondent in 2006 and 2007 but testified that he did not hire Petitioner in 2008 because the other workers did not want to work with him. Mr. Diprizio testified that, despite not being hired, Petitioner used to come to the job site every day and was "stubborn" about wanting to be hired. He testified that he never gave Petitioner a paycheck in 2008 and he did not instruct Petitioner to do any work for Respondent or personally for himself on the date of accident. (T.67-69).

Petitioner testified that, following his accident, Mr. Diprizio paid for his first medication prescription (T.33) and also gave him a check, dated July 25, 2008, which Mr. Diprizio said was for the money that was owed to Petitioner and also to "please don't worry about the medical bills." (T.14-15). This check was in the amount of $912.00, made payable to "Cash," and was from the account of Giuseppe A. Diprizio. (Px13).

Mike Diprizio's testimony on this issue is confusing and evasive. He testified that it was his son's personal check and was not made out to anybody. He admitted that it was his signature and handwriting but "not the seven" referring to the date of "7/25/08." He testified that "maybe something was erased and the "7" was put in. (T.75). Mr. Diprizio initially testified that he "thinks" he did deliver a check to Petitioner one time after he was hurt but he didn't remember the reason. (T.76). He thought it was related to a snowplowing job that Petitioner did with him months earlier in December 2007. (Id.). Then, under questioning by the Arbitrator, he changed his testimony and said that this check was delivered to Petitioner "before he got hurt" and that he never gave a check to Petitioner after June 2008. (T.76-77).

However, under cross-examination questioning regarding the circumstances surrounding his son's check, Mr. Diprizio admitted that sometime in the middle of July 2008 he had a conversation with his son and told him "that I used to owe [Petitioner] some money." (T.83-84). Then, Mr. Diprizio changed his testimony to claim that it was in April 2008 when he got the check from his son. (T.84). Mr. Diprizio then admitted that Petitioner had actually done the snowplowing work for him in January and February of 2008.

This brings up an additional discrepancy in Mr. Diprizio's testimony. He initially testified that Respondent was working on a job at church parking lot at Fullerton and Addison in April 2008 and this is when Petitioner came to the job site every day looking for work. (T.66). However, he then indicated that this was the same job that was being worked on at the time of Petitioner's accident. (T.67-72). On cross-examination, Mr. Diprizio again claimed that Petitioner was coming to the job site in April because that is when "we start the season." (T.79). During questioning by the Arbitrator about the confusion between when this job was (April) and when Petitioner was injured (June), Mr. Diprizio said that it was actually in June when they did the church parking lot job and that this was the one and only job Respondent did that year. (T.82).

Returning to the issue of the $912 check, we note that Mr. Diprizio testified that he intended to pay Petitioner for the January and February snowplowing work after he got paid

from the church parking lot job, which happened in June. (T.87). As such, we find Mr. Diprizio's testimony evasive and not credible that he did not write the "7" (i.e., July) on the check and that he did not give Petitioner the check after he was injured. If Respondent only had one job in 2008, being the one in June at the time which Petitioner's accident occurred, and Mr. Diprizio was waiting to be paid for that job in order to pay Petitioner for snowplowing work that was done earlier in the year, then it would have been impossible for him to have paid Petitioner prior to his accident. Either Mr. Diprizio was not being truthful about Respondent only having one "job" in 2008, the one in June, or he was not being truthful about when he gave Petitioner the check. If Respondent actually did perform other jobs in 2008, then this lends credibility to Petitioner's testimony that he also worked for Respondent in April because that is the start of the season. On the other hand, if Respondent only performed the one job in June, then this lends credibility to Petitioner's claim that he was given the check after he was injured. We also note that Mr. Diprizio never denied paying for Petitioner's first prescription or telling Petitioner not to worry about the medical bills.

Another concern we have is Mr. Diprizio's testimony that he never gave Petitioner a paycheck in 2008. (T.67). Although the questioning was related to Petitioner's work for Respondent, it appears that Mr. Diprizio sometimes performed work through his company but possibly at other times personally. He admittedly did perform snowplowing work in January and February 2008, and hired Petitioner to do that work with him. Even though the $912 check was paid from his son's account, it appears that this was, at least in part, for wages that Petitioner earned while doing the snowplowing jobs. Whether this check was an official "payroll" check from Respondent showing that taxes and deductions were taken out or it was a personal check from Mr. Diprizio's son's account, the fact remains that Mr. Diprizio did pay Petitioner in 2008 for work that he performed in 2008. We find Mr. Diprizio's testimony about his refusal to hire Petitioner in 2008 for Respondent to be not credible as he certainly hired Petitioner to do work in some capacity and through some entity for the ultimate benefit of Mr. Diprizio in 2008. Whether the snowplowing work was performed through Respondent itself, Mr. Diprizio personally, or some other third party isn't entirely clear, but it does cause us to question Mr. Diprizio's credibility on the issue of employer/employee relationship.

In summary, we find Mr. Diprizio's testimony to be less credible than that of Petitioner. When Petitioner was injured, he called Mr. Diprizio first and it was Mr. Diprizio who returned to the yard and took him to the hospital. The undisputed testimony of Petitioner is that Mr. Diprizio paid for Petitioner's first medication prescription and told him not to worry about the medical bills. Based on all of the above and the record as a whole, we believe the totality of the evidence favors a finding that Petitioner has met his burden of proof of showing that an employer/ employee relationship existed at the time of his accident.

Having found that Petitioner was employed by Respondent, we also find that he was cutting wood for Respondent in the yard used by Respondent when his injuries occurred. Therefore, we find that Petitioner sustained accidental injuries that arose out of and in the course of employment. We further find that Petitioner's medical treatment was reasonable, necessary, and causally related to his work injury and award medical expenses in the amount of $38,006.89 under §8(a) of the Act subject to the medical fee schedule in §8.2.

Petitioner alleged, on the Request for Hearing form, that he was temporarily totally disabled from June 2, 2008 through June 24, 2008. Although we note that Petitioner's testimony indicated that he was off work longer than that, we find that Petitioner's stipulation is controlling

in this case and he is entitled to 3-2/7 weeks of temporary total disability benefits.

We note that, despite the severity of the accident, Petitioner did not actually lose any portion of his fingers because they were repaired surgically. As such, this is not an amputation case. Petitioner demonstrated his range of motion to the Arbitrator and testified that it is difficult for him to grasp things like spark plugs or bolts when he works on his car. His middle and second fingers do not bend or extend fully. He has weakness in his left hand. Based on the above, and the record as a whole, we find that Petitioner is entitled to awards under §8(e) of the Act for the loss of use of 50% of the left index finger (21.5 weeks), 40% of the left middle finger (15.2 weeks), and 3% of the left thumb (2.28 weeks) for a total of 38.98 weeks permanent partial disability.

We note that Petitioner did not include average weekly wage as an issue on the Petition for Review or in his brief, but we address this issue sua sponte as it is necessary for the resolution of this case. Although we are aware that Petitioner submitted paycheck stubs from 2007 into evidence, we find that Petitioner's employment was terminated in November 2007. He testified that he was rehired in May 2008 at a lower wage rate of $15 per hour and that his paycheck always showed 38 hours per week regardless of how many hours he worked. There is no evidence as to how many weeks or parts thereof Petitioner actually worked after he was rehired. Based on the facts in evidence, we find that Petitioner's average weekly wage was $570.00 ($15 per hour for 38 hours per week).

Finally, based on the circumstances of this case, we find that Petitioner is not entitled to penalties and attorney's fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $380.00 per week for a period of 3-2/7 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 $342.00 per week for a period of 38.98 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 50% of the left index finger, 40% of the left middle finger, and 3% of the left thumb.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $38,006.89 for medical expenses under §8(a) of the Act subject to the medical fee schedule in §8.2.

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

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

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the

13IWCC1005

benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,700.00. 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: NOV 2 5 2013

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

SE/
O: 11/6/13
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ESPINOSA, RUBEN
Employee/Petitioner

Case# **08WC042405**

13IWCC1005

MGD CEMENT CONSTRUCTION INC AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 5/23/2013, 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:

2255 LUCAS & APOSTOLOPOULOS LTD
MAXINE R GRIEF-BLESS
881 W LAKE ST
ADDISON, IL 60101

2349 MARITOTE, R MARK PC
107 THIRD ST
BLOOMINGDALE, IL 60108

5031 ASSISTANT ATTORNEY GENERAL
JILL OTTE
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

13IWCC1005

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

RUBEN ESPINOSA,
Employee/Petitioner

v.

MGD CEMENT CONSTRUCTION, INC., and the Illinois State Treasurer as Ex-Officio Custodian of the Injured Worker's Benefit Fund,
Employer/Respondent

Case # **08** WC **42405**

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Wehaton**, on **April 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 _____

FINDINGS

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

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent. SEE DECISION

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

Based on the foregoing findings, findings on all other issues are moot.

ORDER

BASED ON ARBITRATOR'S FINDINGS OF NO EMPLOYMENT RELATIONSHIP AND NO ACCIDENT, NO COMPENSATION IS AWARDED.

Injured Workers' Benefit Fund

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

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

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

Carolyn Doherty
Signature of Arbitrator

5/23/13
Date

MAY 23 2013

FINDINGS OF FACT

13IWCC1005

Petitioner, a 53 year old laborer, testified that on 6/2/08, he worked for Respondent MGD Cement Construction. Respondent is located on Grace St. in Addison, Illinois. Respondent was uninsured on 6/2/08. PX 11. As such, the Illinois Workers' Benefit Fund was named in this matter and was represented at trial as was Petitioner and Respondent.

Petitioner testified that he worked on a seasonal basis for Respondent. Petitioner testified that Respondent was a cement company that closed down in the winter. In the Spring it was determined who was available to work and when. Petitioner testified that his brother in law Vince also worked for Respondent. Petitioner testified that he reported to the company owner Mike DiPrizio. Petitioner testified that at times, he has also worked for Mike's son, Guiseppe DiPrizio, at a different business.

Petitioner testified that he first worked for Respondent in 2006 and 2007 as a laborer and driver. In 2007, Petitioner was paid at the rate of $19.00 per hour. Petitioner testified that he worked 35 to 45 hours per week but his paycheck always showed 38 hours per week in 2007 and 2008. PX 12 is Petitioner's W2 statement from 2007 showing Respondent as his employer and wages of $12,540. PX 13 is a group exhibit containing pay stubs supporting the 2007 wages as well as unemployment earnings March, April and June 2008. The pay stubs end in November 2007. Petitioner testified that in May 2008 he once again started work for Respondent as a laborer and driver and that he reported to Respondent's owner, Mike DiPrizio. PX 13 does not contain any W2 or pay stubs from 2008. PX 13 does contain a photo copy of a check dated 7/25/08. The check is a personal check from the account of Giuseppe A. DiPrizio made out to "cash" in the amount of $912. The check was signed by Mike DiPrizio. The account is not a joint checking account. The check is dated 7/25/08 but it is clear that the "7" is written over another figure which is difficult to identify. Petitioner testified that he received this check from Mike DiPrizio and that Mike told him the check was meant to cover three weeks of "money owed" to Petitioner. Petitioner received $912 when he cashed the check. Only the front of the check is depicted on the photo copy.

Petitioner testified that he was working for Respondent as a truck driver on 6/2/08. He testified that he arrived at work a 7 am on 6/2/08 at the company yard. Petitioner used a key to enter the yard. Petitioner testified that he was given the key by Mike DiPrizio in 2006. Once at the yard, Petitioner was instructed by Mike DiPrizio that there was no work that day because the job site was not ready. Petitioner further testified that Mike told him and a few other workers in the yard to cut wood to be used as concrete stakes on the jobsite. Petitioner has performed this type of work for Respondent in the past and uses a cutter on the yard premises. While using the saw to fashion the stakes, the wood became stuck in the machine, kicked back and injured Petitioner's left hand thumb, index and middle fingers.

Petitioner testified that he took off his gloves and saw one finger that looked broken and one finger dangling. He was frightened and called Mike. Petitioner testified that the told Mike he was hurt and Mike returned to the yard a few minutes later. Mike took Petitioner in his own car to a walk in clinic where his injuries were addressed. Petitioner was sent the same day to Glen Oaks Hospital and Mike drove him to the hospital. The Glen Oaks admission record of 6/2/08 indicates Petitioner was "...cutting a piece of wood when the saw had a knot. As a result the wood ejected away from the saw and hyperextended the patient's left index and third digit. As a result, he sustained an incomplete amputation of the left index and third finger with highly comminuted fracture of the proximal phalanx of the index

finger and the middle phalanx of the third finger which involved the interarticular surface of the PIP joints of the third finger. He also sustained a small laceration to the thumb." Examination revealed an incomplete amputation of the index finger hanging by radial skin flap. The impression was "saw left index and third digit with incomplete amputation and a severe soft tissue injury in the third finger." Dr. Patari recommended exploration and repair of all structures including bone, tendon and nerve. Surgery was performed the same day on in the form of open reduction and internal fixation of the left index proximal phalanx fracture, flexor tendon repair, extensor tendon repair and ulnar digital nerve repair, and open reduction and internal fixation of the articular middle phalanx fracture of the third digit and partial excision of the flexor tendon. The thumb laceration was repaired and irrigation and debridement was performed of all three digits, index, third and thumb. PX 2.

Petitioner was released the next day and told to follow up on 6/9/08. Petitioner followed up with Dr. Patari on 6/9/08 who noted Petitioner was healing well. Petitioner was sent to physical therapy which he attended at Advanced Medical Specialist in Elk Grove through 8/29/08. PX 7. At a follow up with Dr. Patari on 6/16/08 Petitioner was to resume activities as tolerated and continue PT. On 6/23/08, additional x-rays were performed and good fracture alignment and healing was noted for the third middle phalanx but there was still a comminuted fracture of the second proximal phalanx without significant healing. PX 2. Dr. Patari reviewed the x-rays and noted that Petitioner was "doing well." He was to follow up. Petitioner's next ortho follow up was on 10/6/08. Dr. Patari noted on exam full thumb range of motion, limited index finger range of motion and limited third finger range of motion. He read x-rays from that date to show non union of the index finger fracture. Dr. Patari recommended home exercise and radial splinting for the index finger and continued PT to increase range of motion of the third finger. Petitioner was to follow up in one month.

Petitioner followed up with Dr. Patari on 11/3/08. PX 8. Dr. Patari notes that after the surgery, Petitioner had good healing but has since "... developed a nonunion of the proximal phalanx of the index finger and also had developed ulnar deviation of the index finger and has about 50% range of motion of the PIP joint of the third digit. Dr. Patari examined Petitioner to determine if any surgery could be done to improve the function of the index finger. Dr. Patari recommended no further treatment of the third finger stating that any attempt at release to improve the range of motion may result in further regression. With regard to the index finger, he stated that Petitioner may benefit from a joint arthroplasty of the index finger but further investigation was necessary to see whether an implant was feasible. If not, Dr. Patari noted that Petitioner would benefit from a fusion of the index PIP joint. Surgery would only be performed if Petitioner "cannot live with 15 degrees of ulnar deviation that he has." PX 8. Fusion surgery would place the index finger in a neutral position and would not make Petitioner more functional. PX 8. At the follow up on 12/1/08, Petitioner reported that he is able to perform all regular activities of daily living and has improved function on the third digit. Petitioner also reported the ability to pinch and grip things using the index finger. When offered the possibility of surgery and improved function of the index finger Petitioner responded "He is doing fine with all of the activity." Dr. Patari noted "Therefore, I do recommend living with his condition at this time. He should continue his regular activity. Return to gainful employment and he can follow up with me as needed." Petitioner was given an unrestricted full duty release to work on 12/1/08. PX 8.

Petitioner has had no medical care since December 2008. Petitioner testified that Mike no longer wanted to pay for his medical bills so he stopped treating as he could not pay for the treatment. Petitioner testified that he "could not do a lot of work" because of his fingers. Petitioner eventually returned to work

for another employer in a factory cutting paper and last worked in September 2012. Petitioner is not currently working and testified that he is unable to find work because of problems with his left hand. Petitioner did not receive any pay from any source between the date of accident and 12/1/08.

At trial, Petitioner demonstrated that he can partially straighten his hand and that his second and middle finger don't fully bend. Petitioner testified that his left hand is weaker than his right hand and that he is unable to fully bend or extend the injured fingers. Currently, Petitioner feels pain and discomfort in his left hand when it is very cold and when he lifts something heavy over 50 pounds. Petitioner does not take any medication for his hand.

Petitioner testified that he gave the medical bills to Mike and that Mike paid the bills for awhile but then stopped paying the bills. Petitioner testified that he stopped receiving medical bills after he filed his claim. Prior to the filing he received unpaid bills. Petitioner attached a list of medical bills totaling $38,006.89 to ARB EX 1. None of those bills are paid by any source.

On cross-exam, Petitioner was asked why he did not report his accident immediately to any other workers in the yard instead of calling Mike, who was offsite, for help. Petitioner testified that he did not go to other workers for help because he was "afraid" and nervous after he saw his hand. He testified that his mind "wasn't working" and it didn't occur to him to ask others for help. Further, he testified that there were no other Respondent employees present. Petitioner was asked if he was afraid to talk to other yard workers because he was not supposed to be at work that day. After a significant pause, Petitioner did the not agree that he was not supposed to be working for Respondent on 6/2/08 or on any other day.

Mike DiPrizio testified as company president. Mr. DiPrizio testified that he did not hire Petitioner to work in 2008 at any time because the other workers did not want to work with Petitioner. He testified that he "made it clear" he would not hire Petitioner at any point. Mr. DiPrizio testified that MGD Cement had only one job in 2008 and that the company ceased operating after that job. Specifically, he testified that in June 2008 he was working on a church parking lot paving job in Addison. He testified that Petitioner came to the church parking lot job site on approximately three to four days before the accident looking for work. Mr. DiPrizio refused Petitioner work on all dates. Mr. DiPrizio testified that on 6/2/08, Petitioner came to the church parking lot job again looking for work. Mr. DiPrizio again told Petitioner there was no work available for Respondent. Mr. DiPrizio testified that the job was completed at 11:30 am and that he instructed "Manuel" to bring the truck back to the yard. Thereafter, Mr. DiPrizio went home. He testified that he later received a call from Petitioner reporting that Petitioner hurt his hand and that Mr. DiPrizio should come to the yard.

Mr. DiPrizio denied giving Petitioner a paycheck in 2008. However, he later testified that the check for $912 at PX 13 was a check he gave to Petitioner for snow plow work done earlier in 2008. He testified that he had to wait until the church parking lot job was completed before he could pay Petitioner for the snow plowing which is why the check is dated in July 2008. However, Mr. DiPrizio did not explain why the check was written on his son's account and why it was made out to "cash."

CONCLUSIONS OF LAW

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

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 business ... in which electric, gasoline, or other power driven equipment is used in the operation thereof." 820 ILCS 305/3 (LEXIS 2005). Trial testimony supports a finding that Respondent's business required the use of power driven equipment and tools in working with cement. As such, the Arbitrator notes that Respondent MGD Cement was involved in work which was extra hazardous under Section 3 of the Act and as such was operating as an employer under and subject to the Act.

The existence of an employer-employee relationship between Petitioner and Respondent is a prerequisite to determining further compensability of Petitioner's claim. Determination of the existence of an employer-employee relationship rests on the totality of the circumstances in each case with the right to control the manner in which work is performed as the most important consideration.

The Arbitrator initially notes that the issue of employer-employee at trial hinged on whether Petitioner had *actually been hired* to work by Respondent in 2008 so as to make his very presence in the work yard on 6/2/08 valid. Petitioner asserts that he was hired by Respondent and told to work in the yard that day. Respondent asserts that it did not hire Petitioner at any point in 2008 making his presence in the work yard voluntary and not that of a Respondent employee. Neither party contests that Petitioner worked for Respondent in *2007*. In fact, the 2007 employment relationship is supported by the W2's and pay stubs from *2007* contained in PX 13. However, no such pay records were offered at trial in support of a *2008* employment relationship. The check for $912 purportedly dated in July 2008 contained in PX 13 is at best questionable and is insufficient to prove any employment relationship.

The Arbitrator notes that the record is without objective evidence to sufficiently support a finding that Petitioner was hired as an employee in 2008. Accordingly, the Arbitrator's determination of this threshold issue was based primarily on the credibility of the witness testimony at trial. The Arbitrator considered and weighed the testimony of Petitioner and Mr. DiPrizio on the issue of whether Petitioner was actually hired in 2008. Mr. DiPrizio clearly and convincingly testified that he refused Petitioner's requests for work each time he appeared at Respondent's one and only job site in 2008, including on the date of the accident. Petitioner offered equivocal and hesitant testimony on the issue of his hire and specifically, whether he was supposed to be at the yard at all on June 2, 2008. After consideration of the witness testimony, the Arbitrator places greater weight on the testimony of Mike DiPrizio and finds his version of events more plausible than that of Petitioner. Specifically, the Arbitrator finds that although Petitioner was present in the yard using a saw on June 2008, he failed to meet his burden to prove that he was there as an employee of Respondent so as to satisfy the requirement of an employment relationship under the Act. That being said, determination of the right to control the work is not necessary. Finally, it follows that Petitioner also failed to meet his burden to prove that an accident occurred that arose out of and in the course of any employment by Respondent.

Based upon the totality of evidence at trial, including the testimony of Petitioner and Mike DiPrizio, the Arbitrator finds that Petitioner was not hired by Respondent to work for MGD Cement at any time in 2008, thus there was no employee-employer relationship on June 2, 2008, and no accident occurred arising out of and in the course of any employment with Respondent. Accordingly, all remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDRES ZARATE-MARTINEZ,

Petitioner,

vs.

NO: 11 WC 35712

15IWCC0491

TORRES' SON, INC. and ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND ,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Arbitrator's decision with regard to temporary total disability and 20% of the left foot. We modify the award made on the basis of the skin graft taken from Petitioner's left thigh from 2% of the man as a whole to 2.5% of the left leg. This is a specific insult to the leg itself, not the man as a whole, and the appropriate award is a percentage of the leg. We feel that this insult was relatively minimal, and thus find that the award itself should be appropriately minor as a percentage of the leg.

The Illinois State Treasurer as ex-officio custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and

allowed under Section 4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund. This award is entered against the Injured Workers' Benefit Fund as permitted and allowed under Section 4(d) of the Act, except for the penalties and attorney fees against the Respondent, Torres' Son, Inc. under Sections 19(k), 19(l) and 16 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $300.00 per week for a period of 5-3/7 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 $270.00 per week for a period of 38.775 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 20% of the left foot and 2.5% of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $7,920.62 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,058.00 for medical payments Petitioner made out-of-pocket to Centegra Hospital and Mercy Health System for services that were reasonable, necessary and related to the accident of April 19, 2010.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $10,633.59 as provided in §19(k) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $2,126.71 as provided in §16 of the Act; the balance of attorneys' fees to be paid by Petitioner to his attorney.

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.

15IWCC0491

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $45,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 3 0 2015
TJT: pvc
o 5/5/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZARATE-MARTINEZ, ANDRES
Employee/Petitioner

Case# **11WC035712**

TORRES' SON INC AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0491

On 5/13/2014, 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:

0247 HANNIGAN & BOTHA LTD
PATRICK CZUPRYNSKI
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

TORRES' SON INC
26716 N MAIN ST
WAUCONDA, IL 60084

5199 ASSISTANT ATTORNEY GENERAL
MELISSA HINTERHAUSER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Andres Zarate-Martinez
Employee/Petitioner

v.

Torres' Son, Inc. and Illinois State Treasurer as ex-oficio custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **11** WC **35712**

Consolidated cases: _____

15IWCC0491

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

FINDINGS

On **April 19, 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 **$23,400.00**; the average weekly wage was **$450.00**.

On the date of accident, Petitioner was **30** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

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

ORDER

Respondent shall pay reasonable, related and necessary of medical services of $7,920.62, as provided in Section 8(a) of the Illinois Workers' Compensation Act ("Act").

Respondent shall pay Petitioner out of pocket medical expenses amounting to $2,058.00 for payments made to Centegra Hospital and Mercy Health Systems for services that were reasonable, necessary and related to the April 19, 2010 accident.

Respondent shall pay Petitioner permanent partial disability benefits of $270.00/week for 33.4 weeks, because the injury sustained caused 20% loss of use of the left foot, as provided in Section 8(e)(11) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $270.00/week for 10 weeks under 8(d)(2) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $300.00/week for 5 and 3/7 weeks for the time period of April 20, 2010 through May 26, 2010.

Respondent, Torres' Son, Inc., shall pay Petitioner $10,633.59 in penalties pursuant to 19(k) of the Act, $10,000.00 Pursuant to 19(l) of the act and $2,126.71 pursuant to Section 16 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was names as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund permitted and allowed under Section 4(d) of this Act, except for the Penalties awarded against the Respondent, Torres' Son, Inc., under section 19(k), 19(l) or 16(a) of the Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing to the Petitioner pursuant to Section 5(b) and 4(d) of the Act. Respondent/Employer/Officer/Owner shall reimburse the injured benefit fund for any compensation obligations Respondent/Employer/Officer/Owner that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

R Falcon
Signature of Arbitrator KM

5/5/14
Date

MAY 13 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATOR DECISION

Andres Zarate-Martinez
Employee/Petitioner

Case #: 11WC35712

v.

Torres' Son, Inc. & Illinois State Treasurer
As ex-oficio custodian of the
Injured Workers' Benefit Fund
Employer/Respondent

Arbitrator's Findings of Facts and Conclusion of Law

I. Findings of Fact

This action was pursued under the Illinois Workers' Compensation Act by Petitioner, Andres Zarate Martinez, and sought relief from Respondent-Employer, Torres Sons, Inc. This action also sought relief from the Injured Workers' Benefit Fund because the employer did not maintain workers' compensation insurance. (Petitioner's Exhibit "Px." 5). A hearing was held before Arbitrator Falcioni on April 21, 2014. Petitioner notified the employer of the hearing by mail. The employer did not appear for any of the arbitration proceedings and was not represented by an attorney. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings.

Petitioner testified that he was 30 years old, married, and with one dependent child on the date of the accident. He testified that he worked for Torres Sons, Inc. for three years prior to the accident. He was referred to the employer through a friend, and interviewed with Mr. Torres, the owner, before being hired. Petitioner stated that he worked as a landscaper/gardener, and his job duties included cutting grass, laying mulch, gardening and trimming trees. He testified that he used the company's tools to complete his tasks which included a tractor and leaf blower. Petitioner testified that he was a salaried employee earning $450.00, paid in cash, per week.

Petitioner testified that on the morning of April 19, 2010 he was riding on a tractor while working at a job in Round Lake. He stated that the tractor tipped over and hooked onto his foot. After the tractor tipped, he looked down and saw blood. His friend Oscar was present and witnessed the event. Petitioner testified that after the accident occurred on April 19, 2010, he instructed Oscar to call the Owner to notify him of the injury. Petitioner testified Oscar called the Owner, Mr. Torres. Petitioner testified that he was then taken to the hospital by ambulance.

At the hospital, Petitioner's left foot and left ankle were x-rayed twice. (Px. 1 at 6 and 7). No fractures or bony abnormalities were seen in the first x-ray at 9:01am, however, a subsequent x-ray at 9:55am notes that foreign bodies were removed from Petitioner's subcutaneous tissue posterior and inferior to the calcaneus. (Id). On April 20, 2014, Dr. Paul Dillon performed a full-thickness debridement and split-thickness skin graft measuring 10cm squared using Petitioner's left thigh as a donor cite. (Px. 1 at 8). Petitioner followed up with Dr. Dillon on April 30, 2010 and May 26, 2010. (Px. 2 at 3-5). On May 26, 2010, Dr. Dillon found the skin to

be healed and directed Petitioner to follow up as needed. (Px. 2 at 3). Petitioner testified that he has not treated for this injury since May 26, 2010.

Petitioner testified that he did not work from April 19, 2010 until May 26, 2010 while he was treating for his left foot injury. Petitioner testified that he did not receive compensation from the employer for this period of time nor was there any payment of medical benefits by his employer. Petitioner testified that he returned to his position at Torres Sons, Inc. for another two months, but the work ended after that.

Petitioner Testified that his current employment is tending to horses and his job requires him to be on his feet for the entire time he is at work, 8 hours per day. Petitioner stated that in the morning, he feels pain in his foot and work aggravates his pain. Additionally, after working, Petitioner testified his foot will sometimes become numb and swollen and rubbing his hands over his foot will reduce the swelling. Petitioner testified he is not actively seeking medical treatment for his left foot.

II. Conclusions of Law

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

The Petitioner testified that the employer, Torres' Son, Inc. business was landscaping services in and around Lake County, Illinois which includes cutting grass, mulching and gardening. Petitioner testified that as a part of his employment, he used an employer provided leaf blower and tractor. The arbitrator finds that Torres' Son, Inc. business and activities are sufficient to subject Torres' Son, Inc. to the automatic coverage provision of Section 3(8), 3(10) and 3(15) of the Illinois Workers' Compensation Act.

B. Was there an employer employee relationship?

The unrebutted testimony of the Petitioner established an employee employer relationship between Torres' Son, Inc. and Petitioner at the time of the accident. Petitioner Testified that he worked for Torres' Son, Inc. for three years prior to the April 19, 2010 accident. Petitioner further testified that he was interviewed and hired by the owner, Mr. Torres; was paid a salary of $450.00 per week from Torres' Son, Inc.; and the tools he used while performing his job duties were provided by Torres' Son, Inc. The Arbitrator finds that Petitioner proved by a preponderance of evidence that an employee employer relationship existed on April 19, 2010.

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

The unrebutted testimony of the Petitioner and the medical records admitted into evidence establish, by a preponderance of evidence, the April 19, 2010 accident arose out of and in the course of Petitioner's employment with Torres' Son, Inc. Petitioner testified that on the morning of April 19, 2010, he was driving a tractor for Torres' Son, Inc., when the tractor tipped over. As the tractor tipped over, the tractor caught his left foot and ankle. Petitioner looked at his ankle and saw blood. The medical records confirm that the Petitioner was seen on April 19, 2010 for left ankle pain and an open wound to the left foot. (Px. 1 at 5-8). The Arbitrator finds that preponderance of evidence establishes Petitioner suffered an accident that arose out of and in the course of his employment with Torres' Son, Inc.

D. What was the date of accident?

Based upon the testimony of the petitioner and corroborating medical records, the petitioner has established that he sustained an injury that arose out of and in the course of his employment on April 19, 2010

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

The unrebutted testimony of the Petitioner establishes timely notice of the accident to the owner of Torres' Son, Inc. on April 19, 2010. Petitioner testified that after the accident occurred, he instructed his co-worker, Oscar to call the owner to tell him about the accident. Petitioner testified that the co-worker called the owner and reported the injury to the owner, Mr. Torres. The Arbitrator finds that the petitioner proved he gave notice of this injury to the Respondent within 45 days of the April 19, 2010, accident.

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

Petitioner testified that since the accident, he experiences pain, numbness and swelling of his left foot. The Arbitrator finds that the unrebutted testimony of the Petitioner establishes that his current condition of ill-being, namely: numbness, pain and swelling of his left foot is causally related to the April 19, 2010 accident.

G. What were petitioner's earnings?

The Petitioner testified he was a 3 year employee of Torres' Son, Inc and at the time of the accident he was earning a salary of $450.00 per week. The Arbitrator finds the Petitioner's testimony credible and unrebutted. Therefore, the Arbitrator finds the preponderance of evidence establishes an average weekly wage of $450.00.

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

The Petitioner testified that his date of birth is October 2, 1979. The Arbitrator finds Petitioner was 30 years old on the date of the accident.

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

Petitioner testified that he was married at the time of the accident. Further, Petitioner testified he has a child, who at the time of hearing was 17 years of age. This was unrebutted testimony. The Arbitrator finds the Petitioner was married with one dependent child at the time of the April 19, 2010 accident.

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

The Petitioner testified he sought treatment for his left foot and ankle between April 19, 2010 and May 26, 2010. Petitioner testified he was transported to Centegra Hospital by ambulance. On April 19, 2010, X-rays were taken of Petitioner's left ankle and foot at the hospital. (Px. 1 at 5-7). On April 20, 2010, Dr. Paul Dillon performed a full-thickness debridement and split thickness skin graft measuring 10cm sq. (PX. 1 at 8). Petitioner followed up with Dr. Dillon on April 30, 2010 and May 26, 2010. (Px. 2 at 3-5). On May 26, 2010, Dr. Dillon discharged Petitioner from care and requested Petitioner to follow up as needed. (Px. 2 at 3).

Petitioner testified he received no payment of benefits from the Respondent, Torres' Son, Inc. Petitioner presented the following medical bills and outstanding amounts, which were admitted into evidence as Plaintiff's Exhibit 16:

Anesthesia Associates of Crystal Valley, S.C. - $1,090.00
Centegra Northern Illinois Medical Center - $5,103.02
McHenry Radiologist Imaging Associates - $126.00

McHenry Health Systems - $1,601.60

The medical bills presented also provide that the Petitioner has paid out of his own pocket: $1,600.00 to Centegra Hospital. (Px. 16 at 8); and $458.00 to Mercy Health Systems. (Px. 16 at 11, 14).

Based upon the testimony of the Petitioner and the Petitioner's exhibits, the Arbitrator finds that the services rendered to the Petitioner for treatment between April 19, 2010 and May 26, 2010 was medically reasonable, necessary and related to Petitioner's work injury. Hence, the Arbitrator finds that the Respondent, Torres' Son, Inc. shall pay the medical bills pursuant to the fee schedule or negotiated rate, whichever is less, pursuant to the Illinois Workers' Compensation Act.

Further, the Arbitrator finds that the Respondent, Torres' Son, Inc. shall pay the Petitioner for out of pocket medical expenses of $2,058.00.

K. Is the Petitioner entitled to temporary total disability benefits?

To show entitlement to TTD benefits, the Petitioner must prove not only he did not work, but that he was unable to work due to the injury in question. *Gallentine v. Industrial Commission*, 201 Ill. App. 3d 880 (2 Dist. 1990). Petitioner testified that he was off of work from April 19, 2010 through May 26, 2010 because he was treating for his work-injury. The treating doctors provided no opinions as to whether the Petitioner could return to work pre or post operatively. The Arbitrator finds that Petitioner was temporary and totally disabled due to the work injury from April 20, 2010 through his date of discharge by Dr. Dillon on May 26, 2010 and is entitled to 5 and 3/7 weeks of TTD benefits.

Using the TTD rate of $300.00, 5 and 3/7 weeks amounts to $1,628.57. The Arbitrator finds that the Respondent shall pay the Petitioner $1,628.57 in TTD benefits.

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

Petitioner suffered a left foot laceration after the tractor he was driving tipped over on April 19, 2010. On that day, small foreign bodies were identified in the subcutaneous tissue posterior and inferior to the calcaneus were removed. (Px. 1 at 7). On April 20, 2010, Petitioner underwent full thickness debridement and split-thickness skin graft, using the left thigh, that measured 10cm sq. (Px. 1 at 8). On May 25, 2010, Dr. Dillon noted that the Petitioner suffered a Workers' Compensation injury to the lateral left ankle in a tractor accident and that the Petitioner was doing well, skin healed and to follow up as needed. (Px. 2 at 3).

At hearing, Petitioner testified that he currently experiences pain, numbness and swelling in his left foot due to the April 19, 2010 accident. Petitioner now works tending horses which requires him to be on his feet for all eight hours of the work day. Petitioner testified that he feels pain in the morning and that his work increases his left foot pain. Additionally, Petitioner testified that sometimes his foot will be swollen at the end of the work day and rubbing his foot with his hands helps reduce the swelling. The medical records do not detail any of Petitioner's subjective complaints while receiving treatment from April 19, 2010 through May 26, 2010.

Petitioner did not speak English, testified that he has received an education up to the first grade and showed a partial inability to articulate his testimony at hearing. However, based upon the Petitioner's credible testimony, the medical exhibits demonstrating: foreign body removal, debridement, skin graft with an donor cite from the Petitioner's left thigh, the Arbitrator awards 20% loss of use of the left foot pursuant

to 8(e)(11) of the Act for the injuries sustained to Petitioner's left foot and 2% loss of use person as a whole under section 8(d)(2) of the Act due to the skin grafting of Petitioner's left thigh. No evidence regarding the effect of this injury upon Petitioner's future earning capacity was elicited. The Arbitrator considered all relevant factors in arriving at this award.

M. Should penalties or fees imposed upon Respondent?

Section 19(k) of the Act states, in pertinent part:

> "In case where there has been any unreasonable or vexatious delay of payment... the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of that amount payable at the time of such award."

Section 19(l) of the Act states, in pertinent part:

> "If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing for the delay...In case the employer...shall without good and just cause fail , neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or Commission shall allow the employee compensation in the sum of $30 per day ...not to exceed $10,000.00."

Section 16 of the Act states, in pertinent part:

> "Whenever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of...unreasonable or vexatious delay...within the purview of the provisions of paragraph (k) of Section 19 of this act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier."

Petitioner issued a demand for payment of outstanding medical bills to Dwight C. Adams and Associates on October 15, 2012 and has issued numerous requests for hearings directed at the employer via certified mail which, each time, returned to the Petitioner's attorney as "unclaimed." The Arbitrator finds that the Employer has failed to provide an explanation as to why it has made no payment of benefits to the Petitioner since the work-related accident of April 19, 2010. Four years and three days has passed since the date of accident and no payment of benefit has been made. This Arbitrator finds that there has been an unreasonable and vexatious delay of payment and awards penalties in the amount of $10,633.59 pursuant to 19(k) of the Act, $10,000.00 Pursuant to 19(l) of the act and $2,126.71 pursuant to Section 16 of the Act. against the Respondent, Torres' Son., Inc only.

N. Is Respondent due any credit?

Respondent, Torres' Son, Inc. failed to appear at hearing and no evidence was admitted or provided which demonstrates Torres' Son, Inc. is due any credit. Thus, the Arbitrator finds that the Respondent is not due any credit pursuant to the Act.

O. Was sufficient notice sent to the Respondent/Employer?

Section 7030.20 of the "Rules Governing Practice Before the Workers' Compensation Commission," establish the practice for setting a case for trial:

> ...If any party fails without good cause to appear, the Arbitrator will hear the motion for trial date ex-parte and if the Arbitrator determines the matter ready for trial will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify opposing party of the trial date.

The Respondent, Torres' Son, Inc. was given adequate notice of this matter and trial occurring on April 21, 2014. Petitioner's Exhibit 19 provides the last known address of the Respondent, Torres' Son, Inc. is 162 S. Waterford Drive, Round Lake, IL 60073. On September 26, 2013 Petitioner's Attorney sent a request for hearing to via certified mail to Torres' Son, Inc. (Px. 10). On December 13, 2013, Petitioner sent Torres' Son, Inc. a request for hearing via certified mail for hearing on January 17, 2014. (Px.17) On January 17, 2014, the matter was set for trial on January 29, 2014. On January 17, 2014, Petitioner sent a trial notice to Torres' Son, Inc. via certified mail. (Px. 18). On January 29, 2014, Torres' Son, Inc. failed to appear, Petitioner's oral ex-parte motion for trial was granted and the matter was set for trial on February 19, 2014 in Rockford, Illinois. On January 30, 2014, Petitioner sent notice to Torres' Son, Inc. regarding the February 19, 2014 trial date, certified mail. (Px. 20). On February 19, 2014, Torres Son, Inc. failed to appear and Petitioner's oral ex-parte motion for trial was granted and the matter was set for trial on April 21, 2014. On February 20, 2014, Petitioner issued a trial notice to Torres' Son, Inc. via certified mail regarding the April 21, 2014 trial date. (Px. 21). On April 11, 2014, after the Waukegan status call, Petitioner again sent notice of the April 21, 2014 trial date via certified mail. (Px. 22). Attorney for the Injured Workers' Benefit Fund was also provided notice of the hearing and trial dates above and is included as a part of Petitioner's exhibits. (Px. 9, 12, 14, 17, 18, 20, 21, 22) Attorney for the Fund appeared on behalf of the Fund at all hearings.

Based on the above, the Arbitrator finds that Petitioner has provided adequate notice to Respondent/Employer.

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

Nicol E Falcioni

Arbitrator Robert Falcioni

May 5, 2014

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TARA CARBONE,

Petitioner,

vs. NO: 13 WC 27868

ILLINOIS DEPARTMENT OF HUMAN SERVICES, 15IWCC0492

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

The Commission affirms and adopts the Arbitrator's decision with regard to the finding that Petitioner failed to prove that she sustained an accidental injury arising out of and in the course of her employment on July 15, 2013. Additionally, the Commission specifically finds that Petitioner failed to prove that her need for left wrist/hand surgery is causally related to her employment with Respondent.

In reviewing the medical evidence in this case, in particular the operative report of Dr. Sipe, we note that there is no clear evidence the Petitioner sustained a left triangular fibrocartilage complex (TFCC) tear (Petitioner's Exhibit 3). On August 16, 2013 Dr. Sipe noted pain at the TFCC region with ulnar and radial deviation, however examination was difficult due to global wrist pain (Petitioner's Exhibit 2). An EMG that was performed based on a differential diagnosis of carpal tunnel syndrome was negative (Petitioner's Exhibit 2). While the MRI arthrogram of September 11, 2013 (Petitioner's Exhibit 3) notes deformity of the TFCC with probable tear of the ulnar homologue and surrounding synovitis, the operative report itself wherein Dr. Sipe visualized the inner wrist did not specifically reflect a TFCC tear, but rather noted: "The ulnar side of the wrist did have synovitis around which may have been *either* (emphasis added) a tear or congenital opening at the ulnar side of the TFCC ligament." Dr.

15IWCC0492

Sipe's report also indicated that the TFCC itself had appropriate connection both volar and dorsally. Further, the final diagnosis noted in the operative report was "Left wrist triangular fibrocartilage complex (TFCC) injury with local synovitis." (Petitioner's Exhibit 3). This diagnosis does not mention a TFCC tear, nor does it give any indication that the TFCC treatment was for an acute pathology.

An initial x-ray on August 16, 2013 at Pontiac Hospital indicated a negative ulnar variance. On April 30, 2014 Dr. Urbanosky noted that bilateral wrist x-rays reflected negative ulnar variance in both the left and right wrists, 4 millimeters on the left and 3 millimeters on the right.

The Commission finds that the greater weight of the evidence supports the factual finding that the Petitioner's left wrist condition which resulted in surgery with Dr. Sipe was a congenital, bilateral condition that is not causally related to the July 15, 2013 incident at work testified to by Petitioner. As noted above, we have affirmed the Arbitrator's finding that this incident did not constitute a compensable accident under Illinois law. Thus, the Petitioner has both failed to prove that she sustained an accident arising out of and in the course of her employment with Respondent on July 15, 2013, as well as failed to prove her left wrist condition that was surgically corrected was causally related to the July 15, 2013 incident.

Based on the denial of benefits, the Commission fixes no appeal bond in this matter. Based on the Respondent being the State of Illinois, pursuant to Section 19(f)(1) of Act, the decision of the Commission is not subject to judicial review.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on July 15, 2013 is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has failed to prove that her left wrist/hand condition is causally related to her employment with Respondent.

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

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

DATED: JUN 3 0 2015
TJT: pvc
o 5/5/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

CARBONE, TARA
Employee/Petitioner

Case# **13WC027868**

IL DEPT OF HUMAN SERVICES
Employer/Respondent

15IWCC0492

On 7/29/2014, 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:

1315 DWORKIN AND MACIARIELLO
JULIO COSTA
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

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

3201 ASSISTANT ATTORNEY GENERAL
MONICA J KIEHL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 29 2014

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

15IWCC0492

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tara Carbone
Employee/Petitioner

v.

Illinois Department of Human Services
Employer/Respondent

Case # 13 WC 27868

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 **Geneva**, on **June 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, **7/15/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$71,435.00**; the average weekly wage was **$1,373.00**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$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's injury did not arise out of Petitioner's employment with Respondent. Therefore, 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 of Arbitrator

7/28/14
Date

JUL 29 2014

FINDINGS OF FACT

Petitioner is claiming she sustained an injury to her left hand when she was attempting to open a door at work on July 15, 2013. At issue in this case is accident, causation, TTD and medical expenses.

The Petitioner testified that she was employed by the Department of Human Services for approximately two years and two months at the time of the accident. She was a case worker, and her duties included providing link cards, medical cards, typing, writing and doing interviews. Petitioner testified that she felt fine on the day of the accident and was in a stable, healthy condition. On the date of the accident, she was exiting the building through the North employee entrance and exit door, which only employees used. On one side of the door was a key pad that employees used to punch in a code, and on the other side of the door was a lever that you pushed to open the door from the inside. She testified that she used this door every day and that on July 15, 2013, the door jammed and wouldn't open. While attempting to open the door, Petitioner testified that she had terrible pain in her left wrist. She denied having any pain prior to the date of her injury.

Petitioner testified that the standard protocol was to report an incident, and the supervisor would give you the paperwork to fill out. Petitioner testified that she notified her supervisor, Margaret O'Leary, and she was given a worker's compensation packet. She left work that day within 15 minutes of the accident. Petitioner testified that she was told someone had inspected the door following her incident. Petitioner called her family doctor and was told she had to go to St. James which is in Pontiac, approximately seventy miles away. Petitioner stated that Ms. O'Leary was aware that she was going to St. James Occupational Health. At St. James Occupational Health she told Dr. Wright that she hurt her wrist on a door that jammed. Petitioner underwent x-rays and she was diagnosed with a bad sprain. They gave her a hard splint and an ace bandage, prescribed Ibuprofen and told her she could return to work with no use of her left hand. Respondent could not accommodate these restrictions.

Petitioner also saw Dr. Richard Saylor and testified that she told him the door had jammed. Petitioner testified that she needed to see an orthopedist, but she couldn't because worker's compensation denied her claim. Petitioner eventually saw Dr. Sipe, who prescribed an MRI and EMG which showed Petitioner had a torn ligament in her wrist. Petitioner testified that Dr. Sipe related her injury to the work incident. Petitioner had surgery on October 8, 2013. After surgery, she was told she could not work at all; she was not to use her left hand. She was given a hard splint, pain medication and anti-inflamatories. Petitioner started physical therapy approximately one month later, and she attended it three times per week. Petitioner was released to work on December 2, 2013. Petitioner was off work from July 15, 2013 through December 2, 2013.

Petitioner testified that following her return to work, she was still having pain and swelling and went to Hinsdale Orthopedics and saw Dr. Cory, where she was given a cortisone injection. Petitioner testified that she told Dr. Cory that she hurt her hand because the door jammed. Petitioner had another MRI which indicated that there was the same tear in the ligament, and there was cartilage damage and a cyst, which the doctor related to the work injury. Another surgery was recommended, but Petitioner has not had it yet. The last day Petitioner worked was May 14, 2014, and she remains off work as of the date of trial.

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Petitioner testified that her injury has affected every aspect of her life and daily activities. Petitioner owes approximately $30,000.00 in medical bills, because her group insurance would not cover it as it was a work-related injury.

On cross-examination, the Petitioner testified that the door had jammed, and she denied telling Dr. Cory that she tried to open a door that had been locked. Petitioner further denied telling Dr. Sipe that she tried to open a door that had been locked. Petitioner testified that she went to push the door, and it didn't open; she stated that the lock mechanism had to reset. She further stated that she was at the facility on June 18, 2014 (the day before trial) to have her address changed.

Margaret O'Leary, Petitioner's supervisor, testified for the Respondent. Ms. O'Leary stated that she has worked at the Department of Human Services her entire career, approximately 35 years, and was working on the date of the Petitioner's injury. Ms. O'Leary testified that she filled out a report of injury which stated that Petitioner had told her that she was injured when the lever on the door malfunctioned. (RX 1.) Ms. O'Leary further testified that she then checked the door for defects and found none. She further testified that 99.9% of the employees use this door, and it is usually locked. If any employee was having problems with this door, they would report it to her; no one had ever reported having any problems with this door. Ms. O'Leary testified that she personally uses this door at least twice a day, and she has never had a problem with it. As to the condition of the door presently, Ms. O'Leary testified that on June 11, 2014, she received an e-mail indicating that the door in question was in need of repair. (RX 2.) She stated that it was damaged by the cleaning crew on June 10, 2014 while they were using something to prop the door open. She stated that this door never had this problem before, and the door was not in the same condition as it was on the date of the injury. Ms. O'Leary testified that she had seen the Petitioner the day before trial (June 18, 2014) when Petitioner came to the facility. While Petitioner was there, Ms. O'Leary was told that Petitioner was taking pictures of the door in the condition it was in on June 18, 2014. Ms. O'Leary testified that there was currently a sign on the door that stated the door was damaged, and Petitioner told Ms. O'Leary that that was "good for my case."

On cross-examination, Ms. O'Leary testified that Petitioner was a good employee, that any injuries were reported to her, and that there were no security cameras. When asked why the Supervisor's Report wasn't filled out until two days later, and not on the date of the injury, Ms. O'Leary testified that she needed to receive the paperwork from Petitioner before filling out the report. Ms. O'Leary testified that she checked the door; there are three separate doors that have to be gone through, and she checked all three on the day of the incident and found all the doors operational. She went through all three doors twice and, every time, the doors were operational. Ms. O'Leary further testified that she did not know that the Petitioner was going to the hospital, and she didn't recall her saying that she was in pain. She further stated that she didn't recall if Petitioner was excused to go to the hospital.

On re-direct, Ms. O'Leary stated that she had received no complaints about the door jamming between June 15, 2013 and June 17, 2014. On re-cross, Ms. O'Leary stated that the type of inspection she did was the usual inspection that would be done to determine the door was operational. She was allowed to go through the doors, and they never jammed on her. She further stated that she was not aware of any other supervisor receiving complaints about the door.

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CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has not met her burden of proof. Specifically, the Arbitrator finds that the simple act of attempting to open a door does not rise to the level of an accident without a showing that the door in question was defective. "An employee's injury is compensable under the Act only if it arises out of and in the course of the employment." Litchfield Healthcare Center v. Industrial Comm'n, 349 Ill.App.3d 486, 489, 812 N.E.2d 401, 285 Ill.Dec. 581). Both elements must be present at the time of the claimant's injury in order to justify compensation. Illinois Bell Telephone Co. v. Industrial Comm'n., 131 Ill.2d 478, 483, 546 N.E.2d 603, 605 (1989). There is no question that this incident occurred in the course of Petitioner's employment. The pivotal question is whether the Petitioner's injuries arose out of her employment. "Arising out of the employment refers to the origin or cause of the claimant's injury." Caterpillar Tractor Co. v. Industrial Comm'n., 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Tractor at 667. For an injury to be found to arise out of one's employment, there must be a special risk or hazard which becomes part of the employment. "Special hazards or risks encountered as a result of using a usual access route satisfy the 'arising out of' requirement of the Act." Litchfield Healthcare at 491. A defective door would constitute such a special hazard or risk. However in this case, the only evidence that Petitioner injury was caused by a defective door was her own testimony. This testimony was rebutted by Respondent's witness, Mrs. O'Leary, who tested the alleged door in question and did not find it to be defective. Mrs. O'Leary credibly testified that there were no reports of any defects in the door in question and that she was able to open and close the door without any problems before and after Petitioner's alleged accident. Although Mrs. O'Leary testified that the door was recently undergoing repair, this was due to a malfunction preventing the door from closing –which occurred almost a year after the date of Petitioner's accident. Given all these facts, the Arbitrator finds that the Petitioner's injury did not arise out of her employment.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEPHANIE M. RICHESON,
Executrix of Estate of
RICHARD V. HAUBOLD,

Petitioner,

vs. NO: 07 WC 55739

FREEMAN UNITED COAL MINING COMPANY, 15IWCC0493

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Sangamon County. Pursuant to the Circuit Court's Order dated May 14, 2014, this matter was reversed and remanded to the Commission for a re-hearing on all issues.

This matter was previously tried before the Arbitrator on August 6, 2012. The Arbitrator found that the Decedent, Richard Haubold, failed to prove an occupational disease arising out of and in the course of his employment. The Arbitrator further found that the evidence presented as to coal dust exposure was for a job that the Decedent performed more than four years prior to his last job that was on the surface. The Petitioner, Stephanie Richeson, appealed to the Commission. The Commission issued its Decision (13 IWCC 929) on November 1, 2013 affirming and adopting the Decision of the Arbitrator.

The Circuit Court reversed and remanded this matter back to the Commission finding the Commission's Decision contrary to the law set forth in *Freeman United Coal Mining Company v. Industrial Commission*, 188 Ill. 2d 243 (1999). The Circuit Court found that the Commission's

conclusion that Decedent was not exposed to coal dust on his last day of employment erroneous as *Freeman* held "[n]othing in the Act, however, makes an employer's liability contingent on a claimant's ability to link his condition to exposure on the final day of employment with that employer."

The Commission adopts the findings of facts contained within the Decision of the Arbitrator (07 WC 55739) dated August 27, 2012 and incorporates them by reference herein.

According to Section 1(d) of the Occupational Disease Act:

> An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists…
>
> If a deceased miner was employed for 10 years or more in one or more coal mines and died from a respirable disease there shall, effective July 1, 1973, be a rebuttable presumption that his or her death was due to pneumoconiosis…

The evidence establishes that Mr. Haubold had been employed by Freeman United Coal Mining Company for 32 years; the majority of which was spent working underground. Paul Garrison testified that Mr. Haubold performed dusty jobs and that there was a lot of dust in the air. Pursuant to Section 1(d) of the Act, Mr. Haubold is conclusively deemed to have been exposed to the hazards of an occupational disease.

Mr. Haubold died on October 24, 2008. According to the death certificate, the cause of death was "most c/w combination of moderate cardiomegaly and moderate coronary artery atherosclerosis." An autopsy revealed moderate coronary artery atherosclerosis (left main, left circumflex 60% occluded) and moderate cardiomegaly (550 gm). The respiratory system had marked anthracosis and the hepatobiliary system had mild steatosis. The incidental findings revealed a goiter (240gm) and focal squamous metaplasis, right pulmonary bronchioles. Pursuant to the Act, Decedent is entitled to the rebuttable presumption that his death was due to pneumoconiosis.

The Petitioner and Respondent each obtained expert opinions. Dr. Robert Cohen performed a b-read at the request of the Petitioner. Dr. Cohen found his review positive for opacities of pneumoconiosis at a profusion of 1/0 p/q. He diagnosed Decedent with coal workers' pneumoconiosis (CWP) and chronic bronchitis as a result of his 32 years of exposure to coal dust. PX.1.

Dr. Henry Smith reviewed the record at the request of the Petitioner. Dr. Smith opined that the Decedent had simple CWP with small opacities, primary p, and secondary q in the upper, mid and lower zones bilaterally, of a profusion 1/1. PX.2.

Dr. Michael Alexander reviewed the chest films at the request of the Petitioner. He found small round opacities present bilaterally that were consistent with pneumoconiosis, p/p, 1/0. He diagnosed Decedent with CWP. PX.4.

Dr. David Rosenberg performed a review at the request of the Respondent. Dr. Rosenberg opined that Decedent did not have evidence of interstitial lung disease, did not have any significant respiratory impairment, and had no obstruction or restriction. RX.2.

Dr. Jerome Wiot performed a review at the request of the Respondent. He found no evidence of CWP. There was a large goiter extending into the mediastinum on the CT. Decedent had minimal apical pleural thickening. Dr. Wiot stated this was very common in the general population. RX.1.

It is the function of the Commission to resolve disputed questions of fact, including those of causal connection, to decide which of conflicting medical views is to be accepted and to draw permissible inferences. *Material Service Corp. v. Industrial Comm'n* (1983), 97 Ill. 2d 382, 454 N.E.2d 655. In the presence of conflicting medical opinion, the Commission's determination is given substantial deference and will be upheld unless it is contrary to the manifest weight of the evidence. *Material Service Corp.*, 97 Ill. 2d 382, 454 N.E.2d 655. The Commission is the judge of the credibility of witnesses. *Caterpillar Tractor Co. v. Industrial Comm'n* (1983), 97 Ill. 2d 35, 454 N.E.2d 252. It is the peculiar province of the Commission not only to determine the credibility of witnesses but also to weigh the testimony and to determine the weight to be given to the evidence. *Berry v. Industrial Comm'n* (1984), 99 Ill. 2d 401, 459 N.E.2d 963; *Dunker v. Industrial Comm'n* (1984), 126 Ill. App. 3d 349, 466 N.E.2d 1255.

The Commission finds that the Respondent did not overcome the rebuttable presumption afforded to the Decedent. In support of its finding, the Commission finds the opinions of Dr. Cohen, Dr. Smith, and Dr. Alexander more persuasive than the opinions of Dr. Wiot and Dr. Rosenberg. Dr. Cohen diagnosed Decedent with CWP and chronic bronchitis as a result of his 32 years of exposure to coal mine dust. Mr. Garrison's un-rebutted testimony bolstered Dr. Cohen's opinion. Mr. Garrison testified that the Decedent worked dusty jobs and used toxic glue. Mr. Garrison further testified that he personally observed the Decedent wheezing and coughing, despite the Decedent being a non-smoker. Mr. Garrison's testimony is supported by the medical records which document a history of a chronic cough and shortness of breath, and the chest x-rays which was positive for opacities consistent with pneumoconiosis.

In further support of the opinions of Dr. Cohen, Dr. Smith and Dr. Alexander is the fact that the Act dictates that the Decedent was exposed to the hazards of an occupational disease due

15IWCC0493

to his work history in the coal mines. The evidence supports a finding that the Decedent developed CWP as a result of his 32 years of exposure to the coal dust, which lead to his death.

The Commission finds that the Petitioner is entitled to 10% MAW as a result of Decedent's CWP.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 10 percent loss of use of the person-as-a-whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 30 2015

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 05-11-15
052

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Takesha Williams,
Petitioner,
vs.
University of Illinois,
Respondent,

NO: 12WC 30384

15IWCC0494

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

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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

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

DATED: JUN 30 2015
MJB/bm
o-06/23/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

WILLIAMS, TAKESHA
Employee/Petitioner

Case# **12WC030384**

15IWCC0494

UNIVERSITY OF ILLINOIS
Employer/Respondent

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.

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:

0668 LAW OFFICE OF PAUL E SELIN
116 N CHESTNUT ST
SUITE 200
CHAMPAIGN, IL 61826

0904 STATE UNIVERSITY RETIREMENT SYS
PO BOX 2710 STATION A*
CHAMPAIGN, IL 61825

0734 HEYL ROYSTER VOELKER & ALLEN
JOE GUYETTE
102 E MAIN ST SUITE 300
URBANA, IL 61801

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

1073 UNIVERSITY OF ILLINOIS
OFFICE OF CLAIMS MANAGEMENT
100 TRADE CENTER DR
SUITE 103
CHAMPAIGN, IL 61820

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

OCT 30 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
19(b)

Takesha Williams
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # 12 WC 30384

Consolidated cases: n/a

15IWCC0494

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Urbana, on September 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 (manifestation), February 21, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $37,044.80; the average weekly wage was $699.49.

On the date of accident, Petitioner was 34 years of age, single with 4 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 24, 2014
Date

OCT 30 2014

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of February 21, 2012, and, because of repetitive overuse of arms, Petitioner sustained bilateral shoulder injuries. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner worked for Respondent as a cook for approximately 10 years. Petitioner worked in a kitchen adjacent to Respondent's residence halls so her job duties required her to cook food for approximately 1,000 students every day. Accordingly, Petitioner was required to prepare/cook food in very large quantities.

At trial, Petitioner's counsel introduced into evidence two photos of the large pots that food was cooked in as well as a photo of the large utensils used by Petitioner (Petitioner's Exhibits 2, 3 and 4). The basis of Petitioner's claim was that she had to stir/mix the food in the pots in a repetitive manner and that this caused her to sustain injuries to both of her shoulders.

The large pots are used to cook pasta, various sauces, soups, etc. One of the utensils used by Petitioner was a large paddle which she would use to stir the food in the pots. Another utensil Petitioner would use was a pole with a ball-type object on the end of it which Petitioner used to break up large quantities of ground beef, usually 100 to 150 pounds. Petitioner testified that she would use both of her hands to stir the foods at chest or shoulder height. Petitioner stated that the difficulty she experienced when stirring the food depended upon what was being cooked. Petitioner encountered more problems when stirring food such as pasta and macaroni and cheese than she would when stirring soups.

Petitioner estimated that the amount of time she would spend cooking large quantities of food using the pots and utensils was approximately 15 to 18 hours per week. The maximum amount of time Petitioner would spent performing this task on any given day was about three hours. On those occasions, Petitioner was not stirring constantly because she had to perform other tasks such as adding ingredients. The amount of stirring required was also dependent upon what was being prepared.

Respondent's counsel introduced into evidence Petitioner's job description (Respondent's Exhibit 3). On cross-examination, Petitioner reviewed this document and agreed that it was accurate and complete. Petitioner further acknowledged that the 14 duties listed on the job description accurately described her day to day activities. Petitioner agreed that stirring food in the pots at chest or shoulder height was a small portion of her total job duties as a cook.

Carrie Anderson testified on behalf of the Respondent. At the time this case was tried, Anderson was the Respondent's Executive Chef for Residential Dining. At the time of Petitioner's "manifestation," Anderson was Petitioner's direct supervisor. Anderson testified that approximately 20 cooks (including Petitioner) worked under her supervision at that time. The

cooks were assigned to one of 10 stations and were rotated from one cooking station to another. Depending on Petitioner's assignment, she could spend up to 50% of time working around the pots or none at all.

Anderson also testified that the large pots used steam heat which she described as being more "gentle" than flame heat. Because of this, the food in the large pots was less likely to burn and required less stirring. Anderson also stated that kitchen laborers were available to assist the cooks in both food preparation and serving.

Petitioner testified that she first began to experience symptoms in both shoulders sometime in 2009. Petitioner was seen by Dr. Steven Thatcher, a physician associated with Christie Clinic Department of Physical and Pain Medicine, on April 13, 2009. At that time, Petitioner complained of pain in both shoulders, more on the right than left as well as numbness/tingling in the left hand. Dr. Thatcher's diagnosis was overuse syndrome and muscular pain of both upper extremities as well as shoulder bursitis. Dr. Thatcher ordered physical therapy (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Thatcher on March 12, 2010; however, her primary complaint was in regard to the neck and left upper extremity. On clinical examination, Dr. Thatcher noted some tenderness of the deltoid, trapezius and cervical paraspinal muscles. An EMG/nerve conduction study was performed which was normal. Dr. Thatcher referred Petitioner to Dr. Matt Stringer, a chiropractor.

On March 22, 2011, Petitioner was seen by Physician's Assistant Brian Shore for bilateral shoulder pain, more on the right than left. PA Shore examined Petitioner and opined that she had bilateral rotator cuff tendinitis with impingement syndrome and shoulder pain. He recommended Petitioner continue with therapeutic exercises (Petitioner's Exhibit 5).

On May 3, 2011, Petitioner was seen by Dr. Denis Williams, an orthopedic surgeon. At that time, Petitioner stated that she had bilateral shoulder pain for years and the pain was worsened by lifting and overuse. On clinical examination, there were some positive findings and Dr. Williams opined Petitioner had bilateral shoulder pain and possible bilateral impingement syndrome. Dr. Williams again saw Petitioner on October 18, and December 15, 2011, and he suspected that Petitioner's symptoms may have been related to the cervical spine. He ordered an MRI scan of the cervical spine and referred Petitioner to Dr. Charles Shyu (Petitioner's Exhibit 5).

Dr. Shyu examined Petitioner on January 6, 2012, and reviewed the MRI scan. He opined that Petitioner's symptoms were not related to the neck and stated that the bilateral shoulder pain was of "unknown etiology." (Petitioner's Exhibit 5).

On January 13, 2012, Petitioner was seen by Dr. Charlotte Schuchart, an internist. Petitioner still complained of bilateral shoulder pain occurring around the biceps tendon. Dr. Schuchart indicated she was going to refer Petitioner to Dr. Bane.

At trial, Petitioner testified that she continued to work through the pain and did not lose any time from work until February 21, 2012, when she could no longer perform her job because of the persistent bilateral shoulder pain. Petitioner has not worked since that time.

Dr. Schuchart ordered an MRI scan of the left shoulder which was performed on March 6, 2012. It did not reveal any tears (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Williams on March 8, 2012, and she still complained of bilateral shoulder pain, more on the left than right. Dr. Williams noted that Petitioner had an appointment to be seen by Dr. Bane, but also noted that Petitioner may also be seen again by Dr. Thatcher (Petitioner's Exhibit 5).

Dr. Thatcher saw Petitioner on March 26, 2012, and he noted that Petitioner did not have spinal pathology and that there was no neurological deficit in the upper extremities. He opined that Petitioner may have had tendinopathy from the use of the arms but that this was "completely conjecture." He stated that Petitioner might consider seeking other employment "...if she feels that is aggravating to her condition." (Petitioner's Exhibit 5).

Petitioner was seen by Dr. Williams on April 19, 2012. He noted her continued bilateral shoulder symptoms but stated that he was not convinced that Petitioner had impingement syndrome because of her symptoms and the lack of a complete response to injections (Petitioner's Exhibit 5).

Ultimately, Dr. Williams performed arthroscopic surgery on Petitioner's left shoulder on September 13, 2012. The procedure consisted of subacromial decompression and extensive debridement. Dr. Williams noted that there was no rotator cuff pathology. The surgical diagnosis was stated as left shoulder impingement syndrome (Petitioner's Exhibit 5).

Dr. Williams saw Petitioner following the surgery on October 23, 2012. In regard to etiology, Dr. Williams noted in his record "It is unclear exactly how this started. It is certainly possible that due to her work activity with repetitive strain-type motions this certainly could have caused her issues with her shoulder if it is truly from her shoulder." (Petitioner's Exhibit 5).

Petitioner continued to be seen by Dr. Williams but still experienced left and right shoulder pain. When he saw her on February 12, 2013, he noted that she had continued bilateral shoulder pain which appeared to be neurologic in origin (Petitioner's Exhibit 5).

Petitioner was subsequently seen by Dr. Daniel Dethmers on April 11, 2013. At that time, Petitioner informed Dr. Dethmers that her left shoulder range of motion had improved but that it was still painful. She also stated that she had developed similar symptoms in the right shoulder. His assessment was unspecified disorders of bursa and tendons in the shoulder and pain in joints/shoulder. Dr. Dethmers suggested possible surgical procedures with Petitioner either a tenotomy or tenodesis (Petitioner's Exhibit 5). Neither surgical procedure was performed.

At the direction of Respondent, Petitioner was examined by Dr. Kevin Walsh, an orthopedic surgeon, on March 24, 2013. In connection with his examination of Petitioner, Dr. Walsh

reviewed medical records and the diagnostic studies. Petitioner also described her work activities to Dr. Walsh and he also reviewed Petitioner's job description. Dr. Walsh opined that Petitioner's impingement syndrome was not caused by her work activities. He specifically stated that stirring food in a pot would not cause this condition and that impingement syndrome related to activity was due to repetitive strenuous overhead activities, not the type of activities Petitioner engaged in as a cook. He also opined Petitioner was at MMI and could return to work without restrictions (Respondent's Exhibit 1).

On July 15, 2013, Petitioner was examined by Dr. Edward Kolb, an orthopedic surgeon. At that time, Petitioner described a three year history of bilateral shoulder pain which she attributed to her days as a cook for Respondent. Dr. Kolb diagnosed Petitioner with bilateral impingement syndrome and bicipital tendinitis. Dr. Kolb recommended steroid injections to the biceps tendon (Petitioner's Exhibit 6).

Dr. Kolb saw Petitioner on August 19, and September 16, 2013, and Petitioner still had bilateral shoulder symptoms. He recommended continued conservative treatment. Dr. Kolb ordered an MRI scan of the right shoulder which was performed on October 30, 2013. The MRI revealed some arthritic changes and a probable intrasubstance partial tear. Dr. Kolb saw Petitioner on November 11, 2013, and, on examination noted that the impingement sign was negative. He also noted that Petitioner's symptoms were not in a consistent location for impingement syndrome or AC joint arthritis. He discussed possible surgery with Petitioner but could not guarantee the results (Petitioner's Exhibit 6).

Dr. Kolb again saw Petitioner on April 21, 2014, and she continued to complain of right shoulder symptoms. Dr. Kolb's diagnosis was right shoulder SLAP tear, bicipital tendinitis and rotator cuff strain; however, he noted that Petitioner's examination findings were less than consistent with some of her objective findings. He ordered an MRI arthrogram of the right shoulder (Petitioner's Exhibit 6).

An MRI arthrogram was performed on April 30, 2014, which revealed partial thickness tears to both the supraspinatus and infraspinatus tendons. Dr. Kolb saw Petitioner on May 4, 2014, and, based on the MRI arthrogram findings, recommended surgery. In regard to the etiology of the condition, Dr. Kolb noted that while Petitioner was working as a cook, she did a moderate amount of lifting, stirring and other processes with her upper extremities. He opined that Petitioner's symptoms were aggravated by her job duties as a cook (Petitioner's Exhibit 6).

Respondent's Section 12 examiner, Dr. Walsh, was provided with further medical records which he reviewed. Dr. Walsh prepared a supplemental report dated June 15, 2014, in which he opined that the changes noted in the MRI scan were degenerative and not related to Petitioner's work activities. He noted that Petitioner's symptoms were disproportionate to the objective findings, that additional surgery was not appropriate and that Petitioner could return to work without restrictions (Respondent's Exhibit 2).

Dr. Kolb was deposed on July 25, 2014, and his deposition testimony was received into evidence at trial. Dr. Kolb's testimony was consistent with his medical records regarding his treatment of Petitioner. In regard to the issue of causality, Petitioner's counsel propounded the following

question to Dr. Kolb: "Dr. Kolb, in the course of an eight-hour day Takesha would spend five to six hours cooking at these kettles or similar kettles. She would have to dump goods into the kettles. Some representative foods that she would prepare and cook would include chili, pasta noodles, pasta sauce, macaroni and cheese, soups and stews, including vegetable beef, ham and bean, jambalaya, clam chowder, gumbo and gravy. She would use the utensils identified in Exhibit 3 to stir and blend ingredients continuously as they cooked in the kettles. She would hold the utensils with both hands at or above shoulder height to do so. The amounts and ingredients, to give you some sense of scale, might include 120 to 150 pounds of ground beef in one of these larger kettles, 100 pounds of spaghetti sauce, 80 pounds of different sorts of pastas. When the food was cooked she would use a one-half gallon metal ladle to transfer the prepared food into the appropriate container?" In response to whether or not these activities could have caused or aggravated the conditions that Dr. Kolb diagnosed and treated, Dr. Kolb opined that the work activities could have caused or aggravated Petitioner's shoulder conditions (Petitioner's Exhibit 7; pp 18-19).

When Dr. Kolb was cross-examined, he agreed that his opinion was based on the accuracy of the history provided to him by Petitioner and the description of her work duties (Petitioner's Exhibit 7; p 37).

At trial, Petitioner testified that she still has bilateral shoulder pain and has not been able to return to work. She does want to proceed with the treatment recommended by Dr. Kolb.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury that manifested itself on February 21, 2012, and that her present condition of ill-being is not causally related to her work activities.

In support of this conclusion the Arbitrator notes the following:

The basis of Petitioner's claim was that she had to stir/mix foods in large pots at chest or shoulder height in a repetitive manner and that this caused her to sustained injuries to both of her shoulders.

The exact amount of stirring/mixing that Petitioner was required to engage in cannot be determined with any precision; however, the evidence clearly indicates that this was just one of many tasks Petitioner had to perform as a cook.

Petitioner agreed that the job description was complete and accurate and that stirring food in the pots was a small portion of her job as a cook. She stated that the maximum time she would spend performing this task was three hours and, even then, she was not stirring constantly and would perform other cooking tasks.

Carrie Anderson, Petitioner's supervisor, credibly testified that there were 20 cooks, including Petitioner who would rotate from one cooking station to another. Anderson also testified that, because the pots were steam heated, less stirring was required. Further, she also stated that kitchen laborers were available to assist the cooks.

Respondent's Section 12 examiner, Dr. Walsh, obtained a work history from Petitioner and reviewed her job description. Dr. Walsh opined that Petitioner's bilateral shoulder condition was not related to her work activities and that impingement syndrome is due to repetitive strenuous overhead activities.

While Dr. Kolb opined that Petitioner's bilateral shoulder condition was related to her work activities, the Arbitrator is not persuaded by this opinion because it is based on an inaccurate description of Petitioner's work activities.

The Arbitrator finds the opinion of Dr. Walsh to be more persuasive.

In regard to disputed issues (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES BUSCHSCHULTE,
Petitioner,
vs.
BEELMAN TRUCKING,
Respondent,

15IWCC0495

NO: 12WC 20495

DECISION AND OPINION ON REVIEW

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

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

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

DATED: JUN 30 2015
MJB/bm
o-06/23/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSCHSCHULTE, JAMES
Employee/Petitioner

Case# **12WC020495**

15IWCC0495

BEELMAN TRUCKING
Employer/Respondent

On 11/5/2014, 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 0.06% 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:

0969 THOMAS C RICH PC
MICHELLE RICH
#6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

James Buschschulte
Employee/Petitioner

v.

Beelman Trucking
Employer/Respondent

Case # 12 WC 20495

Consolidated cases: ____

15IWCC0495

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **September 11, 2014**. By stipulation, the parties agree:

On the date of accident, **January 11, 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 **$55,990.61**, and the average weekly wage was **$1,076.74**.

At the time of injury, Petitioner was **49** years of age, ***married*** with **1** dependent child.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $646.04/week for 187.5 weeks, because the cervical spine, left shoulder, and right shoulder injuries sustained caused the 37.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $646.04/week for 66.3 weeks, because the injuries sustained caused the 10% loss of the left arm, 10% loss of the left hand, and 10% loss of the right hand, as provided in Section 8(e) 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.

Arbitrator Molly Dearing

October 31, 2014
Date

NOV 5 - 2014

ILLINOIS WORKERS' COMPENSATION DECISION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

JAMES BUSCHSCHULTE
Employee/Petitioner

v.

Case # 12 WC 20495

BEELMAN TRUCKING
Employer/Respondent

15IWCC0495

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, Petitioner was forty nine years of age (Arb. X 1), and employed by a Respondent as an over the road truck driver. Petitioner had been so employed for over fifteen years. The parties stipulated that Petitioner sustained accidental injuries when, on January 11, 2011, he was dispatched to a scrap yard to retrieve bushings, and while pulling out bows from the trailer of his truck, he felt his shoulders pop and his neck stiffen.

Following the accident, Petitioner sought medical care and treatment with his family physician, Dr. Robert Davidson, who noted neck pain, shoulder pain, and numbness in Petitioner's hands. MRIs of Petitioner's cervical spine, right and left shoulders as well as nerve conduction studies with regard to his upper extremities were recommended. PX 3, 4.

Petitioner was referred to Dr. R. Peter Mirkin, an orthopedic spine specialist, who initially evaluated him on February 9, 2011. Dr. Mirkin took the history of the injury and noted that the MRI of Petitioner's cervical spine revealed moderate to severe narrowing of the right C3-4 foramen, mild to moderate posterior bulge at C6-7 with small central disc protrusions at that level, as well as mild to moderate stenosis at C3-4 with cord edema. He also noted limited range of motion in Petitioner's neck, and a markedly positive Spurling sign. Dr. Mirkin felt the MRI scan showed disc protrusion and large osteophyte at C3-4 compressing his spinal cord, along with changes at other levels. His impression was cervical radiculopathy for which he recommended therapy, a trial of anti-inflammatory medications, and epidural steroid injections. If Petitioner failed to improve following these recommendations, Dr. Mirkin opined he may require further evaluation and treatment. PX 6.

Following the epidural steroid injections, Dr. Mirkin noted only temporary improvement. As a result, a myelogram of Petitioner's cervical spine was recommended. Dr. Mirkin also noted that surgery had been recommended on Petitioner's shoulder and that an EMG/nerve conduction study had also been ordered, which Dr. Mirkin felt would be helpful. Dr. Mirkin ultimately reviewed the results of the myelogram, which revealed significant spondylitic disease a C3-4, as well as a disc protrusion at C6-7, which were both causing some degree of compression of the thecal sac with the most severe compression at C3-4. Dr. Mirkin indicated that if Petitioner could not live with his symptoms, he would offer a C3-4 decompression and fusion, and indicated that Petitioner may need another procedure at C6-7 and/or C5-6 in the future. He opined that Petitioner's "work activities" may have aggravated his cervical spine condition. PX 6.

On May 10, 2011 Petitioner underwent a microdissection, anterior cervical discectomy with decompression of the spinal cord at C3-4, partial vertebrectomy/corpectomy at C3 and C4 with decompression of the spinal nerves, an interbody fusion at C3-4 with placement of interbody cage and locking plate. PX 6, 12.

On February 9, 2011, Petitioner presented to Dr. George Paletta for complaints relative to his shoulders and upper extremities. At that time, Dr. Paletta took the history of Petitioner's injury and noted Petitioner was experiencing pain in both shoulders, left greater than right, as well as numbness in both hands. Dr. Paletta also reviewed MRIs of Petitioner's right and left shoulders, which he indicated demonstrated signs of AC joint irritation with hypertrophic degenerative changes and acute inflammatory response, as well as fluid in the subacromial space and chronic rotator cuff tendinopathy with a possible low-grade partial tear. Dr. Paletta diagnosed an acute AC joint irritation in the setting of hypertrophic degenerative changes, and rotator cuff strain with probable partial thickness rotator cuff tear. Conservative treatment in the form of a Medrol Dosepak, physical therapy and possible steroid injections was recommended. Dr. Paletta also indicated that if Petitioner did not improve following those treatments, he may ultimately require arthroscopy with subacromial decompression, rotator cuff debridement, and distal clavicle excision. He opined that Petitioner's shoulder complaints were causally related to his work injury. PX 7.

On March 2, 2011 and March 7, 2011, Petitioner underwent subacromial steroid injections to his left and right shoulders, respectively, with Dr. Matthew Bayes. PX 8.

Petitioner returned to Dr. Paletta on March 30, 2011 with continued pain and symptoms in his shoulders. Dr. Paletta noted that the injections to Petitioner's shoulders had provided only minimal relief, but that from a diagnostic standpoint, he indicated that the injection confirms the subacromial space as a contributing source of his shoulder pain. As Petitioner's symptoms did not improve, he recommended that Petitioner consider surgical treatment to both shoulders, and recommended that the left, more symptomatic shoulder be addressed first in the form of an arthroscopy with subacromial decompression, bursectomy, and acromioplasty. Before proceeding with surgery, however, Dr. Paletta recommended an EMG and nerve conduction study to evaluate his complaints of numbness and tingling in the upper extremities. PX 7.

EMG and nerve conduction studies were performed on April 12, 2011 by Dr. Alam, and Dr. Paletta reviewed the results of same on April 21, 2011. He noted that the results demonstrated findings consistent with C3-4 radiculopathy, moderately severe bilateral carpal tunnel syndrome, left worse than right, and mild left cubital tunnel syndrome. Dr. Paletta indicated that if Petitioner's cervical spine was cleared by a specialist, it would be reasonable to consider ulnar nerve transposition and carpal tunnel release on the left side, and also indicated that Petitioner may require a carpal tunnel release on the right. PX 7.

Petitioner returned to Dr. Paletta on July 27, 2011, following surgery on his cervical spine. Dr. Paletta indicated that based on the results of the nerve conduction study, he recommended left shoulder arthroscopy, as well as an ulnar nerve transposition at the level of the elbow and a carpal tunnel release on the left side be performed at the same time so a second anesthesia would not be required. Dr. Paletta opined that Petitioner's job duties contributed to and aggravated his carpal and cubital tunnel syndromes, as his job required significant hand intensive activity including rolling tarps, lifting, pushing and pulling. PX 7.

On July 28, 2011, Petitioner underwent a left shoulder arthroscopy with debridement, subacromial decompression, bursectomy and acromioplasty. Intraoperatively, Dr. Paletta noted a tear of the intra-articular portion of the long head of Petitioner's biceps tendon. PX 7, 13. On October 13, 2011, Petitioner then underwent a left carpal tunnel release as well as a left ulnar nerve transposition, which was done subcutaneously. PX 7, 13.

Petitioner returned to Dr. Paletta on February 29, 2012 with continued, nonspecific complaints in his right upper extremity and shoulder. He did not localize any pain specifically to the AC joint or any other portion of the shoulder, and he denied radiating pain. A physical examination revealed full range of motion, mild discomfort at the end ranges, mild tenderness at the AC joint, no tenderness at the bicipital groove, some mild pain on cross body adduction testing, normal rotator cuff function, and normal strength. Dr. Paletta's impression was persistent right shoulder pain. Dr. Paletta recommended an MR arthrogram of the right shoulder, which he indicated revealed no evidence of significant rotator cuff pathology, mild rotator cuff tendinopathy, no partial or full thickness tear, normal labrum, minimal thickening of the biceps tendon, and mild hypertrophic degenerative changes. Dr. Paletta recommended over-the-counter medications, and released Petitioner to return on an as needed basis relative to the right shoulder. PX 7.

On May, 2, 2012, Petitioner returned to Dr. Paletta with continued symptoms in his right hand, for which Dr. Paletta recommended a new nerve conduction study. This was performed on the same day, and revealed evidence of severe sensory and motor median neuropathy across the right carpal tunnel, including evidence of external involvement. Dr. Paletta noted that the findings were more severe than they were one year prior. Based upon the nerve conduction study results, and Petitioner's persistent symptoms, Dr. Paletta recommended Petitioner undergo a right carpal tunnel release, which was ultimately performed on May 10, 2012. PX 7, 16. Petitioner returned to Dr. Paletta on May 25, 2012 for a postoperative visit with regard to his right carpal tunnel release, and presented with recurrent complaints in his neck, for which Dr. Paletta recommended a referral to Dr. Matthew Gornet. PX 7.

Petitioner presented to Dr. Gornet on June 11, 2012 with complaints of neck pain, headaches, and pain into both trapezius, left worse than the right. Dr. Gornet took the history of Petitioner's injury and prior surgical treatment. Dr. Gornet reviewed plain radiographs of Petitioner's cervical spine, which showed a lucent line through the hardware graft consistent with delayed healing or nonunion of his prior fusion. Dr. Gornet also reviewed Petitioner's prior MRIs, which he indicated revealed spondylosis with spinal cord compression at C3-4 and a right-sided herniation at C4-5 and a central herniation at C6-7 and a subtle annual tear at C5-6. Dr. Gornet opined that Petitioner may have a continued problem in his cervical spine, as there was ample evidence for disc injury at C6-7 and possibly C4-5 which would continue to cause his symptoms, as well as a failed fusion at C3-4. He recommended a CT myelogram to further evaluate the status of Petitioner's fusion as well as a new MRI with gadolinium. Dr. Gornet also opined that Petitioner's current symptoms were causally related to the January 11, 2011 accident. PX 17.

Dr. Gornet reviewed Petitioner's new CT myelogram and MRI scan on August 6, 2012. He indicated that the MRI showed an obvious large disc herniation at C6-7, which was also present on the initial MRI scan of January 24, 2011, as well as a disc herniation at C5-6 left which correlated with a portion of Petitioner's symptoms. He also noted continued foraminal stenosis and disc pathology at C3-4 with spinal cord changes at that level. Dr. Gornet also reviewed the CT myelogram which confirmed the presence of a failed fusion at C3-4 which correlated with

Petitioner's symptoms. Dr. Gornet opined that Petitioner would require surgical intervention including an AP fusion at C3-4 and disc replacement surgery at C6-7 and C5-6. PX 17.

Petitioner underwent a three level disc replacement at C3-4, C5-6 and C6-7 on April 24, 2013. PX 17, 20. Petitioner continued to improve following surgery. Dr. Gornet placed him at maximum medical improvement on April 8, 2014 with permanent restrictions of local driving only, limited to less than ninety minutes to two hours at a time. PX 17.

At Arbitration, Petitioner testified that his condition substantially improved following his neck surgery with Dr. Gornet, which lessened his headaches and allowed him to function normally. He continues to complain of occasional headaches typically incited by the jarring and bouncing motions of his work truck. Petitioner reported pain in his shoulders and neck when he shovels or sweeps his trailer, or does work around the house. He testified to a loss of range of motion in his shoulders, and indicted that the amount of lifting and overhead lifting he can perform is now limited and less than it was before this injury. Petitioner testified that he has persistent symptoms in his hands and elbows, and specifically that the palm of his left hand is still numb and the numbness and tingling moves down into his middle and ring fingers. He indicated he has a loss of grip strength in his hands, and that he is unable to carry the amount of weight he used to with his hands.

Petitioner testified that his hobbies have also been adversely affected as a result of his injuries. Specifically, he indicated that he enjoyed working on cars and rebuilding engines prior to his injuries, but he now requires assistance to lift the weight of an engine or pull the heads or intake off a car, rotating the tires, putting brakes on a vehicle, or changing the oil in a car. Petitioner also indicated that he has trouble sleeping following the injury. Petitioner takes Tylenol, Mobic, and muscle relaxers. Petitioner testified that his job is essentially the same as it was prior to his work accident. Petitioner further testified that there are no stipulated miles as to how far he can drive with the permanent restriction of local driving, but that the restriction means he can be home at night to take his medications. He testified that Respondent is accommodating his driving restriction "wonderfully".

CONCLUSIONS OF LAW

As a result of the accident, Petitioner underwent multiple procedures on various parts of his body, including a cervical fusion at C3-4, a left shoulder arthroscopy with debridement, subacromial decompression, bursectomy and acromioplasty, a bilateral carpal tunnel release, a left cubital tunnel release, and a three level disc replacement at C3-4, C5-6 and C6-7. Petitioner also underwent subacromial steroid injections to his left and right shoulders. At Arbitration, Petitioner testified to ongoing pain, complaints, and functional limitations following his work injuries and resultant treatment. Petitioner returned to work for Respondent in his capacity as a truck driver performing all of his essential pre-injury work duties with the restriction of local driving, which Respondent is accommodating. The Arbitrator finds Petitioner's return to his pre-injury position for Respondent significant in determining Petitioner's permanent partial disability.

In light of the foregoing and the record in its entirety, the Arbitrator finds that Petitioner sustained 10% loss of use of his left arm, and 10% loss of use of his left and right hands, pursuant to Section 8(e) of the Act. The Arbitrator further finds that Petitioner sustained 37.5% loss of the person as a whole for injuries suffered to his cervical spine, and left and right shoulders, 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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Pacheco,

Petitioner,

vs.

NO: 13 WC 08020
13 WC 08021
13 WC 08022

Burke Beverage, Inc.,

Respondent.

15IWCC0496

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Respondent herein and notice given to all parties, the Commission after considering the issues of causation, medical expenses, prospective medical care, temporary total disability benefits, average weekly wage, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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 based on our complete review of the record we find that Petitioner failed to prove entitlement to penalties under Section 19(k) and attorney's fees under Section 16 of the Illinois Workers' Compensation Act (hereinafter "Act").

During the Commission's extensive review of the record, we noted that Dr. Singh's findings were based on incorrect information and assumptions. The Commission notes that Dr.

15IWCC0496

Singh's findings do not match the diagnostic findings and his opinions are not supported by the medical records. The MRI of the lumbar spine, taken on March 21, 2013, showed disc space narrowing and disc desiccation with central disc protrusion/annular with the protrusion abutting the exiting L5 nerve roots which "may be contributing to a bilateral L5 radiculopathy." (PX2) The radiologist and Dr. Zindrick agreed with this finding, and only Dr. Singh did not, finding that Petitioner merely sustained a lumbar muscular strain and suffered from degenerative disc disease at L4-5. (RX1-ERX3) Dr. Singh's diagnosis ignores the central disc protrusion/annular tear revealed in the MRI.

The Commission further notes that Dr. Singh admitted as his evidence deposition that he was unaware of all of the accidents Petitioner had suffered in Respondent's employ, specifically the November 2012 accident. (RX2-pgs.26,31) Further, Dr. Singh released Petitioner to unrestricted work as a forklift operator, which was not Petitioner's job. (RX1-ERX3) The Commission notes that Petitioner only worked as a forklift operator while on restricted duty as a result of the accidents. Finally, the Commission notes that while Dr. Singh offered a causation opinion regarding Petitioner's June 25, 2102 accident and his ongoing condition of ill-being, Dr. Singh admitted that he was unaware as to the mechanism of injury. (RX1-pg.33) And as previously mentioned, he released Petitioner to unrestricted duty to a restricted duty job and admitted that he did not know how much lifting Petitioner's job required. (RX1-pg.37) Dr. Singh admitted that he assumed that Petitioner's job was, at least, a medium demand level job. (RX1-pg.38)

While the Commission did not find Dr. Singh's findings and opinions persuasive in this case, our review of the record indicates that he did, at least, review the diagnostic exams and some of the medical records. Based on his review of what he was provided, though incomplete and incorrect, Dr. Singh reached a different conclusion than Dr. Zindrick. While questionable, the Commission finds that Respondent's reliance on Dr. Singh's opinions does not appear to rise to the level of unreasonable and vexatious.

As noted by Respondent in its Statement of Exceptions, Dr. Singh answered hypotheticals regarding the reasonableness of injections, but then specifically stated that Petitioner did not require any injections. The Commission finds that Respondent's reliance on such an opinion is not unreasonable. Therefore, the Commission finds that Petitioner failed to prove Respondent's behavior to be unreasonable and vexatious and, as such, failed to prove entitlement to an award of penalties under Section 19(k) and attorney's fees under Section 16 of the Act. However, the Commission finds that Respondent failed to pay medical expenses and temporary total disability benefits for over 333 days. As such, Petitioner has proven entitlement to penalties under Section 19(l) of the Act.

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, dated September 26, 2014, is modified as stated above, and is otherwise affirmed and adopted.

15IWCC0496

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $565.28 per week for a period of 63-4/7 weeks, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 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 $6,790.05 for medical expenses under Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay pursuant to the applicable medical fee schedule continuing treatment by Petitioner with a pain clinic for injections as prescribed by Dr. Zindrick.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $7,016.62 for advances paid to Petitioner.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $45,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 3 0 2015
MJB/ell
o-05/05/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

PACHECO, JASON M
Employee/Petitioner

Case# **13WC008020**

13WC008022

13WC008021

BURKE BEVERAGE INC
Employer/Respondent

15IWCC0496

On 9/26/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
RANDALL W SLADEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jason M. Pacheco
Employee/Petitioner

v.

Burke Beverage, Inc.
Employer/Respondent

Case # **13** WC **8020**

Consolidated cases: **13 WC 8021 & 13 WC 8022**

15IWCC0496

An *Application for Adjustment of Claim* was filed in these matters, and a *Notice of Hearing* was mailed to each party. These matters were heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **07/29/2014**. 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. ☒ 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 _____

15IWCC0496

FINDINGS

On the dates of each accident, **06/25/12 & 11/20/12 & 02/18/13**, 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* sustain accidents that arose out of and in the course of employment.

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

Petitioner's current condition of ill-being *is* causally related to these accidents.

In the year preceding each injury, Petitioner earned **$44,423.60(13WC8020); $43,515.68 (13WC8021); $44,092.36 (13WC8022)**; the average weekly wage was **$854.30(13WC8020; $836.84 (13WC8021); $847.93(13WC8022)**.

On the date of each accident, Petitioner was **29** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$7,016.62** for other benefits, for a total credit of **$7,016.62**.

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 $565.28/week for 63-4/7 weeks, commencing 05/10/2013 through 07/29/2014, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $6,790.05, as provided in Section 8(a) of the Act.
Respondent shall pay to Petitioner penalties of **$5,570.88**, as provided in Section 16 of the Act; **$17,854.42**, as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) of the Act.

Respondent shall authorize and pay pursuant to the applicable fee schedule continuing treatment by the petitioner with a pain clinic for injections as prescribed by Dr. Zindrick.

Respondent shall be given a credit of $7,016.62, for advances paid to Petitioner.

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

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Findings of Fact

The disputed issues in these matters are: 1) causal connection; 2) earnings; 3) average weekly wage; 4) temporary total disability; 5) penalties; 6) attorney's fees; 7) medical bills; and 8) whether the petitioner is entitled to prospective medical care. *See*, AX1.

On June 25, 2012, Jason Pacheco, (the "petitioner"), was a 29-year-old order filler for Burke Beverage Inc., (the "respondent"), which is a liquor distributorship located in McCook, Illinois. Petitioner worked in the warehouse facility pulling and filling orders for delivery.

Petitioner testified that he had been employed by the respondent for approximately five and one-half (5.5) years, prior to his first injury on June 25, 2012; but had only been an order filler for a few months prior to that date. Petitioner offered credible, unrebutted testimony that his job required him to work continuously on his feet, pulling cases of beer ranging from five pounds to forty pounds each. He estimated that he would pull between 1000 to 1500 cases per day, stacking them on pallets to levels over his head. They would then be loaded onto delivery trucks.

Petitioner identified PX 6(a) as a true and accurate photographic representation of how the cases of beer are stacked at the respondent's facility, to be pulled by order fillers. Each pallet load would be stacked as high as six and one-half (6.5) feet high. Petitioner testified that he was instructed to take an entire level of cases off a pallet before removing any others, to prevent the product from falling. The petitioner was also required to stand on his toes to reach over the higher levels of cases to pull those from the back to the front. To do so he would reach over the higher levels, grab the cases with his right hand, pull the cases to the edge of the stack before grabbing and lowering the product onto his pallet. It is unrebutted that the petitioner was not experiencing any pain, soreness or disability to his upper, mid or lower back, prior to the accident of June 25, 2012.

13 WC 08020

The parties stipulate that on June 25, 2012, the petitioner was pulling 40-pound cases of beer off the top level of a 6.5 foot stack of product. To do so he reached up over the stack to grab a case of beer. When pulling the case forward, he felt an immediate sharp, burning pain in his upper back. Petitioner indicated the pain was on the right side of his back just below the shoulder blade. Petitioner testified that after notifying his supervisor, he was placed on light duty driving a forklift, which requires minimal manual lifting.

On June 27, 2012, Respondent sent petitioner to LaGrange Medical Center (the "Center"). Petitioner was examined and he provided a consistent history of reaching overhead for a 40-pound case of beer. He complained of pain in his right, upper back, worse with movement and lifting. The doctor advised physical therapy and light duty, with the restriction of lifting no more than ten (10) pounds. It is unrebutted that the petitioner returned to work and performed desk duties. He presented to the

Center for treatment on June 29, and July 2, 2012. He attended physical therapy sessions on July 2, and July 6 with good but not complete relief. He was discharged to return to work in a full duty capacity, on July 9, 2012. Petitioner testified that he did return to his full duties as an order filler, lifting 1000 to 1500 cases of beer per shift and continued to have lingering pain in his right upper back. PX1.

13 WC 08021

On November 20, 2012, it is stipulated that the petitioner was bending over to stack a 20-pound case of beer on a pallet when he experienced burning pain in his upper back, as well as pain traveling down his mid-back to his belt line.

On December 6, 2012, Petitioner was sent to the Center, complaining of scapular pain as well as mid-back pain. He was diagnosed with chronic right-sided sub scapular pain/strain and it was noted that the petitioner had already been placed on light duty, driving a forklift. He was advised to re-start physical therapy and remain on light duty. Petitioner attended physical therapy from December 10, 2012 through January 2, 2013 and other than a flare up of mid-back pain on December 27, 2012, Petitioner noted good but not complete pain relief.

On January 4, 2013, petitioner was released to return to work in a full duty capacity, pulling and stacking stock. Petitioner testified that his upper and mid-back pain continued to bother him and worsen throughout his shifts.

13 WC 08022

It is stipulated that on February 18, 2013, the petitioner sustained a third injury while lifting 15-pound packs of beer. Petitioner presented again to the doctors at the Center, whose notes indicate that he had been having residual pain in his back for at least a week prior to the most recent injury. Again, he was advised to start physical therapy; and given restrictions of no lifting greater than fifteen (15) pounds. It is agreed that the petitioner's job duties were changed as he now worked with a forklift, as an accommodation of his light-duty restrictions. Petitioner testified that he was able to perform the functions of his employment while on light duty, i.e. driving the forklift, while he continued to pursue treatment with the doctors at the Center. The Center's record of February 25, 2013, confirms that the petitioner was able to perform his light duty job of driving a forklift.

The petitioner testified that as his condition was not improving, he asked the doctors at the Center to perform diagnostic testing to determine the nature of his back injuries. The office record of February 27, 2013 notes that the petitioner demanded an MRI. The doctors refused.

On March 4, 2013, the petitioner noted that the pain was now radiating into his lower back. The doctors at the Center offered an injection without the benefit of any diagnostic testing. Petitioner declined the injection until further diagnostic testing was performed. The doctor then discharged the

petitioner and advised him to seek treatment from his personal physician. While the office note suggested that there was no physiological basis for his complaints, it is undisputed that the Center performed one x-ray of petitioner's back and refused his request for an MRI. Petitioner continued to work light duty as a forklift driver.

Petitioner then sought the care of Dr. Michael Zindrick at Hinsdale Orthopaedic Associates. Petitioner initially presented to Dr. Zindrick, an orthopaedic spine specialist, on March 11, 2013, complaining of continuing lower and mid-back pain, which worsened over the course of his work shift. X-rays were provided and an MRI of the petitioner's lumbar and thoracic spine was prescribed. Petitioner was kept on light duty, specifically restricted to driving the forklift and no lifting over 10-15 pounds. Dr. Zindrick noted that the petitioner was suffering from dorsal spine and lower back pain, due to his work injuries. PX2.

The MRIs were performed on March 21, 2013. On April 11, 2013, the petitioner returned to Dr. Zindrick, still complaining of lower and mid-back pain. The diagnosis was mid and lower back pain with L4-L5 disc desiccation; and bulging, which was coming in contact with the L5 nerve root. Petitioner was continued on his light duty restrictions and referred to a pain clinic for dorsal and lumbar injections.

On May 10, 2013, the petitioner received a letter advising him that he had been terminated from his employment with the respondent because of the petitioner incorrectly picking product for delivery while working in his light duty capacity. RX3.

Respondent scheduled an independent medical examination pursuant to Section 12 of the Act with Dr. Kern Singh, on June 17, 2013.

While Respondent has not paid temporary total disability ("TTD") benefits, from the date of termination to the present time, certain advances were paid to the petitioner for which the respondent will receive a credit.

On June 17, 2013, Petitioner presented to Dr. Singh, by request of Respondent. The petitioner testified that prior to the examination; he filled out forms depicting a pain diagram. Petitioner testified that when filling out the pain diagram, he noted pain radiating from his low back down the back of his left leg and the diagram in the records is consistent with the petitioner's testimony. Petitioner testified that he did not cross out the diagram of radicular leg pain. The petitioner testified that the entire physical examination by Dr. Singh lasted less than five minutes and that Dr. Singh provided no recommendations to the petitioner at the time of his examination. RX2 at 13.

Dr. Singh's report of that examination noted that the petitioner complained of upper and lower back pain. Dr. Singh did not have a copy of Petitioner's MRI to review. Based upon the information

presented to him, Dr. Singh opined that the petitioner suffered thoracic and lumbar muscular strains and that his prognosis was guarded. Dr. Singh also advised that the petitioner should continue working in a light duty capacity, with lifting, pushing-pulling less than ten (10) pounds; in addition to minimal bending, kneeling, stooping and squatting. Dr. Singh opined that the petitioner was not at MMI and deferred any additional opinions until he reviewed the MRI films. RX2, pp. 4-8.

On July 17, 2013, Dr. Singh authored an addendum report after reviewing the MRI films. That report continued to conclude that the petitioner suffered from thoracic and lumbar muscular strain, but also concluded that the petitioner was at maximum medical improvement ("MMI") and that no additional treatment was necessary. The doctor stated that, "The patient's symptoms do not correlate with the radiographic studies". Dr. Singh stated that the petitioner could return to work as a forklift driver. Based upon the opinion of Dr. Singh, no additional TTD or medical benefits have been extended to the petitioner. RX1.

On June 18, 2013, Kelley Burgess, Dr. Zindrick's physician's assistant, saw Petitioner. It was noted that the petitioner has pain radiating into his left leg. Medication was prescribed as well as a referral for injections to petitioner's dorsal and lumbar spine at a pain clinic. The petitioner was taken off work due to his continuing complaints.

On July 15, 2013, Petitioner returned to Dr. Zindrick. Petitioner testified that he was not being paid TTD and had been fired, therefore, he asked the doctor to lessen his restrictions so that he could proceed to search for employment. The records note that Dr. Zindrick continued to advise the need for injection therapy.

Petitioner saw Dr. Zindrick on September 16, 2013, January 7, 2014, March 4, 2014 and lastly on June 2, 2014. Dr. Zindrick continues to recommend the injections, which the respondent continues to deny. Petitioner's restrictions are currently: no lifting greater than 30 pounds. He can sit, stand, and walk as comfort allows and remains limited in bending, kneeling, squatting and pushing/pulling. It is uncontested that these restrictions are lower than the demands of his job as an order filler.

Deposition of Dr. Michael Zindrick taken November 13, 2013

Dr. Zindrick is a board certified orthopedic surgeon, specializing in surgery of the spine. He testified that he has treated thousands of patients with traumatic spine injuries over his nearly 30-year career. He has been the petitioner's treating orthopedist since March 11, 2013. Dr. Zindrick's medical history documents all three of the petitioner's injuries.

Dr. Zindrick opined that the MRI of the petitioner's thoracic spine showed normal disc function, normal cord, and normal vertebrae. With respect to the MRI of the petitioner's lumbar spine, Dr. Zindrick noted that it showed abnormality at L4-L5 including disc desiccation, disc bulging and annular tear abutting the L5 nerve root. Dr. Zindrick stated that there was "no question" that the

bulge was abutting the nerve root. Dr. Zindrick explained that this abnormality at L4-L5, under load, could create and account for the pain, discomfort and radiating pain, from which the petitioner suffers.

With respect to the petitioner's thoracic spine, Dr. Zindrick opined that it is a soft tissue injury to the musculature, which the petitioner continued to re-injure, due to each of the three accidents. Dr. Zindrick recommended trigger point or facet injections to petitioner's dorsal spine, based upon the determination of the anesthesiologist at the pain clinic.

With respect to the petitioner's lumbar spine, Dr. Zindrick opined that the petitioner would require a course of epidural steroid injections. Dr. Zindrick has continued to keep the petitioner on restrictions. He opined that the petitioner would not be able to return to the full duties of an order filler, due to the heavy nature of the lifting required. He continues to treat the petitioner with medication while awaiting authorization for the injections.

Dr. Zindrick reviewed the opinions contained in Dr. Singh's report and addendum; and agrees with Dr. Singh that the petitioner sustained a thoracic soft tissue injury. He agrees that the lumbar MRI shows disc degeneration at L4-L5. However, he notes that Dr. Singh's reading of the lumbar MRI contradicts his reading of the film, as well as that of the radiologists, as they read the lumbar MRI as definitively disclosing an L4-L5 bulge, impinging upon the L5 nerve root. PX3.

Deposition of Dr. Kern Singh taken April 3, 2014

Dr. Singh testified that he examined the petitioner at the respondent's request on June 17, 2013 and that he reviewed limited records provided by the respondent. Dr. Singh testified that at the time of his examination, the petitioner had reported only back pain and that he believed Petitioner's full duty employment was that of a forklift operator. Based upon his examination of June 17, 2013, he diagnosed the petitioner as having thoracic muscular and lumbar strain to his mid-back. On June 17, 2013, Dr. Singh opined that the petitioner could only perform light duty work with lifting no more than ten (10) pounds; and limited pushing and pulling, bending, kneeling, stooping and squatting. Dr. Singh asked to review the actual MRIs before providing additional opinions.

Dr. Singh further testified that he later reviewed the petitioner's lumbar and thoracic MRIs. He testified that the petitioner's thoracic MRI showed no stenosis. Unlike Dr. Zindrick, Dr. Singh testified that the petitioner's lumbar MRI was essentially normal and only showed L4-L5 desiccation, with no central or foraminal stenosis. He did not believe the MRI showed a bulge or annular tearing. Moreover, Dr. Singh opined that the petitioner did not report any radicular leg pain to him. Based upon these conclusions, Dr. Singh opined that the petitioner did not require further medical treatment; and that he could return to work in his full duty capacity, of driving a forklift. He also lifted the ten (10) pound lifting restriction he had imposed after his June 17, 2013 examination.

Upon cross-examination, Dr. Singh testified that he had no independent recollection of the petitioner as he provided his sworn testimony, having only seen him one time, eight months prior. Dr. Singh performs approximately fifteen (15) to twenty (20) Section 12 examinations per month and charges $1,000.00 per exam. Sixty-five percent (65%) of his examinations regarding work injuries are on behalf of respondents. At the time of his deposition, he referred to those records sent to his attention by the respondent although those medical records had been purged prior to his deposition.

The doctor has no recollection of how long his examination of the petitioner lasted; and was unaware of the fact that the petitioner sustained three accidents. Contrary to Dr. Singh's testimony, his own office records note that the petitioner did report radicular pain down the back of his left leg to the knee. Dr. Singh testified that the petitioner "crossed out" the drawing of leg pain although he does not remember the petitioner crossing it out. He has no independent recollection of discussing radicular leg pain with the petitioner.

Dr. Singh incorrectly believed that the petitioner's full job duties were those of a forklift operator and had no idea as to the amount of weight or number of cases the petitioner's job required him to handle either as a forklift operator or as an order filler. At the time of his initial examination of the petitioner on June 17, 2013, Dr. Singh diagnosed the petitioner as suffering from thoracic and lumbar strains caused by the work accidents; and that the petitioner required 10-pound lifting restrictions, and that he was not at MMI. After reviewing the MRI, he did not change his diagnosis but did opine that the petitioner no longer required restrictions and was at MMI, without re-examining the petitioner.

Dr. Singh had not reviewed the testimony of Dr. Zindrick, however did testify, on cross-examination, that with respect to the recalcitrant nature of the petitioner's upper back pain, it is not unreasonable to try trigger point injections, as prescribed by Dr. Zindrick. When specifically asked if he disagreed with Dr. Zindrick's conclusion that the lumbar MRI disclosed a bulging disc touching the L5 nerve root, Dr. Singh could not testify that Dr. Zindrick's interpretation of the MRI was incorrect. RX1.

Testimony of Kenneth Donarski

Respondent offered the testimony of Kenneth Donarski, respondent's general manager. Mr. Donarski testified that the respondent typically offers the job of forklift driver, when necessary to accommodate an employee's lifting restrictions. Mr. Donarski further testified that the petitioner was terminated on May 10, 2013, for picking the wrong product and not for any intentional or malicious conduct. He viewed the photographs of cases of products and confirmed that that was an accurate picture of how the cases are stacked in the warehouse. He also confirmed Petitioner's description of his duties and Petitioner's version of the accidents.

Currently, the petitioner continues to experience burning pain in his upper back and pain into his lower back, on a daily basis, which worsens throughout the day. He takes medication prescribed by Dr. Zindrick. Petitioner testified that because he has been denied benefits, he is doing a self-directed

search to obtain employment within his restrictions. Petitioner testified he applied to be a paid caregiver for his mother who suffers from breast and brain cancer as well as dementia. However, he was found not qualified to do so. Petitioner testified that he graduated from college with a degree in law enforcement, but has been unable to perform the physical examination necessary to accept employment on a police force. He testified to being able to ride a motorcycle.

Petitioner testified that he has accepted occasional employment with Live Nation Worldwide, Inc., as a sedentary usher. He has worked minimal hours and earned a total of $182.27 for the past month. He further testified that his condition is not improving and that he would like to undergo the injection therapy at a pain clinic, as advised by Dr. Zindrick. PX7.

Conclusions of Law 13 WC 8020; 13 WC 8021; 13 WC 8022

The Arbitrator incorporates herein the decision in 13 WC 8020 with the consolidated matters of 13 WC 8021 and 13 WC 8022, by reference. Specifically, the Arbitrator notes that the parties have consented to a single Decision regarding all three consolidated matters.

F. Is Petitioner's current condition of ill-being causally 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).

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 Arbitrator finds that the petitioner's current condition of ill-being is causally related to three stipulated injuries culminating in the last accident of February 18, 2013. There is no contention that the petitioner suffered from any pre-existing problems with his upper, mid or lower back. The respondent has stipulated to each of the petitioner's three work injuries. There is no question that the petitioner was working by accommodation of the respondent, in a restricted capacity, as of the date of his termination, on May 10, 2013.

In addition, he was under the restrictions of his treating physician, Dr. Michael Zindrick who had advised additional treatment and not found the petitioner to be at MMI. Dr. Singh, on June 17, 2013, also felt the petitioner had not reached MMI.

It is evident that the sole contention as to causal connection is based upon the opinions of the petitioner's treating physician, Dr. Michael Zindrick, as opposed to the opinions of Dr. Singh. While the Arbitrator is not compelled to accept the opinion of a treating physician over that of the Section 12 examiner, it is clear, that the opinions of Dr. Zindrick are more persuasive than those of Dr. Singh.

Dr. Zindrick has treated the petitioner since March 11, 2013 and continues to treat him to the present. Dr. Zindrick has opined that the petitioner sustained a muscular soft tissue injury to his thoracic spine, which he continued to re-injure, due to two subsequent stipulated work-related accidents. The recalcitrant nature of the three injuries, as well as the petitioner's credible continuing complaints of pain, led Dr. Zindrick to prescribe trigger point injections to the petitioner's thoracic spine.

With respect to the petitioner's lower back, Dr. Zindrick has diagnosed a L4-L5 annular tear and bulge, which he has identified as impinging upon the petitioner's L5 nerve, causing his current condition of pain. Dr. Zindrick has prescribed epidural steroid injections by a qualified pain clinic to help alleviate petitioner's condition of ill-being. The Arbitrator notes that Dr. Zindrick was asked to review the MRI of the petitioner's lumbar spine at the time of his deposition and unequivocally states that the impingement is evident on the films.

Dr. Singh agrees with Dr. Zindrick's diagnosis of a soft tissue muscular injury to the petitioner's thoracic spine. However, Dr. Singh does not read the lumbar MRI to show any bulge or L5 impingement to account for the petitioner's complaints of ill-being. The Arbitrator finds Dr. Zindrick's opinions to be more persuasive than those of Dr. Singh.

G. What are the Petitioner's earnings in 13 WC 8020?

Petitioner alleges an average weekly wage of $854.30 per week. Respondent alleges an average weekly wage of $779.62 per week. The petitioner has submitted wage records tendered by the respondent as PX 8. Although those records do not provide the full wages for 52 weeks, they do disclose that the petitioner consistently was paid $21.30 per hour from December 9, 2011 through February 10, 2012. Thereafter, he was paid $21.90 per hour until the date of his first injury on June

25, 2012. Deducting occasional overtime wages there is a total of $24,774.62 in total wages for the twenty-nine (29) weeks preceding his injury. Therefore, the best evidence presented indicates an AWW of $854.30 ($24,774.62 ÷29 weeks=$854.30). The Arbitrator notes that the parties have stipulated that all benefits due and owing should be calculated as per the petitioner's AWW associated with the injury date of February 18, 2013 now pending as the consolidated matter 13 WC 8022.

G. What are the Petitioner's earnings in 13 WC 8021?

Petitioner alleges an average weekly wage of $836.84 per week. Respondent alleges an average weekly wage of $779.62 per week. The petitioner has submitted wage records tendered by the respondent as PX8. These records do account for all 52 weeks prior to petitioner's injury of November 20, 2012. Adding the petitioner's wages at straight time and removing any payments for hours of service over 40 hours per week equals income for the period of 12/09/11 through 11/23/12 in the amount of $43,515.94. Dividing that amount by the 52 weeks leaves an AWW of $836.84. The Arbitrator notes that the parties have stipulated that all benefits due and owing should be calculated as per the petitioner's AWW associated with the injury date of February 18, 2013 now pending as the consolidated matter 13 WC 8022.

G. What are the Petitioner's earnings in 13 WC 8022?

Petitioner alleges an average weekly wage of $847.93 per week. Respondent alleges an average weekly wage of $779.62 per week. The petitioner has submitted wage records tendered by the respondent as PX 8. These records do account for all 52 weeks prior to petitioner's injury of February 18, 2013. Adding the petitioner's wages at straight time and removing any payments for hours of service over 40 hours per week equals income for the period of 02/24/2012 through 02/15/2013 in the amount of $44,092.74. Dividing that amount by the 52 weeks leaves an AWW of $847.93. The Arbitrator notes that the parties have stipulated that all benefits due and owing should be calculated as per the petitioner's AWW associated with this injury date of February 18, 2013.

L. What temporary benefits are in dispute?

It is well settled that when a petitioner seeks TTD benefits, the dispositive inquire is whether the petitioner's condition has stabilized, i.e., whether the petitioner has reached maximum medical improvement. *Interstate Scaffolding v. Industrial Comm'n*, 236 Ill.2d 132 (2010). In the present matter it is clear that the petitioner has not yet reached MMI. As noted above, the Arbitrator finds the opinions of Dr. Michael Zindrick, the petitioner's treating orthopod, to be most persuasive. Dr. Zindrick has consistently opined that the petitioner requires trigger point injections to his dorsal (thoracic) spine as well as epidural steroid injections to his low/mid back performed by a qualified pain clinic. This has been the prescription since April 11, 2013. That treatment is being denied by the respondent based upon the opinions of Dr. Singh. As stated above, the Arbitrator finds Dr. Singh's opinions to be without merit.

The fact that the petitioner has recently found occasional employment at Live Nation Worldwide, Inc. within his current restrictions does not inure to the respondent's benefit and it can receive no credit. According to his testimony, Petitioner has worked limited hours and earned only $182.27 from June 8, 2014 through July 19, 2014, based upon only 11.17 hours of work with Live Nation Worldwide, Inc. Petitioner's schedule notes only four dates of available work within the upcoming month. This limited work, within his restrictions, does not prove that the petitioner's condition has stabilized. *Sunny Hill of Will Cnty. v. IL Workers' Compensation Comm'n*, 2014 IL App. (3d) 130028WC (2014). Further, petitioner is not prohibited from earning occasional wages while still being entitled to TTD. *J. M. Jones Co. v. Industrial Comm'n*, 71 Ill.2d 368 (1978).

The Arbitrator finds that the petitioner is entitled to TTD from May 10, 2013 through the date of the 19(b) hearing, i.e., July 29, 2014, a period of 63-4/7 weeks. It is stipulated that the petitioner sustained three accidents arising out of and in the course of his employment. After each of the first two accidents, the petitioner was provided lifting restrictions and lost no time from work. After the injury of February 18, 2013, the petitioner was placed on forklift duties. This allowed him to work without the excessive heavy lifting of his position as an order filler. On May 10, 2013, the respondent terminated the petitioner for the stated reason that he incorrectly picked various orders. Mr. Donarski testified that the petitioner was being provided light duty work ,driving a forklift, at the time of his termination.

J. Were the medical services provided to Petitioner reasonable and necessary?

Based upon the above the Arbitrator awards the petitioner medical bills as follows:

a)	Hinsdale Orthopaedic Assoc.	$ 6,464.00
b)	Prescriptions	$ 326.05
Total:		$ 6,790.05

These bills shall be paid pursuant to the applicable fee schedule.

K. Is Petitioner entitled to prospective medical care?

The Arbitrator finds the opinions regarding prospective medical care offered by Dr. Michael Zindrick to be credible. Therefore, the respondent shall authorize treatment with the petitioner's choice of pain clinic at the referral of Dr. Zindrick, and pay the reasonable and necessary charges for said treatment prescribed, pursuant to the applicable medical fee schedule.

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

Petitioner requested penalties and fees for Respondent's failure to authorize treatment for Petitioner's back and for failure to pay temporary total disability benefits.

Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but

are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

The Arbitrator notes that "[s]pecific procedures or treatments that have been prescribed by a medical service provider are 'incurred' within the meaning of section 8(a) even if they have not been performed or paid for." *Bennett Auto Rebuilders, Inc. v. Industrial Comm'n,* 306 Ill. App. 3d 650, 655-56 (1999). The claimant bears the burden of proving, by a preponderance of the evidence, his or her entitlement to an award of medical care under section 8(a). *Westin Hotel v. Industrial Comm'n,* 372 Ill. App. 3d 527, 546 (2007).

Although Respondent relies on the opinions of Dr. Singh to deny treatment recommended by Dr. Zindrick, a conflicting medical opinion does not present an absolute defense to imposition of 19(l) penalties. "The test is not whether there is some conflict in medical opinion. Rather, it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all circumstances presented. *Continental Distributing v. Industrial Comm'n,* 98 Ill.2d 407 (1983).

The respondent's denial of TTD and payment of outstanding medical bills is unreasonable and vexatious. The respondent's reliance upon the opinions of Dr. Singh is equally meritless in that Dr. Singh's opinions are not sustainable. The Arbitrator further notes that Dr. Singh stated under oath that the injections prescribed by Dr. Zindrick for the petitioner's upper back are reasonable. Yet the respondent authorized nothing. Likewise, it is clear that the petitioner's condition has yet to stabilize without the required treatment. The Arbitrator awards attorney's fees and penalties.

Accrued TTD of $35,935.41 minus advance of benefits in the amount of $7,016.62 leaves unpaid benefits of $28,918.79. Including the denied Medical Bills of $6,790.05 the unpaid compensation due to date is $35,708.84. Fifty percent (50%) of that compensation is $ 17,854.42.

Petitioner is further entitled to penalties pursuant to Section 19(l) of the Act in the amount of $10,000.00 which is the limit allowed because the compensation unreasonably refused has extended over 333.33 days.

Petitioner is further allowed attorney's fees caused by the respondent's unreasonable and vexatious actions in the amount of $ 5,570.88 based upon 20% of the penalties due pursuant to Sec. 19(k) and 19(l) of the Act.

15IWCC0496

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13 WC 08020; 13 WC 08021; 13 WC 08022
SIGNATURE PAGE

Signature of Arbitrator

September 26, 2014
Date of Decision

SEP 26 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James E Riddle,
Petitioner,
vs.

15IWCC0497

NO: 10 WC 49325

Edwardsville School District No.7,
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, notice, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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

DATED: JUN 30 2015
KWL/vf
O-6/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0497

RIDDLE, JAMES E
Employee/Petitioner

Case# **10WC049325**

EDWARDSVILLE SCHOOL DISTRICT NO 7
Employer/Respondent

On 11/17/2014, 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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0497

JAMES E. RIDDLE
Employee/Petitioner

v.

EDWARDSVILLE SCHOOL DISTRICT NO. 7
Employer/Respondent

Case # **10** WC **49325**

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 **Belleville** on **August 26, 2014**, and in the city of **Springfield** on **September 11, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 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 not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$22,649.07**; the average weekly wage was **$435.56**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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 that he sustained an accident that arose out of and in the course of his employment with Respondent on October 13, 2010. Petitioner failed to prove that his current condition of ill-being is causally related to the alleged accident. Claim 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.

Arbitrator Molly Dearing

November 10, 2014
Date

NOV 17 2014

15IWCC0497

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES E. RIDDLE
Employee/Petitioner

v. Case # 10 WC 49325

EDWARDSVILLE SCHOOL DISTRICT NO. 7
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging repetitive injuries to his low back and left leg as a result of repeatedly lifting heavy trash bags for Respondent. Arb. X 2.

At the time of his accident, Petitioner was forty six years of age (Arb. X 1), and he was employed by Respondent as a custodian. He had been so employed since February 2009, at which time he began working as an evening classroom custodian sweeping, mopping, emptying trash, and wiping chalkboards. Petitioner testified that these duties had no impact on his low back symptoms. A few months after he began working for Respondent, in about May 2009, Petitioner temporarily volunteered to work the day shift to fill a vacancy. He testified that he agreed to work the day shift "for a while" until the regular day-shift custodian returned. However, the day-shift custodian never returned. Petitioner testified that he requested to return to the evening shift, but his request to transfer was denied and he remained on the day shift until he resigned on October 13, 2010.

Petitioner testified that the work activities of the day-shift custodian job were more physically laborious than those of an evening custodian. He testified that the day position involved running to classrooms to clean up vomit and spills, and taking out the trash during the lunch period for 2,400 students. Petitioner stated that he was responsible for removing the trash bags from cans, collecting trash off of the tables, putting the trash bags into carts, and lifting the bags from the cart into the dumpster. Then, he would sweep and mop the kitchen and dining areas.

Petitioner testified that he performed job duties associated with the lunch period for approximately one month on the day shift in 2009 before the students were released for summer. He continued cleaning for Respondent over the summer, and resumed handling cafeteria lunch duties in the fall of 2009. He stated that his job duties of the day shift did not bother him for the first year he worked in that position, or the 2009-2010 school year, because at that time, Respondent used Styrofoam trays and the trash bags weighed less than 35 pounds. Petitioner testified that problems began when Respondent ceased using Styrofoam in May 2010 and began using reusable plastic trays. He stated, ". . . And I noticed right away that the bag weight increased dramatically, because the kids were throwing – just dumping their food in there and there was no Styrofoam to take up the space in the bags. So I noticed in May that it was – there was going – you know, the bags were getting heavier." Petitioner testified that he began feeling pain in his low back shortly after school started in early September 2010. Petitioner testified that he gave notice of his symptoms to Rick Everage, Assistant Principal in charge of custodians, Tom Manis, Head

Custodian, and John Martin, Food Supervisor. Petitioner testified that he also reported his complaints to Candy Sullivan, the Head Cook, and to fellow custodians. He further testified that he was discouraged by Mr. Everage from reporting his injury to Company Nurse in September or October 2010 because Mr. Everage stated that doing so could jeopardize his plans to substitute teach.

Petitioner testified that he had planned on eventually working part-time to restart his silk screening business, but stated that he resigned from Respondent's employment early out of concern of serious injury. Petitioner testified that he applied for work with the Madison Community School District several months before his resigned from his position with Respondent because he wanted to supplement his income from his silk screening business, as he "already planned on quitting eventually to start my business", and because he wanted "to get off the everyday trash bag thing."

Petitioner resigned from his position with Respondent on October 13, 2010. A note from "Clucky Duck Screen Printing Airbrushing and More..." signed by Petitioner announces Petitioner's resignation from Respondent's employment, and indicates that he "will be available still for substitute teaching (I'm on the list), substitute monitor and substitute custodian for Dist. 7. I am going to pursue my art career again as a graphic artist, silk screen printer and airbrush artist...." RX 5. Petitioner testified that he did not mention his back symptoms in his resignation letter because he was not yet aware that he suffered serious injury and believed that his back pain would resolve once he stopped lifting trash bags. Petitioner is currently self-employed printing t-shirts and sweatshirts, and performing other artwork. He denied lifting anything heavier than 35 pounds in the course of his silk screening business, though he conceded on cross-examination that he lifted a piece of machinery with another individual in 2011 that weighed 75 pounds that caused a rupture of his biceps tendon.

Petitioner testified to low back symptoms of tightness and minor aching beginning in 2002, and he described these symptoms as isolated. Petitioner testified that prior to his employment with Respondent, he managed these occurrences conservatively with medication and hot showers, and his symptoms subsided. He denied undergoing a MRI or CT scan of his back prior to becoming employed by Respondent.

When Petitioner's symptoms did not resolve in 2010, he presented to his family physician, Dr. Lopatin, on November 1, 2010, and described low back pain radiating into his left leg. Petitioner reported to Dr. Lopatin that "over one month ago while still a custodian he was lifting heavy trash bags into the dumpster and he started noticing pain on the left side of the back. The pain then started radiating into the buttock, down the leg and eventually all the way into his left foot. He describes a tingling sensation in the foot that feels like pins and needles. He says that the pain is 'absolutely horrible' and he was unable to find a position that was comfortable enough to sleep last night." Petitioner reported minor improvement with pain medication. Dr. Lopatin noted in his objective findings that Petitioner was visibly uncomfortable during his examination and was lying on his right side on the examination table when he first entered the room. PX 3.

Upon physical examination, Dr. Lopatin produced a positive straight leg raise test on Petitioner's left side at 30 degrees. Petitioner's right side was negative except for tight hamstrings on the right side. Dr. Lopatin's assessment was low back pain and sciatica. Radiographs obtained from the Imaging Center of Southern Illinois showed mild degenerative changes with borderline

narrowing of two inferior vertebral interspaces, and were negative for acute osseous abnormalities, including spondylolisthesis or spondylolysis. PX 3, 4.

The Imaging Center's clinical history indicated, "[p]rior low back pain, which eventually subsided. Now experiencing extreme pain and left hip radiating down to left ankle." PX 4. Dr. Lopatin recommended a tapering course of medication and an MRI if Petitioner's condition did not improve with medication. PX 3.

Petitioner's wife referred him to Dr. Anthony Margherita of West County Spine & Sports Medicine. On November 29, 2010, Petitioner reported a two-month history of symptoms of lower left back pain radiating through the hip and into the left lower extremity onset by heavy lifting and turning. Petitioner reported that his symptoms gradually worsened. The intake indicates that up to that date Petitioner had neither filed nor made plans to file a workers' compensation claim. PX 5.

Dr. Margherita noted on November 29, 2010 that Petitioner performed janitorial work lifting 50-80 pound trash bags. A physical examination of Petitioner's lumbar spine showed limited lumbar spine flexion and extension, as well as positive left-sided straight leg raise and slump sit test. Dr. Margherita diagnosed acute radiculopathy, recommended a MRI, and prescribed prescription medication. PX 5.

Petitioner's MRI was performed by St. Luke's CDI Frontenac on the same day. The imaging sequence revealed a L4-5 posterior disc bulging with a central/left paracentral disc herniation exhibiting caudal extension and producing left lateral recess stenosis, minimal posterior disc bulging asymmetric to the right with a posterior high intensity zone at L5-S1, minimal disc posterior disc bulging asymmetric to the left at L2-3, a likely central disc herniation at T11-12, and a mild posterior disc bulging at T12-L1. PX 6.

Dr. Margherita also recommended and performed electrodiagnostic studies to rule out diabetic peripheral neuropathy. These studies showed a normal NCV of the lower extremities and an abnormal EMG, indicative of a neuropathic problem of his lumbar spine. Dr. Margherita believed that the findings of L4-5 radiculopathy localizing to the left L5 nerve root were consistent with Petitioner's clinical impression. Further paraspinal localization could not be provided due to Petitioner's discomfort during the paraspinal examination. Dr. Margherita recommended a select nerve root injection. PX 5, 7.

Petitioner returned to Dr. Margherita on December 21, 2010, and reported improvement in his symptoms following the injection. PX 5. However, Petitioner continued to have findings upon physical examination. Dr. Margherita recommended a second select nerve root injection, which he underwent on January 18, 2011. PX 5, PX 7. Dr. Margherita's note of January 25, 2011 indicated that Petitioner's condition had improved, though Petitioner continued to complain of mild back pain, spasms, and pain in his hip, knee, and buttock. Dr. Margherita recommended physical therapy, which Petitioner attended at Apex Physical Therapy from February 7, 2011 through March 4, 2011. PX 5, PX 8.

On February 15, 2011, Petitioner's condition was improved, and Dr. Margherita noted no significant changes and that Petitioner's condition was stable. Petitioner's physical examination remained positive for limited extension and flexion of his lumbar spine. Dr. Margherita ordered him to continue physical therapy. PX 5.

On March 16, 2011, Petitioner was prescribed another select nerve root injection (PX 5), which he underwent on March 29, 2011 (PX 7), and thereafter, Dr. Margherita noted continued improvement, no significant changes, and that Petitioner's condition was stable. Petitioner was eventually released to return on an as needed basis on November 1, 2011. PX 5.

Petitioner returned to Dr. Margherita on July 10, 2012 secondary to an increase in his back pain over the last six months. Despite the improvement for approximately six months after his series of injections, Petitioner reported an increase in low back pain with pain "now" on both sides of his low back. Dr. Margherita's assessment remained lumbar radiculopathy and he recommended additional physical therapy. PX 5, 9.

On August 27, 2012, Petitioner felt his symptoms necessitated another injection, which was performed on October 9, 2012. PX 5, PX 7. Petitioner received two more injections for left sided low back pain on January 28, 2013, and March 18, 2013. PX 7. Follow-up visits show that although Petitioner gained some benefit from the injections, he continued to have persistent symptoms. PX 5, 7. On June 17, 2013, Petitioner complained of bilateral shoulder pain and some tingling into the left upper lift and shoulder, and neck pain on August 12, 2013. PX 5.

At Arbitration, Petitioner testified that he continues to have symptoms while lifting, bending, cleaning or sitting for prolonged periods of time.

Dr. Margherita testified by way of evidence deposition on January 11, 2012. Dr. Margherita is a board certified physical medicine and rehabilitation specialist. He testified that Petitioner's wife is a patient of his, and she referred Petitioner to him for evaluation and treatment of his radiculopathy. Dr. Margherita testified that he first attempted to address Petitioner's symptoms with prescription medication, such as Nucynta and Diclofenac. He testified, however, that Petitioner's EMG study was very abnormal and showed abnormalities in five muscles in Petitioner's left leg that all link to the L-5 nerve. He also testified that Petitioner's MRI showed significant left-sided disc herniation between L4 and L5. Based on these findings, he recommended a course of select nerve root injections in order to reduce the nerve inflammation brought about by the disc herniation. Despite improvement from the first injection, Petitioner still had left-sided neural tension signs. Dr. Margherita recommended a course of injections, medication and physical therapy. PX 5.

Dr. Margherita testified that Petitioner's films did not demonstrate long-standing degenerative disc disease or anything that would close down his canal space explanatory of his symptoms. He stated that, "[h]e had no evidence of significant stenosis or narrowing in his spinal canal. He had some mild degeneration, but he's overweight, he had some mild degeneration, but nothing that would be considered a causative factor with regard to disc herniation." Based upon Petitioner's clinical history, the diagnostic findings, the medical records and the radiographic images, he opined that Petitioner's L4-5 disc herniation and his L5 lumbar radiculopathy was caused by the lifting Petitioner performed while employed by Respondent. He stated, "[h]is history and exam, his MRI, EMG were all consistent, in my opinion the lifting that he described from a historical standpoint, the time course that he described in terms of the evolution of his symptoms, were all consistent." He further testified that Petitioner's radicular symptoms were "part and parcel" with his condition of his ill-being, and that the additional information provided to him on August 1, 2011 reinforced his opinion. He testified that all of Petitioner's diagnostic studies and treatment were reasonable, necessary, and necessitated by Petitioner's work activities. On cross-examination, Dr. Margherita refused to answer a hypothetical question regarding whether his causal connection

opinion would change if the evidence at Arbitration revealed that Petitioner did not complain of low back pain or lower extremity discomfort until he stopped working for Respondent on October 13, 2010. PX 5.

Petitioner was examined by Dr. Frank Petkovich on March 5, 2012 pursuant to Section 12 of the Act, and Dr. Petkovich testified by way of evidence deposition on April 23, 2012. Upon presenting to Dr. Petkovich, Petitioner reported that the trash bags became heavier and more compact when Respondent switched from using Styrofoam trays at the high school in favor of plastic ones, and he indicated that he informed his supervisor that the lunch bags were too heavy. Petitioner, however, denied any injury while working for Respondent, and he reported to Dr. Petkovich that he resigned from his employment with Respondent to start his own business performing artistic type work. Dr. Petkovich testified that when Petitioner presented to him on March 5, 2012, Petitioner was doing well except for occasional discomfort in his left lower extremity. He also felt that Petitioner had full range of motion on that date. Dr. Petkovich believed his examination of Petitioner's lower extremities was normal despite decreased sensation, which he characterized as mild in nature. He diagnosed Petitioner with a lumbar disc protrusion with herniation at L4-5 with underlying degenerative lumbar disc disease at L4-5 and L5-S1. Dr. Petkovich testified that a disc herniation can be a natural progression of degenerative disc disease, and testified that he believed that Petitioner's MRI showed degenerative lumbar disc disease at L4-5 and L5-S1. Dr. Petkovich did not believe that Petitioner's employment with Respondent was responsible for his degenerative changes, his herniation at L4-5, or his current symptoms, and he did not believe Petitioner required restrictions or any further treatment. RX 2.

On cross-examination, Dr. Petkovich could not identify any record of back pain prior to Petitioner's employment with Respondent subsequent to 2002. He further acknowledged that Petitioner's job description at the Edwardsville School District included "essential physical requirements" of lifting, pulling, pushing and moving items 40 to 60 pounds on a regular and repetitive basis and emptying trash cans up to 40 pounds on a repetitive basis. Dr. Petkovich found that Petitioner's medical treatment was reasonable, with the exception of Petitioner's EMG/NCV, which he felt was a "waste of money" because it "further substantiated what was already known." Dr. Petkovich testified that he did not believe that anyone could specify a weight at which a patient could sustain a disc herniation while lifting, and opined that an injury can occur while lifting as little as five pounds. Dr. Petkovich opined that repeated heaving lifting of trash bags was not a causative factor in the development of his low back and lower extremities symptomatology because Petitioner reported lifting heavy bags in Spring 2010 but did not complain of any pain until September 2010, though he acknowledged that Petitioner could have experienced "some element of discomfort in his lower back or in his upper back or in his arms or his legs" as a result of lifting bags on some days. Dr. Petkovich acknowledged that, "I don't know what type of back pain he had prior to that time, prior to his employment with the Edwardsville School District. I think that he may – I think that looking at his MRI study from 2010, I'm sure that he did have some back pain prior to his employment with Edwardsville School District. He may have just, you know, tried to just, you know, ignore the pain and live with it...Well, it is supposition on my part, but it's also based upon my experience as an orthopedic surgeon and doing spinal surgery for the past 32 years." Dr. Petkovich reviewed a narrative history provided by Petitioner regarding his job duties for Respondent, and he testified that it would not change his opinion. RX 2.

John A. Martin, Food Service Director for the Edwardsville School District, testified at Arbitration. In that position, Mr. Martin manages the food operations of 14 schools, plans menus,

and trains employees on meal preparation and service. Mr. Martin does not supervise custodians. He denied that Respondent made a decision in May 2010 to utilize exclusively plastic trays, as suggested by Petitioner, and he believed the high school utilized the same percentages of Styrofoam trays versus plastic trays throughout 2008, 2009 and 2010. Mr. Martin did not believe that a trash bag without Styrofoam trays would weigh any more than a bag with them, and he explained that there is only so much waste that can be placed into the trash bags before they tear. Mr. Martin testified that the bags of trash represented in Respondent's Exhibit 4 exemplified the average weight of trash bags over the years. He testified that Petitioner informed him he was leaving Respondent's employment to become an art teacher for Respondent. Mr. Martin denied that Petitioner reported to him he was resigning secondary to his low back, and testified that had Petitioner done so, he would have had Petitioner call Company Nurse, a service utilized by Respondent to report injuries. See RX 7.

Tammy Manley, Assistant Head Custodian for Respondent, testified at Arbitration. Ms. Manley testified that plastic and Styrofoam trays were used on both sides of the food line and that each student chooses which tray he or she will use. Ms. Manley testified that she took the pictures submitted as Respondent's Exhibit 4, and he stated that the trash bags reflected therein represent the normal capacity for waste. She testified that the use of plastic trays remained the same throughout 2008, 2009, 2010, and to the present. Ms. Manley denied filling up a 55 gallon drum of trash and leaving it for Petitioner to take out so she could take a smoke break. Ms. Manley also denied being told by Mr. Everage not to overfill her drum so that Petitioner would have to lift her trash, and she denied that Petitioner reported an injury to her secondary to lifting trash bags. She testified that had Petitioner informed her of such an injury, she would have told him to call Company Nurse.

Rick Everage testified at Arbitration. Mr. Everage is presently employed as an Assistant Job Superintendent for Blue Ray Construction, and he previously worked for Respondent as Assistant Principal until he retired in June of 2013. Mr. Everage denied that Respondent exclusively utilized plastic food trays beginning in 2010, and stated that Respondent utilized both Styrofoam and hard clad trays. He testified that he frequently assisted janitors in his position for Respondent, and lifted trash bags. Mr. Everage denied that trash bags weighed 50 to 80 pounds, he denied discussing Petitioner's low back symptoms with him, and he denied discouraging him from reporting his symptoms to the Company Nurse. Mr. Everage testified that generally an administrator or supervisor, rather than an employee, would call Company Nurse because Respondent had to document the information and send it to the District office. Mr. Everage testified that he did not call Company Nurse for Petitioner, and he denied telling Ms. Manley not to overfill her trash cans.

Tom Manis testified by way of evidence deposition. Mr. Manis is the Head Custodian for Respondent, and he testified that he works the evening shift from 3:00 p.m. to 11:30 p.m., while Petitioner worked the day shift from 8:00 a.m. to 4:30 p.m. He testified that he had some contact with Petitioner. Mr. Manis recalled that Petitioner told him he was resigning from his custodial position with Respondent to pursue his silk screening business. He denied Petitioner reporting to him that he injured his back while lifting trash bags, and he testified that had Petitioner reported an injury to him, he would have advised him to call Company Nurse. RX 9.

Petitioner recalled himself as a rebuttal witness at Arbitration. Petitioner testified that during a discussion with Mr. Everage, he believed that Mr. Everage made notes, discouraged him from reporting his symptoms as he previously testified, and ultimately did not complete a report.

Petitioner testified in rebuttal that Ms. Manley rolled a 55-gallon trash can to student tables and put her trash bags in the cart while he collected the trash from the tables and approximately ten cafeteria trash cans, loaded the cart, and took them out to the dumpster. Petitioner testified that when he collected trash from the cans on Ms. Manley's side of the cafeteria, they were overflowing, sometimes onto the floor, because students poured trash into her can. He testified that she did not empty it, but instead would leave it for Petitioner to collect while she went on break. He testified that he would barely have anything to grab to tie the trash bag and put it in the cart. Petitioner testified that he complained about the situation to Tom Manis, and stated that "[i]t was, I would say, several occasions. I couldn't give you the exact date, but in that period of September – October I told him that the Styrofoam trays not being in the trash is leaving much more room for the food and trash bags are getting too heavy…."

Pictures were admitted as Respondent's Exhibit 4. RX 4-0001 reflects the cart Petitioner utilized to transfer trash bags to the dumpster. Petitioner testified that in order to get the trash bags to the dumpster, he had to lift the trash bags out of the trash disposal receptacles, place them into a rolling trash can, which he then rolled to the trash cart depicted in Respondent's Exhibit 4, before loading the trash bags into the cart, rolling the cart to the dumpster, and lifting the trash bags into the dumpster. RX 4-0003 depicts the dumpsters which serve as the final destination for the trash bags. RX 4-0002 and RX 4-0004 depict custodians holding trash bags, which Petitioner characterized as "a little bit of food and a lot of air." RX 4-0005 depicts a trash bag on a scale, and additional pictures reflect trash bags weighing 17 pounds, 7.4 pounds and 17 pounds respectively. RX 4-0005 through 4-0008.

Petitioner's employee evaluation of July 27, 2009 reveals that Petitioner was deemed to be an exceptional employee in all categories, including quality of work, quantity of work, attendance, dependability, relationships with others, judgment, adaptability and work habits. Additional subsequent employee evaluations reflect exceptional marks in work habits, quality and quantity of work, dependability, and in all areas with the exception of attitudes and relationships with others, which were moved to satisfactory. It is noted that Petitioner displayed a positive and enthusiastic attitude about work and that he was loyal and displayed a positive attitude toward the students and the public. It was also noted that Petitioner "generally works well with others", but that he "[o]n occasion…will voice his opinion in a negative tone toward other employees." RX 5.

A letter from Petitioner to Nancy Spina, Rick Everage, and Steve Morrison dated October 29, 2009 admitted as part of Respondent's Exhibit 5 states that Petitioner volunteered to temporarily fill the position of Roy Plegge on the day shift, and Petitioner was requesting to be returned to his evening position. That request was denied by Respondent, as reflected in the Memorandum from Respondent to Petitioner of October 30, 2009. RX 5.

A letter from Petitioner to Nancy Spina dated May 11, 2010 was admitted as part of Respondent's Exhibit 5. Therein, Petitioner again requests Respondent return him to the evening shift and states that he "would like to regain the evening stipend on my paycheck…I would also like to work alone on a cleaning run again instead of being the utility man that I am now. The expansive walking distances which I have to cover very frequently throughout the day are starting to wear on my ankles and knees. Returning to the more confirmed space of a cleaning run would extend my longevity as a custodian for District 7. The stress of working with a coworker I am seemingly in constant conflict with is also becoming too much to bear. Tammy Manly and I do not compliment

[sic] each other well as a team...I have come to realize that I need to be on a different shift away from Tammy or in a position other than custodian for the upcoming school year." RX 5.

A Report of Injury dated December 22, 2010 was admitted as part of Respondent's Exhibit 5. The Report indicates an incident date of October 13, 2010. An administrative assistant called to report that a first notice of injury was delivered to Respondent from an attorney, but she was unaware of any additional information regarding the incident other than what was received in the letter. RX 5.

Records from Madison Community Unit School District #12 were admitted as Respondent's Exhibit 6. On August 10, 2010, Petitioner applied for a position as a teacher and custodian, and noted that he was able to perform the essential requirements of the job. He stated that he resigned from his position with Respondent due to "transition to part time employment". On July 14, 2010, Petitioner underwent a pre-employment health examination for Madison Community Unit School District #12, at which time it was noted that Petitioner's general physical condition was "overweight, otherwise healthy appearing" with "no significant abnormalities". RX 6.

CONCLUSIONS OF LAW

In regard to disputed issues (C) and (F), given the common evidence and facts relative to both issues, the Arbitrator addresses them jointly.

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel Co. v. Indus. Comm'n*, 6 Ill. 296, 300 (Ill. 1955). An injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro v. Industrial Commission*, 207 Ill. 2d 193, 204-205 (2003). There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Edward Hines Precision Components v. Indus. Comm'n*, 356 Ill. App. 3d 186, 193-194 (2d Dist. 2005). Circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 95 (4th Dist. 1994); *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59 (1982).

In the present case, the Arbitrator finds Petitioner's testimony highly suspect. Specifically, the Arbitrator questions Petitioner's proffered rationale as to his request to return to the day shift. His testimony at Arbitration insinuated that he requested Respondent transfer him back to his original evening shift because the job duties customarily part of the day shift caused him low back pain. Yet, in his own correspondence dated May 11, 2010 to Nancy Spina, Petitioner points to a myriad of reasons for requesting a transfer to the evening shift, including "regaining the evening stipend on my paycheck," working alone on a cleaning run, alleged wearing on his knees and ankles from the "expansive walking distances", and the "stress of working with a coworker". RX 5. By virtue of Petitioner's own written statement, Petitioner's rationale for requesting a transfer to the evening shift predated any development of alleged low back symptomatology and was solely made for reasons unrelated to any low back complaints. As such, the Arbitrator finds Petitioner's suggestion at Arbitration that he requested a transfer to the evening shift because his job duties associated with the day shift caused him low back symptomatology to be incredulous.

Petitioner's testimony as to the basis of his resignation from Respondent's custodial employment on October 13, 2010 is similarly questionable. At Arbitration, Petitioner testified that he resigned his position with Respondent because he was afraid of seriously injuring himself while lifting trash bags, and because "I thought I can't keep going like this. I'm going to end up hurt." Petitioner prepared a narrative report regarding his job duties, where Petitioner stated that "[e]very day my back hurt more and more and I finally had to quit my job because my back couldn't take it anymore." RX 2 (2-0073). Petitioner testified that when he provided notice of his retirement by way of his Clucky Duck flyer dated September 28, 2010 he did not mention any low back complaints because he "was just giving notice about leaving" and because he thought that his back pain would resolve after he separated from his daytime position. However, Petitioner's testimony is disingenuous because he applied for a teaching and custodial position with Madison County School District, as well as for a substitute custodial position for Respondent. Although Petitioner testified that the substitute custodial position for Respondent is strictly an evening position, the Arbitrator is not persuaded by Petitioner's justification, given that Petitioner nonetheless applied for a custodial position with Madison County School District that may likely subject him to the same laborious job duties he claims caused him low back symptomatology for Respondent.

Furthermore, Mr. Manis testified that Petitioner reported to him that he was resigning from his position with Respondent to pursue his silk screening business, and Mr. Martin testified that Petitioner told him that he was leaving Respondent's employment to become an art teacher for the District. Petitioner acknowledged that he started getting his silk screening business "together in the summer of 2010 in order to start the business" and that he applied for the position with Madison County School District a few months prior to his resignation from Respondent because "I wanted to supplement my income that I would hopefully be getting, because I already planned on quitting eventually to start my business...and I wanted to get off of the everyday trash bag thing." Yet, it belies credulity for Petitioner to state that he wanted to "get off the everyday trash bag thing" when he applied to Madison County in August 2010 when he does not allege an onset of low back symptomatology until September 2010. Regardless, as with his rationale for requesting to return to the evening shift, the evidence suggests that Petitioner intended to resign from his position with Respondent well before he developed any alleged low back complaints and for reasons wholly unrelated to his alleged work injury.

Moreover, Petitioner's testimony at Arbitration concerning the physicality of his present employment for Clucky Duck Screen Printing was disingenuous. Petitioner testified on a direct examination that a silk screener is not a heavy job, and he described his position as utilizing a squeegee to pull dye over t-shirts. He stated that lifting boxes of shirts is the heaviest part of his current position, and testified that boxes weighed "at most 35 pounds" and that he "will take some shirts out to make it lighter." He denied lifting machinery or anything other than boxes of shirts in his current position, specifically stating that his machines are on wheels. He further testified that he quit lifting after he was injured in 2010 and stated that the only lifting he performed at any time was for Respondent. However, Petitioner's medical records indicate that his testimony is simply inaccurate, as Petitioner ruptured the biceps tendon of his left arm while moving a piece of equipment in 2011. PX 5. When confronted about his biceps tendon injury on cross-examination, Petitioner conceded that he and another individual were lifting a belt for his printing business, but attempted to minimize this fact by claiming the machinery weighed "75 pounds at the most" and he "was careful to lift with his arms." The Arbitrator, however, is not persuaded by Petitioner's attempts to rehabilitate his own testimony.

The testimony of John Martin, Tammy Manley and Rick Everage very credibly rebutted that of Petitioner concerning the virtually exclusive use of plastic reusable trays in 2010, as well as Petitioner's testimony regarding his reports of low back complaints to them resultant from lifting heavy trash bags. Mr. Manis too denied Petitioner's claims that he reported a low back injury from lifting trash bags. Mr. Martin, Ms. Manley and Mr. Everage all candidly and consistently denied that trash bags weighed 50 to 80 pounds, and the Arbitrator finds the testimony of Mr. Everage highly persuasive, given that he saw Petitioner on a daily basis during the time period at issue while he was employed as Assistant High School Principal, he testified he assisted custodians in that position and lifted trash bags himself, and he was no longer employed by Respondent at the time of Arbitration, which negates any suggestion of motive to testify in favor of Respondent or against Petitioner. The photographs admitted in Respondent's Exhibit 4 corroborate the testimony of Mr. Martin, Ms. Manley and Mr. Everage, and rebut Petitioner's testimony that Respondent utilized plastic trays exclusively beginning in May 2010, as the Arbitrator notes that white Styrofoam trays can be seen within the clear trash bags. RX 4.

The Arbitrator finds Petitioner incredulous in light of his testimony at Arbitration. The Arbitrator finds Petitioner's testimony was not candid or forthcoming, and points to the multiple inconsistencies in his testimony as exemplifications of same.

Lastly, the Arbitrator notes that the causation opinion of Petitioner's treating physician, Dr. Margherita, is based in part upon a history of injury given to him by Petitioner. Dr. Margherita testified that Petitioner's "...history and exam, his MRI, EMG were all consistent, in my opinion the lifting that he described from a historical standpoint, the time course that he described in terms of the evolution of his symptoms, were all consistent." PX 5. The Arbitrator is disinclined to rely upon the opinions of Dr. Margherita because they are based upon a history of injury reported to him by Petitioner, whose testimony the Arbitrator finds not to be credible and inherently unreliable given the multitude of inconsistencies therein. Furthermore, Dr. Margherita's opinions are undermined by his refusal to answer Respondent's hypothetical question regarding whether his causal connection opinion would change if Petitioner did not complain of low back pain or lower extremity discomfort until he stopped working for Respondent on October 13, 2010, given that the record affirmatively establishes that Petitioner did not complain of any symptomatology or seek treatment until after he resigned, and because Dr. Margherita rendered opinions for Petitioner based in part upon hypothetical information provided to him by Petitioner's counsel in a letter dated August 1, 2011. See PX 5.

Petitioner's claim in this matter regarding the issues of accident and causation essentially rests upon his testimony and the history given by him to Dr. Margherita. Given the Arbitrator's foregoing conclusions concerning Petitioner's credibility, the numerous inconsistencies within his testimony and between Petitioner's testimony and the record, and in light of the record in its entirety, the Arbitrator does not place evidentiary weight on Petitioner's testimony or any history of accident given by him to his treating physician. Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the credible evidence that he suffered accidental injuries that arose out and in the course of his employment with Respondent on October 13, 2010, and that his current condition of ill-being is causally related to his alleged work accident.

The Arbitrator finds that the remaining issues of notice, medical bills and permanent disability benefits are moot, and the Arbitrator accordingly makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hasan Cehic,
Petitioner,
vs.

15IWCC0498
NO: 04 WC 26393

Galesburg Register Mail,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 26, 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: JUN 30 2015
KWL/vf
O-6/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0498

CEHIC, HASAN
Employee/Petitioner

Case# 04WC026393

GALESBURG REGISTER MAIL
Employer/Respondent

On 9/26/2014, 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 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

. E OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0498

Case # 04 WC 26393

Hasan Cehic
Employee/Petitioner

v.

Galesburg Register Mail
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 **Bloomington**, on **July 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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

15IWCC0498

FINDINGS

On **September 9, 2003**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 **$8,188.39**; the average weekly wage was **$341.18**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent child.

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

ORDER

Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

September 22, 2014
Date

SEP 26 2014

FACTS:

The Petitioner testified that he was born in Yugoslavia and came to the United States in 1996 at the age of 42. He testified that he did not speak English when he came to the United States, and the Arbitrator notes that he presently speaks English with a heavy accent. The Petitioner testified that he worked continuously from the time he arrived in the United States until September of 2003. He testified that he initially found work at a meat packing plant and that he later worked at a painting company, a farmland plant and then a printing business. The Petitioner testified that he began working for the Respondent on March 10, 2003.

The Petitioner testified that his job at the Respondent required him to move pallets of paper, load paper into the printing presses, fill the presses with ink and water, change printing plates, and move the printed paper form the presses to pallets. The Petitioner testified that he normally worked from 7:00 a.m. until the days print run was completed which was scheduled to be around 4:00 p.m. The Petitioner testified that as part of his job he would also clean the press room and move boxes and rolls of paper. The Petitioner described that a large part of his job required him to work on the press line, standing in place and lifting printed copies of papers from a conveyor on his right side and moving/carrying the papers to his left side where they were stacked onto a pallet. The Petitioner also described that his work on the line also required him to "jog" papers.

The Petitioner testified that in the summer of 2003 he began to feel soreness in his neck and left arm. The Petitioner described that during August of 2003 he tried to move a wheeled cart but the cart's wheels were locked and he experienced soreness in his neck and left arm. He testified that he did not report an injury or seek any medical treatment at that time because he thought the pain would go away. The Petitioner testified that he continued to work his regular job until September 9, 2003 when he pulled a pallet jack which became stuck on something on the floor. The Petitioner testified that he had to pull the jack with more force to get it to move and that, as he did so, he felt a pinch and hotness in his neck and left shoulder and worsening pain in his shoulder. The Petitioner testified that he reported his injury that day and was directed to seek treatment at OSF Medical Group.

On September 15, 2003 the Petitioner presented to Dr. Grady's office at the OSF Medical Group with complaints of constant left shoulder pain radiating to his neck, the left side of his head and left arm. He also complained of numbness and tingling in his fingers and weakness in his left hand. The record notes a history of pain for two weeks and a denial of injury. The Petitioner returned to Dr. Grady on October 15, 2003 with complaints of left shoulder, neck, and arm pain with numbness in the fingers. Dr. Grady ordered a cervical MRI and a left shoulder MRI which were performed on October 17, 2003. The cervical MRI was reported to demonstrate mild degenerative changes at C5-C6 without significant compromise of the spinal canal or neural foramina, and the left shoulder MRI was reported to be unremarkable. Dr. Grady then referred the Petitioner for physical therapy.

On November 14, 2003 The Petitioner returned to Dr. Grady with complaints of pain in his neck and arm on the left side as well as left hip pain. Dr. Grady took the Petitioner off work

through November 18, 2003. On November 18, 2003 the Petitioner returned to Dr. Grady and reported that he felt better and had less pain. Dr. Grady allowed the Petitioner to return to work. On December 3, 2003 the Petitioner reported complaints of headaches, left hip pain, and increased left side pain, and he was referred to Dr. Prentice, an orthopedic surgeon.

The Petitioner saw Dr. Prentice on December 4, 2003 with complaints of left shoulder, neck, and upper back pain as well as left hip pain which radiated down the left leg. Dr. Prentice recommended cervical traction and took the Petitioner off work for 2 weeks. On December 18, 2003 the Petitioner reported that he was doing much better and that the traction was doing a lot of good. Dr. Prentice instructed the Petitioner to continue with the traction and he allowed the Petitioner to return to work. On January 7, 2004 the Petitioner returned to Dr. Prentice and reported that he was getting better but still had some problems.

On May 11, 2004 the Petitioner was examined by Dr. Robert Martin at the request of the Respondent. Dr. Martin noted that the Petitioner reported that he had some pain in his neck prior to October 17, 2003 but that on October 17, 2003 his neck pain got much worse without any specific injury. Dr. Martin noted that the Petitioner had complaints of constant pain in the back of the neck radiating to the left shoulder and down the left arm to the ring and little fingers with tingling and numbness in the fingers. Dr. Martin also noted complaints of headaches and difficulty sleeping. Dr. Martin examined the Petitioner and reviewed his medical records and MRI scans, and he diagnosed the Petitioner with degenerative disc disease of the cervical spine and probable left cubital tunnel syndrome. Dr. Martin noted that the area of the Petitioner's cervical degenerative disc disease noted on the MRI was not the area that would cause numbness and tingling in the left ring and little fingers. Dr. Martin noted that the Petitioner did have a positive Tinel's sign at the left elbow which could be indicative of left cubital tunnel syndrome and he suggested an EMG. Dr. Martin opined that the Petitioner's neck and shoulder symptoms were coming from his degenerative disc disease which was not caused by his work activities and he opined that the Petitioner's condition was not causally related to his work.

On June 7, 2004 the Petitioner saw Dr. Nikolav, a neurologist at the Galesburg Clinic. Dr. Nikolav noted complaints of pain in the neck, the left shoulder and arm, and the low back, and a history of an injury on September 15, 2003. On June 9, 2004 the Petitioner underwent an EMG/NCV study which was reported to demonstrate evidence of C5-C6 radiculopathy and no evidence of entrapment neuropathy at the wrist or elbow. The Petitioner returned to Dr. Nikolav on June 24, 2004 and the doctor noted that the Petitioner was doing better and that physical therapy had proven helpful. Dr. Nikolav's assessment was left C5-6 radiculopathy and he advised the Petitioner to follow up as needed. Dr. Nikolav also held the Petitioner off work completely for two weeks and then to return to work on July 6, 2004 with restrictions which consisted of lifting no more than 5 pounds, no work above shoulder level and no pushing or pulling. On July 15, 2004 Dr. Nikolav referred the Petitioner to the pain clinic for an epidural steroid injection for the left C5-6 radiculopathy.

On July 20, 2004 the Petitioner saw Dr. Miller who gave the Petitioner a cervical epidural steroid injection at C5-C6. The Petitioner reported no improvement with the injection

and Dr. Miller asked Dr. Grady to refer the Petitioner to a neurosurgeon.

The Petitioner then saw Dr. Lin, a neurosurgeon on August 3, 2004 with complaints of pain in the neck and left shoulder with pain radiating down his left arm into the fingers. Dr. Lin ordered a cervical myelogram which was reported to demonstrate foraminal stenosis at C5-6 and C6-7 which was worse on the left. Dr. Lin recommended cervical decompression surgery and on September 1, 2004 the Petitioner underwent posterior cervical foraminotomy on the left from C5 to T1. Dr. Lin continued the Petitioner off work following the surgery and the Petitioner attended physical therapy from October through December 8, 2004.

On February 11, 2005 the Petitioner returned to Dr. Lin with complaints of pain in the left arm and occasional focal tenderness over the left thumb and left elbow. Dr. Lin noted that the Petitioner's complaints did not appear to be radicular and he concluded that the Petitioner had reached maximum medical improvement and could return to work.

On July 7, 2005 the Petitioner returned to Dr. Nikolav and complained that he was worse than he was prior to surgery and that he still had left sided neck pain and shoulder pain down his arm with tingling and numbness into his fingers. Dr. Nikolav diagnosed the Petitioner with chronic pain syndrome and instructed him to return to Dr. Lin.

On December 6, 2005 the Petitioner returned to Dr. Lin with complaints of pain in his neck and left shoulder and occasional numbness in his right hand. Dr. Lin noted that the Petitioner had reached maximum medical improvement "several months ago" and he indicated that the Petitioner's pain "certainly could be related to repetitive motion required in his previous job as a publisher."

On June 19, 2006 the Petitioner went to the emergency room at Galesburg Cottage Hospital. He complained of pain in his head, neck, and left back and hip, and he indicated that the onset of the pain was "2–4 days ago." The Petitioner was diagnosed with chronic myofascial pain and he was discharged.

On August 2, 2006 the Petitioner saw Dr. Schierer, an orthopedist, on referral from Dr. Enoch. Dr. Schierer noted a history of a neck injury while working on September 15, 2003 and "some type of cervical procedure two years ago." Dr. Schierer noted that the Petitioner reported that he had pain in his neck, the left side of his face, and down his left arm into his fingertips. Dr. Schierer diagnosed the Petitioner as status-post cervical spine surgery with recurring pain and he recommended that the Petitioner see a neurosurgeon.

On August 10, 2006 Dr. Marc Soriano completed a records review at the request of the Respondent. Dr. Soriano reported that the Petitioner's diagnosis was post C-5 through T-1 left hemilaminectomy and foraminotomy with left shoulder pain originating on or about September 15, 2003. Dr. Soriano reported that based upon the Petitioner's medical records and his job description, no documented work injury occurred. Dr. Soriano opined that it was possible but not probable that the Petitioner's repetitive motion injury at work caused an injury to the Petitioner's left shoulder, arm, or hand resulting in his subjective complaints. Dr.

Soriano further opined that the Petitioner at no time demonstrated any objective findings indicating a clear radiculopathy and that despite the Petitioner's subjective complaints, there was no obvious source of his ongoing pain. Dr. Soriano also opined that there was no evidence that any of the mild impingement noted at C5-6 or C6-7 could have been responsible for the Petitioner's claimed numbness and tingling in his ring or fifth finger or his subjective complaints of pain in the left shoulder radiating down the arm. Dr. Soriano opined that the surgery performed on the Petitioner was unnecessary and non-indicated and that "there is clearly no causal relationship between the claimant's repetitive work motions, any specific work injury and the subsequent surgery or subjective complaints of which he complains." Dr. Soriano also opined that, on an objective basis, the Petitioner was capable of a full return to work without restriction. In a subsequent letter report dated December 26, 2006, Dr. Soriano reported that he had reviewed a video tape of the Petitioner's work activities, a written job description, and an updated medical record from Dr. Lin and that he found no cause to change the opinions he rendered in his initial report.

On October 4, 2006 the Petitioner returned to Dr. Lin with complaints of neck pain, left shoulder pain and occasional numbness in his thumb. Dr. Lin noted left biceps and triceps weakness but normal range of motion in the left shoulder. Dr. Lin ordered a cervical MRI which was performed on October 26, 2006 and was reported to demonstrate minimal to mild diffuse posterior bulging of the C5-C6 disc. The Petitioner returned to Dr. Lin on December 13, 2006 and Dr. Lin noted that the MRI showed a disc bulge but no neural compression or spinal cord compression. Dr. Lin noted that the Petitioner had no surgical lesion and he had no further recommendation regarding pain management.

In December of 2006 and February and May of 2007, the Petitioner saw Dr. Enoch for his complaints of pain in his neck and back. In July of 2007 Dr. Enoch referred the Petitioner to Galesburg Anesthesiology and, on August 7, 2007, the Petitioner saw Dr. Adkins. Dr. Adkins noted a history of an injury at work while lifting a heavy object in an awkward fashion. Dr. Adkins diagnosed the Petitioner with cervical postlaminectomy syndrome, left cervical radiculopathy and cervical spinal stenosis. Dr. Adkins prescribed Lyrica, a Medrol Dosepak, and a TENS unit and indicated that cervical epidural steroid injections could be considered as a very last resort. On November 14, 2007, December 5, 2007, and January 10, 2008, Dr. Adkins administered cervical epidural steroid injections to the Petitioner at C7-T1. In January of 2005 the Petitioner saw Dr. Adkins' partner, Dr. Kane, who recommended that the Petitioner return back to his neurologist for a re-evaluation.

In a letter report dated February 8, 2008 Dr. Lin reported that the Petitioner's final diagnosis was persistent mechanical neck pain and that he had reached maximum medical improvement in February 2005. Dr. Lin indicated that the Petitioner's disability was due to his pain and that he would defer the imposition of any permanent restrictions to the results of a functional capacity evaluation. Dr. Lin indicated that he did not have the specifics regarding the Petitioner's "work-related injury" but he opined that the Petitioner's pain could be related to the work injury.

On February 20, 2008 the Petitioner returned to Dr. Lin with complaints of neck pain

and left arm pain that radiated to his thumb as well as left facial numbness. Dr. Lin referred the Petitioner to Dr. Dr. Nikolav for evaluation of "his new left-sided facial numbness. The Petitioner then saw Dr. Nikolav who ordered an MRI of the Petitioner's brain which was reported to be normal. On April 9, 2008 Dr. Lin who noted that he had no further intervention or treatment to offer the Petitioner.

The Petitioner then returned to Dr. Kane who administered cervical epidural steroid injections at C7-T1 on April 21, 2008 and May 19, 2008. On June 13, 2008 Dr. Kane ordered a left shoulder MRI which was performed on June 18, 2008 and was reported to demonstrate mild degenerative changes at the AC jointwith minimal indentation on the rotator cuff musculotendinous structures, and very minimal fluid within the subacromial – subdeltoid bursa. On July 18, 2008 the Petitioner returned to Dr. Kane who noted that the MRI findings were just a degenerative process.

On September 29, 2008 the Petitioner saw Dr. Schierer regarding his left shoulder pain and Dr. Schierer administered an epidural steroid injection. On October 27, 2008 Dr. Schierer noted that the Petitioner's left shoulder was no better after the injection and that the Petitioner's problem seemed to be coming from his cervical spine, not his shoulder.

Throughout 2008, 2009, 2010, and 2011, the Petitioner continued to receive epidural steroid injections in his cervical spine. The records demonstrate that more than twenty cervical epidural steroid injections were administered to the Petitioner. On July 18, 2011 Dr. Kane noted that the Petitioner had ongoing cervical radiculopathy which was refractory to basically all forms of therapy and he opined that the Petitioner was unable to hold a job of any physical intensity and his lifting should be limited to 25 pounds above shoulder level. Dr. Kane recommended the Petitioner get a second opinion to either validate the correctness of the surgery or offer some input to try to alleviate the pain in a more lasting fashion.

On October 24, 2011 the Petitioner saw Dr. Purighalla who diagnosed the Petitioner with cervical spinal stenosis, cervical disc displacement, numbness and cervicalgia. Dr. Purighalla recommended the Petitioner continue to treat conservatively with medications, physical therapy and epidural steroid injections or selective nerve blocks. Dr. Purighalla noted that, if all of the conservative measures failed, the Petitioner might benefit from an anterior cervical discectomy and fusion at C5-C6.

Throughout 2012, the Petitioner continued to receive epidural steroid injections in his cervical spine from Dr. Kane. In 2013 the Petitioner saw Dr. Peachey of Cottage Medical Group and in January of 2014 the Petitioner saw Dr. Snyder of the Institute of Physical Medicine and Rehabilitation. Dr. Snyder, a physiatrist, diagnosed the Petitioner with left upper extremity pain/shoulder pain, possible left carpal tunnel syndrome and cervicalgia and recommended an MRI of the left shoulder and an EMG/NCV of the left hand. The MRI was reported to demonstrate some fraying and a partial tear of the supraspinatus tendon but no full thickness tear and the EMG was reported to demonstrate very mild left median nerve compression neuropathy at the wrist. Dr. Snyder opined that nothing needed to be done in regards to the mild carpal tunnel syndrome but she indicated that a subacromial injection

might benefit the Petitioner as far as pain relief. Dr. Snyder also suggested that the Petitioner might benefit from physical therapy for the left shoulder.

The Petitioner testified that he currently continues to experience constant pain and stiffness in his neck. He testified that the pain wakes him up during the night and that he has difficulty lifting or carrying anything with his left arm. He testified that lifting too much with his left hand causes pain and that the level of his constant pain and stiffness increases with prolonged reading, watching television, and sitting. The Petitioner testified that his pain today is the same as it was when he was first injured and that his pain now radiates down into his upper back and up into his face. The Petitioner testified that he continues to receive cervical epidural steroid injections and that he has received in excess of 40 such injections from November of 2007 through the present time. The Petitioner testified that the injections have not provided him with any relief from his pain.

The Petitioner testified that since the termination of his employment in May of 2005 he has applied for only two jobs. He testified that he applied for a dishwashing position at two restaurants in Galesburg sometime in 2007 but was not hired. The Petitioner testified that he does not believe that he could work fast food, he cannot clean his apartment, he cannot read or work a desk job due to his pain. The Petitioner testified as of the time of trial that he is not actively looking for a job as he feels he is not capable of working.

On cross examination the Petitioner testified that he did fill out an accident report in this matter which described an injury on August 12, 2003. This report is signed and dated by the Petitioner on November 15, 2003. The Petitioner's initial Application for Adjustment of Claim indicated a date of accident of September 15, 2003. This was later amended to a date of accident of October 17, 2003. The Petitioner also met with the HR Director, Mary Yung, who filled out a Form 45 with the information given to her by the Petitioner. This document evidences a date of accident of November 7, 2003.

Mary Yung, the Respondent's Human Resources Director in 2003, testified that on November 11, 2003 she completed an Employer's First Report of Injury (RX 1) based upon information provided to her by the Petitioner. Ms. Yung also testified that she was familiar with the Petitioner's job duties while he was employed by the Respondent and that those duties would vary and were considered lightweight. Ms. Yung also testified that all of the jogging activities and other work the petitioner performed would have been below shoulder level. Ms. Yung testified that she did prepare a job video which showed the various job duties the Petitioner performed, including "jogging" activities and the activities involved in cleaning the press, filling the ink and the water, and changing the plates in the press. (RX 20) Ms. Yung testified that the Respondent asked the Petitioner to return to work at various times throughout the pendency of his workers' compensation claim, both before and after the surgery performed by Dr. Lin. Ms. Yung testified that the position the Petitioner worked was available after the Petitioner's surgery and after the Petitioner's release to return to work by Dr. Lin in February of 2005. Ms. Yung testified that the Petitioner was terminated in May of 2005 for job abandonment.

The October 22, 2010 testimony of Dr. Julian Lin was admitted into the record as Petitioner's Exhibit 2. Dr. Lin testified as to the course of treatment he rendered to the Petitioner including the C5 through T1 foraminotomy he performed on the Petitioner on September 1, 2004. Dr. Lin testified that following that surgery the Petitioner was somewhat improved but that by December of 2004 similar, nonfocal, pain had returned and by December of 2005 the Petitioner wasn't any better. Dr. Lin opined that the pain that the Petitioner was reporting in December of 2005 "certainly could have been related to repetitive motion required in his previous job as a publisher" but he also acknowledged that "there could be several reasons" for the Petitioner's pain. Dr. Lin testified that when he last saw the Petitioner on April 9, 2000, the Petitioner's pain "wasn't coming from the areas I worked on."

On cross-examination, Dr. Lin testified that in formulating his opinions with regard to causation, he was relying solely upon the fact that the Petitioner reported to him that he was injured at work as a printer. Dr. Lin acknowledged that he had no knowledge or awareness of the details regarding the Petitioner's work activities or the number of hours or days he worked each week, and that he did not review any description of the type of work the Petitioner performed nor did he review any job description or video. Dr. Lin also acknowledged that the Petitioner had reached maximum medical improvement as of February 11, 2005 and he opined that the Petitioner was not in need of any further medical treatment, epidural steroid injections or physical therapy after that date.

The August 29, 2012 testimony of Dr. Sean Kane was admitted into the record as Petitioner's Exhibit 3. Dr. Kane testified as to the course of treatment he rendered to the Petitioner including the cervical epidural steroid injections he administered to the Petitioner form 2007 through July 30, 2012. Dr. Kane opined that the Petitioner was not able to return to any type of physical work but he testified that he had no opinion with regard to a causal relationship between the Petitioner's work activities and his condition.

The June 11, 2013 testimony of Dr. Robert Martin was admitted into the record as Respondent's Exhibit 18. Dr. Martin testified as to the history provided to him by the Petitioner, the treatment records he reviewed, and his examination findings of May 11, 2004. Dr. Martin also testified that he was familiar with the type of job activities that the Petitioner performed for the Respondent. Dr. Martin testified that he diagnosed the Petitioner as having degenerative disease, degenerative disc disease of the cervical spine, and probable left cubital tunnel syndrome, and he opined that none of those conditions was either caused or aggravated by the Petitioner's work. Dr. Martin further opined that the Petitioner was not a surgical candidate at the time of the examination and that the subsequent surgery performed on the Petitioner was not causally related to the Petitioner's work activities.

The October 10, 2013 testimony of Dr. Morris Marc Soriano was admitted into the record as Respondent's Exhibit 21. Dr. Soriano testified as to the records review he performed regarding the Petitioner's medical treatment and he noted that the Petitioner's physical examination and diagnostic studies were for the most part unremarkable. Dr. Sorianno opined that there was no indication for surgery to be performed on the Petitioner

and the surgery that was performed on the Petitioner should not have been performed and had no relationship to the Petitioner's symptomatology. Dr. Soriano testified that his diagnosis of the Petitioner was status post posterior laminectomy C5 through T1 and idiopathic left shoulder pain. Dr. Soriano opined that the Petitioner's diagnosis was in no way caused by the Petitioner's work activities for the Respondent and that, as of the date of his records review, the Petitioner had reached maximum medical improvement. Dr. Soriano further indicated that all of the Petitioner's postoperative examinations were normal and his subjective complaints didn't correlate with any objective findings, and he opined that there was no reason to place the Petitioner on any work restrictions. Dr. Soriano also testified that he reviewed a job analysis and a video of the Petitioner's work activities and he opined there was no indication that any of the Petitioner's work activities would aggravate his cervical spine or cause it to worsen beyond normal progression.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner has alleged a repetitive trauma injury with a manifestation date of September 9, 2003. The Petitioner testified to an onset of "soreness" in his neck and left arm in the summer of 2003 as well as a specific incident while moving a cart in August of 2003 and a specific incident when he pulled on a pallet jack on September 9, 2003. The Petitioner testified that he reported the incident of September 9, 2003 and was directed at that time to seek medical care. Thereafter, the Petitioner sought medical treatment with Dr. Grady, Dr. Prentice, and Dr. Nikolav, and on September 1, 2004 the Petitioner underwent surgery by Dr. Lin. The Petitioner testified that the surgery provided him with no relief of his symptoms and that he has continued to treat for his complaints since that time without any relief from his symptoms.

The voluminous medical records introduced into the record by the Petitioner demonstrate that following his surgery by Dr. Lin, the Petitioner saw Dr. Enoch and Dr. Schierer and he then began treating with Dr. Adkins and then Dr. Adkin's associate, Dr. Kane. The records demonstrate that the Petitioner also sought treatment with Dr. Purgihalla, Dr. Peachy, and Dr. Snyder. The Petitioner acknowledged that, since the time of his surgery by Dr. Lin, he has received in excess of forty cervical epidural steroid injections which have provide him with no relief of his symptoms. The Petitioner testified that his symptoms persist through the present time and he testified that he is unable to work in any capacity due to his condition of ill-being.

A claimant seeking benefits for a repetitive trauma injury must meet the same burden of proof as a claimant alleging a single definable accident. The claimant must prove a precise identifiable date on which the accident manifested itself and must also prove that the injury is

causally related to the employment. Additionally, in order to be entitled to benefits the claimant must prove that his current condition of ill-being is causally related to the alleged injury. The Arbitrator finds that the Petitioner has failed to meet his burden of proof in the instant matter.

Initially, the Arbitrator notes that several of the histories noted in the Petitioner's medical records conflict with the Petitioner's testimony regarding the onset and unabated continuance of his symptoms. The Arbitrator notes that when the Petitioner saw Dr. Grady on September 15, 2003, he denied any injury and he reported a two week history of pain in his left shoulder, his neck, the left side of his head, and his left arm, as well as numbness and tingling in his fingers and weakness in his left hand. When the Petitioner was seen by Dr. Martin on May 11, 2004 the Petitioner reported that he had some pain in his neck prior to October 17, 2003 but that on October 17, 2003 his neck pain got much worse without any specific injury. Dr. Lin noted a history of neck and left shoulder pain since September of 2003 after an injury at work. Subsequent to the surgery he performed on the Petitioner, Dr. Lin noted overall improvement in the Petitioner's condition until December of 2004 when he noted the return of similar pain complaints which were "nonfocal". When the Petitioner first saw Dr. Adkins in August of 2007, he reported that he had hurt himself at work while trying to lift a heavy object in an awkward position.

Other records introduced into the record also conflict with the Petitioner's testimony regarding the manifestation date of his alleged injury. When the Petitioner's accident report was completed on November 10, 2003, the Petitioner indicated that the repetition of his job duties caused him to have pain in his neck beginning on August 12, 2003. When the Petitioner signed his initial Application for Adjustment of Claim on May 26, 2004 an accident date of September 15, 2003 was alleged and when the Application was amended on June 14, 2004 an accident date of October 17, 2003 was alleged. When the Petitioner met with Mary Yung, he provided her with a date of accident of November 7, 2003. At trial, the Petitioner's Application for Adjustment of Claim was amended to allege an accident date of September 9, 2003.

The Arbitrator also notes that the only medical opinion which relates the Petitioner's condition to his employment activities is that of Dr. Lin. Dr. Lin opined that the treatment he rendered to the Petitioner, including the foraminotomy that he performed on the Petitioner's cervical spine, was related to the Petitioner's alleged work accident in September of 2003. Dr. Lin also opined that the pain that the Petitioner was reporting in December of 2005 could have been related to the repetitive motion required by his job with the Respondent. Dr. Lin acknowledged however that that he had no knowledge or awareness of the details regarding the Petitioner's work activities or the number of hours or days he worked each week, and that he did not review any description of the type of work the Petitioner performed nor did he review any job description or video. Dr. Lin also testified that the Petitioner had reached maximum medical improvement as of February 11, 2005 and he opined that the Petitioner was not in need of any further medical treatment, epidural steroid injections or physical therapy after that date. Dr. Lin testified that when he last saw the Petitioner on April 9, 2008, the Petitioner's pain wasn't coming from the areas he operated on.

The Arbitrator further notes that no specific causation opinion was contained in the voluminous records of any of the Petitioner's other treating physicians and no causation opinions from any of the Petitioner's other treating physicians was offered into the record. Dr. Kane, who testified as to the course of treatment he rendered to the Petitioner and opined that the Petitioner was unable to return to any physical work due to his pain, testified that he had no opinion with regard to any causal relationship between the Petitioner's condition and his work activities.

Dr. Lin's opinions of causation are contradicted by the opinions of Dr. Martin and Dr. Soriano. Dr. Martin testified that the Petitioner's neck and shoulder symptoms were coming from his degenerative disc disease which was not caused by his work activities and he opined that the Petitioner's condition was not causally related to his work. Dr. Martin testified that he was familiar with the type of job activities that the Petitioner performed for the Respondent and he opined that the Petitioner's condition was neither caused nor aggravated by the Petitioner's work. Dr. Martin further opined that the Petitioner was not a surgical candidate at the time of his examination of the Petitioner and that the subsequent surgery performed on the Petitioner was not causally related to the Petitioner's work activities. Dr. Soriano testified that the Petitioner's physical examination and diagnostic studies were for the most part unremarkable and he opined that there was no indication for surgery to be performed on the Petitioner. Dr. Soriano opined that the Petitioner's condition was in no way caused by the Petitioner's work activities for the Respondent and that, as of the date of his records review, the Petitioner had reached maximum medical improvement. Dr. Soriano testified that all of the Petitioner's postoperative examinations were normal and his subjective complaints didn't correlate with any objective findings, and he opined that there was no reason to place the Petitioner on any work restrictions. Dr. Soriano also testified that he reviewed a job analysis and a video of the Petitioner's work activities and he opined there was no indication that any of the Petitioner's work activities would aggravate his cervical spine or cause it to worsen beyond normal progression.

While the Arbitrator notes the opinions of Dr. Lin, the Arbitrator finds that opinions of Dr. Martin and Dr. Soriano to be more credible, reliable and persuasive in the instant matter. In so finding, the Arbitrator notes that Dr. Martin testified that he was familiar with the type of job activities that the Petitioner performed for the Respondent and Dr. Soriano testified that he reviewed a job analysis and a video of the Petitioner's work activities for the Respondent while Dr. Lin acknowledged that he had no knowledge or awareness of the details regarding the Petitioner's work activities or the number of hours or days he worked each week, and that he did not review any description of the type of work the Petitioner performed nor did he review any job description or video. The Arbitrator further notes that Dr. Martin's opinion that the Petitioner was not a surgical candidate was supported by the fact that the Petitioner continued to report complaints of the same pain following the surgery performed by Dr. Lin.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove accidental injuries which arose out of and in the course of his employment with the Respondent. The Arbitrator further finds that the Petitioner failed to prove any current condition of ill-being which is

causally related to his employment activities for the Respondent.

Having found that the Petitioner failed to meet his burden of proof regarding the issues of accident and causation, determination of the remaining disputed issues is moot and the Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Francisco Antunes,

Petitioner,

15IWCC0499

vs.

NO: 11 WC 40542

Norwood Paper and Superior Personnel,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent Superior Personnel herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, penalties and fees and liability between respondents Norwood Paper (borrowing employer) and Superior Personnel (loaning employer) and being advised of the facts and law, modifies the Decision of the Arbitrator dated March 26, 2014 as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner was a 35-year-old machine operator on September 9, 2011. He is an undocumented worker who speaks English as a second language and testified via an interpreter at arbitration. Petitioner worked intermittently at Norwood Paper via various staffing agencies, beginning in 1998. Agreements between Norwood Paper and Superior Personnel are in evidence as Norwood Paper's exhibit #1. Petitioner filed two Applications for Adjustment of Claim. In 11 WC 40542, Petitioner alleged left lower extremity injuries sustained on September 9, 2011 in a trip and fall accident. In a companion case, 12 WC 37219 Petitioner alleged left shoulder injuries sustained on October 3, 2012 operating a paper trimming machine. Petitioner filed a 19(b) petition in that case seeking temporary total disability benefits and prospective medical treatment for the left shoulder and neck. Petitioner has not worked at Norwood Paper since October 3, 2012; he claims that he has been unable to find work within his restrictions.

A consolidated hearing was held on January 3, 2014. Petitioner testified on his own behalf and Respondent Superior Personnel called Norwood Paper's plant manager, Mr. Zeman. No representatives from Superior Personnel or its workers' compensation insurance carrier testified at hearing. In a decision dated February 11, 2014, the Arbitrator found that Petitioner sustained a 20% loss of use of the left leg and 2.5% loss of use of the left foot as a result of the September 9, 2011 accidental injury. The Arbitrator awarded temporary total disability benefits from September 22, 2011 through November 13, 2011, from November 29, 2011 through December 2, 2011 and from December 19, 2011 through August 14, 2012, and $1,920.00 in §19(l) penalties. Norwood Paper filed a §19(f) motion to correct a clerical error, asserting that the parties stipulated at hearing that Superior Personnel would accept liability to pay any benefits awarded. (T. 16) On March 26, 2014, the Arbitrator issued a corrected decision reflecting that stipulation.

On review, Petitioner argues that the Arbitrator erred in failing to award §19(k) penalties and §16 attorney's fees to Petitioner and failed to award the proper amount of temporary total disability benefits, and that the Arbitrator erred in designating liability between respondents. Superior Personnel cross-appealed, arguing that the Commission should strike the Arbitrator's award of §19(l) penalties and find that temporary total disability benefits from November 29, 2011 through December 2, 2011 and December 19, 2011 through January 30, 2012 were not warranted as light duty work continued to be available during that time. Superior Personnel also argues that the Arbitrator's award of 20% of the left leg and 2.5% of the left foot is excessive.

After considering all of the evidence we vacate the Arbitrator's award of §19(l) penalties and the Arbitrator's award of 2.5% of the left foot. We modify the Arbitrator's award of permanent partial disability to the left leg to 12.5% and modify the Arbitrator's award of temporary total disability benefits to September 22, 2011 through November 13, 2011 and January 31, 2012 through August 14, 2012. All else is otherwise affirmed.

Temporary Total Disability

On September 12, 2011, Petitioner was given work restrictions of 50% sedentary duty and a weight limit of twenty pounds. Petitioner testified that he continued working until he went on temporary total disability starting September 22, 2011. Petitioner's entitlement to temporary total disability benefits from September 22, 2011 through November 13, 2011 was not disputed. Petitioner underwent surgery on January 31, 2012 and his entitlement to temporary total disability benefits from the date of surgery through August 14, 2012 was also agreed upon. However, the Arbitrator further awarded temporary total disability benefits from November 29, 2011 through December 2, 2011, and then resuming on December 19, 2011 and continuing through August 14, 2012. Petitioner testified that on November 28, 2011, Ms. Campbell, who administers the workers' compensation program, and Mr. Zeman, the plant manager at Norwood Paper, told him that light duty was no longer available. Petitioner agreed that he received a check from the insurance company in February of 2012 indicating that he received benefits covering the time period from November 28, 2011 through February 14, 2012. Respondent Superior Personnel maintains that benefits were issued on a disputed basis.

We vacate the Arbitrator's award of temporary total disability benefits from November

29, 200 through December 2, 2011 and from December 19, 2011 through January 30, 2012 because we find no credible evidence that light duty work was not available to Petitioner at either Norwood Paper or Superior Personnel. Superior Personnel argues that there was a history of Norwood Paper accommodating Petitioner's restrictions, and no credible evidence contradicts the logical presumption that light duty work would have continued until Petitioner's surgery on January 31, 2012. Mr. Zeman testified that in a meeting on or about November 28, 2011 Petitioner was offered the position of "sheeter operator" and "stacker." According to Mr. Zeman, Petitioner rejected the job offer at that time and did not return to work. Mr. Zeman testified that light duty work would have remained available to Petitioner so that he could work until he underwent knee surgery and denied that he told Petitioner that light duty was no longer available. Mr. Zeman also testified that Superior Personnel called him to confirm that light duty work was available.

Penalties and Fees

Section 19(l) of the Act provides that if the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

The Arbitrator awarded $1,920 in §19(l) penalties for the 64 day period from December 20, 2011 through February 21, 2012; the Arbitrator found that Superior Personnel knew or should have known by December 20, 2011 of the need for a significant surgery and increased work restrictions by Dr. Ho yet did not issue any benefits until two months later on February 22, 2012. The Arbitrator concluded that a delay in payment occurred but that it was not an extensive delay and therefore declined to award §19(k) penalties and §16 attorney's fees. We reverse the Arbitrator's award of §19(l) penalties because it is not supported by a preponderance of the evidence where Petitioner failed to prove that his restrictions could no longer be accommodated after November 28, 2011. Furthermore, benefits were paid in a timely fashion once it became known that Petitioner underwent surgical intervention on January 31, 2012. There is no indication in the record of when Norwood Paper or Superior Personnel learned that Petitioner underwent surgery on January 31, 2012; therefore payment of temporary total disability benefits cannot be considered unreasonably delayed.

Permanent Partial Disability

We vacate the Arbitrator's award of 2.5% of the left foot because we find no medical evidence of permanent injury related to the September 9, 2011 accident. On the date of accident, Petitioner was examined at Clearing Clinic and diagnosed with a left ankle sprain. During

subsequent examinations there was no mention of Petitioner's left ankle and on September 26, 2011 the records note that Petitioner's left ankle condition had resolved. Petitioner did not report any left ankle complaints during the independent medical examinations in April 2012, July 2012 or April 2013. There is no credible evidence supporting Petitioner's testimony at hearing that he has constant pain in the left ankle.

We modify the Arbitrator's award of 20% of the left leg and find that Petitioner sustained permanent partial disability to the extent of 12.5% of the left leg as a result of the September 9, 2011 accident. On January 31, 2012 Dr. Ho performed an arthroscopic repair of Petitioner's medial meniscus tear. Petitioner was released to return to full duty work on September 27, 2012 and continued working at Norwood Paper. On April 1, 2013, Petitioner was examined by Dr. Karlsson at the request of Superior Personnel's insurance company for a final independent medical examination and impairment rating. Dr. Karlsson found that Petitioner sustained lower left leg impairment to the extent of 4% of the leg.

Section 8.1(b) states in determining the level of permanent partial disability the Commission shall base its determination on the following factors: 1. The reported level of impairment pursuant to evaluation under Subsection A; 2. The occupation of the injured employee; 3. The age of employee at the time of injury; 4. The employee's future earning capacity, and 5; Evidence of disability corroborated by the treating medical records.

Although Petitioner did not offer an impairment rating, the Commission is not obligated to directly follow the impairment rating of Dr. Karlsson. We note that Dr. Karlsson's impairment rating was specific to the medial meniscus tear and did not account for the chondral changes in the patellofemoral joint. Dr. Karlsson testified that some of these changes were related to the accident by way of an aggravation to a preexisting condition. The nature of Petitioner's employment as a temporary laborer is understood to be variable but physically demanding. Petitioner was thirty-five years old on September 9, 2011 and is expected to endure working for many years. No evidence was offered related to any impact on Petitioner's future earnings capacity and Petitioner is not under any physical restrictions related to the September 9, 2011 accident. We note that Dr. Ho and Dr. Karlsson expected Petitioner's left knee to remain somewhat symptomatic and Petitioner complains of swelling, instability, and pain in the left knee. Although Dr. Ho released Petitioner from active care at his last examination on February 4, 2013, he did not discount Petitioner's subjective complaints and administered an injection into Petitioner's left knee.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission holds the lending employer, co-Respondent Superior Personnel, liable for benefits based on the stipulation between Norwood Paper and Superior Personnel that, in the event of an award in this case, Superior Personnel is responsible for paying those benefits and waives any right to reimbursement from Norwood Paper. (T. 16-17)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Superior Personnel pay to Petitioner the sum of $400.71 per week for a period of 35 and 4/7 weeks from September 22, 2011 through November 13, 2011 and January 31, 2012 through August 14, 2012,

that being the period of temporary total incapacity for work under §8(b) of the Act, with Respondents receiving credit for the $17,964.67 in benefits paid prior to arbitration.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Superior Personnel pay to Petitioner the sum of $360.64 per week for a period of 26.875 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 12.5% loss of use of the left leg.

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

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

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

DATED: JUN 3 0 2015
o-4/21/15
RWW/plv
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

ANTUNEZ, FRANCISCO J
Employee/Petitioner

Case# **11WC040542**
12WC037219

NORWOOD PAPER AND SUPERIOR PERSONNEL
Employer/Respondent

15IWCC0499

On 3/26/2014, 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:

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

0766 HENNESSY & ROACH PC
GUY E DITURI
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

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 (§(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

15IWCC0499

Francisco J. Antunez
Employee/Petitioner

Case # 11 WC 40542

v.

Consolidated cases: **12 WC 37219**

Norwood Paper and Superior Personnel,
Employers/Respondents

An *Application for Adjustment 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 Molly Mason, Arbitrator of the Commission, in the city of Chicago, on 1/3/14. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS 15IWCC0499

On 09-09-11, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

In the year preceding the injury, Petitioner earned $31,255.12; the average weekly wage was $601.06.

On the date of accident, Petitioner was 35 years of age, single , with 2 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 $17,964.67 for TTD, $_____ for TPD, $_____ for maintenance, and $_____ for other benefits, for a total credit of $17,964.67.

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

ORDER

The Arbitrator holds only the lending employer, co-Respondent Superior Personnel, liable for benefits based on the stipulation between Norwood Paper and Superior Personnel that, in the event of an award in this case, Superior Personnel is responsible for paying those benefits and waives any right to reimbursement from Norwood Paper. T. 16-17.

Respondent Superior Personnel shall pay Petitioner temporary total disability benefits of $400.71/week during the following three intervals: September 22, 2011 through November 13, 2011 (7 4/7 weeks – stipulated), November 29, 2011 through December 2, 2011 (3/7 week) and December 19, 2011 through August 14, 2012 (34 2/7 weeks), with Respondents receiving credit for the $17,964.67 in benefits paid prior to trial.

Respondent Superior Personnel shall pay Petitioner permanent partial disability benefits of $360.64 per week for 47.175 weeks because the injuries sustained caused the 20% loss of use of the left leg (43 weeks) and the 2.5% loss of use of the left foot (4.175 weeks), as provided in Section 8(e) of the Act.

Respondent Superior Personnel shall pay Petitioner Section 19(l) penalties in the amount of $1,920.00. The Arbitrator declines to award Section 19(k) penalties or Section 16 attorney fees, as requested by 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 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.

Molly C Mason
Signature of arbitrator

3/26/14
Date

MAR 2 6 2014

Francisco Antunes v. Norwood Paper
and Superior Personnel
11 WC 40542 and 12 WC 37219 (consolidated)

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner placed permanency at issue in the first case, 11 WC 40542. The second case, 12 WC 37219, was tried pursuant to Sections 19(b) and 8(a).

Petitioner is undocumented. He testified through a Spanish-speaking interpreter. He demonstrated some facility in English at one point during the hearing, when recounting a conversation.

Petitioner testified he began working for Respondent Norwood Paper [hereafter "Norwood"] in 1998. He worked for Norwood through a staffing agency. [On January 1, 2011, Respondents entered into a written agreement, extending through January 1, 2015, with Respondent Superior Personnel agreeing, inter alia, to supply Norwood with temporary workers and to maintain workers' compensation coverage on those workers. Norwood Exh 1.]

In 11 WC 40542, the parties agree that Petitioner sustained an accident at work on September 9, 2011. Respondent Norwood stipulated it was the borrowing employer as of said date. Arb Exh 1.

Petitioner testified he worked as a machine operator as of September 9, 2011. His job duties included placing rolls of paper into a machine and pushing, pulling and carrying various objects, including pallets and mechanical parts. Each pallet weighed 50 pounds. The parts ranged in weight from 50 to several thousand pounds.

Petitioner testified that, on September 9, 2011, he was pushing a skid when he stepped into a square hole that was between the skid and a table protector. His left foot got stuck in the hole but his body continued moving forward. A co-worker named Pedro came to his aid and helped him extricate his foot from the hole. He rested for a while and tried to move his foot around. He felt a lot of pain in his chest, left Achilles tendon and left knee.

Petitioner saw Dr. Ellen Fertelmeister at the Clearing Clinic later the same day. The doctor described Petitioner's chief complaint as follows: "My left foot got caught in between metal tubes. I fell and twisted my left knee. I hurt the left knee and ankle." Petitioner complained of constant left knee pain, rated 8/10, and left ankle pain, rated 6/10.

Dr. Fertelmeister noted that Petitioner denied any previous illnesses or surgeries.

On left knee examination, Dr. Fertelmeister noted an antalgic gait, tenderness to palpation at the lateral and medial joint lines and a positive lateral McMurray's sign. On left

foot and ankle examination, she noted limited flexion and lateral deviation and tenderness at the Achilles.

Left knee X-rays showed a small suprapatellar joint effusion. Left ankle X-rays showed an ill-defined sclerotic lesion.

Dr. Fertelmeister diagnosed a left knee contusion and sprain/strain and a left ankle sprain. She indicated these conditions were "probably related to work activities." She prescribed a left knee brace, a left ankle wrap, Ibuprofen and an analgesic balm. She released Petitioner to regular duty with use of the brace and wrap and instructed him to return in four days. PX 1.

Petitioner returned to the Clearing Clinic on September 12, 2011 and saw Dr. Peter Sorokin. Petitioner complained of constant left knee pain, rated 7/10, and constant left ankle pain, rated 6/10.

Dr. Sorokin's examination findings were very similar to those made by Dr. Fertelmeister. He prescribed physical therapy and instructed Petitioner to continue taking the Ibuprofen and using the knee brace and ankle wrap. He released Petitioner to light duty with half of his time spent sitting and no lifting/pushing/pulling over 20 pounds. He instructed Petitioner to return to the clinic in one week. PX 1.

Petitioner underwent an initial evaluation at Clearing Clinic Physical Therapy on September 14, 2011. The evaluating therapist noted that Petitioner primarily complained of left knee pain and also reported "numbness and tingling from knee to foot, fatigue and edema left leg and cramps in left calf." She described Petitioner's gait as antalgic. She was unable to perform McMurray testing "due to severity of pain in flexion." Petitioner continued attending therapy on a regular basis thereafter through November 4, 2011. PX 1.

Petitioner returned to the Clearing Clinic on September 19, 2011 and again saw Dr. Sorokin. The doctor's examination findings were unchanged. He advised Petitioner to continue attending therapy and wearing the brace and wrap. He continued the previous work restrictions. PX 1.

At the next visit, on September 26, 2011, Dr. Sorokin noted that Petitioner reported some improvement of his left knee and "no problems over left ankle." On left ankle examination, the doctor noted a normal range of motion and no swelling or tenderness. He continued the previous treatment recommendations and work restrictions. PX 1.

On October 4, 2011, Dr. Sorokin prescribed a left knee MRI "due to persistent symptoms after trial of PT, light duty." He continued the previous work restrictions and added Meloxicam to Petitioner's medications. At the next three visits, on October 11, 18 and 26, 2011, the doctor continued the previous work restrictions and noted he was awaiting approval of the MRI. PX 1.

The left knee MRI, performed without contrast on November 2, 2011, showed an oblique tear through the posterior horn of the medial meniscus with the possibility of discoid meniscus and "increased signal intensity within the anterior and posterior horns of the medial meniscus suggestive of mucoid degeneration." PX 1.

On November 4, 2011, Dr. Fertelmeister discussed the MRI results with Petitioner and referred Petitioner to Dr. Ho, an orthopedic specialist. She noted that the case manager obtained a November 14, 2011 appointment with Dr. Ho. She released Petitioner to restricted work with sitting 20% of the time and lifting/pulling/pushing limited to 20 pounds. PX 1.

Dr. Ho's initial history of November 14, 2011 reflects that Petitioner injured his left knee at work on September 9, 2011 when his left foot became caught between two metal bars, causing him to fall and twist the knee. The history also reflects that Petitioner "remains on restricted duty at work and this sounds like a desk job." The doctor indicated that a case manager, Ms. Gonzalez, acted as Petitioner's interpreter during the examination.

Dr. Ho described Petitioner's past medical and surgical history as negative.

On left knee examination, Dr. Ho noted a grade 1 effusion, full active extension, near full flexion, more pain on lateral rather than medial McMurray's and stable ligaments to testing.

Dr. Ho noted that no X-rays were available but that he did have access to the MRI films. He interpreted the MRI as showing some increased signal in the posterior horn of the medial meniscus "but no distinct tear," some thinning of the articular cartilage of the lateral patella facet, some increased signal at the proximal patellar tendon, with possibly a small bony ossicle, some mildly increased signal in the inferior pole of the patella and a mild effusion in the knee joint proper. He described Petitioner as having a bipartite patella but indicated this appeared to be "quiet on the MRI films."

Dr. Ho's impression was "twisting injury to the left knee with probable patellar chondromalacia secondary to the injury and possible intrasubstance medial meniscus tear." He injected the left knee with Kenalog and instructed Petitioner to resume therapy. He imposed restrictions of no kneeling, squatting, crawling, climbing or lifting over forty pounds. He instructed Petitioner to return to him in six weeks, indicating he would consider a diagnostic arthroscopy at that point if Petitioner was no better. PX 2, Grp 1 of 4.

Petitioner underwent an initial physical therapy evaluation at WCS on November 22, 2011. In a subsequent note, the therapist indicated that on November 28, 2011, Petitioner complained of increased left knee and low back pain secondary to "significant amounts of walking beyond his restrictions at work." The therapist also indicated that Petitioner reported being told that day that no more work was available for him.

Petitioner returned to Dr. Ho on December 19, 2011. The doctor noted that Petitioner's left knee pain had improved but that he was still experiencing daily locking episodes. On

examination, the doctor noted no detectable effusion, moderate crepitation with popping in the patellofemoral joint on active extension and good patellar tracking.

Dr. Ho's impression was "probable chondral injury of left patellofemoral joint, secondary to twisting and direct trauma to left knee 3 months ago." He recommended an arthroscopy and patellar chondroplasty. He indicated Petitioner might also require a lateral release and/or microfracture. He indicated surgery would be scheduled "once we receive insurance approval." He advised Petitioner to continue with a quadriceps strengthening program on his own. He released Petitioner to restricted duty with unlimited sitting, no kneeling, squatting, bending or crawling, standing and walking limited to 4-5 hours per day and no lifting over 40 pounds. He indicated he sent a carbon copy of his note to Jackie Gonzalez, R.N. Karlsson Dep Exh 4. PX 2, Grp 1 of 4. Formal physical therapy was discontinued on December 19, 2011, with the therapist noting Dr. Ho's surgical recommendation.

On December 28, 2011, Petitioner filed a Section 19(b) petition alleging that Respondent had not accommodated his restrictions since December 19, 2011. PX 3. On January 17, 2012, Petitioner filed a Petition for Additional Compensation and Attorney Fees alleging he performed light duty from November 9, 2011 until November 28, 2011, at which point his supervisor told him light duty was no longer available. PX 5.

Dr. Ho next saw Petitioner on January 24, 2012. The doctor noted that Petitioner's friend or brother along with Jackie Gonzalez, the case manager, were also present. On examination, the doctor noted no detectable effusion, full active extension and flexion and tenderness along the medial patellar facet and joint line. Petitioner signed a surgical consent form. Dr. Ho signed a form indicating surgery was scheduled for January 31, 2012 and Petitioner was to "continue same restrictions" until then, at which point he was to go off work.

On January 31, 2012, Dr. Ho performed a left knee arthroscopy with extensive chondroplasty of the patella, including microfracture and chondroplasty of the lateral tibial plateau. He also performed a partial medial meniscectomy and lateral retinacular release. In his operative report, he described the anterior and posterior cruciate ligaments as intact. He also noted Grade 4 changes of the bipartite patella, which he described as "partially separated from the main body of the patella." PX 2, Grp 2-3 of 4.

Petitioner returned to Dr. Ho one week postoperatively. Dr. Ho's resident noted that Petitioner was using a CPM machine from 0 to 90 degrees and wearing a brace in a locked position while standing. On left knee examination, the resident noted a grade 2 effusion and a passive range of motion to 90 degrees of flexion.

Dr. Ho instructed Petitioner to stay off work, continue using the CPM machine and brace and return in five weeks, at which time he anticipated starting therapy. PX 2, Grp 2 of 4.

On February 22, 2012, Technology Insurance Company issued a check in the amount of $4,107.54 in payment of temporary total disability benefits from November 28, 2011 through

February 14, 2012. PX 6. On direct examination, Petitioner testified he did not work during this interval.

Petitioner returned to Dr. Ho on March 8, 2012. The doctor indicated that Petitioner "has not done any physical therapy and is completely done with the CPM machine." The doctor described Petitioner as doing well. He noted a range of motion from 0 to 90 degrees with the brace unlocked. He provided Petitioner with a new hinged brace and instructed Petitioner to wean off the crutches and bear weight as tolerated. He instructed Petitioner to "work on strengthening and range of motion" and return at the three-month point. PX 2, Grp 3 of 4.

At Respondent's request, Petitioner saw Dr. Karlsson, an orthopedic surgeon, for a Section 12 examination on April 16, 2012. In his report of April 18, 2012, Dr. Karlsson indicated a professional interpreter was present throughout this examination.

Dr. Karlsson's report sets forth a consistent account of the work accident and subsequent care. The doctor noted that Petitioner reported reduced pain following the surgery but complained of weakness and felt as if his left knee was going to give out with extended walking. He also noted that Petitioner complained of swelling, especially following therapy sessions.

Dr. Karlsson noted that Petitioner denied any past history of left knee problems.

Dr. Karlsson found Petitioner capable of primarily seated work, with standing and walking restricted to 50% of the day. He indicated Petitioner should avoid extensive squatting or kneeling. He anticipated Petitioner being able to resume full duty within two months. Karlsson Dep Exh 6.

Petitioner returned to Dr. Ho on May 2, 2012. Petitioner complained of some lateral patellofemoral pain with prolonged weight bearing or flexion activities. He indicated he was attending therapy on a regular basis.

Dr. Ho noted the recent Section 12 examination and Dr. Karlsson's findings as to Petitioner's work capacity.

On left knee examination, Dr. Ho noted a trace effusion, full active extension and flexion with a complaint of pain at 90 degrees, good patellar tracking and no medial joint line pain.

Dr. Ho recommended another six weeks of therapy, with Petitioner transitioning to work conditioning during this period. He estimated that Petitioner would reach maximum medical improvement in three months.

At the next visit, on June 5, 2012, Petitioner reported some improvement but complained of some medial joint line pain. On examination, Dr. Ho noted a trace effusion and a full, pain-free range of motion with some minor popping and crepitation. He instructed

Petitioner to continue therapy, start work conditioning on June 30, 2012 and return to him in six weeks.

At Respondent's request, Dr. Karlsson re-examined Petitioner on July 18, 2012, again with the aid of an interpreter. He noted that Petitioner had completed therapy and fifteen days of work conditioning. He also noted that Petitioner reported having remained off work because his employer could not accommodate his restrictions. He indicated Petitioner reported gains in strength but complained of back pain with knee flexion.

On re-examination, Dr. Karlsson noted a range of motion of 0 to 150 degrees in both knees, no effusion in either knee, trace medial and lateral joint line tenderness in the left knee, negative McMurray's in both knees and 1+ patellofemoral crepitans in the left knee. He described Petitioner's gait as normal.

On review of the therapy records, Dr. Karlsson noted that Petitioner had made gains in floor to hip lifting and carrying.

Dr. Karlsson again diagnosed Petitioner with a "twisting injury to the knee with a medial meniscal tear and some degree of chondral damage to the patellofemoral joint." He indicated Petitioner was making somewhat slow but steady progress, therapy-wise. He recommended that Petitioner finish work conditioning over the next several weeks "and then return to old work duties after his next evaluation with Dr. Ho." He indicated Petitioner should avoid kneeling, squatting, climbing and crawling while finishing work conditioning. He also indicated Petitioner could switch from taking one Naprosyn per day to taking Aleve or Ibuprofen. He did not anticipate the need for long-term restrictions. Karlsson Dep Exh 11.

On August 13, 2012, Petitioner returned to Dr. Ho. The doctor noted that Petitioner had undergone an IME and a functional capacity evaluation since the last visit. [The Arbitrator notes that no functional capacity evaluation is in evidence.] He indicated Petitioner "passed the FCE at heavy-medium demand levels." He also indicated that Petitioner expressed concern about having to stand at work for 10 hours a day with only one 30-minute break.

On left knee examination, Dr. Ho noted no detectable effusion, a click and a small amount of crepitation with active knee extension and pain at the lateral patellar facet.

Dr. Ho released Petitioner to regular work but with 15-20 minute breaks every 3-4 hours during the following six weeks. He instructed Petitioner to return to him in six weeks.

Petitioner testified he resumed full duty on August 15, 2012 but took periodic breaks during his first five or six weeks back on the job.

Petitioner returned to Dr. Ho on September 24, 2012. The doctor noted that Petitioner complained of "some difficulty with pain and swelling in his knee toward the end of a workday . . . despite taking a 15-minute break during his workday." The doctor further noted that

Petitioner had also developed left Achilles tendinitis since resuming work. He indicated that Petitioner's employer had changed his schedule so that Petitioner was working 8-hour rather than his previous 10-hour shifts four days per week.

On left knee examination, Dr. Ho noted a trace effusion, a full range of motion and no crepitation.

Dr. Ho also noted tenderness along the Achilles tendon, with no significant swelling. He diagnosed "recurrent patellofemoral pain, left knee, 7 ½ months status post microfracture patella and secondary left Achilles tendonitis."

Dr. Ho injected Petitioner's left knee with Kenalog. He also prescribed heel lifts for Petitioner's shoes with respect to the left Achilles tendonitis. PX 2, Group 4 of 4.

Dr. Ho issued two work status notes indicating Petitioner should remain off work on September 24, 25 and 26 and should resume full duty on September 27, 2012 with a 15-20 minute break at 9:00 AM, after the first three hours of work, in addition to his lunch break. Karlsson Dep Exh 4. PX 2, Grp 4 of 4.

Petitioner's second claim, numbered 12 WC 37219, alleges a left shoulder injury of October 3, 2012. Petitioner testified his left shoulder bothered him at work during the two weeks preceding October 3, 2012.

Petitioner testified that, on October 3, 2012, he was performing a trimmer job in "position one." This position was equipped with an "air table" but, according to Petitioner, this device had not been working correctly during the two weeks preceding October 3, 2012. Air was escaping toward the bottom rather than the top of the machine. Petitioner testified he had alerted his supervisors, April and Matt, about this situation. He told them he could tell the air machine was not working correctly because the paper he had to lift "weighed too much."

Petitioner testified he was working in pain on October 3, 2012 when he pulled paper and heard his left shoulder "snap." He turned to Carlos Bravo, another machine operator who was working next to him, and told him about the accident. He reported the accident to April and Matt within three minutes of the accident. He went to the office and, speaking English, told April he had hurt himself. Matt was either in the office at that point or he arrived shortly thereafter. He told both individuals he was pulling paper when his shoulder snapped. He also indicated he tried to continue working but was unable to. April and Matt asked whether his shoulder hurt a lot and he said yes. They then switched him to a stacking job. He performed stacking for five or ten minutes and then said he was unable to continue. David, who is in charge of maintenance, took him to Concentra Medical Centers, where he saw Dr. Cindy Ross.

Dr. Ross's note of October 3, 2012 describes Petitioner as making the following statement concerning his injury of earlier that day: "I was using too much force and I hurt my shoulder and heard a pop." The doctor's note also reflects that, at 8:30 that morning,

Petitioner was "pushing a heavy [100#] roll of paper" when he felt a "crack" and pain in his left shoulder. Dr. Ross indicated that Petitioner denied any history of similar symptoms or injury. Her note also refers to a "comprehensive questionnaire" which is not in evidence.

Dr. Ross indicated that Petitioner complained of pain in his left shoulder, left trapezius and left rhomboid. She noted he was taking Naproxen as needed for his knee.

On cervical spine examination, Dr. Ross noted spasm and palpable tenderness of the left trapezius and rhomboid muscles as well as a negative Spurling's. On left shoulder examination, she noted tenderness of the posterior aspect of the shoulder, painful range of motion testing in all planes and negative supraspinatus and drop arm testing.

Dr. Ross obtained a left shoulder X-ray. She assessed Petitioner as having strains of the shoulder, trapezius and rhomboid. She prescribed Ibuprofen, one week of therapy, home exercises and ice/heat packs. She released Petitioner to light duty with no lifting over 10 pounds, no pushing/pulling over 20 pounds and no reaching above shoulder level. She instructed Petitioner to return in two days.

Petitioner underwent a therapy evaluation at Concentra the same day. The evaluating therapist noted that Petitioner "initially started feeling some left shoulder pain about two weeks back" and reported this to his supervisor, who moved him to another position, where he continued experiencing symptoms. The therapist also noted that, earlier that morning, Petitioner had "felt a pop and sharp pain in his left shoulder when handling material." He indicated the pain was in the left shoulder upper trapezius and scapular area.

Petitioner returned to Concentra on October 5, 2012 and again saw Dr. Ross. The doctor's note reflects that Petitioner reported improvement and had not been working "because no light duty available." The doctor instructed Petitioner to continue therapy and return in a week. She continued the previous work restrictions. RX 2.

On October 10, 2012, Dr. Ross noted improvement but indicated Petitioner still complained of constant mild pain "on top of the left trapezius muscle." On cervical spine examination, the doctor noted "diffuse palpation tenderness of the left trapezius muscle," spasm and a full range of motion. She noted no abnormalities on left shoulder examination. She diagnosed a trapezius strain. She continued the previous work restrictions and directed Petitioner to continue therapy. RX 2.

On October 15, 2012, a physical therapist noted that Petitioner reported he was feeling much better and was performing modified work. The therapist indicated that Petitioner "is having no pain today." Three days later, a different therapist noted that Petitioner was performing modified work and denied any left shoulder pain. That same day, October 18, 2012, Dr. Ross indicated that Petitioner "still complains of residual pain in the anterior aspect of his left shoulder when pushing with resistance." On left shoulder examination, Dr. Ross rated the Hawkins impingement sign as +/- but otherwise noted no abnormalities. She diagnosed a

shoulder strain. She increased Petitioner's lifting capacity from 10 to 15 pounds and continued the other restrictions. She instructed Petitioner to return on October 25, 2012. On that date, she noted that Petitioner "still complains of pain in his left trap and in the left superior aspect of the shoulder, particularly with the lifting and with internally rotating his left shoulder." She did not comment as to whether Petitioner was working. On left shoulder examination, she noted tenderness of the superior aspect, pain with abduction at 120 degrees, negative Hawkins impingement testing and +/- supraspinatus testing. She again diagnosed a shoulder strain. She dispensed a Medrol Dosepak and gel. She instructed Petitioner to continue therapy. She ordered a left shoulder MRI. RX 4 at 46. She decreased Petitioner's lifting capacity to 10 pounds and continued the other restrictions. She instructed Petitioner to return on November 1, 2012. [A separate work activity status report reflects that Dr. Ross kept Petitioner at the 15-pound level.] RX 2.

Under cross-examination, Petitioner testified that, in 2012, his last visit to Concentra took place on October 25, 2012. He also testified that October 25, 2012 was "maybe" the last day he worked for Respondents.

Petitioner returned to Dr. Ho on November 5, 2012. The doctor noted that Petitioner derived some improvement secondary to the injection he administered at the previous visit. He noted that Petitioner was now complaining of primarily anterior knee pain.

On left knee examination, Dr. Ho noted flexion from 0 to 145 degrees, no tenderness to palpation and stability to valgus and varus stress.

Dr. Ho prescribed six additional weeks of physical therapy, with an emphasis on lower extremity strengthening. He instructed Petitioner to return to him in six weeks. He released Petitioner to full duty. PX 2, Grp 4 of 4.

Petitioner returned to Dr. Ho on December 17, 2012 and again complained of left knee pain, worse with activity and deep flexion. Dr. Ho noted that Petitioner was seeing another orthopedic surgeon for his shoulder.

On left knee examination, Dr. Ho noted a mild effusion, a range of motion from 0 to 140 degrees, tenderness over the medial and lateral joint line and stability to varus and valgus stress.

At Petitioner's request, Dr. Ho prescribed work hardening. He also prescribed anti-inflammatories and a repeat left knee MRI. He released Petitioner to full duty. Karlsson Dep Exh 4. PX 2, Grp 4 of 4.

On December 21, 2012, Technology Insurance Company issued a check in the amount of $4,808.52 to Petitioner. This check represented payment of temporary total disability benefits from October 3, 2012 through December 25, 2012. The check reflects a date of loss of September 9, 2011. PX 3A.

Petitioner underwent the repeat left knee MRI on January 19, 2013. The radiologist compared the MRI with both the first MRI and with the left knee X-rays performed on January 23, 2012. He noted a small to moderate joint effusion, interval removal of a bipartite patellar fragment, a vertical tear of the posterior horn of the medial meniscus and thinning and irregularity of the articular cartilage of the lateral facet of the patella with a small amount of underlying bone marrow edema. Karlsson Dep Exh 4.

Petitioner's last visit to Dr. Ho took place on January 23, 2013. Dr. Ho noted that Petitioner's left knee pain improved postoperatively but was "not fully resolved." Petitioner reported experiencing six weeks of pain relief following the September 2012 injection. Petitioner also complained of Achilles tendonitis which he described as "moderate in severity." This pain had worsened during work hardening but was now back to baseline. Petitioner also complained of left shoulder pain for which he was seeing another doctor.

On left knee examination, Dr. Ho noted no effusion, a range of motion from 0 to 135 degrees, crepitus in the patellofemoral joint with ranging, tenderness to palpation at the patellar tendon origin of the patella, a positive patellar grind, stability to ligamentous stress and tenderness to palpation of the Achilles about 3 centimeters proximal to its insertion in the calcaneus.

Dr. Ho interpreted the repeat left knee MRI as showing a medial meniscus tear, "substantial cartilage damage on the inferior articular surface of the patella" and an ossicle inferior to the patella. He noted that Petitioner did not complain of any pain on the medial side of the knee joint despite the meniscal tear. He attributed Petitioner's pain to "the cartilage damage on his patella." He also indicated Petitioner "may have a component of patellar tendonitis as well." He injected Petitioner's left knee with Kenalog, Lidocaine and Marcaine. He told Petitioner he could return for additional injections as needed. He instructed Petitioner to continue using anti-inflammatories and performing home exercises.

Dr. Ho obtained ankle X-rays. He indicated the X-rays did not show any bony abnormalities. He indicated Petitioner should "work with his therapist on stretching and eccentric strengthening" to try to resolve his Achilles pain.

At the end of his note, Dr. Ho indicated he would see Petitioner back on an as needed basis. On a separate form, he released Petitioner to full duty and found Petitioner to be at maximum medical improvement with respect to his left knee and ankle injuries. Karlsson Dep Exh 4. PX 2, Grp 4 of 4. RX 1.

At Respondent's request, Dr. Karlsson conducted a third examination of Petitioner on April 1, 2013. On this occasion, Dr. Karlsson examined Petitioner's left shoulder as well as his left knee.

The doctor's report of April 3, 2013 reflects that an interpreter was present throughout the examination.

Dr. Karlsson's history reflects that, while Dr. Ho released Petitioner to full duty with respect to his left knee, Petitioner never actually resumed full duty because he "had already had problems with the shoulder by this time."

Dr. Karlsson's history of the October 3, 2012 accident reflects both that Petitioner injured his left shoulder while pushing heavy paper rolls and that the injury occurred while Petitioner was pushing and pulling heavy paper rolls. The history also reflects that Petitioner is right-handed and denied any prior history of left shoulder problems. Petitioner indicated he had been off work since the accident and was now subject to a 15-pound lifting restriction.

With respect to his left knee, Petitioner complained of pain in the anterolateral aspect, swelling and fatigue. With respect to his left shoulder, Petitioner complained of weakness, difficulty lifting the left arm overhead, numbness primarily in the thumb and index finger and pain over the anterior pectoral region.

On bilateral knee examination, Dr. Karlsson noted a range of motion of 0 to 120 degrees, versus 0 to 130 degrees on the right. He also noted trace medial and lateral joint line tenderness in the left knee only.

On cervical spine examination, Dr. Karlsson noted a full range of motion but complaints of some discomfort over the lower cervical region and upper thoracic region at the extremes of all motions. He also noted tenderness in the left paracervical and perithoracic musculature in the upper thoracic region and over the left trapezius.

On left shoulder examination, Dr. Karlsson noted no tenderness at the AC joint or lateral acromion, reported difficulty with adduction and forward elevation, with complaints of pain in the trapezius and upper thoracic spine only, and a negative impingement sign. Passively, the left arm could be brought to full overhead elevation.

Dr. Karlsson indicated he reviewed records from Concentra, the report concerning the repeat left knee MRI and various work status notes authored by Dr. Ho.

Dr. Karlsson indicated that the only objective finding relative to the left knee was a "slight loss of flexion." He agreed with Dr. Ho's finding that Petitioner was at maximum medical improvement with respect to the knee. Based on his previous report, he opined that Petitioner would have been able to resume full duty "in the near future" following his July 2012 examination.

Dr. Karlsson characterized all of the left shoulder findings as purely subjective. He indicated there was "no atrophy, deformity, spasm, etc. to qualify as an objective clinical finding." He recommended home exercises but otherwise found Petitioner to be at maximum

medical improvement with respect to the shoulder. He indicated that the left shoulder injury consisted of "perhaps a muscle strain." He stated there would be "no impairment rating based on the AMA Sixth Edition Guides for the left shoulder." He found Petitioner to be capable of full duty with respect to the left shoulder. Karlsson Dep Exh 7.

In a separate report also dated April 3, 2013, Dr. Karlsson found that Petitioner's overall impairment rating is 4% impairment to the lower extremity. He indicated this percentage converts to 2% impairment of the whole person based on Table 16-10 of the AMA Guides. He categorized Petitioner as having a Grade 2 functional history modifier "with a moderate problem with an antalgic limp and using a cane at times."

On April 8, 2013, Petitioner returned to Concentra Medical Centers and saw Dr. Cindy Ross. Dr. Ross noted that Petitioner reported he had "not worked since October." She also noted that Petitioner complained of pain in the left anterior shoulder and the left trapezius muscle. She indicated that Petitioner had seen a doctor at the carrier's request the preceding week and that, according to Petitioner, this doctor had instructed Petitioner to follow up with her. She also indicated that Petitioner reported he did not receive authorization "for the left shoulder MRI that was ordered in October." [See a discussion of the MRI prescription in Dr. Karlsson's first deposition. RX 4 at 46.]

On cervical spine examination, Dr. Ross noted a full range of motion, a negative Spurling's and "diffuse palpation tenderness of the left trapezius muscle."

On left shoulder examination, Dr. Ross noted tenderness of the anterior aspect of the AC joint, a full range of motion and negative supraspinatus and impingement testing. She described the right shoulder as unremarkable.

Dr. Ross diagnosed strains of the left shoulder and left trapezius/rhomboid. She indicated Petitioner should see an orthopedic surgeon as soon as possible. RX 2.

Dr. Mercier, an orthopedic surgeon, saw Petitioner at Occspecialists on April 19, 2013. He noted he was seeing Petitioner at Dr. Ross's referral. He indicated that Petitioner primarily complained of pain over the posterior side of his neck extending into the superior border of the trapezius but "also [has] left anterior left shoulder pain."

On examination of Petitioner's neck, Dr. Mercier noted pain over the left paraspinal and left trapezius areas, without spasm. On left shoulder examination, he noted pain over the AC joint, anterior rotator cuff and biceps tendon. He also noted a full but painful range of motion. He described Petitioner's rotator cuff testing as "painful but not weak."

Dr. Mercier addressed Petitioner's treatment needs as follows:

> "Because of the long-term nature of this problem and the fact that he has not been able to return to

work even with work restrictions, we will proceed with an MRI of the cervical spine and left shoulder. He is given Naprosyn for his symptoms and we will see him as soon as the MRI is completed."

RX 2.

On May 14, 2013, Dr. Mercier noted that Petitioner "has full motion of his shoulder but still has pain in his neck and shoulder as before." He also noted that Petitioner felt he was unable to resume his normal job duties and that "apparently he is not working as no light duty is available." He indicated that, per Petitioner, the MRIs had been formally denied. As an alternative to the MRIs, he suggested a functional capacity evaluation with validity testing and/or an IME. He released Petitioner to restricted duty and instructed Petitioner to return either after the functional capacity evaluation or the IME. RX 2.

Dr. Karlsson gave a deposition on behalf of Respondent on June 17, 2013.

With respect to Petitioner's left knee, Dr. Karlsson testified he agreed with Dr. Ho's opinion that Petitioner was capable of full duty from September 2012 forward. RX 4 at 11.

Dr. Karlsson interpreted the repeat left knee MRI of January 19, 2013 as showing some post-surgical meniscal changes and no other areas of significant pathology. RX 4 at 11.

Dr. Karlsson testified that, when he examined Petitioner's left knee on April 1, 2013, he noted a slightly decreased range of motion of 0 to 120 degrees versus 0 to 130 on the right. He also noted trace tenderness to palpation on both the medial and lateral joint lines. RX 4 at 12. He found Petitioner to be at maximum medical improvement. RX 4 at 13. He performed an AMA Guides impairment rating. He found Petitioner to have a 4% lower extremity impairment. This converts to a 2% whole person impairment. RX 4 at 13. In making this rating, he started with Petitioner's "diagnosis-based impairment," which was the meniscal tear. RX 4 at 14. The "default grade" for this would be a 3% lower extremity impairment but he bumped this up to 4% based on Petitioner's "functional history modifier." RX 4 at 15.

Dr. Karlsson testified Petitioner's impairment was in the "lower range," as evidenced by his ability to resume full duty. From a medical standpoint, he would not expect the impairment to affect Petitioner's future earnings. RX 4 at 17-18.

Dr. Karlsson testified that Petitioner complained of decreased movement and weakness in his left shoulder at the April 1, 2013 examination. Petitioner also complained of numbness in the thumb and index finger of the left arm. RX 4 at 20. He indicated his pain was over the anterior chest region, over the top of the trapezius muscle and over the lateral strap musculature of the neck. RX 4 at 20. Petitioner "did not have any pain radiating down the arm." RX 4 at 20, 22. Petitioner had "full range of motion of the cervical spine itself." RX 4 at 22, 24.

Dr. Karlsson testified he noted no objective left shoulder abnormalities on April 1, 2013. RX 4 at 22. On October 25, 2012, Dr. Ross of Concentra noted a subjective complaint of pain upon abduction at 120 degrees, tenderness on the superior aspect of the shoulder and +/- supraspinatus testing. RX 4 at 24. Dr. Ross diagnosed a non-specific shoulder/upper arm strain. RX 4 at 25.

Dr. Karlsson testified he examined Petitioner's left shoulder and neck on April 1, 2013. Petitioner exhibited a normal range of cervical spine motion. Petitioner brought his left arm only to 90 degrees but indicated that "what stopped him [from further elevating the arm] was pain in the area of the trapezius." RX 4 at 27. Petitioner did not complain of left shoulder pain. The impingement sign was negative. RX 4 at 27. At most, Petitioner had a strain of the trapezius and the muscles in the upper back. RX 4 at 28. Between October 3 and October 25, 2012, Petitioner's complaints varied and did not fall into one particular diagnostic category. RX 4 at 28. As of October 25, 2012, Petitioner would have been able to work as a trimmer operator, a loader or a stacker. RX 4 at 29. As of April 1, 2013, Petitioner did not require any formal cervical spine or shoulder treatment but should be doing home exercises. RX 4 at 30-31. Based on the AMA Guides, Petitioner would have a zero impairment rating for his shoulder. RX 4 at 33.

Dr. Karlsson testified that, when Petitioner returned to Concentra in April of 2013, he actually exhibited a better range of shoulder motion. RX 4 at 34-35. The April 2013 Concentra records did not prompt him to change the opinions he voiced on April 1, 2013. There was no basis for the work restrictions that the Concentra providers imposed. RX 4 at 36. Dr. Mercier's examination findings varied somewhat from his own in that Dr. Mercier noted some tenderness over the anterior rotator cuff and biceps tendon. RX 4 at 37.

Dr. Karlsson testified that Dr. Mercier's findings did not prompt him to change any of his own opinions. RX 4 at 38.

Under cross-examination, Dr. Karlsson testified he did not review the film of the first left knee MRI of November 2, 2011. RX 4 at 41. When he performed the AMA rating, he considered the injury that would give the highest degree of impairment, i.e., the meniscal tear. RX 4 at 42. Some of the chondral changes that Dr. Ho noted during the knee surgery pre-dated the work accident. In Petitioner's case, the twisting injury to the knee was sufficient to cause some of his pre-surgical symptoms. RX 4 at 43.

Dr. Karlsson testified there was no need for Dr. Ross to order a left shoulder MRI on October 25, 2012 since there was "no joint-centered pathology on exam." RX 4 at 46-47. It was not unreasonable to order the MRI, however, since Petitioner had some pain with raising his arm to 120 degrees. RX 4 at 49. Dr. Karlsson acknowledged he did not know whether Respondent authorized care between October 25, 2012 and April 2013. RX 4 at 49.

Dr. Karlsson testified he is not familiar with Dr. Mercier. RX 4 at 50. He acknowledged that reasonable orthopedic surgeons can differ as to what type of treatment to prescribe, especially if they have different information at hand. RX 4 at 51.

Dr. Karlsson testified he obtained certification in AMA impairment ratings after taking a course and examination in November 2012. RX 4 at 51.

Dr. Karlsson testified he had no reason to test Petitioner's overhead elevation against resistance since Petitioner complained of pain when abducting/elevating his arm to 90 degrees. RX 4 at 53.

On redirect, Dr. Karlsson testified Petitioner has a developmental change known as a "bipartite patella," meaning that his kneecap is in two pieces rather than one. RX 4 at 53. If Petitioner was an avid soccer player, he would be more prone to developing arthritis in his knee. RX 4 at 55. Petitioner's gait was normal as of April 1, 2013. Dr. Karlsson testified he used a modifier indicating an antalgic gait when making the impairment rating based on Petitioner's functional history. RX 4 at 55. He gave Petitioner the benefit of the doubt in so doing. RX 4 at 56. He disagreed with the need for the left shoulder MRI that Dr. Ross prescribed but he does not view the prescription as unreasonable. RX 4 at 57. Dr. Mercier noted some tenderness over the rotator cuff and biceps tendon. This could be considered an indication for getting an MRI. He himself did not note these findings when he examined Petitioner. RX 4 at 58.

Under re-cross, Dr. Karlsson testified that Dr. Ross did not describe the origin of Petitioner's pain on October 25, 2012. Dr. Ross simply indicated Petitioner had pain with abduction to 120 degrees. RX 4 at 59.

On July 17, 2013, Petitioner underwent a left shoulder MRI. The MRI, performed without contrast, showed a Type 2 SLAP tear with a small paralabral cyst. The interpreting radiologist also noted that portions of the anterior labrum appeared to be torn. He also noted an increased signal in the supraspinatus tendon, representative of either a partial tear or tendinopathy. RX 5, Exh 1.

On July 30, 2013, Petitioner returned to Dr. Mercier. The doctor's note of that date reads in part as follows:

> "The patient comes in today with his MRI of the left shoulder that does reveal a SLAP lesion with cyst formation and possible anterior labral tear. He has mild AC joint arthropathy with a possible partial rotator cuff tear."

Dr. Mercier discussed various treatment options, including surgery, with Petitioner. He indicated that Petitioner was unsure as to which option to pursue. He indicated Petitioner should undergo a cervical spine MRI to rule out any other causes of his pain. He released

Petitioner to work with no lifting over 20 pounds and instructed him to return in one week. RX 5, Exh 2.

Petitioner returned to Dr. Mercier on August 6, 2013, with the doctor noting he had decided to "proceed with an arthroscopy and possible open rotator cuff repair and SLAP lesion repair." Dr. Mercier released Petitioner to restricted duty and instructed him to return in two weeks.

On August 28, 2013, Dr. Karlsson issued a supplemental report after reviewing a disc of the left shoulder MRI and the most recent records from Concentra and Dr. Mercier.

Dr. Karlsson indicated he essentially agreed with the radiologist's interpretation of the MRI. He described the MRI findings as "incidental," noting that Petitioner "had no findings at the time of [his] evaluation of rotator cuff tendinitis, partial-thickness tearing or a SLAP tear." He indicated the MRI findings could be "either chronic or acute." In his opinion, the presence of the paralabral cyst "point[ed] to the labral tear being present for three or more months." He indicated there was "nothing about the MRI that would [reveal] whether or not [the findings] were caused by an injury more than half a year earlier or simply degenerative." Based on the MRI alone, he could not rule out the October injury as a cause of the findings but indicated Petitioner's mechanism of injury and complaints were not consistent with the MRI. Specifically, he noted Petitioner had "no symptoms of popping which would be a common symptom with a SLAP tear." He described Petitioner's symptoms as more in the neck, superior musculature and AC joint.

Dr. Karlsson also indicated that "pushing rolls on rollers would not be stressful to the rotator cuff and would not be the type of injury to cause a labral tear." He found Petitioner to be at maximum medical improvement from the alleged accident of October 3, 2012. He indicated Petitioner would have been capable of full duty from October 25, 2012 to the present.

On October 15, 2013, Dr. Mercier gave a deposition on behalf of Petitioner. Dr. Mercier testified he obtained board certification in orthopedic surgery in 1978. PX 2A at 5. Mercier Dep Exh 1.

Dr. Mercier testified he first saw Petitioner on April 19, 2013, at the referral of Dr. Cindy Ross. Dr. Ross is associated with Concentra. PX 2A at 6. Petitioner provided a history of the October 3, 2012 accident. As of April 19, 2013, Petitioner "was complaining of primary pain over the posterior side of the neck extending into the superior border of the trapezius with anterior left shoulder pain." PX 2A at 7.

Dr. Mercier testified he examined Petitioner on April 19, 2013 but "really didn't make a diagnosis on that date." PX 2A at 7. He prescribed Naprosyn and MRIs of the cervical spine and left shoulder. He released Petitioner to restricted duty. PX 2A at 8.

Dr. Mercier testified that, at the next visit, on May 14, 2013, Petitioner exhibited a full range of left shoulder motion but still complained of neck and left shoulder pain. Petitioner reported he felt unable to resume full duty and was not performing light duty since no such duty was available. Petitioner also indicated the MRIs had "been denied." PX 2A at 8. As an alternative to the MRIs, Dr. Mercier prescribed a functional capacity evaluation with validity profiling or an IME. Dr. Mercier testified that, as of May 14, 2013, he was unaware Petitioner had already undergone an IME. PX 2A at 8. He again released Petitioner to restricted duty. PX 2A at 8.

Dr. Mercier testified that Petitioner subsequently underwent a left shoulder MRI. He had "no reason to change what the radiologist said" about this MRI. He could not recall whether he personally reviewed the MRI films. He usually has no opportunity to do so because "the machine that reviews the MRIs at Concentra is not working." PX 2A at 9.

Dr. Mercier testified he discussed treatment options with Petitioner on July 30, 2013. Petitioner seemed to want to undergo left shoulder surgery but, because Petitioner was "still complaining of radicular neck pain," the doctor recommended he undergo a cervical spine MRI "to make sure that [he would not be] operating on a shoulder that had a herniated disc in the neck." PX 2A at 9. On August 6, 2013, Petitioner confirmed he wanted to undergo left shoulder surgery. Dr. Mercier again released him to restricted duty and indicated he would await authorization of the surgery. PX 2A at 10.

Dr. Mercier testified that the mechanism of injury Petitioner described, i.e., pushing a 100-pound roll of paper, was an "adequate mechanism to cause a SLAP lesion." He doubted he would encounter a rotator cuff tear in addition to the SLAP lesion but he could not rule this out. PX 2A at 12. It appears Petitioner may have also had "some elements of a neck injury." The left trapezius and rhomboid pain that Petitioner complained of could be "either a primary problem in those areas or referred pain." It is "a little" sketchy whether the neck pain Petitioner complained of in 2013 is related to the accident but "if you're going to operate on somebody that is complaining of left radicular neck pain, you better make sure they don't have a herniated disc, especially at C4-5, that's going to give you shoulder pain as a referred pain. You can do all the shoulder surgery you want and not resolve the problem." PX 2A at 13.

Dr. Mercier testified it is almost impossible to diagnose a SLAP lesion on physical examination. The only way to determine whether someone has such a lesion is to perform an arthroscopy. PX 2A at 14.

Dr. Mercier did not believe there was a connection between the work accident and the mild AC joint arthritis shown on MRI. PX 2A at 14.

Under cross-examination, Dr. Mercier testified he does not know whether Petitioner is right- or left-handed. He does not know when Petitioner began working for Respondents or whether he was off work for a substantial period before October 3, 2012. PX 2A at 15. It was Petitioner who said no light duty was available. He (Dr. Mercier) did not confirm this. PX 2A at

16. He never saw a formal job description. Petitioner did not indicate he had been offered a job as a stacker, which would require lifting no more than 9 to 18 pounds. Dr. Mercier testified that this job would constitute light duty. PX 2A at 16. He does not believe he reviewed the left shoulder MRI films. MRIs do not enable a physician to precisely date any abnormality. PX 2A at 17. Most partial-thickness rotator cuff tears are degenerative. Many patients of Petitioner's age will demonstrate such tears on MRI. PX 2A at 17. He views Petitioner's AC joint arthritis as an incidental finding. PX 2A at 17. The MRI showed a paralabral cyst. Petitioner "could have easily developed [such a] cyst" between October 2012 and the July 2013 MRI. PX 2A at 18. If Petitioner had no prior problems with his shoulder, that is presumptive evidence that the cyst did not pre-date the SLAP lesion. An individual can have an asymptomatic SLAP lesion. PX 2A at 18. He based his surgical recommendation on Petitioner's complaints and his examination findings. PX 2A at 18-19. On October 3, 2012, Petitioner had posterior shoulder pain and pain with shoulder range of motion at Concentra. "This is enough information to lead one to believe that there could be some abnormality in the shoulder joint." PX 2A at 19. If Petitioner complained of his shoulder before October 3, 2012, that could prompt him (Dr. Mercier) to change his opinion as to causality. PX 2A at 21. He does not know the specifics of Petitioner's accident, in terms of arm positioning or whether the paper was on rollers. A person's arms do not have to be elevated above shoulder level in order for the rotator cuff to be stressed. PX 2A at 22. A SLAP lesion is a "very common problem with a fall or a push." PX 2A at 22. The physical therapy note of October 3, 2012 shows that Petitioner indicated he had shoulder pain during the preceding two weeks. The left shoulder MRI findings could have pre-existed October 3, 2012. PX 2A at 23. One of the procedures he proposed was a biceps tenodesis. The biceps anchor was torn. The term "SLAP lesion" means that the area where the biceps tendon attaches to the glenoid labrum is torn. PX 2A at 24. The physical therapy note of October 3, 2012 reflects complaints of pain in the left upper trapezius and rhomboid but it is not a physical therapist's role to provide a diagnosis. PX 2A at 25. The diagnosis code that Dr. Ross used was non-specific. PX 2A at 26. If Respondent had offered Petitioner work with no lifting over 9 to 18 pounds, Petitioner could have performed that work up to the date of left shoulder surgery. PX 2A at 26. Some of Dr. Ross's findings were not consistent with a labral injury. PX 2A at 27. A SLAP lesion is "not a major injury to the shoulder" but it can cause chronic pain. PX 2A at 27. Range of motion is somewhat effort-dependent. PX 2A at 28. There was a significant gap in care between October 25, 2012 and April 8, 2013. Dr. Mercier testified he has no idea what Petitioner did during this gap. PX 2A at 28. When Petitioner was last seen on October 25, 2012, he complained of pain in the left trapezius and left superior aspect of the shoulder. Those complaints would not be consistent with a labral injury. PX 2A at 28. Any neck injury "is fairly sketchy" and only remotely noted on April 8, 2013. He is recommending a cervical spine MRI because Petitioner is complaining of both left radicular neck pain and a shoulder problem. PX 2A at 29. On April 19, 2013, Petitioner's complaints were not consistent with a labral injury. PX 2A at 31. He recommended an FCE because the insurance carrier would not allow him to proceed with the MRIs. PX 2A at 33. He does not know Dr. Karlsson and did not review any of Dr. Karlsson's reports. PX 2A at 33. Orthopedic surgeons can differ on issues such as necessity of care and work capacity. PX 2A at 33-34.

On redirect, Dr. Mercier testified no one provided him with a job description. He would have allowed Petitioner to perform occasional, but not continuous, overhead lifting of 9 to 18 pounds. PX 2A at 34. He does not know whether Concentra sends the light duty forms to employers but he is sure the insurance companies get them. PX 2A at 35. A paralabral cyst can develop right after a labral tear. PX 2A at 35. Dr. Ross is an internist but she has always practiced in an industrial medicine setting. PX 2A at 36. Dr. Ross diagnosed a shoulder strain on October 25, 2012. She did not have the benefit of the MRI on that date. PX 2A at 36. The physical therapy note of October 3, 2012 reflects that Petitioner chiefly complained of pain in his left shoulder, upper trapezius and scapular area. PX 2A at 37.

At his continued deposition, on November 18, 2013, Dr. Karlsson testified he reviewed the CD of the films of the July 17, 2013 MRI. The films were of diagnostic quality. RX 5 at 5. His interpretation of the films does not differ significantly from the radiologist's interpretation. RX 5 at 5. The MRI showed increased signal in the supraspinatus, consistent with some rotator cuff tendinitis but not consistent with a full-thickness tear. At least 30% and possibly as high as 60% of patients Petitioner's age will show some "high signal" on shoulder MRI scanning. The AC arthropathy shown on the MRI is also seen in the vast majority of such patients. The glenohumeral arthritis shown on the MRI is a "little bit less common" but is still a degenerative finding. RX 5 at 8. As for the labral fraying, at least 30% of patients Petitioner's age would show this. The cyst next to the labrum on the MRI is "less common." RX 5 at 8.

Dr. Karlsson testified that, as an orthopedic surgeon, he would not operate based solely on MRI findings. RX 5 at 8. He would want to know that the patient's symptoms correlated with those findings before operating. RX 5 at 10. When he examined Petitioner, his findings did not correlate with the MRI. Petitioner "had no tenderness at the shoulder" and "did not have pain that would be a sign of any problem in the rotator cuff or labrum." Petitioner's pain was "in the region of the neck and shoulder," away from the shoulder joint, and in the trapezius muscle. RX 5 at 11. Dr. Mercier elicited a little tenderness at the AC joint but he described supraspinatus and impingement testing as negative. Dr. Mercier had "no findings consistent with rotator cuff problems." RX 5 at 12. A complaint of tenderness is subjective in nature. RX 5 at 12-13.

Dr. Karlsson testified that pushing a roll of paper weighing several hundred pounds would not cause labral or partial-thickness rotator cuff abnormalities. RX 5 at 13.

Dr. Karlsson opined that the findings shown on the July 17, 2013 left shoulder MRI are "completely incidental." RX 5 at 13-14. If Dr. Mercier is recommending a SLAP repair or a biceps tenodesis and possible rotator cuff repair, that treatment would not be medically necessary. RX 5 at 14. Left shoulder surgery is not warranted in Petitioner's case. RX 5 at 15. Petitioner remains at maximum medical improvement. RX 5 at 15. Petitioner is capable of regular duty. A cervical spine MRI is not warranted because there are "no signs of radicular symptoms." RX 5 at 16.

Under cross-examination, Dr. Karlsson testified that Petitioner could abduct to 90 degrees on April 1, 2013. Normal abduction is 180 degrees. RX 5 at 17. Dr. Karlsson could not specifically reference any journal articles in support of his opinions concerning MRI findings in certain patient populations. RX 5 at 17. The partial-thickness tearing of the rotator cuff shown on the July 17, 2013 MRI could be acute in nature. The AC changes and paralabral cyst would not be acute. RX 5 at 18. Paralabral cysts can develop on their own but are "very commonly associated with a" SLAP tear. Three months would be on the low end of the timeline for developing such a cyst after a SLAP tear. RX 5 at 18. There is no way to look at the left shoulder MRI and determine which findings could be related to an accident in October 2012. RX 5 at 19. A labral tear can result from age-related degenerative fraying. It can also result from a fall onto an outstretched arm or a sudden jerking of the arm. RX 5 at 20. Steady pulling would not typically cause a labral tear. RX 5 at 21. The complaints that Petitioner voiced on April 1, 2013 were referable to his trapezius, not his shoulder. He (Dr. Karlsson) "would not place [Petitioner] on any restrictions whatsoever." RX 5 at 23. In his last report, he indicated Petitioner had no symptoms of popping, which would be consistent with a labral tear. Petitioner did, however, tell him he heard a noise in his shoulder when he felt the onset of pain. RX 5 at 25. He would not expect a "simple pushing motion" to cause a labral tear. It is a "sudden traumatic loading" that typically causes tearing. RX 5 at 26.

On redirect, Dr. Karlsson testified that range of motion testing is effort dependent. RX 5 at 28. The paralabral cyst shown on the MRI could certainly have predated October 3, 2012. The cyst "could be years or decades old." RX 5 at 28. Not all labral tears result in popping but "one of the common symptoms is the patient having a sensation of popping or clicking in the joint." RX 5 at 30-31. Glenohumeral arthritis could have, on its own, led to the labral tear but it's "not a real common cause." RX 5 at 31.

Under re-cross, Dr. Karlsson testified that repetitive popping, snapping or clicking is a common symptom of a labral tear. RX 5 at 32. There is a degree of subjectivity and effort in range of motion testing. RX 5 at 33. Nowhere in his report did he indicate that Petitioner was anything less than fully cooperative. RX 5 at 33.

On further redirect, Dr. Karlsson reiterated that it is recurrent, rather than initial, popping that is indicative of a labral tear. Dr. Mercier did not mention any complaint of popping. RX 5 at 34-35.

Under re-cross, Dr. Karlsson testified that not all popping in the shoulder joint stems from a labral tear but a labral tear is one of the things that can cause recurrent popping. RX 5 at 35. Not all labral tears give rise to popping. RX 5 at 35.

Under cross-examination, Petitioner testified he came to the United States from Mexico in 1997. He was in the military in Mexico. The Social Security number on his Applications does not belong to him. He is not here legally.

Petitioner testified he regularly played in a soccer league until the summer of 2011. He did not finish the summer season. He has not played soccer since then.

Petitioner initially denied injuring his left knee before September 9, 2011. He then recalled experiencing some left knee swelling after falling at work several years earlier. He did not file a claim in connection with this fall. The paper rolls he had to push and pulled weighed up to 6,000 pounds. Originally, three helpers assisted him with this. Then two of the helpers were eliminated. He sometimes used a forklift to move the rolls.

Petitioner testified his left knee was swollen between the September 9, 2011 accident and his surgery. If Dr. Ho indicated on October 4, 2011 that Petitioner's left knee was not swollen, he was wrong. Petitioner testified he worked between November 14 and 28, 2011 subject to the restrictions Dr. Ho imposed on November 14, 2011. At a meeting held on November 28, 2011, Respondents offered him a light duty job as a stacker. He never said the stacker job was "beneath" him. He performed this job while attending physical therapy but his knee started hurting while he was bending to do the stacking. He complained of pain and asked to be able to use a forklift. At that point, the level he was working at was adjusted so that he could avoid bending.

Petitioner testified he complained of his left shoulder as well as his left knee when he saw Dr. Ho in December 2012 because he had injured his left shoulder in the interval since the last visit. Petitioner testified he did not decline to have Dr. Ho treat his left shoulder. In January of 2013, Dr. Ho released him to full duty, following a repeat left knee MRI. When he saw Dr. Karlsson in April 2013, an interpreter was present. He did not complete a form that day but he did respond to questions asked of him.

Petitioner testified he "maybe" last worked for Respondents on October 25, 2012. He was not sure. After he stopped receiving benefits, he began cutting his neighbor's grass on an occasional basis. The neighbor's yard is about 11 feet by 13 feet in size. His brother also cuts the neighbor's grass. His brother also shovels snow. The neighbor pays his brother about $25 to do this.

Petitioner testified he has not applied for unemployment benefits.

On redirect, Petitioner testified he does not have a legal Social Security number. Neither Respondent questioned the Social Security number he used at work. At the point at which he told Dr. Ho about his shoulder, he was already undergoing shoulder care at Concentra. He was satisfied with the care he received at Concentra.

Under re-cross, Petitioner testified his last visit to Concentra in 2012 took place on October 25, 2012.

On further redirect, Petitioner testified he was awaiting authorization for a left shoulder MRI as of October 25, 2012.

Matthew Zeman testified on behalf of Respondent. Zeman testified he has worked for Respondent Norwood since 1998. He has been the plant manager since 2009. He is familiar with Petitioner. As of September 9, 2011, Petitioner worked as a machine operator. Petitioner did not testify accurately with respect to his job duties. Petitioner had to push a skid out of a machine but the skid was on rollers and only about 10 to 15 pounds of force was required to move it. Petitioner did not have to perform any pulling. The heaviest item that Petitioner had to carry weighed 38 pounds.

Zeman testified that, on November 14, 2011, Petitioner presented a note from Dr. Ho setting forth multiple restrictions. In response to this note, Zeman offered Petitioner his old job but with a helper. Petitioner did attempt to perform this job but he did not like it. He told Petitioner to avoid the stairs. Petitioner indicated he preferred to work in the trimmer room. Three jobs are performed in this room. Two of those jobs are "trimmer operator" and "stacker." A trimmer operator is required to push strips of paper and activate a machine. An "air table" adjacent to the machine functions so as to suspend the paper strips, thus making the strips easier to lift and move. An "air table" is similar to an "air hockey" table except that it creates more air pressure. Petitioner performed the trimmer operator job for a while but then complained of his shoulder. Petitioner also worked as a stacker, lifting paper into an L-shaped area. All of the lifting was below shoulder level.

Zeman testified that Respondent had work within Dr. Ho's restrictions. This work remained available until Petitioner's knee surgery of January 31, 2012. At no point did he tell Petitioner that light duty was no longer available. He told Petitioner he could modify the stacker job so as to prevent Petitioner from having to bend. Petitioner indicated he did not want to do this, indicating it was "too much of a hassle." Petitioner did not resume light duty before the knee surgery. After the surgery, Petitioner returned to work as a sheeter operator on August 14, 2012.

Under cross-examination in the first case, Zeman testified he has no ownership interest in Norwood. His father is a part-owner. If the "air table" was not working properly, the employee was supposed to alert him. April Campbell oversees Norwood's workers' compensation program. All of the workers are "cross-trained."

Zeman testified he does not interact with the workers' compensation adjuster. He does not know why the carrier paid temporary total disability benefits. Petitioner initially indicated he did not want to work as a sheeter operator but later performed that job.

Zeman testified that the skids are on rollers. He learned about the force requirements from the previous plant manager.

Zeman testified that Petitioner has worked on and off at Norwood for thirteen years. Petitioner worked through various agencies. He has no file concerning Petitioner. He has no access to any personnel file that might pertain to Petitioner. Before the first accident,

Petitioner was written up by someone more than once for insubordination or refusing a job assignment. He has control over which individuals get sent to Norwood by the staffing agencies. It is April Campbell who completes Form 45s. He is over April Campbell, seniority-wise.

Under re-cross, Zeman testified there are files concerning Petitioner but he does not have those files. He has no idea whether April Campbell interacts with the workers' compensation adjuster. Light duty slips are given to Laura Martin. April Campbell interacts with Respondent Superior Personnel. Clearing Clinic is the designated company clinic. This clinic sends light duty notes to both Respondents.

With respect to the second case, Zeman testified that, when Petitioner returned to work in August 2012, he started as a trimmer loader, turning on the "air table" and placing paper on tables. From the "air table," the paper slides down into the back of the machine. Petitioner also worked as a trimmer operator and stacker. At that point, Petitioner was at full duty with the proviso that he was allotted certain break time. Petitioner also worked as a trimmer operator and stacker. A trimmer operator pushes a button to cut paper into strips. The strips are then flipped around. The job involves more pushing than pulling. A stacker takes the finished reams and stacks them to a maximum height of 50 inches. The heaviest ream weighs 9 pounds. The table on which the stacks are made is at hip height. The reams, when stacked, ends up being below an average person's shoulder height.

Zeman acknowledged that Petitioner complained about the "air table" but indicated Petitioner complained only that some holes in the table were not functioning. The table has 36 air holes. Less than 10 percent of the holes were not working. He (Zeman) tested the machine at that point and it still worked correctly. He tried to clean these holes, using a drill bit. He and Dave then put caulking in under the table. Following these repairs, Petitioner did not lodge any more complaints.

Zeman testified that, on October 3, 2012, Carlos Bravo came to his office and told him that Petitioner wanted to talk to him. He went to Petitioner. Bravo and a stacker were also present. It was about 7:30 or 8 AM. Petitioner told him he thought he hurt his shoulder but was not sure where he had hurt it. Petitioner told him it hurt to work. He (Zeman) suggested that Petitioner move to the loader position. When Petitioner took his knee-related break at 9 AM, Petitioner indicated he wanted to go to the clinic.

Zeman identified RX 3 as a report he created on October 5, 2012. [Respondent Superior Personnel ultimately opted not to offer RX 3 into evidence.]

With respect to his current left knee and ankle complaints, Petitioner testified his left knee swells when he walks and feels "disconnected." He has tripped due to this. If he walks to the store, he experiences numbness the next day. He no longer takes any medication for his knee. His left ankle swells and he experiences constant pain in the area of his left Achilles tendon.

Petitioner testified he still wants to undergo the left shoulder surgery Dr. Mercier recommended. He feels numbness and constant pain in his left shoulder. If he carries something, he feels as if his bone is "coming out." He has difficulty carrying his young son. If he lies on his left shoulder while sleeping, he wakes up. He experiences pain when he washes his hair. It is difficult for him to lift his head and move his head backward.

[CONT'D]

Arbitrator's Credibility Assessment

Petitioner backtracked on a couple of answers relating to prior left knee injuries and soccer playing. Petitioner testified he misunderstood the time frame of Respondent's counsel's inquiry as to the latter.

Overall, the Arbitrator found Petitioner to be a credible witness.

Arbitrator's Conclusions of Law Relative to 11 WC 40542

Did Petitioner establish a causal connection between his undisputed work accident of September 9, 2011 and his claimed current left knee and left ankle conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his undisputed work accident of September 9, 2011 and his claimed current left knee condition of ill-being. In so finding, the Arbitrator relies in part on Petitioner's testimony. Under cross-examination, Petitioner acknowledged experiencing some left knee swelling after a fall at work years earlier but testified he did not file a claim in connection with this injury. Petitioner testified he was able to perform a variety of physical tasks for Respondents before the September 9, 2011 accident. He also testified to an abrupt onset of pain in his left knee following the accident. The chain of events in this case supports a finding of causation.

The Arbitrator also relies on causation-related opinions voiced by the treating and examining physicians. Petitioner underwent care at Concentra the same day the accident occurred, with Dr. Fertelmeister taking a history of the accident and indicating Petitioner's symptoms probably stemmed from his work activities. Concentra eventually referred Petitioner to Dr. Ho, who also linked the left knee problems to the accident. Respondent's Section 12 examiner, Dr. Karlsson, noted some pre-existing left knee conditions, specifically a bipartite patella and chondral damage, but attributed both the medial meniscal tear and "some of the chrondral damage" to the work accident. Karlsson Dep Exh 6.

The Arbitrator further finds that Petitioner established a causal connection between his undisputed work accident of September 9, 2011 and his current claimed left Achilles condition of ill-being. Petitioner testified he felt pain in his left Achilles area immediately after the accident. This pain subsequently subsided, per the records from the Clearing Clinic (PX 1) but, on September 25, 2012, Dr. Ho noted that Petitioner began experiencing pain in his left Achilles tendon area after returning to work. Dr. Ho described this pain as "secondary" to Petitioner's recurrent left knee pain. Karlsson Dep Exh 4. On January 23, 2013, Petitioner complained of pain in the same area and indicated this pain had flared during work hardening. Dr. Ho

indicated Petitioner would benefit from Achilles tendon therapy and possibly an injection.

Respondent's Section 12 examiner, Dr. Karlsson, did not address Petitioner's left Achilles tendon condition.

Is Petitioner entitled to temporary total disability benefits?

The parties agree Petitioner was temporarily totally disabled from September 22, 2011 through November 13, 2011, a period of 7 4/7 weeks, and from January 31, 2012 through August 14, 2012, a period of 28 1/7 weeks. The dispute lies in whether Petitioner was also temporarily totally disabled from November 29, 2011 through January 30, 2012. Arb Exh 1.

The Arbitrator finds that, in addition to the stipulated periods, Petitioner was temporarily totally disabled from November 29, 2011 through December 1, 2011 and from December 19, 2011 through January 30, 2012, a total of 6 4/7 weeks. In so finding, the Arbitrator elects to rely on the contemporaneous treatment records rather than the witnesses' somewhat tortured attempts to recall what happened, accommodation-wise. On November 23, 2011, Dr. Ho noted that Petitioner "remains on restricted duty" and was performing what appeared to be a "desk job." The doctor prescribed therapy and imposed multiple restrictions on that date. He noted the presence of Jackie Gonzalez, R.N., the nurse case manager. Subsequent therapy notes reflect that, on November 28, 2011, Petitioner reported increased symptoms secondary to "significant amounts of walking beyond his restrictions at work." Those same notes reflect that Petitioner reported being told that no more accommodated duty was available. Gonzalez's report of December 2, 2011 reflects that "Matt, the employer contact, was able to accommodate" the restrictions Dr. Ho imposed on November 23, 2011. As of December 12, 2011, however, the therapist described Petitioner as "off work." On December 19, 2011, Dr. Ho recommended surgery, "once we receive insurance approval," and discontinued formal therapy. Dr. Ho again imposed restrictions on December 19, 2011 but these restrictions were considerably more stringent than those he had imposed on November 23, 2011 in that he was now limiting Petitioner's walking and standing.

Norwood's witness, Matthew Zeman, testified that restricted duty was available to Petitioner between November 28, 2011 and his knee surgery but Zeman focused on the lifting and bending Petitioner would have been required to perform. Zeman never indicated he would have been able to provide work within the updated December 19, 2011 restrictions.

What is the nature and extent of Petitioner's injury?

The Arbitrator has previously found that Petitioner established causation as to left knee and left Achilles tendon conditions of ill-being. With respect to the left Achilles tendon injury, the Arbitrator awards 2.5% loss of use of the left foot, or 4.175 weeks of compensation, under Section 8(e) of the Act.

With respect to the left knee injury, the Arbitrator awards permanency equivalent to 20% loss of use of the left leg, or 43 weeks of compensation, under Section 8(e) of the Act.

In making these permanency awards, the Arbitrator considers all of the factors set forth in Section 8.1b of the Act, noting that Respondents offered an AMA Guides impairment rating only with respect to the left knee injury. Respondents' examiner, Dr. Karlsson, concluded that Petitioner has a 4% loss of use of the left leg, which is equivalent to 2% loss of use of the whole person. Under cross-examination, Dr. Karlsson acknowledged that the rating pertains only to Petitioner's meniscal injury and not to his chondral changes. He also acknowledged that the accident of September 9, 2011 caused some of these changes. In January of 2013, Dr. Ho, who was not a physician of Petitioner's selection, primarily attributed Petitioner's ongoing knee complaints to his chondral changes. From a technical standpoint, he found Petitioner to be at maximum medical improvement but he indicated he expected Petitioner's left knee and left Achilles tendon area to remain symptomatic.

The Arbitrator notes that Petitioner was 35 years old as of the first accident, at which point he had worked intermittently for Respondents for nine years. The Arbitrator considers that Petitioner has spent much of his adult life performing tasks of a physical nature. Petitioner credibly testified that his knee and ankle complaints affect his ability to engage in certain physical activities.

Is Respondent liable for penalties and fees in 11 WC 40542?

Petitioner seeks an award of penalties and fees based on what he perceives as an unreasonably late payment of temporary total disability benefits by Respondents on February 22, 2012, covering the period November 28, 2011 through February 14, 2012. PX 6.

Respondents contend they are not liable for penalties and fees because Petitioner failed to produce evidence as to when they became aware of Dr. Ho's surgical recommendation and/or any "off work" notes.

For the reasons stated above, the Arbitrator has resolved the temporary total disability dispute by awarding benefits from November 29, 2011 through December 1, 2011 and from December 19, 2011 through January 30, 2012.

In analyzing the issue of penalties and fees, the Arbitrator notes that Dr. Ho was not a physician of Petitioner's selection and that it was Respondent's nurse case manager, Jackie Gonzalez, R.N., who set up Petitioner's initial visit with the doctor. The Arbitrator further notes that Ms. Gonzalez was "in the loop," information-wise, by virtue of attending Petitioner's visits to Dr. Ho or by being copied in on Dr. Ho's notes. Dr. Ho first recommended surgery on December 19, 2011, "pending insurance approval." His note of that date reflects he sent a carbon copy to Ms. Gonzalez. On that date, he added restrictions relative to the amount of standing and walking Petitioner could perform. Zeman did not testify that Respondents offered

to accommodate the updated restrictions. According to Dr. Ho, Ms. Gonzalez attended Petitioner's January 24, 2012 appointment. Petitioner signed a surgical consent form at this appointment. Dr. Ho completed a note continuing the previous restrictions to the date of surgery, at which point Petitioner would be off work.

Respondent did not issue temporary total disability benefits until February 22, 2012, despite the foregoing and only after Petitioner filed a 19(b) petition on December 28, 2011, via certified mail (delivered on January 6, 2012) and a penalties/fees petition on January 17, 2012. PX 3-6.

The Arbitrator finds that Respondents, through Jackie Gonzalez, R.N., knew or should have known of the need for a significant surgery and increased work restrictions by December 20, 2011 yet did not issue benefits until two months later. A delay in payment occurred but it was not an extensive delay, in the Arbitrator's view. On this record, the Arbitrator opts to award Section 19(l) penalties in the amount of $1,920.00. The Arbitrator arrives at this figure by multiplying $30.00 per day times 64 days, the period running from December 20, 2011 through February 21, 2012. The Arbitrator declines to award Section 19(k) penalties and fees, as requested by Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Francisco J. Antunes,

Petitioner,

15IWCC0500

vs.

NO: 12 WC 37219

Norwood Paper and Superior Personnel,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner and Respondent Superior Personnel herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, prospective medical treatment, temporary total disability, penalties and fees, and designation of liability between respondents Norwood Paper (borrowing employer) and Superior Personnel (loaning employer) and being advised of the facts and law, reverses the Decision of the Arbitrator dated March 26, 2014 and finds that Petitioner failed to prove that he sustained a compensable work-related accident on October 3, 2012. Petitioner was a 36-year-old undocumented worker. He testified that he began working as a machine operator for Norwood Paper in 1998 via various staffing agencies; most recently he was placed in employment at Norwood Paper by Superior Personnel. Petitioner alleged that he sustained left shoulder injuries while performing his job duties on October 3, 2012.

In a companion case (11 WC 40542) Petitioner alleged a work-related injury to his left knee occurring on September 9, 2011. Petitioner twisted his left knee and required an arthroscopic repair of a medial meniscus tear. Petitioner returned to full duty work by September 27, 2012. One week later, on October 3, 2012, Petitioner alleged the second claim of injury. Petitioner filed a 19(b) petition in this case seeking temporary total disability benefits and prospective medical treatment for the left shoulder and neck. Petitioner's cases were

consolidated for arbitration on January 3, 2014. Petitioner testified on his own behalf and Superior Personnel called Norwood Paper's plant manager, Mr. Zeman. No representatives from Superior Personnel or its workers' compensation insurance carrier testified at hearing. Petitioner has not worked at Norwood Paper since October 3, 2012; he claims that he has been unable to find work within his restrictions.

In a decision dated February 11, 2014, the Arbitrator found that Petitioner sustained a compensable work-related accident on October 3, 2012 and that his current condition of ill-being is related to the injury. The Arbitrator ordered respondents to pay temporary total disability benefits and medical benefits for treatment including the recommended cervical spine MRI and continued treatment by Dr. Mercier. Norwood Paper filed a §19(f) motion to correct a clerical error, asserting that the parties stipulated at hearing that Superior Personnel would accept liability to pay any benefits awarded. (T. 16) On March 26, 2014, the Arbitrator issued a corrected decision reflecting that stipulation. On review, Superior Personnel argued that the decision of the Arbitrator should be reversed in its entirety. Petitioner cross-appealed, arguing that the Arbitrator erred in designating liability between respondents and that the Arbitrator should have awarded temporary total disability benefits from October 4, 2012, through July 16, 2013.

After reviewing all of the evidence, we find that Petitioner failed to prove a compensable work-related accident. As we reverse the Decision of the Arbitrator on the issue of accident, it is not necessary to rule on the remaining issues of causal connection, temporary total disability, medical expenses and prospective medical treatment or penalties and fees and the Arbitrator's designation of liability between respondents Norwood Paper and Superior Personnel. First, we examine the conflicting accounts of the accident. On direct examination, Petitioner testified that on October 3, 2012 he was "*working normally, even though it was painful*. I pulled the paper normally. I heard my shoulder snap. I told the guy that was next to me." [Emphasis added] Petitioner explained that he "pulled the paper, and my shoulder snapped. That's what I felt." He testified that approximately three minutes later he reported the incident to April Campbell (Ms. Campbell reportedly administered the workers' compensation program for Norwood Paper) and Matt Zeman: "I let them know that I hurt myself."

Petitioner testified that he told Ms. Campbell and Mr. Zeman that while pulling paper at the trimmer his shoulder snapped and he was not able to continue working due to pain. He testified that his supervisors offered to allow him to work with smaller paper sizes, but he told them he wanted to go to the doctor. He testified that another employee took him to Concentra. Petitioner speaks English as a second language and he agreed that an interpreter was available at each visit to Concentra. Mr. Zeman testified that Petitioner spoke English fairly well and they did not have any significant communication difficulties. The records from Concentra show that Petitioner reported "using too much force" at work and hearing a pop in his shoulder. *He explained that his job involved pushing and pulling heavy rolls of paper weighing 100 pounds.* He reported that he felt a crack in his left shoulder and that the pain began immediately and persisted from that time. On exam, Petitioner was tender to palpation of the left trapezius and

rhomboid with spasm noted. He had full range of motion of the neck but decreased active range of motion of the left shoulder due to pain. A left shoulder x-ray was unremarkable and Petitioner was diagnosed with a shoulder strain and prescribed ibuprofen, cyclobenzaprine, physical therapy, and ice and cold packs. He was placed on modified duty with no lifting over ten pounds, no pushing or pulling over twenty pounds, and no reaching above shoulder level. (PX 1A) Petitioner testified that he took the light duty note back from the clinic and was told by Ms. Campbell that they could not accommodate his restrictions. Petitioner recalled that Mr. Zeman was present, but that he did not participate in the conversation.

On cross-examination, Petitioner testified that he is right-handed. He denied any prior left shoulder injuries but did recall having some sort of treatment left shoulder discomfort that he attributed to "swollen muscles." He did not recall where or when he received this treatment. He agreed that two weeks before the October 3, 2012 occurrence and on the date of accident itself, his left shoulder was already symptomatic. He affirmed that it is his testimony that he was injured while operating the trimmer and pulling stacks of paper. He did not recall exactly what description of the accident he had given to Concentra "because they [Norwood Paper] would switch positions on us, you could even have four or five positions in a day."

On direct-examination, Mr. Zeman testified that on October 3, 2012, a coworker of Petitioner's came to the office at approximately 7:30 or 8:00 a.m. and told Mr. Zeman that Petitioner wished to see him. Mr. Zeman testified that Petitioner said he thought he hurt his shoulder. Mr. Zeman asked if Petitioner would like to go to the clinic but Petitioner tried doing alternate work instead. At about 9:00 a.m. however, Petitioner stated that he wanted to go to the clinic for his shoulder. Mr. Zeman denied that Petitioner reported pushing or pulling anything weighing 100 pounds at the time he was injured. Mr. Zeman testified that he had work available within the restriction Petitioner subsequently obtained from Concentra and that he offered Petitioner a "stacker" position but Petitioner rejected the job. Mr. Zeman testified that the stacker job remains available and that Petitioner never made any attempt to return to work in the year 2013.

Mr. Zeman disagreed with Petitioner's representation of his job duties. Mr. Zeman testified that while skids of paper can weigh up to 2,000 pounds, they are on rollers and only ten to fifteen pounds of force are used to push them. In contrast, Petitioner testified that he would have to push and pull rolls weighing up to 6,000 pounds by himself. Mr. Zeman testified that the heaviest object that Petitioner may have to lift would be empty pallets weighing thirty-eight pounds. Petitioner testified that while performing the trimmer job, the air table was not fully functional; Mr. Zeman denied that the air table was significantly impaired if three or four of the air holes out of thirty-six were not functioning properly.

After considering all of the evidence, we find that Petitioner failed to prove that he sustained a compensable work-related accident. We note that Petitioner was off of work for nearly one year prior to the October 3, 2012 incident as a result of his knee injury. He began light duty work on August 15, 2012 and was not released to full duty work until September 27, 2012.

15IWCC0500

Petitioner was entirely off of work from September 24th through September 26th for unknown medical reasons. Only a few days later, Petitioner alleged the October 3, 2012 accident and did not return to work.

We find that the testimony of Petitioner is contradictory to the testimony of Mr. Zeman and that Petitioner offered no corroboration for his allegations involving the physical force the trimmer operator job required. The burden is on the employee seeking an award to prove by a preponderance of the credible evidence all elements of his claim, including the requirement that the injury complained of arose out of and in the course of his employment. Further, where there is evidence of a preexisting condition it is the employee's burden to show that the preexisting condition was aggravated by the employment. We rely on the records from Concentra showing that Petitioner's symptoms of left shoulder pain were diffuse and nonspecific, and that objective evidence of an acute injury was lacking. Furthermore, Petitioner's account of the accident and his job duties as reported to Concentra appears to be misleading and unreliable. Where we find a lack of credible evidence supporting the Arbitrator's decision, we must reverse the decision and deny benefits in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated March 26, 2014 is hereby reversed.

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

DATED: JUN 3 0 2015
o-4/21/15
RWW/plv
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cathleen Draper,

Petitioner,

vs.

NO. 13 WC 22288

Salem Township Hospital,

15IWCC0501

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission hereby corrects the Decision of the Arbitrator to award temporary total compensation commencing June 26, 2013 pursuant to the parties' stipulation in the Request for Hearing form.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $272.30 per week commencing June 26, 2013 through November 17, 2013 and from December 23, 2013 through June 6, 2014 for a period of 44 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the

15IWCC0501

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 medical bills identified in Petitioner's Exhibit 4 for medical expenses under §8(a) and 8.2 of the Act. Respondent shall be given credit for any medical bills that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is awarded prospective medical care in the form of a second opinion with Dr. McIntosh as recommended by Dr. Froehling and Respondent shall pay for said visit.

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. No bond is required for removal of this cause to the Circuit Court.

DATED: JUN 3 0 2015
SJM/msb
o: 5/27/15
44

Stephen J. Mathis

David Gore

Mario Basurto

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

DRAPER, CATHLEEN
Employee/Petitioner

Case# **13WC022288**

SALEM TOWNSHIP HOSPITAL
Employer/Respondent

15IWCC0501

On 7/30/2014, 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:

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

1109 GAROFALO SCHREIBER STORM
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

15IWCC0501

☐ 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)

CATHLEEN DRAPER
Employee/Petitioner

v.

SALEM TOWNSHIP HOSPITAL
Employer/Respondent

Case # 13 WC 022288

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 3, 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, **6/10/13**, 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 **$21,239.92**; the average weekly wage was **$408.46**.

On the date of accident, Petitioner was **61** 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 is to pay the medical bills identified in Petitioner's Exhibit 4 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.

Respondent shall pay temporary total disability benefits (TTD) to Petitioner in the amount of $272.30 per week from 06/25/13 through 11/17/13 and 12/23/13 through 06/03/14, which totals 44 weeks. Respondent shall be given a credit in the amount of $5,640.74 for TTD that has been paid.

Petitioner is awarded prospective medical care in the form of a second opinion with Dr. McIntosh as recommended by Dr. Froehling and Respondent shall pay for said visit.

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

July 27, 2014
Date

JUL 30 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This claim involves an injury to Petitioner's left knee. This matter is brought to hearing on Petitioner's 19(b) Petition and request for prospective medical care. The disputed issues are: causal connection, liability for medical bills, TTD, and prospective medical care. The only witness testifying before the Arbitrator was Petitioner.

The Arbitrator finds:

On 06/10/13 Petitioner was 61 years old, single, with no dependent children. She started working for the Respondent in 2007 as a housekeeper. Her job duties included mopping, sweeping, vacuuming, picking up trash, picking up biohazard boxes, picking up laundry, cleaning rooms, cleaning bathrooms, changing the linen, washing the beds and changing curtains, and pushing her cleaning cart. Petitioner was on her feet for the entirety of her 8-hour shift.[1]

On 06/10/13 Petitioner had finished vacuuming the clinic lobby. As she was putting the vacuum cleaner away, she was walking at a fast pace, when the vacuum cleaner (of older age) stopped rolling. Petitioner stepped on the back of the vacuum with her left foot, causing her left knee to twist and she fell to the floor. Petitioner felt pain in her left knee. She rated the pain at a 4/10. Petitioner denied ever experiencing knee pain like that before. Accident is not disputed.

Petitioner immediately sought treatment at Respondent's emergency room. The ER records noted Petitioner had a "ground level fall." Petitioner reported it felt like her left knee pulled. X-rays revealed mild osteoarthritis of Petitioner's left knee and patella. The diagnosis was arthritis and arthralgia. Left knee x-rays showed no acute fracture, dislocation, or bone lesion but did show mild osteoarthritis of left knee and patella. Petitioner was told to ice the knee, take Advil, and to follow-up with her family doctor. She was allowed to return to work.

On 06/28/13 Petitioner saw Dr. Alan Froehling, who recommended she undergo a left knee MRI. Dr. Froehling's record noted Petitioner injured herself on 06/10/13 when she fell and twisted her left knee at work. Petitioner reported she had tried to keep working up until about Tuesday, that x-rays showed some mild degenerative medial compartment disease, and that she was in too much pain. Dr. Froehling's physical exam showed slight leg extension lag, pain with force extension, a positive McMurray's test, tenderness to palpation over the medial joint line, and minimal effusion. He believed the findings were consistent with a tear of the medial meniscus of the left knee. Dr. Froehling recommended Petitioner get a left knee MRI. He told Petitioner to ice the knee and not work. (PX 1)

Petitioner underwent the left knee MRI on 07/01/13. It revealed: a prominent bone marrow contusion deep to the posterior half of the medial tibial condyle with minimal fragmentation of the posterior margin without stepoff of the articular surface; a focal horizontal tear to the superior articular surface of the anterior half of the body of the medial meniscus; a small focal disruption of the medial patellar retinaculum just below the joint line level, adjacent to the anterior margin of the medial collateral ligament; mild chondromalacia involving major weightbearing surfces of the medial knee

[1] See also PX 2 for a written job description.

compartment and superior half of the medial patellar facet; minimal left knee joint effusion; a probable minimal strain of the posterolateral bundle of the anterior cruciate ligament; minimal degenerative marginal spurring at the retropatellar joint and mild marginal spurring at the anteromedial aspect of the medial knee compartment; focal cortical desmoid formation at the femoral attachment of the medial head of the gastrocnemius. (PX 1)

On 07/03/13 Petitioner returned to Dr. Froehling. He reviewed the MRI noting he thought the MRI confirmed his clinical suspicion of a torn medial meniscus. He noted Petitioner had pain with weight bearing and was unable to fully straighten her knee. Dr. Froehling told Petitioner to apply ice to the knee, take Ibuprofen, and use a walker. His diagnosis was a bone contusion with a torn medial meniscus. He believed that if Petitioner continued to have symptoms of internal derangement, she would probably be a candidate for a scope. He gave Petitioner an off duty slip until 07/24/13. (PX 3)

On 07/05/13 Petitioner saw her primary care physician Dr. Hyatt Settlemoir who noted that Petitioner had sustained a twisting left knee injury on 06/10/13, that she continued to work until 06/25/13 and that she was unable to bear pain, so she saw Dr. Froehling on 06/28/13 and then underwent a left knee MRI on 07/01/13. He kept Petitioner off work until a re-evaluation by Dr. Froehling on 07/24/13. (PX 2)

On 07/24/13 Petitioner returned to Dr. Froehling. He reviewed a left knee x-ray that showed no fragmentation on the lateral view and the architecture was well preserved. On physical exam, Dr. Froehling noted Petitioner continued to have a popping sensation in the knee, a palpable click at the joint line on the medial posterior aspect, and a positive McMurray's sign. He opined these finding were very characteristic of a torn meniscus on the medial side of her knee, Petitioner would probably need a partial medial meniscectomy, followed by a period of physical therapy. Dr. Froehling kept her off work until surgery. (PX 3)

At Respondent's request, Dr. Petkovich examined Petitioner on 08/20/13. In his written report issued after the examination, Dr. Petkovich noted Petitioner was using a walker to get around and had an antalgic gait. During the 08/20/13 exam, he noted objective findings of small left knee joint effusion throughout the joint, some decrease in flexion, tenderness to palpation along the medial joint line, and tenderness along the undersurface of the medial patella. He noted a positive McMurray's sign for the medial compartment. He reviewed the x-rays taken on 06/10/13 and believed they showed some degenerative arthritic changes. He reviewed the left knee MRI taken on 07/01/13. He believed the MRI was consistent with a tear of the medial meniscus, with a small joint effusion and chondromalacia of the medial femoral condyle. He acknowledged that Petitioner's MRI not only showed the medial meniscus tear but also some chondromalacia, a contusion of the medial femoral condyle, and a strain of part of her ACL, "obviously acute." He opined Petitioner's diagnoses were a tear of the left knee medial meniscus and chondromalacia of the medial femoral condyle. He opined Petitioner's medial meniscal tear was a result of the 06/10/13 work incident. He believed the mechanism of injury, as described by Petitioner, could cause a medial meniscal tear or render symptomatic an already existing but asymptomatic medial meniscal tear. He further noted there appeared to be no alternate mechanism that could explain the correlation between her persistent complaints and the physical/MRI findings. Noting Petitioner had internal derangement in her left knee that would cause further damage to the joint if left alone he opined Petitioner would benefit from arthroscopic surgery on her left knee for a medial meniscectomy, with shaving and debridement. He believed, following surgery, Petitioner would need a course of physical therapy, two to three times a week for up to six weeks. He didn't believe Petitioner could return to work at full duty, but did believe

should could work at light duty. He also didn't believe she had reached maximum medical improvement (MMI) as a result of the 06/10/13 work injury. (RX 2)

On September 11, 2013 Petitioner underwent a right shoulder MRI due to pain and limited range of motion of two years duration and no known injury. (PX 1)

On 10/01/13 Dr. Froehling performed a partial medial meniscectomy. His post-operative diagnosis was a torn meniscus left knee. Inter-operatively he found a "complex tear of the medial meniscus, some mild areas of chondromalacia on the medial femoral condyle," an intact ACL, and some chondromalacia in the lateral compartment. (PX 3)

On October 9, 2013 Petitioner returned to see Dr. Froehling who noted she was walking without any assistive device but still experiencing some leg weakness and concerned about climbing stairs "and such." He felt she would probably do fine but kept her off work. As of October 14, 2013, Dr. Froehling noted Petitioner "demonstated an odd clunking sensation that occurs when she flexes and extends her knee between 10 and 15 degrees of flexion." The semimembranosus tendon appeared to be slightly subluxing and causing a clunking sensation. He noted a similar finding on the right side "but less pronounced." Dr. Froeling felt it was structural and nothing serious. Petitioner still felt a little wobbly and was having trouble going up and down stairs. He recommended she begin physical therapy and remain off work. (PX 3)

Petitioner underwent physical therapy, as instructed, commencing October 17, 2013. (PX 1) On 10/28/13 Petitioner returned to Dr. Froehling who felt she had "turned the corner in physical therapy" and was feeling a lot more normal. Petitioner was still walking without any assistive devices and there was no fluid in the knee. He noted Petitioner's employer had filled her position and Petitioner was unsure if she had a job to return to. Dr. Froehling recommended two more weeks of physical therapy and kept her off work. (PX 3)

At the time of Petitioner's last physical therapy visit, Petitioner was doing well but noting pain in her knee and the inability to squat, get on the floor, or lift over 15 lbs. off the floor without her knee hurting. (PX 1)

On 11/11/13 Dr. Froehling felt Petitioner had "pretty much maxed out on physical therapy." He looked at the wound and thought it was well healed. He noted no fluid in the knee. He thought the knee was stable. His notes indicate Petitioner had been pretty busy at home doing housework, going up and down ladders. He noted that she still had that muscular subluxing on the medial aspect of the knee. He didn't think there was anything that could be corrected surgically. He released Petitioner to return to work, without restrictions, full duty on 11/18/13. Petitioner was to return in six weeks. (PX 3)

On 11/14/13 Petitioner returned to see Dr. Settlemoir, who noted Petitioner had continued moderate to severe knee pain with intermittent swelling of the medial posterior knee. He also noted Petitioner had been released to return to full housekeeping duties but after attempting similar duties at home, she felt unable to return to work. His physical exam was positive for joint pain and joint swelling. Petitioner had tenderness and moderately reduced range of motion. The records indicate Petitioner wanted a second opinion about her proposed ability to be released to full duties and to see if more orthopedic intervention would be necessary. The doctor noted Petitioner would be terminated as of December 12, 2013 if no other jobs opened up. Dr. Settlemoir referred Petitioner to Dr. McMullin. (PX 2; PX 5)

Petitioner did not return to work for Respondent. Petitioner has not worked for any employer since the 06/10/13 work injury. Petitioner testified if she had been offered a position with Respondent she would have attempted to return to work.

On 12/23/13 Petitioner returned to see Dr. Froehling, who noted Petitioner's continued complaints of pain and tenderness along her medial hamstring. He noted the semimembranosus seemed to have some bursitis with a clunking sensation. Dr. Froehling reviewed Petitioner's MRI but could find nothing else to explain what was going on. Dr. Froehling administered an injection to the medial aspect of Petitioner's knee in the area where the muscle was subluxing. He noted Petitioner had attempted to return to work but Respondent had filled her position so Petitioner no longer had a job. Dr. Froehling told Petitioner to return in 2 weeks to see how she responded to the injection. He didn't see any indication for any further surgery at this time. His diagnosis was post-traumatic bursitis of the left knee. Dr. Froehling, at Petitioner's request, gave her restrictions of no climbing, no kneeling and no squatting from 12/23/13 to 01/06/14. (PX 3; PX 5)

On 01/24/14 Dr. Froehling noted Petitioner was still having problems with the subluxing of the medial hamstring. He also remarked the cortisone injection was only of some benefit so he was unsure if it was worth repeating it. Dr. Froehling believed Petitioner would benefit from a second opinion, noting whatever was going on was bothersome and causing some impairment and might prevent Petitioner from being able to be fully functioning especially with climbing and being on her feet all day. Dr. Froehling wished for Dr. McIntosh to examine Petitioner. He noted Petitioner had been having trouble with Respondent as it had been contesting her disability benefits and unemployment application. His diagnosis was painful left knee following injury, post-op arthroscopic meniscectomy and bursitis or subluxation of the medial hamstring tendons. (PX 3; PX 5)

PX. 2 contains an off duty slip from Dr. Settlemoir keeping Petitioner off work from 02/06/14 to 03/07/14. The Arbitrator notes that Dr. Settlemoir did not examine Petitioner that day. (PX 2)

Dr. Petkovich re-examined Petitioner at Respondent's request on February 7, 2014. During the examination Dr. Petkovich took new x-rays, which, in his opinion, showed adequate overall structural alignment but did show some mild degenerative arthritic changes along the medial aspect of the left distal femur. On examination the doctor noted no evidence of inflammation, no joint effusion, and full range of motion. He did note tenderness to palpation along the medial joint line and along the undersurface of the patella medially. Petitioner was further noted to have discomfort under the patella with flexion and extension. Dr. Petkovich acknowledged the positive findings he found on exam but found "no positive findings on objective exam." (RX 3)

He opined Petitioner's diagnoses were a tear of medial meniscus, status post meniscectomy, which was a result of 06/10/13 work incident, and chondromalacia of the medial femoral condyle, which was not aggravated or accelerated as a result of the 06/10/13 work injury. He opined the chondromalacia was present prior to the 06/10/13 work injury and it was not aggravated or accelerated as a result of the 06/10/13 work injury. His physical exam yielded no positive objective findings. He believed Petitioner was capable of performing her regular job duties without restrictions since 11/18/13. He believed there was no physical basis for restricting her from work after 11/18/13. He believed Petitioner had reached MMI and needed no future treatment as of 11/18/13.

Dr. Froehling was deposed on 05/07/14[2]. Dr. Froehling is an orthopedic surgeon who deals with low back problems, arthritis, and extremity injuries. He testified that he has let his board certification expire "because it was too much of a hassle." (PX 5, p. 6) Dr. Froehling's testimony is consistent with the information contained in his medical records. On 06/28/13 he noted Petitioner had pain with extension and difficulty extending her knee. (PX. 5, p. 8) She had a positive McMurray's sign, was tender over the medial joint line, and most of her pain was on the medial side. (PX. 5, p. 8) He believed it was likely she had a torn meniscus. (PX. 5, p. 8) He gave her an off-work slip, recommended some ice and rest, and an MRI scan. (PX. 5, p. 8) On 07/03/13 Dr. Froehling reviewed the MRI and thought it showed a bone bruise or microfracture on the popsterior medial femoral condyle and findings suspicious for a torn medial meniscus. (PX. 5, p. 9) He recommended Petitioner rest, use ice, and stay off her leg. He prescribed a walker. (PX. 5, p. 9) After several weeks of rest, Dr. Froehling took x-rays and did not see any evidence of fragmentation. (PX. 5, p. 9) He carefully evaluated the bone in the back of the condyle. (PX. 5, p. 9) He noted she was having a popping sensation in her left knee and a click at the joint line that suggested a torn meniscus. (PX. 5, p. 9-10) At that time he believed it was worthwhile to perform surgery to take the meniscus out. (PX. 5, p. 10) On 10/01/13 Dr. Froehling performed a partial medial meniscectomy. (PX. 5, p. 10) Inter-operatively, he found a complex tear of the medial meniscus, some mild chondromalacia on the medial femoral condyle, and some mild chondromalacia in the lateral compartment. (PX. 5, p. 11) Dr. Froehling cleaned out the torn meniscus and irrigated the knee. (PX. 5, p. 11) He kept her off work while she attended physical therapy. (PX. 5, p. 11) He allowed her to return to work full duty on 11/18/13. (PX. 5, p. 11) On 12/23/13 Petitioner returned to Dr. Froehling because she was having continued problems with her knee. (PX. 5, p. 11) He noted a "clunking sensation" occurring when Petitioner straightened her knee from about 30 degrees to full extension and her medial hamstring tendon would flip over the medial condyle with the femur. (PX. 5, p. 11-12) When this happened, Petitioner would complain of pain. (PX. 5, p. 12) Dr. Froehling testified it looked like the tendon was subluxating. (PX. 5, p. 12) He administered an injection to the tendon. (PX. 5, p. 12) The most recent time Dr. Froehling examined Petitioner was on 01/24/14. (PX. 5, p. 11) Petitioner told Dr. Froehling the injection helped a little bit but the area continued to cause her problems. (PX. 5., p. 12) Dr. Froehling was concerned about what was going on and believed Petitioner might benefit from some further treatment, so he told Petitioner to get a second opinion. (PX. 5, p. 12) Dr. Froehling opined the bone contusion of the medial femoral condyle, torn medial meniscus, and problem with the subluxation of the medial hamstring tendon were causally related to Petitioner's 06/10/13 twisting injury. (PX. 5, p. 13-14) He did not believe Petitioner had reached MMI. (PX. 5, p. 14) As of 01/24/14 Dr. Froehling would let Petitioner live with the pain and go back to work. (PX. 5, p. 14) He opined the treatment he provided was reasonable and necessary. (PX. 5, p. 15) He opined the recommendation for a second opinion was reasonable and necessary. (PX. 5, p. 15) He opined his recommendation for Petitioner to get a second opinion was causally related to the 06/10/13 work injury. (PX. 5, p. 14)

Dr.Froehling, on cross-examination, acknowledged that by October 28, 2013 Petitioner was feeling more normal and turning a corner in her physical therapy. (PX 5, p. 16) She needed no assistive devices to walk. (PX 5, p. 17) Dr.Froehling testified that his recommendation for a second opinion was both reasonable and necessary. He concluded that Petitioner could return to work as a housekeeper as of January [24], 2014; however, she would not be at maximum medical improvement as there is still more that can be done for her and while he would let her go back to work, she would

[2] The yellow highlights found throughout the doctor's deposition transcript were not made by the Arbitrator.

have to live with the pain in her left knee. He could not speak to the justification of Dr. Settlemoir authorizing Petitioner to be off work between February 6 and March 7, 2013. (RX 5, pp. 14-15)

At the arbitration hearing Petitioner testified that prior to June 10, 2013 she had never injured her left knee, never received any treatment to her left knee, nor was she under a doctor's restrictions for her left knee. Petitioner testified she was able to fully perform her job duties without any difficulty.

Petitioner testified that over the weeks following her initial exam at the emergency room, her right knee condition worsened as all of her job duties caused continued knee pain.

Petitioner testified the first day she missed work due to her injury was 06/25/13.

Petitioner testified that, contrary to the history contained in Dr. Froehling's 11/11/13 report, in the days before 11/11/13 she did not go up and down ladders at home. She testified she did not have any ladders or have any reason to go up and down ladders before 11/11/13. Her home only has three steps in the front and four in the back. Before 11/11/13 her knee hurt while using these steps. She didn't use stairs at home to go up to a second floor or down into a basement.

Petitioner testified that when she walks, it feels like her knee slides to the inside. When she straightens her left leg, she can feel and see the tendon on the medial side of the knee moving back and forth. At the hearing, Petitioner showed the Arbitrator her left knee. The Arbitrator notes a twitch in the medial area, under the skin, when Petitioner straightens her left leg. Petitioner testified the tendon did not twitch before 06/10/13. Currently, walking and activities around the house, like vacuuming, sweeping, and mopping, cause Petitioner to experience left knee pain. Petitioner testified the surgery did provide some relief but did not provide complete relief. Petitioner wants to get a second opinion as recommend by Dr. Froehling. She testified the condition of her knee is the same as when she saw Dr. Froehling on 01/24/14. She currently takes Advil and Tramadol for the left knee pain. Dr. Settlemoir prescribes the Tramadol.

Petitioner's medical bills are found in PX 4.

The Arbitrator concludes:

Petitioner's credibility:

Petitioner was a credible witness. Her testimony was clear, consistent, and she addressed questions with sincerity and believability.

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

Petitioner's current condition of ill-being in her left knee is causally connected to her undisputed work accident of June 10, 2013. This is based upon Petitioner's credible testimony, Dr. Froehling's testimony, the medical records supporting an acute injury occurred to Petitioner's left knee that caused a significant change in the condition of her left knee, and a chain of events.

Petitioner's care and treatment is largely undisputed until mid November of 2013 when she was released to return to work. Petitioner currently seeks a second opinion for a possible muscular

subluxation/bursitis on the medial side of her left knee. Respondent disputes that Petitioner needs such an opinion relying upon Dr. Petkovich's February 4, 2014 report. The problem with Dr. Petkovich's second report is two-fold. First, it is inconsistent with his first report in that when he initially examined Petitioner in 2013 he described his findings of medial tenderness along the medial joint line and under the undersurface of the medial patella as "objective physical findings." (RX 2, p. 5) Then, in his second report he does not consider Petitioner's tenderness in that same area as "objective" findings. This inconsistency is unexplained. Second, Dr. Petkovich never addressed the muscular subluxation/bursitis issue head on. Respondent's carrier never asked if him if he agreed/disagreed with Dr. Froehling's possible diagnosis of it. In his office notes pre-dating the second examination with Dr. Petkovich, Dr. Froehling clearly focused on the possibility of a bursitis/medial hamstring subluxation issue. Dr. Petkovich was not asked if he agreed with that diagnosis. His examination noted subjective complaints of pain in Petitioner's left knee consistent with Dr. Froehling's notes and the physical therapist's November 8, 2013 note. Dr. Petkovich side-stepped it.

Petitioner never had problems with her left knee before the accident. She was able to fully perform her housekeeping duties. Since the accident she has never returned to her pre-accident condition. Her symptoms and complaints remain in the medial side of her knee. While she has similar findings on her right knee Dr. Froehling noted it was more pronounced in her left knee. These problems also surfaced after her surgery and Dr. Petkovich did not address whether Petitioner's ongoing problems (ie. the hamstring tendon) might be related to the surgery. He simply focused on her accident. Dr. Petkovich noted Petitioner suffered an "obviously acute" contusion to the medial femoral condyle. Again, this is the area where Petitioner is noting ongoing problems.

In this instance the Arbitrator assigns more weight to the opinions of Dr. Froehling, Petitioner's treating physician, over those of Dr. Petkovich, an examining physician.

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

All of the medical treatment provided to Petitioner has been reasonable and necessary and Respondent is responsible for the medical bills incurred as a result thereof. Respondent is to pay the medical bills identified in Petitioner's Exhibit 4 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 amounts that have been paid.

While a potential issue was raised at the conclusion of the arbitration proceeding concerning whether Petitioner should be awarded bills owed to Salem Township Hospital since it was both her employer and initial treater and, as both, provided a service for which it did not expect payment, there is no evidence in the record (nor was a stipulation ever provided) from which the Arbitrator may find/infer that Respondent does not wish to be paid. The reality is that it sent a bill(s) to Petitioner.

With regard to disputed issue (L) – TTD Benefits:

The parties agree that Petitioner is entitled to temporary total disability benefits beginning on June 26, 2013 and ending on November 17, 2013. Petitioner claims an additional period of temporary total disability -- December 13, 2013 through June 3, 2014. (AX 2)

Petitioner is entitled to TTD benefits from 06/25/13 through 11/17/13 and from 12/23/13 through 06/03/14, a period of 45 3/7 weeks.

Petitioner is not awarded TTD benefits from December 13, 2013 through December 22, 2013. She was not taken off work nor did she receive any restrictions from any doctor.

Dr. Froehling did impose restrictions effective December 23, 2013 due to ongoing complaints of pain and tenderness along Petitioner's medial hamstring consistent with post-traumatic bursitis of the left knee. She was given an injection and told to return in two weeks. She remained in need of restrictions as of January 24, 2013 and he felt another opinion was warranted as whatever was going on with her was preventing her from being able to fully function on her left leg, especially with climbing and being on her feet all day long. Dr. Froehling has never indicated Petitioner was at maximum medical improvement. When he saw her on November 11, 2013 he wanted to allow her to return to full duty without restrictions, but he had not released her. He then re-examined her on December 23, 2013 and imposed restrictions which Respondent has not accommodated because it terminated Petitioner's employment. While Dr. Petkovich opined Petitioner could be working, the Arbitrator finds (for the reasons set forth above under "Causal Connection") Dr. Froehling is the more persuasive of the two experts. According to Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 923 N.E.2d 266, 236 Ill.2d 132, 337 Ill.Dec. 707 (2010), Petitioner is entitled to TTD.

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

Petitioner is entitled to prospective medical care in the form of a second opinion from Dr. McIntosh. Dr. Froehling opined the current condition of Petitioner's left knee, including the subluxating medial hamstring, and his recommendation for a second opinion were causally related to the 06/10/13 work injury. At the hearing, the Arbitrator witnessed the movement of the tendon along her medial left knee. Petitioner credibly testified that the movement of the tendon did not occur before her 06/10/13 work injury.

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