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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LONIE GINGER,

15IWCC0155

Petitioner,

vs. NO: 09 WC 4336

TA BRINKOETTER & SONS,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes to the Commission on remand from the Appellate Court of Illinois. At arbitration the Arbitrator found Petitioner proved causation of a condition of ill-being of his lumbar spine from a compensable accident on July 11, 2008. The Arbitrator awarded him 62 weeks temporary total disability benefits, 67&4/7 weeks maintenance, $31,581.39 in medical expenses, 225 weeks of permanent partial disability benefits representing loss of the use of 45% of the person-as-a-whole, and ordered Respondent to provide vocational rehabilitation services. Both parties sought review of the Decision of the Arbitrator. Respondent preserved the issues of causation, medical expenses, temporary total disability, permanent partial disability, maintenance, vocational rehabilitation, and "inconsistent award." Petitioner only preserved the issue of the nature and extent of Petitioner's permanent disability. He argued he is permanently and totally disabled from work.

The Commission affirmed and adopted the Decision of the Arbitrator. Respondent appealed to the Circuit Court which confirmed the Decision of the Commission. Respondent then appealed to the Appellate Court which found the Commission decision was interlocutory and the Circuit Court did not have jurisdiction hear the matter because "the Commission ordered the employer to provide the claimant with rehabilitation services. The Commission's decision, however, does not specify a plan for rehabilitation services to be rendered. Determination of the specific rehabilitation program requires further deliberation by either the litigants or the Arbitrator. 'The case reached the circuit court, therefore, before administrative involvement in the case had been terminated.'" The Appellate Court then remanded the case back to the Commission for "further proceedings."

15IWCC0155

Presumably, the Appellate Court remanded the case for the Commission to "specify a plan for rehabilitation services" in order to make the award final and ripe for review on appeal. However, upon reconsideration of the issue upon remand, the Commission concludes that the simultaneous award of permanent partial disability benefits (here 45% of the person-as-a-whole), and requiring Respondent to provide vocational rehabilitation services is inconsistent and inappropriate. The award of permanent partial disability presumes that the claimant has reached maximum medical improvement and that his permanent impairment and future earning potential can be determined at the time of the award. On the other hand, the award of vocational rehabilitation services presumes that such services may foster the claimant's ability to obtain suitable but unspecified employment and therefore his future earning potential has yet to be determined. The claimant's future earning capacity would likely be based on the success of the rehabilitation services provided. In addition, upon completion of vocational rehabilitation, it is certainly possible that a claimant would be able to find suitable employment and in that instance a wage differential award may actually be more appropriate than a permanent partial disability award. Therefore, in order to make the award consistent, final, and appealable the Commission vacates the portion of the award that requires Respondent to provide vocational rehabilitation services.

IT IS THEREFORE ORDERED BY THE COMMMISSION, that the requirement that Respondent provide vocational services in the award of the Arbitrator issued in this claim on January 10, 2012 is hereby vacated and all other portions of the award are affirmed.

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: MAR 4 - 2015

Ruth W. White

Ruth W. White

Charles J. DeVriendt

Charles J. DeVriendt

RWW/dw
O-1/28/13
46

15IWCC0155

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 28, 2015, before a three-member panel of the Commission including members Charles J. DeVriendt, Ruth W. White and Daniel R. Donohoo, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Daniel R. Donohoo on February 23, 2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Donohoo's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Donohoo voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA OLMOS-GARCIA,

Petitioner,

15IWCC0156

vs.

NO: 09 WC 9552

X-PAC,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator awarded Petitioner $6,415.75 in medical expenses and 50 weeks of permanent partial disability benefits representing 10% loss of the use of the person-as-a-whole. The Commission agrees with the Decision of the Arbitrator regarding the issue of causal connection and affirms that portion of the decision. However, after our review of the entire record before us, the Commission modifies the Decision of the Arbitrator to reduce the medical expense award to $916.75 and to reduce the permanent partial disability award to 25 weeks of benefits representing 5% loss of the use of the person-as-a-whole.

Findings of Fact and Conclusions of Law

1. The parties stipulated that Petitioner suffered a work-related accident on August 27, 2008 in which she was struck by a falling wooden crate and pinned between the crate and tires. She did not seek medical treatment until September 3, 2008 when Respondent sent to its preferred medical clinic.

2. Petitioner continued to treat at the clinic until she was released to full duty on September 17, 2008. However, Petitioner testified her low back pain got "worse and worse" and she returned to the clinic on January 9, 2009.

3. Petitioner treated with medication, physical therapy, and epidural steroid injections with little to no benefit. Petitioner also testified she had chiropractic treatment between February 27, 2009 and July 19, 2009, which did provide substantial relief. However, the record before the Commission only includes two notes from a chiropractor dated February 17, 2009 and March 18, 2009 respectively in which her permanent impairment was rated. There were no actual chiropractic treatment records in the transcript.

4. Petitioner was referred for a consultation with a neurosurgeon, Dr. Ridenour, whom she saw on March 5, 2009. Dr. Ridenour diagnosed degenerative disc space changes at L5-S1 with minimal lateral recess narrowing. He realized that she exhausted conservative treatment, but noted that performing surgery for the very modest objective findings is rarely, if ever, helpful and she had no benefit from the epidural. He concluded she was not a surgical candidate.

5. On June 26, 2009, Petitioner presented to Dr. Zelby for a medical examination at Respondent's request pursuant to Section, 12 of the Act. Petitioner complained of persistent pain in the low back, left buttock, left inguinal region and the left leg circumferentially, primarily above the knee but occasionally below the knee. "Her symptoms are exacerbated by everything." She reported no prior episodes of these types of symptoms.

6. On examination, Dr. Zelby noted mild tenderness to deep palpitation of the lumbar spine, positive lying left straight leg raises in the back only, and diminished sensation in the entire left leg. Otherwise his examination appeared to be normal.

7. Dr. Zelby also noted inconsistent behavior responses "for pain on simulation, diminished pain on distraction, and non-anatomic sensory changes." The MRI showed degenerative disc disease at L5-S1with a moderate loss of disc height and mild degenerative endplate changes, miniscule bulging at L4-5, a broad-based disc/osteophyte complex abutting the ventral sac centrally at L5-S1, degenerative changes in the facets, mild thickening if the ligamentum flavum, mild right greater that left later recess stenosis, and moderate right greater than left foraminal stenosis.

8. Dr. Zelby opined that Petitioner's symptoms and response to treatment were consistent with a soft tissue strain. Her current symptoms could not be explained by objective medical findings. She was neurologically intact except for non-anatomic sensory changes. Based on the fairly mild degenerative disc disease at L5-S1 it was difficult to find a medical cause for her subjective complaints. Her current complaints were not related to her work accident. She was at maximum medical improvement for any condition associated with the work injury. She suffered only a modest temporary partial disability and no permanent partial disability. She is able to return to work at full duty.

9. On August 21, 2009, Petitioner presented on her own to Dr. Lane of Comprehensive Orthopedics. She indicted she needed a second opinion regarding a neurosurgeon's opinion that surgery was not needed for her workers' compensation claim. Dr. Lane noted Petitioner had been seen by several orthopedic surgeons for her back and she had an MRI which showed no herniations. He diagnosed chronic low back pain that was not relieved by conservative measures. He advised her to return to the pain clinic. If she were dissatisfied she should go to another pain clinic or to a chiropractor, which helped her in the past. There was nothing he could offer her. He did not know whether the condition was work related.

10. On February 20, 2012, Petitioner presented to Dr. Milas for a medical examination on the recommendation of her lawyer. He interpreted the 2009 MRI as showing a "large" central herniated disc at L5-S1. Dr. Milas evaluated that her impairment rating was 13% of the person-as-a-whole, and opined the impairment and her work accident was the direct result of her impairment. She should have a permanent 10-lb restriction with no repetitive bending, stooping, or twisting and should be evaluated by a spine center.

11. Dr. Milas testified by deposition on August 27, 2012 and testified he would recommend additional treatment including a repeat MRI and if the herniated disc was still present a laminectomy, discectomy, and possible fusion at L5-S1. He also incorrectly testified that Dr. Ridenour saw her "and recommended an operative approach."

12. Petitioner returned to Dr. Zelby for a second Section 12 medical examination. She reported she felt the same as she did three years ago. She had constant 7-10/10 pain in the low back, and left buttock with radiation and numbness in the left leg and occasionally in the right leg. He had about a year of chiropractic treatment but had not had any treatment for two years because her lawyer at the time advised her not to because workers' compensation was not paying. She got another lawyer who sent her to another doctor. She has not worked since the accident because she has a 10-lb restriction.

13. Dr. Zelby's examination appears to have been identical to the examination in 2009. He noted that currently, she reported "a constellation of ongoing subjective complaints with no plausible cause found in the diagnostic studies." In fact there was no objective evidence of any ongoing medical condition. His opinions from 2009 remained unchanged. She suffered only a soft tissue strain which would have required only 3-4 weeks of restricted duty. There was no medical reason why Petitioner could not pursue any vocational activities.

The Arbitrator awarded Petitioner $6,415.75, representing all the medical expenses for which Petitioner submitted bills. However, Petitioner did not submit any treatment records to confirm her alleged chiropractic treatment. Therefore Petitioner has failed to sustain her burden of proving any chiropractic treatment was reasonable or necessary or related to her work accident. Accordingly, the Commission vacates $5,499.00 of the medical award representing the portion of the award corresponding with the alleged chiropractic treatment.

Regarding the permanency award, the Commission finds the opinion of Dr. Milas unpersuasive. His characterization that Petitioner had a "large" herniation was clearly at odds with the interpretation of every other doctor who examined Petitioner and reviewed her MRI. His recommendation for surgery was also directly contrary to the opinions of three other surgeons, Dr. Ridenour, Dr. Lane, and Dr. Zelby, each of whom unequivocally opined that Petitioner was not a surgical candidate because of the minimal objective findings.

In addition, the Commission has serious reservations about Petitioner's credibility. Her allegation that she did not seek any medical treatment for 2½ years despite "constant 7-10/10 pain" is simply not believable. In addition, Dr. Zelby found significant symptom magnification and non-organic pain responses, further putting Petitioner's credibility into question. It is also interesting to note that despite her report of "constant 7-10/10" pain and despite Dr. Milas' recommendation, Petitioner did not seek prospective medical treatment. The Commission concludes that Petitioner suffered a soft-tissue injury in the work accident on August 27, 2008 and reduces her permanent partial disability award to the loss of 5% of the person-as-a-whole.

Finally, the Arbitrator awarded Petitioner permanent partial disability benefits at a weekly rate of $268.67. The accident occurred on August 27, 2008. The Decision of the Arbitrator indicates that Petitioner was single with one dependent child. Based on the date of accident and the fact that Petitioner had one dependent, the current minimum permanent partial disability rate would be $237.67. Apparently, the benefit rate used by the Arbitrator was based on the assumption that Petitioner had two dependents. However, that assumption is contrary to the Arbitrator's findings. Even though Respondent did not preserve the issue of benefit rate on review, the Commission has an obligation to correct any errors that become apparent in our review of the entire record. Therefore, the Commission further modifies the Decision of the Arbitrator to use the correct benefit rate based on the findings of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $237.67 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 loss of the use of 5% of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $916.75 for medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule.

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.

15IWCC0156

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 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: MAR 4 - 2015

Ruth W. White

Charles J. DeVriendt

RWW/dw
O-1/28/15
46

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 28, 2015, before a three-member panel of the Commission including members Charles J. DeVriendt, Ruth W. White and Daniel R. Donohoo, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Daniel R. Donohoo on February 23, 2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Donohoo's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Donohoo voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0156

OLMOS-GARCIA, MARIA T
Employee/Petitioner

Case# 09WC009552

XPAC
Employer/Respondent

On 11/12/2013, 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:

0568 WINSTEIN KAVENSKY & WALLACE
CRAIG KAVENSKY
224 18TH ST
ROCK ISLAND, IL 61201

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JIGAR DESAI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0156

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

MARIA T. OLMOS-GARCIA,
Employee/Petitioner

v.

XPAC,
Employer/Respondent

Case # 09 WC 09552

Consolidated cases: NONE.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Rock Island**, on **October 9, 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 _____

15IWCC0156

FINDINGS

On **August 27, 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 **$17,680.00**; the average weekly wage was **$340.00**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **one** dependent child.

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 $ **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 permanent partial disability benefits of **$268.67**/week for **50** weeks, because the injuries sustained caused the **10%** loss to her **person as a whole,** as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical service of **$6,415.75,** as provided in Section 8(a) of the Act, and subject to the provisions of the medical fee schedule as created in 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.

JOANN M. FRATIANNI
Signature of Arbitrator

November 4, 2013
Date

NOV 12 2013

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

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

On August 27, 2008, a forklift truck backed into Petitioner and pinned her between a crate and a stack of tires. The crate struck Petitioner in her left thigh and hip area pushing her into a wall, and causing her to experience pain in her left thigh and hip.

Following this accident, Petitioner reported it to her supervisor, and then continued to work. When her symptoms increased, Respondent sent her for medical treatment at Genesis Occupational Health on September 3, 2008. A history was recorded consistent with her testimony of injury, and Petitioner complained the left leg pain has been persistent since the accident, with occasional heavy lifting at work increasing her leg pain significantly. Dr. Yankey diagnosed a contusion and strain of the left leg and hip, and prescribed stretching exercises, ice packs and light duty work with a 15 pound weight restriction.

Petitioner then remained on those work restrictions until September 17, 2008, when she was released to regular work, and instructed to continue with home exercises. On September 24, 2008, Dr. Yankey noted the left leg and hip were improved, but she continued to experience intermittent symptoms. Dr. Yankey felt at that time Petitioner had reached maximum medical improvement.

Petitioner testified as she continued to work, her symptoms worsened. She then returned to Genesis Occupational Health on January 9, 2009, with complaints of pain off and on and since worsening. Dr. Brasel prescribed a 20 pound weight lifting restriction with rare bending, stooping and twisting, along with physical therapy. Petitioner underwent physical therapy from January 16, 2009 through February 9, 2009. While in therapy, Petitioner was prescribed a TENS unit by Dr. Brasel, along with an MRI. The MRI was performed on February 10, 2009, and revealed a herniated disc at L5-S1 which could account for right and left sided symptomatology.

Following the MRI, the clinic stopped all physical therapy and referred her for pain management at Genesis Medical Center. She saw Dr. Swanson who administered an intralaminar epidural steroid injection on February 19, 2009. Following this injection, Petitioner experienced an adverse reaction and saw Dr. Ade, her family physician, on February 27, 2009. Petitioner thereafter declined a second injection.

Petitioner was also referred by the clinic to see Dr. Ridenour, a neurosurgeon. Petitioner saw Dr. Ridenour on March 5, 2009, who diagnosed a herniated disc at L5-S1. Dr. Ridenour did not feel Petitioner was a surgical candidate even though conservative treatment failed as she did not respond to the epidural steroid injection. Dr. Ridenour also found that patients with similar findings either saw no or transient improvement to their symptoms following such injections.

Petitioner last saw Genesis Occupational Health on April 3, 2009. At that time her complaints were mostly localized on the left side. She was also diagnosed with a L5-S1 herniated nucleus pulposus with left radiculopathy, and was released to return to return to work with restrictions of occasional bending, twisting, and stooping with no lifting over 20 pounds.

Petitioner then sought treatment with Dr. Richards, a chiropractor. She first saw Dr. Richards on February 17, 2009 and her treatments concluded on July 17, 2009.

15IWCC0156

Petitioner was also seen by Dr. Milas, who testified by evidence deposition that the herniated disc was causally related to the accidental injury of August 27, 2008. Dr. Milas noted moderate weakness of plantar flexion on the left ankle,, and the ankle jerk was significantly diminished as compared to the right. Lumbar motion was restricted in all directions and a mild pelvic tilt was noted. Dr. Milas felt Petitioner should be referred to a recognized spine center for appropriate evaluation and treatment and did not see any likelihood of spontaneous improvement within the foreseeable future. Dr. Milas felt she should be working with a 10 pound weight lifting limit which he felt was permanent.

The only physician in this matter not to diagnose a herniated disc was Dr. Zelby. Dr. Zelby examined Petitioner at the request of Respondent and felt at best she suffered a strain. No explanation is tendered as to why Dr. Zelby stands alone with this diagnosis.

Petitioner testified she continues to experience pain in her left leg and hip which radiates down her leg.

Based upon the above, the Arbitrator finds that the above condition of ill-being is causally related to the accidental injury of August 27, 2008, and that condition of ill-being, mainly a herniated disc at L5-S1, is now permanent in nature.

J. Were 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 medical charge that were incurred after this accident:

Trinity Medical Center	$ 501.75
Dr. David Ade	$ 206.00
Quad Cities Wellness and Rehabilitation	$5,499.00
Comprehensive Orthopedics	$ 209.00

These charges total $6,415.75.

See findings of this Arbitrator in "F" and "L" above.

Based upon said findings, the Arbitrator further finds the above charges to represent reasonable and necessary medical care and treatment caused by this accidental injury, and finds Respondent to be liable to Petitioner for same, subject to the medical fee schedule of Section 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Keith Maffia,

Petitioner,

vs.

NO: 13 WC 8352

15IWCC0157

Con-Way Freight,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection and nature and extent of permanent disability and being advised of the facts and law, corrects the computational and clerical errors in 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 notes that on the Request for Hearing form, the parties stipulated that Petitioner was temporarily totally disabled from February 14, 2013 to February 23, 2013, a period of 1-3/7 weeks, and that Petitioner was temporarily partially disabled from February 24, 2013 to May 27, 2013, a period of 13-2/7 weeks. At the arbitration hearing, the parties agreed that all TTD and TPD benefits were paid at the correct rate, that there was no underpayment or overpayment and that everything had been paid (Tr 8). The Arbitrator did not note the above in his Decision. The Commission corrects the clerical error by adding the above to the Decision of the Arbitrator. The Commission further notes that the Arbitrator gave Respondent credit of $650.99 for TTD benefits paid and $5,854.11 for TPD benefits paid. The Commission will not consider these credit amounts in the calculation of the bond as there was no award of temporary total disability benefits or temporarily partially disability benefits from which to deduct credits.

15IWCC0157

The Commission further notes that the Arbitrator awarded permanent disability of 12.5% loss of use of the left arm, which is 31.625 weeks, not the 31.25 weeks awarded. The Commission corrects this computational error to 31.625 weeks. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 24, 2014 is hereby affirmed and adopted with the above noted clerical and computational corrections.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $683.54 per week for a period of 31.625 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the left arm to the extent of 12.5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $650.99 for temporary total disability benefits and $5,854.11 for temporarily partially disability benefits.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,700.00. 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: MAR 4 - 2015
MB/maw
o02/26/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAFFIA, KEITH
Employee/Petitioner

Case# **13WC008352**

15IWCC0157

CON-WAY FREIGHT
Employer/Respondent

On 2/24/2014, 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 0.07% 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:

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

0560 RUSIN MACIOROWSKI & FRIEDMAN LTD
LINDSEY BEACH
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Keith Maffia
Employee/Petitioner

v.

Con-Way Freight
Employer/Respondent

15IWCC0157

Case # 13 WC 8352

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **December 9, 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 _____

15IWCC0157

FINDINGS

On **February 13, 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 **$59,240.48**; the average weekly wage was **$1,139.24**.

On the date of accident, Petitioner was **43** 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 **$650.99** for TTD, **$5,854.11** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,505.10**.

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 $683.54/week for 31.25 weeks, because the injuries sustained caused 12-1/2% loss of the left arm, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from February 13, 2013 through December 9, 2013, 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

2/21/14
Date

FEB 24 2014

FINDINGS OF FACT

Petitioner's Testimony at Hearing

Keith Maffia ("Petitioner") is claiming an accidental left arm injury on February 13, 2013, while employed with Con-Way Freight ("Respondent") as a Truck Driver Sales Representative. At the time of the accident, Petitioner was 43 years old and had worked for Respondent since 2002.

Petitioner testified that on the day of his accident, he was trying to move some overhead bars from a trailer when he pulled on a piece of equipment and felt a pain in his left arm near his elbow. Petitioner testified that he also heard a "snapping" sound.

Petitioner is a 1987 graduate of Steinmetz High School in Chicago. He did not attend college but did receive a certificate after attending truck driving school. Petitioner does have a current CDL. Before working for Respondent, Petitioner worked for other transportation companies. Specifically, Petitioner worked as a Driver and Dock Worker five years for Consolidated Freightways and worked as a Spotter for CR England for three years.

As of the hearing date, Petitioner works his regular duties as a Truck Driver Sales Representative with Respondent. In his normal shift he works around 12 to 14 hours per day and he is required to line haul drive on a daily basis from his terminal in Joliet, Illinois, to the terminal in Freemont, Indiana, a round trip of 366 miles. Petitioner testified that he drives approximately 6.5 hours during the day and the remainder of his shift is spent loading and unloading the trailer by hand and forklift.

Petitioner testified that since his return to work full duty he has noticed an increase in pain and symptoms in his left elbow and biceps. He testified that he notices an increase in pain while cranking the landing gear and using the converter dolly. He has to use his right arm now to crank the landing gear and he has a hard time lifting and pulling the converter dolly that weighs 500 pounds. He is required to use the converter dolly 4-6 times per day. Petitioner testified that he has a hard time getting into and out of the tractor due to the left arm pain. Petitioner struggles while lifting heavy product and has to ask for assistance in lifting the heavier items, including plywood.

Petitioner testified that he notices an increase in left biceps pain when driving for long periods of time. Straight arm extension causes an increase in left biceps pain. Petitioner owns and rides a motorcycle and he testified that he now has to make stops every 45 minutes while riding the motorcycle due to left biceps pain. He volunteers on the weekends at a food pantry and he is now unable to lift heavier boxes that he used to lift without problem. Petitioner testified that he experiences difficulty being intimate with his wife due to an increase in left biceps pain. Petitioner controls his pain with over the counter Aleve and Ibuprofen.

Medical Records

Petitioner's first medical treatment was at Meridian Medical Associates on the date of the accident. X-rays of his left elbow revealed a possible loose body within the elbow joint. The doctor suspected a biceps rupture and referred Petitioner to Dr Michael Cohen for further evaluation. (PX1)

Dr Cohen examined Petitioner on February 14, 2013. Dr Cohen diagnosed a partial distal biceps tear and prescribed a MRI of the left elbow. The MRI revealed a high grade partial tear to the distal biceps tendon as it inserts on the left radial tuberosity. Dr Cohen recommended a conservative course of treatment and placed Petitioner in a hinge elbow brace. (PX1)

On February 27, 2013, Petitioner sought a second opinion at MK Orthopedics, with Dr Mukund Komanduri. Dr Komanduri prescribed surgery to repair the distal biceps tendon on an emergency basis. He indicated that time is of the essence when performing surgery on a biceps rupture. (PX2)

Petitioner declined the surgery and continued treatment with Dr Cohen. On March 8, 2013, Dr Cohen unlocked the hinge brace and prescribed a course of physical therapy (PX1). Petitioner completed 33 sessions of physical therapy through May 23, 2013 at ATI Physical Therapy (PX3).

Dr Cohen allowed a full duty work release effective May 28, 2013. Dr Cohen discharged Petitioner at maximum medical improvement on June 17, 2013. (PX1)

On August 16, 2013, Petitioner was examined by Dr. Keith Rezin, a board certified orthopedic surgeon, for the purpose of obtaining an impairment rating. At the time of the examination, Petitioner had been found to have reached maximum medical improvement and had returned to work at full duty. Using the AMA Guidelines to Evaluation of Permanent Impairment, Dr. Rezin determined that Petitioner had a diagnosis of distal biceps tendon injury, Class 1. Dr. Rezin further determined that Petitioner had a functional history grade modifier of 1 and a physical examination grade modifier of 1. The clinical studies grade modifier was not used as it was used in determining the diagnosis. Therefore, Dr. Rezin concluded that the net adjustment was 0, resulting in a 5% impairment to the upper extremity which translates to a 3% impairment to the whole person. (RX 1)

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

Petitioner testified that before this accident he never had problems with his left arm. Immediately after the accident on February 13, 2013, he had pain in the left elbow and biceps. Petitioner obtained medical treatment on the date of the accident at Meridian Medical Associates. The doctor suspected a biceps rupture and referred Petitioner to Dr Cohen for further evaluation.

On August 16, 2013, Petitioner was examined by Dr Keith Rezin, a Section 12 independent medical examiner hired by Respondent to perform an impairment rating. Dr Rezin performed an examination and gave an impairment rating of 5% loss of the left upper extremity. Dr Rezin found that Petitioner's current left elbow and left biceps condition is related to the work accident of February 13, 2013. (RX1)

The Arbitrator, relying on the medical records and Petitioner's credible testimony, finds that a causal connection exists between Petitioner's present condition of ill-being and the work accident of February 13, 2013.

With respect to (L.) What is the nature and extent of Petitioner's 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. Dr Keith Rezin's AMA report and deposition were admitted into evidence as Respondent's Exhibit 1. Dr Rezin concluded that Petitioner's impairment is 5% of the left upper extremity, or 3% whole person impairment.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner continues to be employed in his pre-injury employment as a Truck Driver Sales Representative with Respondent. The Arbitrator takes judicial notice that this position involves heavy work and concludes Petitioner's permanent partial disability ("PPD") will be larger than an individual who performs lighter work.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner is 44-years old. The Arbitrator considers 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. Petitioner continues to work with Respondent driving a truck. Petitioner has remained in a full duty capacity with Respondent.

With regards to paragraph (v) of Section 8.1(b) of the Act:

v. Evidence of disability in Petitioner's treating medical records finds that MRI of his left elbow performed on February 20, 2013, revealed a high grade partial tear to the distal biceps tendon as it inserts on the left radial tuberosity. Dr Cohen prescribed a conservative course of treatment and placed Petitioner in a hinge elbow brace through March 8, 2013. Petitioner completed 33 sessions of physical therapy through May 23, 2013 at ATI Physical Therapy. Dr Cohen allowed a full duty work release effective May 28, 2013 and discharged Petitioner at maximum medical improvement on June 17, 2013. At the August 16, 2013 PPI rating examination with Dr Rezin, Petitioner had continued

complaints of weakness with supination of the forearm and with elbow flexion. Petitioner made subjective complaints of pain with repetitive and vigorous activities.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, including Dr Rezin's AMA impairment rating, the Arbitrator concludes that Petitioner has sustained a 12-1/2% permanent loss of the left arm, or 31.25 weeks of PPD benefits.

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

Robert Snedeker,

Petitioner,

vs.

NO: 13 WC 10480

Badger Daylighting,

Respondent,

15IWCC0158

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 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: MAR 4 - 2015

MB/mam
o:1/22/15
43

Mario Basurto

David L. Gore

Stephen Mathis

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

SNEDEKER, ROBERT
Employee/Petitioner

Case# **13WC010480**

15IWCC0158

BADGER DAYLIGHTING
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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0532 HOLECEK & ASSOCIATES
KENNETH SMITH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

15IWCC0158

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert Snedeker
Employee/Petitioner

v.

Badger Daylighting
Employer/Respondent

Case # **13** WC **10480**

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 **New Lenox**, on **June 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. ☐ 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

15IWCC0158

FINDINGS

On the date of accident, **March 11, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$N/A**; the average weekly wage was **$N/A** as explained *infra*.

On the date of accident, Petitioner was **47** 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 **$39,646.77** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,000.00** for other benefits, for a total credit of **$42,646.77**.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident at work. By extension, all remaining issues are rendered moot and all requested benefits and compensation are denied.

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

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

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

Signature of Arbitrator

August 5, 2014
Date

ICArbDec19(b)

AUG 11 2014

15IWCC0158

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION *ADDENDUM*

19(b)

Robert Snedeker
Employee/Petitioner

v.

Badger Daylighting
Employer/Respondent

Case # **13** WC **10480**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute relate to Petitioner's right knee condition and include accident, causal connection, and Petitioner's earnings and average weekly wage, as well as Petitioner's entitlement to a period of temporary total disability benefits beginning on March 23, 2013 through June 6, 2014. Arbitrator's Exhibit[1] ("AX") 1. The parties did not raise any other issues at this hearing. AX1.

Background

Petitioner testified that he graduated from Frost HS in 1983 and then went to work as a heavy equipment operator as a material handler and ran a combination front end loader/excavator. He eventually joined Local 150 of the Operating Engineers in 2001 and has been a member in good standing since that time. Since 2001, Petitioner worked for a variety of employers as assigned by the union dispatch hall.

Previously, Petitioner sustained an injury to his right knee in 1991. He had an ACL reconstruction, recuperated from the injury, and he was eventually released to return to work unrestricted. Petitioner had no medical treatment for the right knee from 1992 until 2011.

Prior to filing the above-captioned claim, Petitioner acknowledged on cross examination regarding several prior personal injury and workers' compensation claims filed against various employers and defendants, including Respondent, since 1999 in both Illinois and Wisconsin. Tr. at 46-50; RX3. Petitioner was unable to recall the injury or reason for some of these claims.

In November 2011, Petitioner went to work for Respondent. He explained that Respondent uses a new way of excavating using high pressure water called "hydro-vac'ing" that allows one to more safely excavate around utilities. Petitioner testified that he was hired by Respondent as an operating engineer. At this time, Petitioner sustained a right ankle injury approximately 1-2 weeks after beginning work for Respondent. That accident involved the CNA insurance company and did not involve Traveler's, the workers' compensation insurer in this case.

Petitioner testified that he had surgery on the right ankle on May 17, 2012 with Dr. Primus. Petitioner then returned to work on or about January 13, 2013. Thereafter, Dr. Primus ordered a functional capacity evaluation. PX6. The functional capacity evaluation completed on February 8, 2013 reflects that was released to heavy

[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. The arbitration hearing transcript is denominated "Tr. at page(s)."

level work and the results of the evaluation were deemed valid. PX1. Specifically, Petitioner showed the ability to lift from the floor to 69 pounds, from knee level to 90 pounds, and from hip to shoulder level to 90 pounds. *Id.* He was also able to lift overhead up to 90 pounds, carry up to 55 pounds, push up to 55 pounds with the upper extremities, pull up to 75 pounds with the upper extremities, and stand continuously up to 50 minutes prior to a voluntarily short sitting break. *Id.* Thus, the evaluator determined that Petitioner was unable to continuously stand for 8-10 hours as indicated in his job description. *Id.* Dr. Primus determined that Petitioner had reached maximum medical improvement on February 15, 2013. PX6.

Petitioner testified that he returned to work and performed maintenance on trucks, greased trucks, and installed equipment, hoses and vacuum lines. Petitioner testified that he was still being paid at union scale at that time, which was $45.10 per hour. He testified that he was able to perform this work without difficulty.

On cross examination, Petitioner testified that he returned to work for Respondent in January 2013 after his first accident and was paid for training at home after that accident for six weeks. From March 2012 through May 2012, Petitioner testified that he was not paid which is why he had to get an attorney. *See also* RX4.

He also testified that when he returned to work in 2012 he had to re-take certification tests for Respondent even though they had not yet expired. Petitioner acknowledged that when he went back to the office in Channahon he was performing office work, which is not work that he would perform as an operator. When returned to work in 2013, Petitioner testified that he had restrictions that prevented him from performing his full duties as an operator and that no one has released him back to full duty work as an operator because of his knee. He further acknowledged that when he came back he did not actually work as an operator although he testified that he worked with Scott Schultz as a vac truck operator a week before he was laid off. He also testified that he did work on a vac truck for some days during the 48 hour work week in 2013 and that he filed a grievance for 8 hours of pay. Petitioner testified that he believed that he completed his vac truck training.

Between his first accident to the ankle up through just before his second accident to the right knee, Petitioner testified that no one released him to go back to work full duty. He was released by Dr. Primus with the restrictions of no standing at length after the functional capacity evaluation. Petitioner testified that when he returned to work in March 2013, he did so as a mechanic to work on semi trucks and not as a swamper or operator. Petitioner acknowledged that he sustained the alleged right knee accident during the first or second week that he returned to work for Respondent after his ankle accident.

As of March 11, 2013, Petitioner acknowledged that the majority of the rooms at Respondent's facility in which he was working had cameras. He testified that he was not aware whether there were cameras in the facility prior to his March accident, but acknowledged that his alleged knee injury occurred in an office in the middle of the building that was supposed to be for Joe, a supervisor. Petitioner testified that the task of building storage shelving is something that he did as an operator.

Petitioner testified that 40 hours per week constitutes a work week within his trade as an operating engineer, which is not guaranteed, and an operating engineer can work a lot more or less in a week. He explained that this depends on the customer's demand, scheduling, weather, unforeseen circumstances like trucks breaking down, etc. He also testified that, while 40 hours of work per week was not guaranteed, operating engineers are guaranteed eight (8) hours per day if they go to work on a given work day.

Petitioner submitted portions of the union contract providing that a normal workday shall constitute eight hours at determined start-time intervals, and that all employees shall be obligated to report for work each day Monday

through Friday. PX2. If the employee is not timely notified pursuant to the union contract that no work will be available the following day and the employee appears for work, he shall be paid pursuant to the terms of the union contract. *Id.*

Petitioner testified that when he returned to work for Respondent in January 2013, he worked 48 hours the first week and that Respondent tried to give him 24 hours per week and then 20 hours a week.

March 11, 2013

At trial, Petitioner testified that he went into the office and there were boxes there. He was assigned to put together sheet metal cabinets. Petitioner testified that Joe, a manager of some sort, brought in tools and told him what to do.

Petitioner was shown Respondent's Exhibit 7, which is comprised of two photographs taken by Joe later on March 11, 2013 showing the cabinet's shipping box with two metal panels directly in front of it and in alignment with the box. In relation to this exhibit, the following exchange occurred on direct examination:

Q Okay. And the - - that metal piece that's laying on the floor directly in front of the cardboard box, is that one of the metal shelves?

A That's one of the sides of the panels. Walls to the cabinets.

Q That's part of what you were assembling?

A That's part of what I was assembling.

Q Okay. Very well. Tell us what happened.

A Like I said they were all over the place. There were more on the floor than what was in this picture [RX7]. I was down on my knees assembling they're like little sheet metal screws you have to tighten them together. I was kneeling on one of the part cabinet and I went to stand up to grab another piece of the cabinet, and when I stood up, the cabinet took off like a surfboard, the panel and it slid across carpet similar to this and my leg went out, I heard a pop and I sat back down - - I fell back down.

Tr. at 35-36. Petitioner testified that he heard a pop and felt a heartbeat-type pulse in his right knee. He testified that he called Joe and told him what happened. Since that time, Petitioner testified that his right knee has never been symptom-free.

Several photographs of the cabinet parts and sheet metal panels were offered into evidence from Petitioner and Respondent. *See* PX4, RX7. Petitioner testified that he took his own pictures of the sheet metal after the accident as he was sitting in the chair while waiting for Joe to tell him whether to go to the doctor. *See* PX4. Petitioner testified that the purpose of taking theses photos was to show where he slipped and that he showed these pictures to Joe. *Id.* He also acknowledged that Respondent's Exhibit 7 depicts the area where the accident took place and of the sheet metal panels on the floor. *Id.*

In relation to alleged accident itself, the following exchange occurred on cross examination:

Q Describe what you were doing immediately before the accident in terms of were you standing up, were you sitting down

A I'd have to work to put these together. Laying the boxes down getting them ready to open up the boxes quite heavy.

Q Okay. And is this one or 2 pieces of shelves on the floor in regards to Respondent's Exhibit No. 7?

A That's two shelves - - that looks like one box and one box is not opened. There were several that needed to be installed.

Q In regards to the shelving on the floor, is that one or two pieces do you know?

A That looks like it's 2 pieces to me.

...

Q Were you sitting, kneeling or standing right before the accident occurred?

A I was on top of the metal screws fastening them together. If you look right here this is being pieced together right there where the 2 pieces are where that lip is, that was being bolted together. That's what I was doing.

... [The Arbitrator notes that the Petitioner marked four locations between the two sheets of metal on the floor where there would be bolts or screws indicating the areas that Petitioner was in the process of fastening when he was allegedly injured.]

A Right, you got to kneel to fasten, to do it.

Q THE ARBITRATOR: Were you kneeling on one of them?

A Yes, on top of them.

Q THE ARBITRATOR: On both of them?

A I was on top of one of them.

...

A I believe that's a picture of a wall prior to my injury.

Q THE ARBITRATOR: What is a picture of a wall prior to your injury?

A A wall of the unit. I believe I stepped on only one before it was fastened together. I believe this is a picture of it after it was assembled.

...

Q Is it your testimony then that there was only 1 piece of the sheet metal on the floor?

A No, it was all over the place. You can see right here more laying right there. [Speculative testimony stricken]

...

Q So there were several pieces of sheet metal?

A Yes, sir.

Q So you weren't in the process of fastening any sheet metal before the injury, is that correct?

A I wasn't in the process of fastening - -

Q Let me ask the question another way. At any point in time before the accident, had you actually got bolts out and start installing them in any of the sheet metal?

A I do not recall. I just recall slipping on the sheet metal and took off like a surfboard.

Q But you were kneeling prior to slipping?

A I believe I was kneeling or getting down to kneel to put a piece together, yeah. It was getting - - it was being assembled. Going through the process of assembling.

Tr. at 72-79. Further cross examination included Petitioner's testimony that the metal panel was under one foot, he stood on the metal panel and slipped, and he did not recall whether he was trying to get off the metal panel on which he was standing when his foot slipped. Tr. at 79-80.

Petitioner completed a written accident report on March 11, 2013 indicating that he was injured while "constructing cabenettry (sic) in Joes office." PX3. In the portion requesting a description of the accident and the equipment/materials/tools involved, Petitioner indicated "Ladder, power drill, hand tools. Was laying on side and kneeling fastening bolts together, stood up and twisted knee[.]" *Id.* Petitioner also identified the cause of the accident to be "manuvering around obsticals (sic) and slipprey (sic) surfaces." *Id.*

On cross examination, Petitioner testified that regarding an additional page that he wrote after he got back from the doctor on March 11, 2013 at Respondent's request. RX1. He indicated that "I was assembling new steel storage cabinetts (sic) for the Badger office and was attempting to stand up and not bend the edges of cabinetts (sic) and twisted right knee in process. Was wearing ankle brace at time of injury." *Id.* Petitioner acknowledged that this handwritten statement does not mention slipping on the sheet metal.

Petitioner was also questioned on cross examination and re-direct examination about the the position of the sheet metal at the time of the accident, whether both pieces of sheet metal for the cabinet were bolted together at the time of the accident, and what the exact mechanism of injury was that caused him to twist his knee. *See also* RX7. Petitioner testified on cross examination that at the time of his accident he is not sure if he was fastening the bolts, all he recalls is that a piece of sheet metal slipped out "like a surf board." He testified that he was either kneeling or starting to kneel when it slipped. He also testified that he was standing with his right foot on the sheet metal when it slipped and that the only way that he could get to the sheet metal was by standing on it. Then Petitioner testified that he was getting up from a position on the floor when the sheet metal slipped. He also testified that he wore a right ankle brace and that his foot dragged with sheet metal when he was getting up, which is when the sheet metal slid. On re-direct examination, Petitioner testified that the first photograph in Petitioner's Exhibit 4 shows the piece of metal that slipped like a surfboard and he believes that the indentation visible in the metal shows where he slipped and boot went with it.

Petitioner acknowledged that Joe was out of the room for about 10 minutes during which time his accident occurred. He did not know if there were any cameras in this room at the time of the accident.

Medical Treatment

Petitioner testified that he went to Concentra Medical Center as directed by Respondent. The Concentra medical records reflect Petitioner's report that "[h]e slipped and twisted his right knee at work today." PX5. He

described that he was "[s]tanding up from kneeling position an (sic) foot slipped on and knee twisted and popped." *Id.* The clinic physician diagnosed Petitioner with a right knee sprain. *Id.* He was instructed to use a flexible knee brace and ice his knee, prescribed Naproxen 550 mg, and released to modified duty work with no lifting/pushing/pulling over 10 pounds, no prolonged standing/walking longer than tolerated, and no squatting/ kneeling or climbing stairs or ladders. *Id.*

Petitioner testified that he had just recently been under care of Dr. Primus for his ankle and he returned to him for follow up as directed by Concentra. The medical records reflect that Petitioner saw Dr. Primus on March 19, 2013 reporting that he "injured his knee while at work he had a slip and fall when his right leg slide (sic) lateral with associated 'pop'. He states the metal sheet metal (sic) slide under his feel (sic) causing the accident." PX6. Dr. Primus diagnosed Petitioner with acute traumatic knee pain and effusion rule out meniscal or ACL tear, and ordered a right knee MRI. *Id.* He also restricted Petitioner from use of the right lower extremity. *Id.* Petitioner returned to see Dr. Primus on May 14, 2013 with no improvement. *Id.*

Petitioner underwent the recommended MRI on May 13, 2013. *Id.* The interpreting radiologist noted the following: (1) extensive postoperative changes including a metal artifact along the lateral aspect of the knee that precludes optimal evaluation of the lateral compartment cartilage and lateral collateral ligament structures as well as portions of the lateral meniscus; (2) inability to visualize the ACL which appears to be completely torn, possibly a chronic finding with a lack of the typical associated bone bruises that would mitigate against an acute process and which he recommended should be clinically correlated; (3) troclear chondromalacia and mild localized lateral femoral condyle chondromalacia; (4) mild areas of marrow edema involving the tibial plateau that might be chronic or acute, a probably Segond fracture of the lateral aspect of the lateral plateau with marrow edema at this site on the STIR coronal sequence suggesting that it was acute and with the presence of an ACL tear suggesting that it might be acute also; and (5) no obvious meniscal tear identified, but again evaluation was limited. *Id.*

On June 14, 2013, Dr. Primus reviewed Petitioner's right knee MRI, diagnosed Petitioner with a knee strain and ACL tear, and recommended right knee arthroscopy and/or ligament reconstruction surgery. *Id.* Dr. Primus maintained his diagnoses and recommendation for surgery as of Petitioner's visit on July 9, 2013 at which time he also noted that Petitioner's physical examination remained essentially unchanged and kept Petitioner restricted to light duty work. *Id.*

Respondent's Section 12 – Dr. Hopkinson

Petitioner then went to William Hopkinson, M.D. ("Dr. Hopkinson") at Loyola on July 19, 2013 as Respondent's request. PX7. Petitioner provided "a history of injuring his right knee on March 11 or March 16, 2013. He states that he was constructing metal cabinets in an office and while stepping on the metal cabinet, the cabinet shelf slipped on the rug floor twisting his right knee." *Id.* Dr. Hopkinson reviewed various medical records, examined Petitioner and rendered several opinions. *Id.*

Dr. Hopkinson diagnosed Petitioner with right knee instability secondary to an anterior cruciate ligament tear, and mild tricompartmental osteoarthritis. *Id.* He noted that the medical documentation that he reviewed supported a causal relationship between the accident in which Petitioner twisted his knee causing valgus stress and his ACL tear. *Id.* He noted that Petitioner's prior ACL repair in 1991 with a full duty return to work did not affect his new injury to the right knee. *Id.* Dr. Hopkinson also restricted Petitioner to light duty work and agreed with Dr. Primus' recommendation for surgery. *Id.*

Continued Medical Treatment

Dr. Primus performed the recommended right knee surgery on July 24, 2013. PX6. Specifically, Petitioner underwent an arthroscopy, partial medial meniscectomy, ACL reconstruction, chondroplasty, and synovectomy. *Id.* Petitioner continued to follow up with Dr. Primus from August 6, 2013 through ___ during which time he remained off work. *Id.* Dr. Primus also aspirated Petitioner's right knee to drain fluid on August 6, 2013 and August 20, 2013. *Id.*

Dr. Primus ordered physical therapy on August 20, 2013, which Petitioner testified that he underwent over many months. *See* PX6. As of October 8, 2013, Dr. Primus released Petitioner back to modified duty work with no use of the right lower extremity. *Id.* As of December 17, 2013, Dr. Primus released Petitioner to sedentary work only. *Id.* Beginning January 28, 2014, Dr. Primus ordered continued physical therapy and light duty work with no lifting/carrying over 20 pounds, no driving or standing over 20 minutes, and limited stairs, ladders, pushing, pulling, bending and stooping. *Id.* On March 7, 2014, Petitioner saw Dr. Primus reporting that he was scheduled for an independent medical evaluation and that he had continued knee pain, popping of the hamstring, daily swelling, numbness and weakness. *Id.*

Second Section 12 Examination – Dr. Dorning

On March 12, 2014, Petitioner submitted to a second independent medical evaluation with Michael Dorning, D.O. ("Dr. Dorning") at MES Solutions at Respondent's request. PX8. Petitioner provided a history that "he was at work on March 11, 2013 and slipped on some metal sheeting, twisting his knee and feeling a pop." *Id.* Dr. Dorning reviewed various medical records, examined Petitioner and rendered several opinions. *Id.*

Dr. Dorning diagnosed Petitioner as 7 ½ months status post repeat right ACL reconstruction. *Id.* He opined that, in reviewing Dr. Primus' medical records, there was a causal relationship between Petitioner's accident at work and his injury. *Id.* He restricted Petitioner to sedentary level work, indicated that no further medical treatment was necessary at that time, and that Petitioner should undergo a functional capacity evaluation to determine Petitioner's work capabilities. *Id.* He also indicated that Petitioner would be at maximum medical improvement nine months status post surgery. *Id.*

Continued Medical Treatment

Petitioner returned to Dr. Primus on April 18, 2014 at which time he decreased Petitioner's work restrictions slightly to include no lifting/carrying over 20 pounds, limited ladders, and occasional use of stairs, pushing, pulling, bending and stooping. *Id.* PX6.

Petitioner last saw Dr. Primus on May 23, 2014 at which time he reported soreness, numbness, and weakness in his right knee. PX9. He also reported some cramping in the hamstring, increased pain with weather changes, and difficulty sleeping. *Id.* After an examination and reviewing Dr. Dorning's Section 12 report, Dr. Primus placed Petitioner at maximum medical improvement and imposed permanent work restrictions with no lifting or carrying over 20 pounds, limited use of ladders, limited squatting/kneeling/crawling, occasional use of stairs, and occasional bending, stooping, pushing, pulling, and repetitive grasping. *Id.*

15IWCC0158

Additional Information

Petitioner testified that he has not had any accidents or injuries since March 11, 2013. Regarding his current condition, he stated that his right knee is weaker, it swells, burns and throbs, and he experiences instability; it is not "normal." Petitioner also testified that he experiences tingling and that his knee falls asleep a lot. Petitioner testified that he is now going to look for other employment within Dr. Primus' restrictions.

Petitioner added that he has no certifications, skills or training other than what he has mentioned today; he only knows how to build dirt roads, knows construction, and has experience performing physical work. Petitioner also testified that, however, that he was a supervisor for a while which required field work supervising concrete finishers in which he performed estimates.

Petitioner testified that to his knowledge there is no light duty work available for him, but he has not looked for any such work.

Patrick Young

Mr. Young was called as a witness by Petitioner. He testified that he is employed as the business agent for Local 150 and has been so employed for seven years. Previously, Mr. Young was an operating engineer for 20 years. Mr. Young testified that he knows Petitioner and understands that Petitioner claims an injury to his right knee and that he has a prior right ankle injury.

Mr. Young has a referral hiring hall that dispatches operators when a work order is called in specifying the operator that is needed. Mr. Young is made aware of operators once they are dispatched through a list of dispatches located in his office. He is responsible for the Will County jurisdiction as a business agent, which includes Respondent.

Mr. Young testified that he assumes that when Petitioner was first dispatched to Respondent before his ankle injury, he was dispatched to a job with Respondent in Kankakee County as a vac truck operator. Between that original dispatch and this injury, Mr. Young testified that he is not aware that Petitioner's designation as a vac truck operator has changed.

Mr. Young also testified that, as an operating engineer, a work week is deemed 40 hours per week 8 hours per day (once you start work), Monday-Friday, with 1 ½ pay on Saturdays and double time pay on Sundays. The hours of an engineer can vary due to weather, the length of the job itself, etc., but there is an 8 hour guarantee. 40 hours of work per week is not guaranteed. *See* PX2. Mr. Young testified that the union contract with these provisions has been in effect since 2010. *Id.* Mr. Young testified that the hourly rate of pay that applied to a vac truck operator during 2011 through 2013 was $46.10 per hour.

Mr. Young also testified that when someone is laid off, the business agent may be made aware of a lay off if the employee wants to file a grievance.

On cross examination, Mr. Young testified that Respondent only hires hydro-vac operators and that the term "swamper" is laborers' terminology. He testified that he did have interaction with Respondent in 2011-2013 and that it would contact Local 150 when it needed operators. Mr. Young also testified that there is an oiler classification and those workers are only dispatched out on cranes to be an extra set of "eyes-and-ears" for an

operator during which time the oiler learns about equipment on a job. The oiler's duties are to check the oil and equipment on a job. However, Mr. Young was not aware that Petitioner was ever dispatched as an oiler.

Mr. Young also testified that Respondent has an internal program for operating engineers and that operators are paid according to different scales before they complete Respondent's program and afterward. Mr. Young was not aware of Petitioner's actual earnings from March 2012 through 2013.

Mr. Young testified that after Petitioner sustained his first accident, he was called in by Mr. Schultz indicating that Respondent was bringing Petitioner back to work in an office. He did not elaborate what type of work Mr. Schultz told him Petitioner would be doing, but testified that office work is within in the regular job duties of an operator.

Mr. Young denied that Mr. Schultz told him that Petitioner would be performing light duty, but acknowledged that at some point Petitioner's counsel told him that Petitioner would be returning to light duty work. He also testified that he was not aware that Petitioner had light duty restrictions when Petitioner returned to work in early 2013. He explained that the union hall has policy in place for putting injured employees on a light duty list, which was never done in Petitioner's case. Workers on the light duty list are paid differently depending on what work they are doing. While he has been the business agent, Mr. Young testified that he has not been asked to place a light duty engineer.

Scott Schulz

Mr. Schulz was called as a witness by Respondent. He is employed by Respondent as the area manager in Joliet, Illinois and was so employed in 2010.

Mr. Schulz testified that Respondent is a non-destructive hydrovac company with an office located in Channahon, Illinois. He testified that Respondent hires out of the union hall. When newly hired, operators are hired as "helpers" and they are mentored and supposed to learn from an operator that has been working for Respondent. Mr. Schulz explained that it usually takes 4-6 weeks of mentorship before Respondent deems the helper ready to go on a truck and that helpers are not paid the same as operators. In November of 2011, Mr. Schulz testified that helpers earned $38.10 per hour and when the helper completed Respondent's training he earned $46.10 per hour. Mr. Schulz testified that these rates were in effect from March 2012 to March 2013.

In terms of the operator job, Mr. Schulz testified that there are some lifting requirements and the individual must stand on their feet all day and be able to climb up and down ladders.

Mr. Schulz also testified that Petitioner started working for Respondent on November 9, 2011 and was injured on November 17, 2011. He explained that Petitioner was employed as a helper, but did not complete the required training to become an operator. After the November of 2011 injury, Petitioner did come back to work for Respondent. He also testified that Petitioner was never released to become an operator working for Respondent.

Mr. Schulz testified that Petitioner returned to work after the 2011 accident, but not physically. He explained that in 2012 Petitioner was performing online training at home and that the pay periods noted in 2012 were for the training work at home; Petitioner did not physically come back to the will county office to report for work. *See* RX4. Respondent submitted Petitioner's time sheets and wage reports from March 24, 2012 through March 16, 2013. RX4. On cross examination, Mr. Schulz testified about Petitioner's rate of pay as reflected in those

records and noted that it was a mistake that Petitioner would have been paid $47 per hour from May 2012 until March 2013.

Mr. Schulz testified that when Petitioner was brought back to work in 2013, he was not brought back as a helper, but rather he was brought back to perform sedentary work in the office. Mr. Schulz testified that a special exception was made to bring Petitioner back to work and he explained that a helper job is not a sedentary job. A helper job would require Petitioner to go out to a truck and help the operator. Mr. Schulz testified that he had no conversation in early 2013with the union hall about Petitioner returning to work and that when Petitioner did return to work in early 2013 he was returned to the office to perform computer work on-site in Channahon. On cross examination, Mr. Schulz testified that originally the union hall dispatched Petitioner to Respondent as a vac operator and he acknowledged that the training program he described is internal. He acknowledged that the individual hired through the union hall would have already been through the training program of the Local 150 operating engineers.

While Petitioner worked in 2013, Mr. Schulz testified that he understood that Petitioner was under light duty restrictions with sedentary work requiring that he not to be on his feet at all and he was also restricted from standing over two hours at a time. He could not recall whether there were weight restrictions, but testified that Petitioner was unable to perform the job as a helper with the restrictions as he understood them. Mr. Schulz also testified that after Petitioner returned to work in January 2013 through the date of his injury in March 2013 he was not maintaining trucks. He also testified that in March 2013 the Channahon facility had surveillance cameras except two locations; his office and the room next door.

Joe Duszynski

Mr. Duszynski was called as a witness by Respondent. Mr. Duszynski testified that he was hired around December 17, 2012 by Respondent as a Field Supervisor and was so employed in March of 2013. Mr. Duszynski was not employed by Respondent when the ankle injury occurred.

When Petitioner returned to Respondent in 2013, Mr. Duszynski testified that Petitioner was not working full time. Mr. Duszynski testified that Petitioner was on light duty work restrictions and performing office work when he first came back. Mr. Duszynski testified that Petitioner's light duty restrictions prevented him from performing the duties of an operator or helper. He explained that a helper assists the operator with remote hoses, getting things into and out of the truck, digging, etc. An operator runs the truck and operates the dig wand and vacuum system. When Petitioner returned to work there was no light duty operator or helper work.

Mr. Duszynski testified that they created a job for Petitioner and that his job duties did not change after he came back to work. Petitioner was not in charge of repairing any of Respondent's trucks and he was exclusively assigned to work at the office in Channahon.

Mr. Duszynski also testified that he was working for Respondent on the claimed date of accident. He testified that he gave Petitioner an assignment to put a cabinet together which was located in a storage room. Petitioner started working around 9:00 a.m. Mr. Duszynski testified that there were some cameras located at the Channahon facility, but not in the office (at the time the storage room) and Mr. Schultz's office. Mr. Duszynski testified that he does not believe that Petitioner worked in that particular room before March 11, 2013.

Mr. Duszynski explained that when Petitioner began building the shelf on March 11, 2013 he was initially in the room, but left after he received a phone call and walked to the other end of the building. Prior to leaving the room, Mr. Duszynski testified that he only saw Petitioner taking things out, not fastening things together.

When Mr. Duszynski left the room, Petitioner called for him to come back down because he had hurt himself. Mr. Duszynski was approximately thirty feet from the room at this time. When Mr. Duszynski returned to the room, Petitioner told him that he had slipped and twisted his knee. Petitioner was sitting in the room at the time. Mr. Duszynski testified that he was gone from the room approximately three minutes.

After Petitioner informed Mr. Duszynski of the accident, he went immediately back into the room and took photographs when they returned from the immediate care facility. *See* RX7. Mr. Duszynski testified that the room was the same from when he came back into the room after Petitioner reported the accident and that he did not move any sheet metal or the chair.

As part of the investigation, Mr. Duszynski also had Petitioner complete an incident report. *See* RX1. Mr. Duszynski testified that Petitioner told him that he was on one knee and standing up and slipped and twisted his knee. He could not recall whether he saw any bolts or tools when he went back into the room. Mr. Duszynski completed certain portions of the incident report and indicated at that time that Petitioner was "assembling a cabinet for an office. He said he stepped on a panel that he laid on the floor and twisted his knee." RX1. In another note, Mr. Duszynski indicated that he had Petitioner "working on putting together a cabinet to go in an office. He had emptied the contents of the box, and was sitting in a chair reading directions when I left the room to take a phone call. I was out of the room for approx. 3 minutes when [Petitioner] asked me to come back into the room. When I walked in the room, [Petitioner] was sitting in the chair and said he had stepped on one of the pieces of the cabinet that he had laid on the floor and sprained his knee. I have him an ice pack from my lunch box to put on his knee, and after 10 minutes or so, he said he wanted to go to the clinic to get it looked at." *Id.* To Mr. Duszynski's knowledge, the accident was not witnessed.

On cross examination, Mr. Duszynski testified that he was not privy to Petitioner's pay or how he was brought back to work through the union hall. He was Petitioner's direct supervisor along with Mr. Schulz, who is Mr. Duszynski's boss. Mr. Duszynski acknowledged that he assigned the work to Petitioner in the camera-less room and that the report was completed after they returned from clinic.

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 (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

In consideration of all of the evidence submitted and after careful deliberation over the testimony proffered at trial, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable accident at work on March 11, 2013 as claimed.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (Ill. Sup. Ct. 1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

The parties' dispute centers on the "arising out of" component and whether Petitioner suffered a twisting injury to his right knee at all, not whether the opinions of Dr. Primus, Dr. Hopkinson and Dr. Dorning (that a twisting injury could cause a complete ACL tear) are persuasive. Indeed, the physicians agree that a twisting injury could cause Petitioner's right knee condition in whole or in part. However, "[l]iability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994). "Expert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003)). Given that the physicians accept Petitioner's reported history inclusive of a twisting mechanism of injury as true, the evidence submitted regarding whether he actually twisted his right knee must first be addressed.

Petitioner testimony about how he twisted his right knee in the short period of minutes that Mr. Duszynski was out of the room varied from direct to cross examination. On direct examination, Petitioner was clear that he "*was down on [his] knees* assembling they're like little sheet metal screws you have to tighten them together. *I was kneeling on one of the part cabinet and I went to stand up* to grab another piece of the cabinet, *and when I stood up, the cabinet took off like a surfboard, the panel and it slid across carpet* similar to this and my leg went out, I heard a pop and I sat back down - - I fell back down." Tr. at 35-36 (*emphasis* added). On cross examination, Petitioner's responses were less clear and evasive. He eventually testified that he was kneeling on one of the metal panels on the floor on which he believed that he stepped, but before it was fastened together with the other metal panel. He added his belief that the photographs in Respondent's Exhibit No. 7 show the two panels after they had been assembled. On further questioning as to whether Petitioner had actually fastened

the two panels together at any of the four points where bolts would be placed, he testified that he could not recall and reiterated that "I just recall slipping on the sheet metal and *took off like a surfboard.*" Tr. at 72-79 (*emphasis* added). On further cross examination questioning, Petitioner testified that he believed that he "*was kneeling or getting down to kneel to put a piece together*..." in the cabinet assembly process when he slipped. Tr. at 72-79 (*emphasis* added).

Petitioner's testimony about the two metal sheets having been placed together on the floor, but not yet fastened, and that "the sheet metal" (without specifying whether it was one panel, both panels, or one wholly or partially fastened set of panels) skidded or took off like a surfboard is incongruent with the photographs that Petitioner took himself. Both of Petitioner's photographs show the metal panels on the floor in perfect alignment with the shipping box behind it. PX4. If Petitioner's testimony is to be believed, these photographs were taken within minutes of his accident. Yet, if the metal panels were to have skidded "like a surfboard" across the carpet they presumably would not be in such concordant alignment with the shipping box. Indeed, Mr. Duszynski's photographs taken later the same day also show the metal panels on the floor in a similarly concordant alignment with the shipping box behind it. RX7. It does not seem plausible that the metal panel or panels could have remained in such alignment with the shipping box if they had skidded across the floor some distance.

After careful consideration of all of the evidence submitted at trial—particularly Petitioner's testimony, Mr. Duszynski's testimony, the medical records, and the photographs—the Arbitrator finds that Petitioner's testimony about the accident is simply not credible. His testimony is inconsistent during direct examination and cross examination, contradicted by the testimony of Mr. Duszynski, and implausible given the improbably perfect alignment of the metal panels on the ground to the shipping box if the panel actually skidded across the floor any distance. Moreover, it is not plausible in consideration of all the evidence in this case including Petitioner's own experience with an ACL reconstruction surgery in 1991 that he could have sustained a complete ACL tear on March 11, 2013—a painful event—and have only minimal swelling noted by a physician within an hour of the alleged acute event.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable accident at work on March 11, 2013 as claimed. By extension, all other issues are rendered moot and all requested benefits and compensation are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony R. Holstine,

Petitioner,

15IWCC0159

vs.

NO: 12 WC 21071

Affordable Roofing,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, permanent partial disability, temporary partial disability, average weekly wage, 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 hereby adopts the Arbitrator's findings of fact and conclusions of law.

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

15IWCC0159

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: MAR 4 - 2015

David L. Gore

DLG/gaf
O: 2/26/15
45

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

15IWCC0159

HOLSTINE, ANTHONY R
Employee/Petitioner

Case# 12WC021071

AFFORDABLE ROOFING
Employer/Respondent

On 2/11/2014, 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 0.11% 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:

0560 WIEDNER & McAULIFFE LTD
RUSSELL P STANDLEE
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

0238 LAW OFFICES OF WOLF & WOLFE
BILL JENSEN
25 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

15IWCC0159

Anthony R. Holstine
Employee/Petitioner

v.

Affordable Roofing
Employer/Respondent

Case # **12 WC 21071**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **November 18, 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 **Wage loss pursuant to Section 8(d)1**

15IWCC0159

FINDINGS

On **5/28/10**, 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 $ **82,004.12**; the average weekly wage was $ **1,577.01**

On the date of accident, Petitioner was 45 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 $ 93,121.69 for TTD, $ **-0-** for TPD, $ **-0-** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **93,121.69** .

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $1,051.34/week for 97-3/4 weeks, commencing June 14, 2010 through April 25,2012, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $ 814.97/week for 29 2/7 weeks, commencing May 1, 2012 through November 21, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, of $664.72 for 250 weeks because the injuries sustained resulted in the loss of use of the person as a whole to the extent of 50% thereof pursuant to Section 8(d)(2) of the Act.

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

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

Signature of Arbitrator

February 4, 2014
Date

FEB 11 2014

15IWCC0159

FACTS

The petitioner, a 45 year old roofer, was employed by the respondent, with the exception of two years, since 1984. He described his activities of a roofer as including manipulating wheelbarrows weighing 250 to 300 pounds containing tear off materials, manipulating a mop, and rearranging hot tar, the end of which weighed anywhere between 35 to 40 pounds. He described climbing ladders, heights between 12 to 40 feet, multiple times per day and manipulating or adjusting those ladders.

In addition to his work for the respondent, the petitioner worked a part-time position as a janitor or caretaker for a church campground, concurrent employment known to the respondent.

Petitioner testified that on May 28, 2010 he sustained an injury to his right hip when he jumped from a truck to the street after which he experienced pain in his right hip and back. A coworker, Jim Wojcik, testified that immediately after the occurrence, the petitioner had remarked to him that he had injured himself. Petitioner testified to having worked sporadically five days subsequent to the occurrence before seeking medical attention from Dreyer Medical Center. He attended Dreyer Medical Center as, from previous work injuries and company policy, it was known to him that that was the industrial clinic where the respondent sent its employees. That fact was confirmed by one of the respondent's co-owners, Witness William Wade.

On May 29, 2010, Petitioner returned to the residence where he had worked the day before to pick up some clay dirt that had been offered to him by the owner of the residence. He acknowledged picking up twenty-five to thirty-five 5-gallon buckets of the dirt that weighed 40 to 50 pounds and then putting them in the back of his truck. He then drove home and unloaded the buckets that day. Later that week, he emptied the buckets.

The petitioner was diagnosed with a fracture of the femoral head. He was put on non-weight bearing and subsequently referred for physical therapy. He performed physical therapy for approximately 12 weeks after which he was transitioned to work hardening. (PX 1). He was released to full duty by Dr. Jacobs-El of Dreyer Medical Clinic as a result of the examination of March 7, 2011. The Petitioner testified he was still experiencing pain at this point.

The petitioner was seen by Dr. Shane Nho at the request of the respondent's carrier on March 11, 2011. Dr. Nho concluded that in addition to the fracture, the petitioner had sustained a right hip labral tear secondary to femoral acetabular impingement.

In response to respondent's inquiries, the doctor confirmed that the petitioner's complaints were related to the work injury and recommended that the petitioner undergo a labral repair and acetabular trimming as well as a femoral osteochondroplasty. According to the doctor's opinion, the petitioner was unable to return to roofer's work at that time as a result of that evaluation. (PX 2).

The respondent referred the petitioner for a functional capacity evaluation which was conducted on March 24, 2011 the result of which questioned the petitioner's ability to return to full duty as a roofer. (PX 3).

As the petitioner did not hear back from the respondent's carrier after the FCE or the independent medical examination by Dr. Nho, petitioner contacted the Respondent's carrier concerning the results and need for further care. It was not until then were they made known to the petitioner. The representatives of the respondent hand-delivered the results of both to his home in person and discouraged him from showing either to his personally selected physician.

The petitioner then first exercised his right of a medical opinion, seeking medical attention at the Castle Orthopedic Group. He was advised by Castle that they did not treat his condition and referred him to Dr. Domb of Hinsdale Orthopedics.

He first sought treatment with Dr. Domb on June 20, 2011. After reading the MRI that had previously been performed at the request of Dreyer Medical, Dr. Domb concurred with the diagnosis of the respondent's expert, Dr. Nho, and recommended surgery to repair the torn labrum. (PX 4).

Dr. Domb performed surgery on August 10, 2011 to repair the right hip labral tear performing an arthroscopic labral debridement, femoroplasty and capsular release. (PX 4).

Post-operatively, the petitioner underwent physical therapy and was eventually transitioned to work hardening at the beginning of 2012. He returned to Dr. Domb's office on February 2 due to continuing right hip complaints and was administered a right hip fluoroscopically guided injection on February 3. (PX 4).

Petitioner underwent a functional capacity evaluation on February 22. The therapist performing the evaluation noted that a detailed job description of a roofer was not available. The evaluation was deemed to be valid and indicated that the petitioner was capable of performing at the very heavy physical demand level. During the evaluation, the petitioner reported right hip pain discomfort with many of the lifting activities. He demonstrated the ability to bend, stoop, squat, crouch and climb stairs at the occasional basis. (PX 5).

Petitioner was evaluated at Dr. Domb's office on February 28, 2012 at which time he was allowed to return to work with no lifting or carrying greater than 40 pounds with only occasional bending, squatting or kneeling and only very occasional ladder work. (PX 4).

Respondent terminated temporary disability based upon an opinion rendered by Dr. Shane Nho who did not reevaluate the petitioner in person but reviewed the results of the February 22 FCE. (R X1 and Nho Dep x 3). The petitioner had been terminated by the respondent in October, 2011 after the accident.

By May, 2012, the petitioner had been permitted by his physician to return to restricted part-time work for the campground for which he earned $14.50/ hour working 15 hours per week.

In September, 2012, the petitioner requested from the respondent, through his counsel, job placement or vocational assistance (PX 6) and said request was ignored.

The petitioner testified that as of November 22, 2012, he was able to supplement his part time work as a janitor for a church campground with another janitorial job with a church daycare. By that time, the campground provided 20 to 25 hours of work per week at $14.50. The Loving Hands Day Care allowed him 20 hours of work per week at an hourly rate of $12.50. The petitioner continues to perform the same two part-time jobs as of the date of his testimony. The parties stipulated that he averages $575.25 working 40-45 hours between the two jobs.

ISSUES

Did an accident occur that arose out of and in the course of petitioner's employment by respondent?

Is petitioner's current condition of ill-being causally related to the injury?

Has the petitioner sustained diminished earning capacity entitling him to temporary partial disability benefits pursuant to Section 8(a) and permanent diminished earning capacity pursuant to Section 8(d)1?

On the issue of the occurrence of the accident, the Arbitrator finds the following facts:

Petitioner testified he sustained an injury to his right hip and leg as a result of jumping off a truck bed while at work on May 28, 2010. Petitioner finished his shift, but his pain continued over the ensuing weekend. Upon his return to work the following week, he reported the accident, in conformance with company policy acknowledged by respondent Witness Wade, to part-owner Bill Triscilla. Mr. Triscilla was not called to testify by the respondent. Over the course of the following 13 days, the petitioner continued to perform his work for the respondent, albeit according to his testimony, in pain for a total of five days in that period.

The petitioner sought medical attention from the Dreyer Medical Clinic, which part-owner of the respondent, Witness Bill Wade, confirmed was the respondent's company clinic for work injuries. There, the petitioner gave a consistent history of injury having sustained an injury to his right leg while hopping off a truck. Consistent with his testimony, he reported that since the date of the injury, his pain had become more severe. (PX 1).

Petitioner's witness, James Wojcik, was questioned on cross-examination concerning the accident. He confirmed that he was at the jobsite on the day of the occurrence and witnessed the petitioner experiencing pain as a result of the episode subsequently reported.

There was no testimony nor medical records offered by the respondent that would provide an alternative explanation for the petitioner's condition of ill-being.

The petitioner was subsequently referred to Dr. Shane Nho by the carrier for the respondent. Dr. Nho was expressly questioned by the respondent carrier whether the condition was related to a work injury, to which he answered in the affirmative. (PX 2). Further, the doctor confirmed that the mechanism of injury as described by the petitioner was sufficient explanation for the petitioner's diagnosed labral tear and fracture. (PX 2).

Based on the record as a whole, the Arbitrator finds that the petitioner has sustained his burden of proof that he sustained an injury while working on May 28, 2010. The evidence of said accidental injury presented by the petitioner has gone unrebutted by the respondent.

Wherefore, the Arbitrator concludes that the petitioner did in fact sustain an accidental injury while at work as described on May 28, 2010 which arose out of his employment.

Regarding the issue of causal connection, the Arbitrator finds the following facts:

The findings and conclusions with reference to the occurrence of an accident are hereby incorporated and included by reference in connection with the Arbitrator's findings with respect to the issue of causal connection.

The petitioner reported a consistent history of injury to respondent's company clinic, Dreyer Clinic, when he first sought medical attention on June 14, 2010. (PX 1). Moreover, there is nothing in the Dreyer Clinic records, or any other medical records in evidence describing the petitioner's subsequent medical treatment that would explain or provide an alternative cause or explanation of the petitioner's diagnosed condition, intervening or otherwise. (PX 1).

The petitioner was evaluated at the request of respondent's carrier by Dr. Shane Nho on March 11, 2011. There, the doctor answered in the affirmative to the question submitted by the carrier, "Has the treatment to date been reasonable and necessary for the reported injury?" (PX 2) Further, in response to the inquiry, was Mr. Holstine's current condition related to the work injury, Dr. Nho provided the following response: Given the petitioner's mechanism of injury it is certainly possible that the patient may have sustained the hip labral tear and a fracture of the femoral head and necessary concurrently . . . the imaging studies are all consistent with a hip labral tear, secondary to the underlying femoral acetabula impingement. (PX 2).

When the petitioner failed to improve, he sought a second opinion from Dr. Benjamin Domb, at which time he gave a consistent history of injury. (PX 4). Based upon his evaluation of the petitioner and a review of the previous MRI performed at the direction of Dreyer Clinic, Dr. Domb concluded that the right labral tear, and the resolved subchondral fracture of the femoral head, were caused by the "work-related injury." (PX 4)

Wherefore, based on the record as a whole, the Arbitrator concludes that the petitioner's current condition of ill-being is causally related to the work injury as described as occurring on May 28, 2010.

On the issues relating to temporary partial disability benefits pursuant to 8(a) AND whether the petitioner has experienced diminished earning capacity pursuant to Section 8(d)1, the Arbitrator finds the following facts:

The petitioner testified that prior to his work injury and for some time, in addition to his employment with the respondent, he was employed part time for a campground owned by the Community of Christ Church. The petitioner's position with the campground was that of a handyman, or janitor. It is undisputed by the respondent that between the petitioner's jobs with the respondent and the campground, he earned an average of $1,577.01 per week.

The petitioner testified that after his surgery of August 10, 2011, and after having undergone approximately 15 weeks of physical therapy and a subsequent period of some six weeks of work hardening, he underwent a Functional Capacity Evaluation on February 22, 2012. (PX 4 &5). The physical therapist performing the Functional Capacity Evaluation specifically noted that a detailed job description (of a roofer) was not available at the time of the study. The FCE report itself is blank in those sections which call for a job information source. (PX 5). The results of the FCE were deemed to be valid and the petitioner reportedly was performing at what was characterized as a very heavy physical demand level. (PX 5).

The petitioner described the essential functions of his job which included lifting and moving wheelbarrows containing debris weighing 250-300 pounds. He described manipulating tar-ladened mops on a repetitive basis weighing 35-40 pounds. He described repetitive lifting and climbing ladders ranging in height from 10 to 40 feet on a daily basis, frequently while carrying tools or equipment. He described while standing on a roof's edge, holding an extension ladder away from the structure while tools or equipment were hoisted up to the roof using a wheel as with a "dumbwaiter."

With the exception of walking up and down 3 stairs during the FCE, none of these functions were tested or evaluated. (RX 5)

Dr. Domb testified that the petitioner was examined on February 2, 2012, about 3 weeks prior to the FCE, and to address the petitioner's complaints of pain, the doctor recommended a second cortisone injection which was administered to the petitioner on February 3, 2012.

The petitioner was examined on February 28 at which time the FCE results were reviewed. (PX7). Dr. Domb testified that the FCE was deemed valid which means the petitioner was giving a full effort. (PX 7 at 45-46). The petitioner was told by his doctor that returning to work as a roofer will just aggravate him over time increasing his need for a total hip replacement. He was given restrictions of occasional bending, squatting or kneeling and only very occasional ladder work. (PX4) He was allowed to return to his work at the campground.

The restrictions were made permanent during an examination conducted on April 25, 2012. He was permitted to perform his work for the campground. (PX 4)

Dr. Domb later testified that the FCE was one component to consider in assessing the petitioner's level of work ability and restrictions. He testified that he also took into consideration not only the petitioner's reported level of pain while performing the FCE, but also the fact that working at the very heavy level would cause progressive deterioration of the hip condition over time which he wanted to prevent. (PX 7 at 30)

Dr. Domb testified that when he last evaluated the petitioner on August 9, 2012, the work restrictions were increased to a 50 pound lifting restriction. He recommended no climbing of ladders (PX7 at 63) and that the petitioner should continue to work at the medium level permanently. (PX 7 at 29)

The petitioner's medium work and lifting restrictions were last re-affirmed by his treatring physicians on November 12, 2013.

Dr. Shane Nho testified on behalf of the respondent. Dr. Nho examined the petitioner on one occasion, five months before the repair of the labral tear performed by Dr. Domb. (RX 1 at 21). After the surgery, Dr. Nho's information concerning the petitioner was admittedly limited to the operative report and the Functional Capacity Evaluation supplied by the respondent's carrier as he had not re-examined him. (Rx 1 at 21)

Dr. Nho's knowledge of the duties required of a roofer was limited to the fact that *they replace roofs*. (Rx 1 at 10). Dr. Nho agreed with Dr. Domb's opinion that given the effects of his work injury, the petitioner is likely to experience arthritic changes in his hip more than one who had not sustained such an injury. (Rx 1 at 29).

Dr. Nho acknowledged that while performing certain portions of the FCE, including lifting and carrying, the petitioner reported pain going down the side and front right of his hip and into his leg. (RX 1 at 30). When questioned whether it was appropriate to release a patient who reportedly is capable of performing a particular lift or carry on a single occasion during which he experiences pain, Dr. Nho testified, *it depends on how significant the pain is*. (RX 1 at 30).

Dr. Nho acknowledged that he released the petitioner to return to full duties as a roofer based upon the FCE despite not knowing what the duties of a roofer were, without a job description of a roofer and without having evaluated the petitioner but one time, five months before Dr. Domb's surgery to repair the labral tear. (PX 1 at 39-40).

After having been released to medium duty with restrictions which allowed for 40 pounds lifting and occasional bending, squatting and kneeling and only occasional climbing of ladders, the petitioner sought, through counsel, the assistance of job placement services/vocational rehabilitation. (PX6). That request was ignored. The petitioner continued to perform his duties as a janitor for the church campground as the duties performed there fell within the restrictions placed upon him by Dr. Domb. That job was part time allowing him work for 20 to 25 hours per week.

The petitioner looked for work within the restrictions placed upon him by his treating physician on his own and eventually located a job with Loving Arms Day Care as a janitor, similar to the work he performed for the church campground. The job started November 22, 2012 and allowed him 20 hours per week.

The respondent produced testimony from a Steven Landrum that he observed the petitioner standing on a work plank after having climbed approximately 14 steps on October 13, 2013. He estimated that the petitioner was at the job for a total of 15 to 20 minutes. The petitioner freely admitted that he was at the job on the date observed by Mr. Landrum, performing activity on the work plank for 15 to 20 minutes fixing electrical wire. He was not paid for that effort.

Petitioner also volunteered that he was on the same job on another date for approximately eight hours. He did not, however, climb a ladder at that time but accessed the work plank by way of a second-story loft. He said he was paid $320.

The petitioner offered the testimony of Jim Wojcik, who confirmed the petitioner worked two side jobs for him since the work accident. One involved payment of $800.00 and another payment of some $320.00. He said the first was a job refurbishing a basement.

The second was one day, performing work at the site described by Witness Landrum. The petitioner did not climb a ladder on the day he was paid. The day he was observed by Witness Landrum he was not paid.

Mr. Wojcik testified that he had offered the petitioner work as a safety monitor on a job that he picked up in Chicago. That position, if accepted, would have paid the petitioner $40.00 per hour. Witness Wojcik testified the petitioner turned down that offer and at least two others because he felt he would be unable to walk or stand all day.

The respondent produced the testimony of William Wade, one of the owners of the respondent. Mr. Wade confirmed that while the respondent was disputing accident, the company policy was for any employee injured to report it to his partner, Bill Triscila, the individual to whom the petitioner testified he reported his injury. Although Mr. Triscila was still part-owner of the respondent, he was not present to testifiy. Witness Wade offered no testimony concerning side jobs the petitioner was alleged to have performed or any other activity the petitioner performed in contradiction to his doctor's work restrictions.

The Arbitrator notes that the opinion upon which the respondent argues that the petitioner can return to work as a roofer, that of Dr. Nho, is itself based upon incomplete or insufficient information. Not only did Dr. Nho not evaluate the petitioner after the performance of surgery, surgery he joined in recommending, but his sole basis for his opinion was the FCE. That test did not have a description of a roofer nor did it test for the essential functions of that job. Dr. Nho admitted during his testimony that the only thing he knows about the job of a roofer was that they replace roofs. He acknowledged that the FCE was the only thing he has (RX 1 at 35-36).

Dr. Domb testified that the FCE was one factor one uses in determining the level of work an individual may return to after treatment. He must take into account what things cause the individual pain while doing them. (PX7 at 29-30)

The Arbitrator notes that the therapist who performed the FCE expressly provided the petitioner reported primarily right hip pain/discomfort with many of the lifting activities and that he demonstrated bending/ stooping, squatting, crouching and climbing stairs (no ladder climbing tested) at the "occasional basis". (PX 5) It is undisputed that the FCE was considered valid. Dr. Nho appears to have ignored or dismissed the therapist's observation is arriving at his opinion

Dr. Domb testified that he released the petitioner to the lower level of work and otherwise restricted him because he had pain when he tried to work at higher physical demand levels..."I did not want him working in pain." (PX 7 at 30)

Dr. Domb testified to another factor he considered; that working at that higher demand level would cause progressive deterioration of his hip over time and I wanted to prevent that as well. (PX7 30-31)

The Arbitrator concludes that the petitioner has returned to work within the restrictions placed upon him by his treating physician. Those restrictions take into account the level of activity the petitioner can safely perform work and perform without pain on a repetitive basis. Dr. Domb testified his restrictions also will help to delay further aggravation of his hip condition and an eventual hip replacement

The restriction make return to work as a roofer impossible. The petitioner, without the benefit of assistance he requested from the respondent, made a diligent search for work within his restrictions. His doctors permitted a return to work at his position as janitor for a campground, so he looked for and located a similar position with a day care facility.

In doing so, he has put together two part-time jobs, both which fall within his permanent restrictions, into a full 40 hour plus work week. The Arbitrator expressly finds that between his two jobs, the petitioner has proven he has achieved or secured suitable employment as contemplated by Section 8(d) (1

The petitioner testified that on or about May 1, 2012 he returned to work for the church campground and continues his employment with the campground working 20 to 25 hours per week earning $14.50 per hour. Beginning on or about November 21, 2012, he began work for Loving Arms Day Care for an additional 20 hours per week at $12.50 per hour. It has been stipulated by the parties that the petitioner, between his two part-time employers, currently averages some $575.25 per week. The parties further stipulated that had the petitioner not sustained his injury and continued to perform his work for the respondent and the campground, he would be earning $1,599.01 per week. The Arbitrator further notes that Petitioner declined three job offers for jobs in the $40.00/hr range that appeared to be within the physical restrictions imposed by Dr. Domb.

Wherefore, based on the record as a whole, the Arbitrator hereby finds that the petitioner has proven he has become incapacitated from his usual and customary line of employment and is entitled to a loss of use of the person as a whole pursuant to Section 8(d)(2) of 50% of the person as a whole.

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

Donald J. Carlsen,

Petitioner,

vs.

City of Naperville,

Respondent.

15IWCC0160

NO: 10 WC 10707

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, 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 15, 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: MAR 4 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 2/26/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARLSEN, DONALD J
Employee/Petitioner

Case# **10WC010707**

CITY OF NAPERVILLE
Employer/Respondent

15IWCC0160

On 9/15/2014, 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:

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

4357 CITY OF NAPERVILLE LEGAL DEPT
KRISTEN N FOLEY
400 S EAGLE ST
NAPERVILLE, IL 60540

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 15IWCC0160

DONALD J. CARLSEN
Employee/Petitioner

v.

CITY OF NAPERVILLE
Employer/Respondent

Case # **10** WC **10707**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 _____

15IWCC0160

FINDINGS

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

Timely notice of the allegation of 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 **$145,994.68**; the average weekly wage was **$2,807.69**.

On the date of accident, Petitioner was **49** years of age, *married* with **0** dependent children.

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

Respondent *has* 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 **$any amount paid** under Section 8(j) of the Act.

ORDER

For reasons set forth in the attached decision, benefits under the Act are denied.

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

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

Signature of Arbitrator

9-15-2014
Date

SEP 15 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DONALD J. CARLSEN,	)	
	)	15IWCC0160
Petitioner,	)	
	)	
vs.	)	No. 10 WC 10707
	)	
CITY OF NAPERVILLE,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The claimant is a right hand dominant man, 49 years old at the time of the asserted date of loss in 2009 and medical treatment in 2009 and 2010. He testified he became employed with the city of Naperville in 1985 and worked at a series of different positions with the city until his job was eliminated due to a general reduction in force at approximately the end of 2009. He asserts carpal tunnel syndrome incurred through repetitive trauma with an effective accident date of December 17, 2009.

The petitioner testified he worked as an administrative analyst for the Public Works and Police departments from 1985 to 1987, and then as a management analyst until 1990. He was appointed as an interim city manager from 1990 to 1991. After that he was the data manager from 1991 to 1996, and then the IT manager from 1996 to 2006. At that point he became the management services business director until that position was eliminated in approximately November 2009. The petitioner testified the management services business director was a management level job, primarily involving desk work and the duties included supervision of fifty people as well as writing software.

Mr. Robert Marshall was called to testify. He had served as the Naperville City Manager from 2005 through 2012 and at the time of trial he was the chief of police for Naperville. He has known the petitioner since the 1980s in the course of city business. He testified the claimant's duties as management services business director involved global supervision of three departments, including general leadership duties such as meetings, strategic planning, budgeting, and administering personnel to include general and specific oversight, evaluations and counseling. Mr. Marshall noted the job involved on-site leadership, department planning, personnel meetings, phone conversations, attendance at City Council hearings, and meetings and interviews with vendors and employees. He characterized the primary duties of the job involving verbal discussion and directorship, with some but intermittent typing, not like data entry or a position as a front-line programmer. It did not involve any activities involving heavy equipment,

power tools, forceful gripping or use of the thumb.

Mr. Marshall testified that in 2009 Naperville hired a strategic consultant to review its city departments and processes. On November 12, 2009, the consultant recommended targeted reduction of approximately fifteen percent of the total city workforce, including the elimination of the claimant's position. The petitioner was informed of the decision that day. On November 19, 2009, the petitioner reported the allegation of the work-related injury, describing a date of loss of May 1, 2009; prior to that time, the claimant had been treating through his group insurance provider as a non-work-related concern. See Respondent's Deposition Group Exhibit 2. Mr. Marshall testified that the city had a very liberal light duty program for on the job injuries and could certainly have accommodated the claimant postoperatively. Mr. Marshall testified that the claimant left the city for his surgery and never returned, but was paid salary through the end of January 2010; however, Mr. Marshall was uncertain how much of the payment through January 31, 2010 was pursuant to the severance agreement and how much was accrued sick time.

The petitioner acknowledged his job involved no forcible gripping or usage of vibratory tools and that he did attend meetings of staff, employees, city council, and other directors, though he disagreed with Mr. Marshall as to the extent of the time spent in meetings. The petitioner testified he also did reading and research, which varied per day from half an hour up to three to four hours depending on the issue and level of research required. The petitioner testified he was an occasional smoker which had begun in his mid-twenties or early thirties. The petitioner asserted a substantial amount of typing including computer programming and email interaction.

The medical records demonstrate that the claimant presented to Dr. Chris Huang at DuPage Medical Group on October 30, 2009. See generally PX3. Dr. Huang noted a diagnosis of bilateral carpal tunnel syndrome with a history of symptoms in the right hand going back a year, worsening over the last six months, with left hand symptoms beginning about three months prior to the appointment. The petitioner reported he had been treating with his family physician for several months and had been prescribed a brace for the right wrist, which had not helped. An EMG study had been performed on September 8, 2009; the actual report is not present, but Dr. Huang noted the test showed moderate right carpal tunnel syndrome and mild left carpal tunnel syndrome. Examination showed a positive Tinel's sign on the right and but negative on the left side. Following evaluation, Dr. Huang recommended right sided carpal tunnel release. PX3.

On December 17, 2009, the claimant underwent right carpal tunnel release surgery with Dr. Huang. No complications were noted. PX3. On December 29, 2009, Dr. Huang saw the petitioner. The petitioner reported relief of the nighttime symptoms and reported doing well. Dr. Huang encouraged the petitioner to use his hand as much as possible and instructed him on scar massage. PX3.

On January 26, 2010, the petitioner reported complete resolution of his nighttime symptoms and finger numbness and reported his left hand was asymptomatic at that time.

Dr. Huang recommended ongoing scar massage on the right side and discharged him from care, noting the claimant should follow up if his symptoms recurred on the left side or if he had any questions or concerns regarding the right sided surgery. PX3. The claimant never returned to Dr. Huang.

On February 8, 2010, the petitioner saw Dr. Michael Vender at the respondent's request pursuant to Section 12 of the Act. Following Dr. Vender's review of the medical records and examination of the petitioner, he concurred with the diagnosis of right carpal tunnel syndrome and the surgery. Dr. Vender opined that the surgery had successfully resolved the condition and no further medical care was needed on the right side, and given the lack of symptoms or complaints on the left side, treatment on the left hand was unnecessary. Dr. Vender opined the petitioner's sedentary office duties would have involved no forceful activity and would have neither caused nor contributed to the development of the carpal tunnel syndrome.

On December 29, 2011, the claimant saw Dr. James Schlenker at the petitioner's attorney's request pursuant to Section 12 of the Act. Following his examination, Dr. Schlenker noted that the left sided symptoms had recently increased in severity but the right hand symptoms had resolved. He assessed the petitioner with bilateral carpal tunnel syndrome, and was at MMI for the right hand. He opined the left side could benefit from further care. He opined the petitioner's work duties did play a role in the development of the condition.

The claimant testified that following his termination from employment at the City of Naperville, he performed several different consulting jobs and then secured a position as the Chief Information Officer for DuPage County at the beginning of August 2010, where he continued to work through the date of trial. This position involves management of the computer systems for the county and is approximately 50% keyboarding with the rest of the time involved in meetings, phone calls, and other administrative tasks. He asserted having some slight symptoms in the left hand but other than the meeting with Dr. Schlenker has pursued no treatment since 2010 for either hand and expressed no interest in scheduling or seeking care for the left hand at the time of trial.

Depositions of Dr. Schlenker and Dr. Vender were conducted on May 24, 2012, and on July 9, 2012, respectively; each maintained their causal opinion during deposition. See PX4, RX1. Dr. Huang did not provide a causation report and was not deposed.

OPINION AND ORDER

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including that the alleged injury arose out of and in the course of employment. See, e.g., *Parro v. Industrial Commission*, 260 Ill.App.3d 551 (1st Dist. 1993). Here, the petitioner relies on a repetitive trauma theory to demonstrate accident and causal connection. In cases relying on the repetitive trauma concept, as opposed to an acute injury, the claimant generally relies on medical testimony to establish the

relationship between the claimant's work and the claimed disability; such an allegation must demonstrate that the injury arose out of repetitive activities and that the state of ill-being complained of is not simply a product of the aging process or of a pre-existing or degenerative condition. See, e.g., *Peoria County Bellwood v. Industrial Commission*, 115 Ill.2d 524 (1987); *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show that 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 this area. *Johnson v. Industrial Commission*, 89 Ill.2d 438 (1982).

The Arbitrator first notes the treating physician, Dr. Huang, did not make a causal assessment and does not reference the claimant's work activities at all; his testimony was not sought. While treating physicians are usually given a degree of deference, in this case the treating physician did not provide an opinion on which to base a determination. An examination of the evidence depositions of the examining physicians shows that Dr. Schlenker testified that his affirmative opinion was based on his understanding that the claimant's employment involved "mostly computer work" for 8 hours a day, 40 hours a week, and the petitioner "has virtually no other tasks besides running a computer." See PX4 p.9 and also pp.46-47. Based upon those facts, Dr. Schlenker opined the claimant's medical condition was attributable to the work activities. PX4 p.16.

However, the claimant admitted having a significant number of job duties beyond programming, and the extent of his computer usage was further disputed by the credible testimony of Mr. Marshall. The Arbitrator notes the claimant's description of his keyboard usage is consistent with a data entry worker or computer programmer, but the claimant's undisputed rank and his own description of his managerial duties as well as the number of supervisees and subordinates he had suggest a far more administrative position. The Arbitrator finds Dr. Schlenker's causal opinion is based on an incomplete and inaccurate description of the petitioner's employment. Given that Dr. Shlenker's analysis of the kinds of stressors the petitioner was exposed to was based on flawed information, its reliability is in serious question, and the Arbitrator finds his opinion to lack credibility.

While work can cause or contribute to the development of carpal tunnel syndrome, it can also develop idiopathically and there are multiple idiopathic conditions which cause or contribute to the development of this condition; the claimant has or was exposed to several of these, including age, body mass index, high cholesterol and smoking. As Dr. Schlenker's opinion is both unreliable and contradicted, the Arbitrator finds the claimant has failed to prove to a medical and surgical certainty that his condition is causally linked to his employment.

The Arbitrator notes all medical expenses were paid through the claimant's group health insurance. The request for 8(j) credit and a hold harmless order, as well as the disputed issues regarding temporary and permanent disability, are rendered moot by the above findings as to accident and causal relationship.

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

LAWRENCE WILLIAMS,

Petitioner,

vs. NO: 11 WC 34038

ILLINOIS CEMENT COMPANY,

15IWCC0161

Respondent.

DECISION AND OPINION ON REVIEW

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

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

The Petitioner alleged two separate work-related incidents. The first incident occurred July 29, 2010 (11 WC 37451) and the second on May 9, 2011 (11 WC 34038). The cases were consolidated at hearing and a single decision was issued. The Arbitrator found the July 29, 2010 accident compensable and also found that Petitioner failed to prove a work-related accident occurring on May 9, 2011.

The Commission affirms and adopts the Arbitrator's decision relating to case 11 WC 34038 finding Petitioner failed to prove a work-related accident occurring on May 9, 2011.

15IWCC0161

A separate decision has been issued for case 11 WC 37451.

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 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: MAR 9 - 2015

Michael J. Brennan

MJB/tdm
O: 2/17/15
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, LAWRENCE
Employee/Petitioner

Case# **11WC034038**
11WC037451

ILLINOIS CEMENT COMPANY LLC
Employer/Respondent

15IWCC0161

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:

1824 STRONG LAW OFFICES
TODD STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

15IWCC0161

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

Lawrence Williams
Employee/Petitioner

v.

Illinois Cement Company LLC
Employer/Respondent

Case # 11 WC 34038

Consolidated cases: 11 WC 37451

An *Application for Adjustment 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 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 7/29/10 & 5/9/11, 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 7/29/10, Petitioner *did* sustain an accident that arose out of and in the course of employment.
On 5/9/11, 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 in part causally related to the 7/29/10 accident.

In the year preceding the injury, Petitioner earned $57,333.86; the average weekly wage was $1,102.57.

On the date of accident, Petitioner was 67 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 in nonoccupational indemnity disability benefits, and $0 in 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 TTD / Maintenance benefits is denied based on the Arbitrator's finding of no accident on 5/9/11 and no causation with regard to the Petitioner's cervical condition.

Respondent shall pay reasonable and necessary medical services limited only to treatment of Petitioner's left epicondylitis, as provided in Section 8(a) of the Act. Petitioner's claim for medical expenses related to his cervical condition is denied based on the finding with regard to causation and accident.

Respondent shall pay Petitioner permanent partial disability benefits of $661.54/week for 25.3 weeks, because the injuries sustained caused the 10% loss of the left arm , as provided in Section 8(e) of the Act.

The Petition for Penalties and Attorneys Fees is denied based on the findings on the issues of accident and causation.

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

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

Gerald A. Granado

Signature of Arbitrator

6/30/14
Date

JUL 2 - 2014

15IWCC0161

FINDINGS OF FACT

Petitioner originally filed four Applications for Adjustment of Claim. which were consolidated at the time of this arbitration hearing. On Petitioner's motion. the Arbitrator dismissed the Application for Adjustment of Claim on case number 11 WC 33849 and 11 WC 37475. The remaining claims are for 11 WC 37451 regarding a date of accident of May 9, 2011 and 11 WC 37451, which regards a date of accident of July 29, 2010. The parties have also indicted to this Arbitrator that there are overlapping issues of causal connection between the remaining two alleged accident injuries. For purposes of judicial economy and because of the overlapping issue of causation, there will be one arbitration decision issued for the two remaining claims.

Although the parties indicated at the beginning of the arbitration hearing, that the issues in dispute are accident, causation, TTD/maintenance. medical expenses. credit, penalties/attorney fees, and permanency - the central issue in dispute is whether or not the petitioner's condition of ill-being with respect to his alleged cervical injuries are causally connected to the alleged accident injuries he sustained on July 29, 2010 and/or the alleged accident of May 9, 2011, or a combination of both.

The parties have stipulated that the Petitioner sustained an accident on July 29, 2010. The Petitioner testified that he slipped and fell while in the course of his employment on that day with an outstretched left arm when he tripped and fell on a concrete riser on the sidewalk leading into the employer's administrative office. Petitioner's job duties at include driving a truck as well as manual labor at Respondent's mining operation. He does not perform over-the-road truck driving duties, but rather drives a truck in a quarry operation driving loads of limestone back and forth between the quarry entrance and a processing plant. The Petitioner described his job duties and specifically described the driving conditions that he is frequently asked to be exposed to up to and including large ruts in the gravel and limestone surfaces of the roadway as well as an extreme vibratory nature of the truck in which he operates.

Following the incident on July 29, 2010, Petitioner reported to Illinois Valley Community Hospital Occupational Health Clinic on September 7, 2010. His initial diagnosis was left elbow epicondylitis. Petitioner continued to work without restrictions.

On February 15, 2011, Petitioner underwent an IME with Dr. John Fernandez. who confirmed the diagnosis of Left elbow lateral epicondylitis. Dr. Fernandez opined that the condition was causally related to the event from July 29, 2010. Dr. Fernandez indicated Petitioner could return to truck driving, but had restrictions of 10 to 20 pounds of force and restrictions from significant amounts of repetition or use of tools with his hands. Dr. Fernandez further added that he believed there would be no permanent impairment due to the Petitioner's epicondylitis.

On March 1, 2011, Petitioner began treatment with Dr. Robert Mitchell. Dr. Mitchell confirmed the diagnosis of lateral epicondylitis. Dr. Mitchell gave Petitioner a cortisone injection in the elbow and prescribed physical therapy. On March 2, 2011, Petitioner was also placed on light duty restrictions of lifting greater than 10 pounds. On March 29, 2011, Petitioner was released to return to regular work by Dr. Mitchell.

Petitioner testified that on May 9, 2011, he was using a shovel at work when his left elbow began to swell and experienced pain in his neck, with pain radiating down to his fingers. Petitioner testified that he provided notice to his co-workers regarding this incident. Petitioner continued to work. He testified that he then went on vacation from May 31, 2011 through June 12, 2011. Petitioner then saw Dr. Mitchell on June 28, 2011, whose records indicate the Petition complained of a heavy, burning sensation in his lateral epicondyle and pain with

soreness and swelling. Dr. Mitchell's records from June 28, 2011 indicate Petitioner had full active and passive range of motion of his left shoulder with tendness over the lateral epicondyle with a small amount of swelling. Dr. Mitchell gave Petitioner work restrictions of no lifting greater than 10 pounds and provided Petitioner with another cortisone injection. On July 19, 2011, Dr. Mitchell notes continued pain in Petitioner's left elbow with numbness shooting down to his fingers. Dr. Mitchell continued Petitioner's light duty work restrictions and ordered an EMG. On August 11, 2011, Dr. Mitchell notes that the Petitioner's EMG was positive for double crush with C-7 radiculopathy, left carpal tunnel syndrome and mild left cubital tunnel syndrome. At this time, Dr. Mitchell's records indicate Petitioner was complaining of paraesthesias in his left upper extremity and radiating pain from his shoulder and neck. At that time, Dr. Mitchell refers Petitioner to follow up with a spine surgeon for an evaluation of Petitioner's neck. Dr. Mitchell later testified via evidence deposition that the Petitioner's left arm epicondylitis was related to his alleged accidents, but that these conditions had resolved and he had no permanent restrictions as a result of these conditions. Dr. Mitchell did not give any opinion regarding Petitioner's alleged neck condition and deferred to the spine specialists on that matter.

Petitioner followed up his neck treatment with Dr. Richard Kube at the Prairie Spine and Pain Institute on August 30, 2011. Dr. Kube's records indicate an assessment of cervicalgia, degenerative disc disease, spinal stenosis and brachial neuritis. Dr. Kube noted that an MRI indicated an annular tear at C5-C6. Dr. Kube ultimately recommended surgery for Petitioner's cervical condition. According to Petitioner's testimony, any further treatment for his cervical condition was denied by Respondent. Dr. Kube testified via evidence deposition that he believed the incident from May, 2011 was either a causative factor or an aggravation of Petitioner's underlying cervical condition.

On December 1, 2011, Dr. Kern Singh performed an IME at the request of Respondent. In his initial report, he indicated that he believed the Petitioner sustained an aggravation of his underlying degenerative cervical condition as the result of his alleged work injuries. On December 19, 2011, Dr. Singh prepared an addendum report essentially retracting his opinion with regard to the issue of causation based on his review of the Petitioner's medical records. Dr. Singh subsequently testified via evidence deposition that his opinion on causation changed because of the gap in the Petitioner's complaints of neck pain, which began in July, 2011.

On February 16, 2012, Petition saw Dr. Mark Lorenz of Hinsdale Orthopaedics on referral from Dr. Kube. Dr. Lorenz diagnosed a herniation at C5-C6. Dr. Lorenz ultimately performed surgery on March 20, 2012 involving a diskectomy and fusion at C5-C6. Dr. Lorenz testified in his evidence deposition that he believed the Petitioner's cervical condition was a result of his injury from July 29, 2010. Following Petitioner's surgery, Dr. Lorenz had Petitioner off work through July 9, 2012. On July 9, 2012, Dr. Lorenz released Petitioner to light duty work and Petitioner worked light duty for Respondent from September 21, 2012 through November 28, 2012.

In November, 2012, Petitioner's restrictions were increased to restrict him from quarry driving, no lifting more than 30 pounds and no exposure to vibration. Petitioner testified that he has been unsuccessful in looking for work within those restrictions. He underwent a vocational assessment by Bob Hammond – a vocational counselor selected by Petitioner's attorney. Mr. Hammond did not believe the Petitioner could find work given his restrictions. Respondent retained Natalie Maurin as their vocational expert. Ms. Maurin believed that the Petitioner was capable of finding work within his restrictions.

The medical records and Petitioner's testimony during cross examination revealed that the Petitioner has been working at the Cedar Creek Ranch, where he had been observed painting. Petitioner also testified that he has ridden all terrain vehicles, and can load/unload, ride and operate a boat without problems to his neck.

15IWCC0161

CONCLUSIONS OF LAW

1. The Arbitrator finds that the Petitioner has not met his burden of proof regarding the issue of whether he sustained an accident on May 9, 2011. This finding is based primarily on the medical records on or around that date. The parties stipulated that the Petitioner sustained an accident on July 29, 2010 involving his left elbow and that is supported by the contemporaneous medical records. However, the Arbitrator notes that there are no medical records contemporaneous with Petitioner's alleged incident from May 9, 2011. In closely reviewing the Petitioner's treating medical records from Dr. Mitchell, the first time Petitioner complained of any neck condition was after his MRI results were reviewed by Dr. Mitchell on August 11, 2011. This is over 3 months after the alleged incident from May, 9, 2011. The Arbitrator finds it highly incredible that the Petitioner injured his neck on May 9, 2011, took a 12 day vacation, continued to work, but had no neck complaints until 3 months later. At most, the records support that the incident on May 9, 2011 was a continuation of the Petitioner's complaints from his July 29, 2010 incident involving his left arm. For these reasons, the Arbitrator finds that the Petitioner did not sustain an accident on May 9, 2011.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has proven that he sustained a left lateral epicondylitis injury, which is causally related to his July 29, 2010 accident. However, Petitioner has not met his burden of proof with regard to the issue of whether his cervical condition is causally related to either the alleged incident on July 29, 2010 or his alleged accident from May 9, 2011. In support of this finding, the Arbitrator again refers to a close analysis of the Petitioner's treating medical records, which do not document any complaints of neck pain until August 11, 2011 – the date Dr. Mitchell reviewed Petitioner's MRI results. This notation of neck complaint is almost a year following the July 29, 2010 incident and 3 months following the alleged May 9, 2011 incident. Given the notable gap in time with regard to the Petitioner's neck complaints and his alleged accident dates, the Arbitrator finds no causal connection between the neck condition and the Petitioner's alleged accidents.

3. Based on the Arbitrator 's findings on the issues of accident and causation, the Petitioner's claim for TTD and maintenance benefits are denied. In support of this finding, the Arbitrator notes that the Petitioner was taken off work due to his cervical condition, which is not causally related to his alleged accidents.

4. Based on the Arbitrator's findings above, the Arbitrator finds that the Petitioner's medical treatment limited to his left epicondylitis was reasonable and necessary. Respondent shall pay for any medical expenses related to treatment of the Petitioner's left epicondylitis, subject to the fee schedule and in accordance with Section 8 of the Act. Petitioner's request for payment of expenses related to the treatment of his cervical condition is denied.

5. With regard to the issue of permanency, the Arbitrator finds that as a result of his accident from July 29, 2010, the Petitioner sustained an injury to his left arm resulting in left laterally epicondylitis. Petitioner underwent conservative treatment and a series of injections in his arm for this condition. Petitioner was able to return to work full duty following his treatment for this condition. Accordingly, the Arbitrator awards the Petitioner 10% loss of use of his left arm pursuant to the Act. Furthermore, the Arbitrator notes that the Petitioner's inability to return to work and his current physical restrictions are due to his unrelated cervical condition.

6. Based on the findings above and the issues in dispute, the Petition for Penalties and Attorney 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 Accident, Notice	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICIA BOGACKI,

Petitioner,

vs.

NO: 11 WC 33739

15IWCC0162

SAM'S CLUB,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission finds Patricia Bogacki sustained a work-related accident arising out of and in the course of her employment on February 13, 2009 and provided timely notice of same. The Commission finds Petitioner's bilateral shoulder condition is causally related to the work accident. The Commission awards Petitioner outstanding medical expenses of $777.15. The Commission further finds Petitioner is entitled to prospective medical treatment as recommended by Dr. Anthony Romeo, Respondent's Section 12 examiner.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the

matter, both from a legal and a medical/legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. According to the Application for Adjustment of Claim filed on September 1, 2011, the Petitioner was a 40 year old, single female with no dependants under the age of 18. The Petitioner alleged internal derangement and tendon tears to her bilateral arms as the result of pulling together shopping carts while at work on February 13, 2009.

2. Ms. Bogacki was employed by Sam's Club as a checkout supervisor for 7 years. She was also employed by Harley-Davidson as an account payable representative. On February 13, 2009, she felt a sharp, shooting pain in both shoulders while pulling together two shopping carts at Sam's. T.12. The incident occurred between 7:30 p.m. and 7:45 p.m. She reported it to her supervisor, Elvia Romero. The door greater, Maria Nitti, was also present and asked the Petitioner if she was okay as she was holding her arms. T.14. Petitioner assumed that a report was filled out. *Id.*

3. Petitioner work at Harley-Davidson from 8 a.m. to 5 p.m. and then Sam's in the evenings and on weekends. She has worked two jobs from 2001 through November 2011, working between 70 and 90 hours per week. T.34.

4. An Associate Accident Review Form was not completed until July 25, 2009. The injury date was listed as March 13, 2009. Her return to work date was listed as July 26, 2009. PX.8. According to the Associate Statement completed on July 25, 2009, Petitioner reported that she told either her co-worker or a cashier of the incident. She stated that she "kinda" reported the injury. She did not report the injury immediately because she could not afford to not work. *Id.*

5. The Petitioner called Raul Vial and Elvia Romero as witnesses on her behalf. Mr. Vial is the Asset Protection Manager for Sam's Club. He testified that not all accidents get reported in a written manner. T.49. He stated that by policy the form is to be completed within 7 days of the accident, which does not always happen. T.54. He did not hear any contradictions between Petitioner's testimony and the report. T.55.

6. Ms. Elvia Romero works in personnel and testified pursuant to Petitioner's subpoena. T.58. She only remembered the Petitioner coming to her and saying she got hurt at work. T.59. She was not positive if an accident report was filled out after the accident. T.60. She noticed that after February 13, 2009, Ms. Bogacki was not able to do a lot of lifting with her shoulder or arm, and she did not have this issue prior to February 13, 2009. T.62. She does not recall an incident occurring on July 25, 2009. T.67.

7. On cross-examination, Ms. Romero did not recall the exact date Petitioner reported the incident to her. T.64. It is company procedure to fill out the accident report as soon as the accident is reported. T.65. The report was filled out on July 25, 2009, which she stated was likely the date of the accident. *Id.*

8. Petitioner testified that she did not seek medical treatment the day of the accident as she thought she pulled something and it would heal with time. T.15. She first sought medical treatment on March 14, 2009.

9. Petitioner had a prior history of shoulder pain. She was seen by Dr. Robert Demke of Barrington Orthopedic Specialists on July 18, 2006 for discomfort in her neck and shoulder. She had symptoms in her right shoulder, right arm and shoulder blade. Dr. Demke noted Petitioner had multiple myofascial restrictions in her neck and scapulohumeral joint. Her symptoms were due to the overuse of her right shoulder due to extreme working conditions, which included working two jobs over 60 hours a week. Dr. Demke noted that her symptoms would continue until she adjusted her work schedule. Physical therapy was recommended. Petitioner was also seen by Dr. Demke on November 3, 2008 for pain in her right shoulder area and into her neck. PX.3.

10. Petitioner presented to Alexian Brothers on March 14, 2009 for right shoulder pain and right arm pain that radiated to the right side of her neck. It was listed as not work-related. PX.1. The record further indicated that Petitioner did a lot of heavy lifting at work. She was diagnosed with shoulder blade pain and a shoulder sprain.

11. Petitioner was seen by Dr. Demke on April 2, 2009. The handwritten record indicated that Petitioner sprained her right shoulder about 3 weeks prior. The diagnosis was a right shoulder sprain. RX.4. Petitioner testified that she was having pain in her shoulders when she lifted things. T.18.

12. Petitioner underwent an MRI of the right shoulder on April 4, 2009 at Alexian Brothers. The MRI revealed mild tendinopathy of the supraspinatus tendon. No rotator cuff tears were detected. PX.3.

13. Petitioner presented to Alexian Brothers on June 28, 2009 for numbness and tingling into her hands and forearms. It was noted this was not work-related. She did not have any muscle or joint pain. She reported right anterior shoulder pain upon awakening 5 days prior. She had throbbing anterior right shoulder pain. She admitted to heavy lifting at work. She was diagnosed with a shoulder sprain. PX.1.

14. Petitioner was seen by Dr. Demke on September 3, 2009 for right shoulder pain and cervical posterior neck pain. She reported right posterior shoulder pain along the

medial border of her scapula which had been present since December 2006 after sleeping on a new pillow. Her pain started to radiate to the left about a month ago. It was again noted to not be work related. She had a positive Hawkins and Neer sign. The impression was right medial scapular pain. PX.3.

15. Petitioner was seen by Dr. Daryl Luke of Barrington Orthopedic Specialist on November 3, 2009. She had a new condition and complained of bilateral shoulder pain after a work injury 9 months prior. Her left shoulder range of motion with active flexion was to 100 degrees with pain and her abduction was 80 degrees. Her internal rotation was up the back to the back pocket and her external rotation was to 40 degrees. She had a positive Hawkins and Neer sign. Her right shoulder revealed active range of motion to 100 degrees and abduction to 80 degrees. Her internal rotation was up the back to the back pocket and external rotation was to 40 degrees. She had a positive Hawkins and Neers sign. X-ray of the left and right shoulder revealed degenerative joint disease of the acromioclavicular joint, type 2 acromion. The assessment was shoulder impingement. PX.3.

16. Petitioner was seen by Dr. Luke on November 24, 2009. She was post bilateral subacromial bursal injections for impingement syndrome which was secondary to a work-related injury. Her left shoulder had improved more than her right. Her right shoulder was somewhat stiff and painful. The impression was bilateral shoulder impingement with poor shoulder range of motion. PX.3.

17. Petitioner was seen by Dr. Demke on December 1, 2009 for right medial scapular pain. She reported a constant stiff, shooting pain in her right shoulder blade with intermittent numbness and tingling in the upper back that radiated to her right neck area. The pain started 3 years ago and had become progressively worse. She also had right hand numbness. She had a trigger point injection in September 2009 that lasted 2 months. Physical therapy for her right shoulder provided moderate relief. The diagnosis was shoulder impingement. PX.3.

18. Petitioner contacted Dr. Luke's office on February 10, 2010 and reported that her boyfriend grabbed both of her shoulders between 10 and 15 times and she was now having increased pain in the shoulder. PX.3.

19. Petitioner underwent an MRI of the left shoulder on February 18, 2010 at Open MRI. The MRI revealed stress changes of the AC joint without definite AC separation, and mild rotator cuff tendinosis without a rotator cuff tear. PX.3.

20. Petitioner underwent a Section 12 examination with Dr. Anthony Romeo on April 30, 2010 at the request of the Respondent. Dr. Romeo diagnosed Petitioner with impingement syndrome and bicipital tendinitis, right shoulder greater than left. Based on the lack of prior shoulder issues, her current condition was causally related

to the work injury. Her subjective complaints were supported by objective findings. She could either live with her condition or undergo surgical intervention. He found no evidence of symptom magnification. PX.3.

21. Dr. Luke performed an arthroscopy of the right shoulder, debridement of the superior labral fraying, arthroscopic subacromial decompression, and mini open bicep tenodesis on May 21, 2010. There was mild fraying of the superior labrum posterior to the bicep tendon. The rotator cuff was intact. PX.3.

22. Dr. Luke performed an arthroscopy of the left shoulder, debridement of anterior and posterior labral fraying, arthroscopic subacromial decompression and mini open bicep tenodesis on November 24, 2010. There was no evidence of glenhumeral joint arthiritis. The anterior and posterior labrum showed some fraying. The bicep tendon was intact, though there was some mild fraying within the bicipital groove, but no evidence of a tear or redness. There was no evidence of a rotator cuff tear. The bicep tendon was partially retracted. PX.3.

23. Petitioner was seen by Dr. Luke on December 14, 2010. He noted Petitioner was improving with physical therapy and had rapid improvement with range of motion and symptoms with the left shoulder compared to the right. She was off work, but wanted to return to work in a restricted fashion. Her anterior pain had resolved on both sides. Passively, her left shoulder forward flexion was to 90 degrees, abduction to 80 degrees, internal rotation to 40 degrees and external rotation to 70 degrees. She had no pain with passive range of motion until the limits. Her right shoulder revealed active forward flexion to 160 degrees, abduction to 120 degrees, internal rotation to the lumbar spine and external rotation to 80 degrees. Her strength was diminished in all planes 4/5. She had a negative Crossover, Speed, O'Brien, Hawkins and Impingement. She was to continue with her left arm in a sling. She was returned to work on December 15, 2010 with a 5 pound lifting restriction. PX.3.

24. Petitioner underwent physical therapy on December 29, 2010. Her right active range of motion with flexion was to 130 degrees, abduction was 105 degrees, internal range of motion was 52 degrees and her external rotation was 72 degrees. On January 3, 2011, her left shoulder active range of motion on flexion was to 105 degrees, passive to 120 degrees, abduction to 80 degrees, passive to 108 degrees, internal rotation to 66 degrees and external rotation to 38 degrees. PX.3.

25. Petitioner was seen by Dr. Luke on January 4, 2011. She reported a significant increase in bilateral shoulder pain after being assaulted by her boyfriend. On January 3, 2011, her boyfriend pulled both of her arms again and hit her in the face. She had bicipital groove tenderness in both shoulders. Her range of motion of the left shoulder was 100 degrees on forward flexion, 90 degrees of abduction and external rotation to 70 degrees. She had no pain with passive range of motion of the left shoulder to the

limits. She had normal strength distal to the shoulder and elbow region on the left. There were no provocative signs to the left shoulder. Her right shoulder range of motion was 140 degrees of forward flexion, 100 of abduction, and external rotation to 70 degrees. There were no provocative signs. Her strength was 4/5 in all planes of the right shoulder. PX.3.

26. Ms. Bogacki testified that after the domestic violence incident, her pain would spike for a little bit (8 to 9 hours) and then go back to the normal levels of pain. T.31

27. Petitioner was seen by Dr. Jonathan Dunn on January 21, 2011 as Dr. Luke was out of the office. She had worsening left shoulder pain after being assaulted by her boyfriend. Her pain had worsened since she last saw Dr. Luke on January 4, 2011. Examination revealed mild to moderate distress. She had significant tenderness over the bicipital groove of her left shoulder. Her active forward elevation was limited to 80 degrees on the left. Her active abduction on the left was to 40 degrees. She had limited external rotation at 10 degrees on the left. She had significant pain with any passive range of motion of her shoulder even with the elbow kept at her side. Her strength was reduced in the biceps, triceps, infraspinatus and subscapularis. She appeared to have lost motion and was more uncomfortable. She received an injection. An MRI of the left shoulder was recommended due to the significant pain. He was concerned about the possibility of failure of the biceps tenodesis or worsening shoulder pain due to this new injury. Her presentation also included adhesive capsulitis as a cause of her worsening shoulder pain as well as complex regional pain syndrome. PX.3.

28. Petitioner underwent an MRI of the left shoulder on January 26, 2011 at Open MRI. There was no evidence of a bicep tendon tear, recurrent labral tear or rotator cuff tear. She had worsening rotator cuff tendinosis. There was fluid in the subacromial/subdeltoid bursa. She had moderate effusion of the acromioclavicular joint postoperative change and worsening surrounding bone marrow edema. There was small glenohumeral joint effusion. PX.3.

29. Ms. Bogacki was seen by Dr. Luke on March 8, 2011. She had a left bicep tendon cortisone injection which provided 20 percent improvement of her left anterior shoulder pain. Her active flexion of the left shoulder was 150 degrees and abduction was 80 degrees. Her bicep strength was 4/5. She had a positive Yergason, Speed, O'Brien and Hawkins. She had a negative Neer, Drop and Crossover. The right shoulder revealed active flexion to 170 degrees and abduction to 100 degrees. The Crossover, Speed, O'Brien, Hawkins, and Neer were all negative. PX.3.

30. Petitioner was seen by Dr. Luke on April 19, 2011. She reported that her right shoulder was much improved compared to the previous visit. She still had good days and bad days. She had bicipital groove tenderness in the left shoulder. Her active

flexion was 0 to 110 degrees and abduction to 90 degrees. External rotation was to 60 degrees. Her bicep strength was 4/5. She had a positive Yergason, Speed, O'Brien, and Hawkins sign. Her Neer, Drop Arm and Crossover tests were negative. The right shoulder had no tenderness. Her active flexion was 150 degrees, and abduction was 110 degrees. Her external rotation was to 70 degrees. The Crossover, Speed, O'Brien, Hawkins, and Neer were all negative. The diagnosis was left shoulder pain. PX.3.

31. According to the nurse's note from Barrington Orthopedics dated June 6, 2011, the Petitioner called and reported that she reinjured her right shoulder at work when she jammed her shoulder on the exit door. She had increased pain and pain with flexion and abduction. PX.3.

32. Petitioner was seen by Dr. Anthony Romeo on June 14, 2011 to determine her left shoulder treatment. He noted Petitioner could either live with her current situation, go to physical therapy and have injections and take anti-inflammatory medication, or undergo a left shoulder arthroscopy, subacromial decompression, distal clavicle resection, evaluation of her rotator cuff and revision open bicep tenodesis. He recommended a repeat MRI to evaluate her rotator cuff. She was to continue her light duty restrictions. PX.3.

33. Petitioner underwent an MRI of the left shoulder on June 23, 2011 at Open Advanced MRI. There were post bicep tenodesis changes, but the bicep tendon appeared to be attached to the anterior aspect of the humeral head with a screw. There was mild degeneration of the acromioclavicular joint. Her rotator cuff was intact. There was some degeneration of the glenoid labrum. PX.3.

34. Petitioner underwent a Section 12 examination with Dr. Prasant Atluri of Hand Surgery Associates on August 9, 2011. She complained of numbness and tingling in both upper extremities. Examination revealed no snapping or crepitus. There was no atrophy when inspected from behind. She had pain with palpation throughout both shoulders, paraspinal, and the supraciavicular area. She reported pain with any rotator cuff testing. She had 5/5 strength in her left shoulder, which seemed slightly weaker than the right. He noted the June 23, 2011 MRI of the left shoulder was of poor quality; however, no rotator cuff tears were seen. His impression was bilateral shoulder pain and numbness and tingling in the bilateral upper extremities. He noted the specific nature of her shoulder pain was unclear at the time. The intra-operative findings did not reveal significant evidence for adhesive capsulitis. He noted that the pre-operative physical findings as well as the response to cortisone injections and improvement in the right shoulder following the subacromial decompression with a biceps tenodesis was suggestive that she may have had impingement syndrome along with biceps tendon related pain in the right shoulder. The pre-operative physical findings as well as the partial temporary relief following the cortisone injections into

the left shoulder were suggestive of some contribution of impingement syndrome to the left shoulder. However, the incomplete relief following the injection and failure to improve postoperatively suggested the left shoulder pain may not represent mechanical shoulder pathology. The numbness and tingling in both shoulders was of unclear etiology. The electrodiagnostic studies were not consistent with her subjective complaints. He stated that the treatment had been reasonable and appropriate. He noted that pushing two carts together with her arms outstretched and abducted would not be expected to contribute to the development of shoulder impingement. It could have contributed to bicep tendinitis. Her initial bilateral shoulder pain would be considered work related. She had no ongoing condition related to her work injury. She was at MMI. She needed no work restrictions. He noted that the increase in shoulder complaints following a domestic violence incident aggravated her shoulder condition and caused the numbness and tingling in the upper extremities. She did not need surgery. PX.3.

35. Petitioner last worked for Sam's Club on November 11, 2011. T.31. She continues to work at her accounting job. T.33.

36. On September 11, 2012, Dr. Luke authored a letter to Petitioner's attorney. He opined that Petitioner's present state of ill-being with respect to both shoulders was a direct result of the work injury. The domestic violence incident that occurred one time may have aggravated her underlying shoulder issues but did not cause her present state of ill-being. She could work full-duty with a chronic lifting restriction of 5 to 10 pounds to both upper extremities. Her chronic pain most likely would not abate with or without any further surgical or nonsurgical intervention. He recommended pain management. PX.3.

37. Petitioner was seen Dr. Luke on March 26, 2013 for bilateral shoulder pain that was intermittent and worsening. There was no radiation. She had been able to work full-duty at her desk job. She reported that right shoulder trigger points were now occurring on the left shoulder. Dr. Luke did not feel her shoulder pain would ever resolve completely. The assessment was bilateral chronic shoulder pain. He recommended an evaluation by Dr. Romeo and if he did not recommend surgery then Dr. Luke would recommend pain management. PX.3

38. Petitioner currently experiences continuous pain in both shoulders. She has problems sleeping at night. T.32. She takes Tramadol once daily. *Id.* She can no longer participate in sports without having pain. She has help carrying the groceries and doing the laundry. T.33. She cannot exercise as much and has lost muscle tone. *Id.* Her pain is not tolerable and she would like to undergo surgery. T.34.

39. Dr. Luke was deposed May 24, 2013 and is a board certified orthopedic surgeon. During the January 4, 2011 examination he noted Petitioner's shoulder pain worsened

the day prior due to the domestic violence. He stated that this event did not break any causal connection. PX.11. pg.29.

40. Dr. Luke testified that he is recommending either surgery, live with the pain, or pain management. PX.11. pg.40. The history of domestic abuse did not change his opinion, it was a temporary aggravation. The treatment he is recommending is causally related to the accident. PX.11. pg.42.

41. Dr. Prasant Atluri was deposed on March 20, 2013 and is a board certified orthopedic surgeon with a certificate of added qualifications of surgery of the hand. RX.1. He performed a Section 12 examination of the Petitioner on July 26, 2011. He stated that the mechanism of injury could have caused pain in her biceps. He could not explain her shoulder pain in the left shoulder. RX.1.pg.17. He stated that some of her complaints could be attributable to the work incident. RX.1.pg.19. Her post-operative complaints, by 6 months, were not related to her work accident. RX.1. pg.20. As of July 2011, she was at MMI. She could work full-duty and without any specific restriction. *Id.* He stated that pulling on the arm 10 to 15 times could be a plausible contributing factor for the development of Petitioner's upper extremity pain. RX.1. pg.24. He did not recommend any further treatment or surgery. RX.1. pg.25.

42. On cross-examination, he testified that he did not recommend a medical work up to clarify the pain. RX.1. pg.32. He thought her treatment was reasonable and necessary. He noted petitioner was complaining of bilateral shoulder pain prior to the domestic abuse issue. RX.1. pg.35. He could not state whether the domestic abuse was a temporary or permanent aggravation as he did not see any point at which it was indicated that her pain had decreased to her prior level. RX.1. pg.36. He was not aware that both Dr. Luke and Dr. Romeo have recommended another arthroscopic surgery. RX.1. pg.37. He stated that her initial bilateral shoulder pain would be considered related to the work injury.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

For an accidental injury to be compensable under the Act, a Petitioner must show such injuries arose out of and in the course of his employment. *Eagle Discount Supermarket,* 82 Ill. 2d at 337-38, 412 N.E.2d at 496; *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill. App. 3d 1103, 1106, 641 N.E.2d 578, 581, 204 Ill. Dec. 354 (1994)."Arising out of" refers to the requisite causal connection between the employment and the injury. In other words, the injury must have

had its origins in some risk incidental to the employment. See *Eagle Discount Supermarket,* 82 Ill. 2d at 338, 412 N.E.2d at 496; *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. "In the course of" refers to the time, place, and circumstances under which the accident occurred. See *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. Whether the claimant suffered from a compensable accident is a question of fact to be determined by the Commission. *National Freight Industries v. Illinois Workers' Compensation Comm'n,* 2013 IL App (5th) 120043WC, ¶ 26, 993 N.E.2d 473.

[A] claimant's testimony, standing alone, may support an award where all of the facts and circumstances do not preponderate in favor of the opposite conclusion. *Seiber v. Industrial Com.*, 82 Ill. 2d 87, 89, 411 N.E.2d 249, 250, 1980 Ill. LEXIS 400, 1, 44 Ill. Dec. 280, 281 (Ill. 1980). The Commission finds the totality of the evidence supports that Petitioner sustained a compensable accident on February 13, 2009. The Commission relies on the Petitioner's consistent history of accident, and the opinions from the medical doctors, including Respondent's Section 12 examiners who found that the mechanism of injury was consistent with Petitioner's condition of ill-being.

Furthermore, 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. The Petitioner's testimony that she encountered difficulty performing her job duties after February 13, 2009 was not rebutted. Rather, Petitioner's witness, Ms. Romero testified that she noticed Petitioner was unable to do a lot of lifting with her shoulder or arm after February 13, 2009. Further, the medical records beginning March 14, 2009 indicate right shoulder pain and that she performed heavy lifting at work. While the Petitioner had prior shoulder issues, no evidence was introduced to support that Petitioner's pre-existing condition prohibited her from performing her job duties. Rather, the evidence establishes that the Petitioner was able to work two job working up to 90 hours per week, every week.

The Commission notes that the medical records reveal that Petitioner was involved in two domestic altercations that involved her shoulders. The Commission does not find that either of those incidents break the chain of causal connection. While the records reflect Petitioner had domestic violence incidents, the records immediately before and after the incidents do not reflect any significant change in her condition.

The first incident was reported in Dr. Luke's record dated February 10, 2010. Petitioner reported increased shoulder pain. The medical records just prior to that incident indicate that Petitioner was experiencing shoulder pain and had poor range of motion. She was also undergoing physical therapy. There is no indication that this event significantly altered her condition or the recommended course of treatment. The second event was documented in Dr. Luke's January 4, 2011 record. Petitioner reported significant increase in shoulder pain as a result of the assault. The Commission notes, however, that the Petitioner underwent surgery on November 24, 2010 and Dr. Luke stated that shoulder pain was to be expected following surgery. Further, the Petitioner had just been returned to work in mid-December. The medical records

from December 2010 reveal that Petitioner did not have full range of motion and had diminished strength.

While the Petitioner testified that this incident caused her pain to spike, the Commission finds that it did not significantly alter her condition or the course of treatment. The Petitioner was still under active medical treatment prior to the assault and her condition had not stabilized. Further, Dr. Luke testified that pulling the arms strained the shoulder, but did not cause any stress changes in the shoulder. He testified that the domestic violence did not break any causal connection. The Commission finds Dr. Luke's opinion persuasive in that he had a lengthy history treating the Petitioner and was familiar with her complaints before and after the surgery. Further, the MRI dated January 26, 2011 revealed joint effusion, which was not present in the subsequent MRI dated June 23, 2011. The MRIs support Dr. Luke's opinion that the domestic violence incidents caused a temporary aggravation, at most.

The Commission finds Dr. Atluri's opinion not persuasive. Dr. Romeo found causal connection on two occasions. Dr. Atluri noted that Petitioner had pain, but did not perform a work-up to determine the cause of the pain. The Commission finds Dr. Atluri's opinion generic in that he finds that 6 months post-op her pain was not related to the original accident despite conceding that the mechanism of injury was consistent with her complaints. Therefore, the Petitioner established accident and causal connection.

The Commission also finds that Petitioner provided timely notice of her injury. Section 6(c) of the Act requires the claimant to give notice of the accident "to the employer as soon as practicable, but not later than 45 days after the accident." 820 ILCS 305/6(c). Section 6(c) further provides that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." *Id.*

Whether the claimant gave timely notice required by section 6(c) of the Act is a finding to be made by the Commission which will not be disturbed on appeal unless it is against the manifest weight of the evidence. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 95, 631 N.E.2d 724, 727, 197 Ill. Dec. 502 (1994). The purpose of the notice requirement is "both to protect the employer against fraudulent claims by giving him an opportunity to investigate promptly and ascertain the facts of the alleged accident and to allow him to minimize his liability by affording the injured employee immediate medical treatment." *United States Steel Corp. v. Industrial Comm'n*, 32 Ill. 2d 68, 75, 203 N.E.2d 569, 573 (1964). The notice is jurisdictional, and the failure of the claimant to give notice will bar his claim. *Thrall Car Manufacturing Co. v. Industrial Comm'n*, 64 Ill. 2d 459, 465, 356 N.E.2d 516, 519, 1 Ill. Dec. 328 (1976). However, a claim is only barred if *no* notice whatsoever has been given. *Silica Sand Transport, Inc. v. Industrial Comm'n*, 197 Ill. App. 3d 640, 651, 554 N.E.2d 734, 742, 143 Ill. Dec. 799 (1990). "If some notice has been given, but the notice is defective or inaccurate, then the employer must show that he has been unduly prejudiced." *Id.*

The Commission finds that the Petitioner provided timely notice of the accident to her supervisor, Ms. Romero. Ms. Romero testified that she recalled that the Petitioner mentioned to her that she got hurt at work. While an accident report was not filled out until July 25, 2009, Ms. Romero testified that she did not recall an incident occurring on July 25, 2009. She further testified that Petitioner was unable to do a lot of lifting after February 13, 2009. While it was company policy to fill out an accident report immediately following an accident, Raul Vial, the Asset Protection Manager for the Respondent, testified that this did not always happen. Further, the Commission finds that the Respondent offered no evidence that it was unduly prejudiced, assuming notice had been found to not be timely.

The Commission further awards Petitioner prospective medical treatment as recommended by Dr. Romeo. The Petitioner is also entitled to medical expenses totaling $777.15.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 29, 2014, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $777.15 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment as recommended by Dr. Romeo.

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.

15IWCC0162

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAR 9 - 2015

Michael J. Brennan

Thomas J. Tyrrell

MJB/tdm
O: 1-6-15
052

Dissent

I respectfully dissent from the Majority's decision. I would affirm and adopt Arbitrator Doherty's decision. The Arbitrator's findings are thorough and persuasive. I would affirm this decision in its entirety.

Kevin W. Lamborn

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

BOGACKI, PATRICIA
Employee/Petitioner

Case# **11WC033739**

SAM'S CLUB
Employer/Respondent

15IWCC0162

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:

1042 LAW OFFICE OF OSVALDO RODRIGUEZ PC
7704 W NORTH AVE
ELMWOOD PARK, IL 60707

0560 WIEDNER & McAULIFFE LTD
JUSTIN SCHOOLEY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

15IWCC0162

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Patricia Bogacki
Employee/Petitioner

v.

Sam's Club
Employer/Respondent

Case # 11 WC 33739

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 **Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **June 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. ☒ 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 **Nature and Extent**

15IWCC0162

FINDINGS

On **2/13/2009**, 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 not*** sustain an accident that arose out of and in the course of her employment.

In the year preceding the injury, Petitioner earned **$51,072.84**; the average weekly wage was **$982.17**.

On the date of alleged accident, Petitioner was **40** years of age, ***single*** with **0** dependent children.

Based on the finding of no accident, no findings are made on the remaining disputed issues. SEE DECISION

ORDER

Based on the Arbitrator's finding of no accident, all benefits are denied. SEE DECISION

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 Doherty
Signature of Arbitrator

7/29/14
Date

ICArbDec19(b)

JUL 29 2014

FINDINGS OF FACT

Petitioner testified that on 2/13/09 she worked as a check out supervisor for Respondent Sam's Club and had been so employed for 7 years. Her job duties included supervising the cashiers, returning merchandise from the front end of the store to the shelves and general supervision of the check out area. Petitioner testified that these job duties required her to lift up to 50 pounds, move a maximum of 10 shopping carts simultaneously, load merchandise into customer cars and team lifts with cashiers.

Petitioner testified that she worked concurrently at Harley performing a desk job including computer work and light filing. The job did not require lifting. Petitioner worked at Harley during the day and at Sam's club at night and on weekends. Petitioner worked between 70 and 90 hours per week between the two jobs.

Petitioner testified that on 2/13/09, she was working for Respondent Sam's Club at the store front getting ready for the close of the store. Accordingly, she was in the process of moving all empty carts to the front of the store. Petitioner testified that she had her left hand on the handle of the cart to her left and her right hand on the handle of the cart to her right as she tried to force the two carts together. Petitioner testified that while forcing the two carts together she felt a sharp shooting pain in both shoulders. Petitioner testified that the incident occurred between 7:30 and 7:45 pm.

Petitioner further testified that the incident was observed by the front door greeter Maria Nitti who asked Petitioner if she was "okay". Petitioner further testified that she reported the incident to an available supervisor, Elvia Romero, "right away." Petitioner assumed Ms. Romero completed a report but she was not certain. RX 2 is an "Associate Accident Review Form." The form indicates that Elvia Romero took the information and that Kathlean Maacon entered the report into the system. The date of injury is listed as 3/13/09 and indicates an initial treatment date of 3/13/09. The report indicates a "treatment notification date" of 3/13/09 and a "date reported to store/location" of 7/25/09. RX 2. The report contains an accident history consistent with Petitioner's trial testimony.

Petitioner called Elvia Romero to testify pursuant to subpoena. Ms. Romero stated that she had no discussions with Petitioner or her counsel prior to trial. Ms. Romero testified that she was working with Petitioner in the same store location in 2009. With regard to an accident, Ms. Romero could not testify that the accident occurred on the date of 2/13/09 but rather testified "I guess all I remember about her having an accident is she came to me and she said she got hurt—at work." T. 59. Ms. Romero testified that she followed procedure and completed the required paperwork and submitted the paperwork to Ms. Maacon. T. 61. She testified that after 2/13/09 she noticed Petitioner was "not able to do a lot of lifting. She wasn't able to do a lot with her arm or shoulder or just her whole arm." T. 62. She does not recall Petitioner having this problem before her accident. Ms. Romero further testified that Petitioner was "doing something with the shopping carts. She was pushing them or pulling them apart when she heard something like snap on her shoulder or hurt on her shoulder, a pain." Finally, she testified that this occurred "the day that she reported the incident." T. 63.

Petitioner called Paul Vial as an adverse witness at trial. Mr. Vial is an asset protection manager for Respondent. He did not work at the same store with Petitioner at the time of her accident. Mr. Vial's job duties include overseeing compliance with the store safety program and to ensure the completion of accident reports. He conceded that not all reports are completed in a written manner. T. 49. Mr. Vial

testified that he reviewed RX 2 and that it contains a consistent incident description with first medical care on 3/14/09. Ms. Maacon entered the claim into the reporting system. Respondent did not call Mr. Vial in its case and performed no cross exam of this witness.

Petitioner testified that she thought the pain would resolve on its own so she did not seek medical treatment immediately. Petitioner testified that she was asked if she wanted medical treatment but responded that she would wait to see if the pain subsided on its own.

Petitioner's first date of treatment for her shoulder complaints was on 3/14/09 when she went on her own to Alexian Brothers. PX 1. The hand written notes from that visit indicate chronic/inactive conditions including "shoulder blade pain x – yrs." The number of years is not discernable on the records. The date of onset is listed at 3/10/09. The written history reads, "right ant shoulder pain upon awakening 5 d ago. Throbbing ant R shoulder pain with rad to arm and hand, exac by movement, improved with ice, constant 2/10. Patient admits to heavy lifting at work." PX 1. Exam showed tenderness and impingement on the right shoulder and trapezius. Petitioner was diagnosed with right shoulder sprain and prescribed a heating pad, massage and Tylenol. PX 1. No work restrictions were provided.

Petitioner next saw Dr. Demke for her right shoulder complaints on 4/2/09. Regarding her prior medical treatment, Petitioner testified that prior to February 13, 2009, she had some treatment for carpal tunnel and elbow problems as well as neck problems but denied treatment for her either shoulder. T. 20-21. Dr. Demke's records reflect that on 1/17/06, Petitioner complained of neck pain. A 2/19/06 cervical MRI was performed due to long term neck pain and the results were negative. Petitioner was sent to physical therapy. On 7/18/06, Petitioner presented to R&S Physical Therapy, reporting that in December 2005, she began having discomfort in her neck and shoulder. Pain was noted mostly in the right side of her neck, but was noted to also extend into the right shoulder and right arm and right shoulder blade. Petitioner reported working many hours but was not sure how the problem started. RX 4. Dr. Demke's records further reflect that on November 3, 2008, Petitioner presented to Dr. Demke reporting pain in her right shoulder area into the neck. No history of injury was reported. Petitioner was diagnosed with a parascapular sprain. RX 4.

On 4/2/09, Dr. Demke's records note that Petitioner reported a sprain to her right shoulder 3 weeks earlier. Petitioner testified that she told Dr. Demke that she had shooting pain in her shoulders when lifting. A right shoulder MRI was ordered and performed on 4/4/09. The MRI results indicated "mild tendinopathy of the supraspinatus tendon. No rotator cuff tear detected." RX 4. Petitioner testified that Dr. Demke prescribed pain medication and advised Petitioner that her right shoulder complaints could heal with medication but that she should return to see him if she did not improve. Petitioner testified that her pain did not improve so Dr. Demke referred her to Dr. Luke for further treatment in September 2009. Petitioner did not seek treatment between April and September 2009 while waiting for the pain to subside on its own.

On 9/3/09 Petitioner saw Dr. Luke who noted "Patient complains of right posterior shoulder pain along the medial border of her scapula since 12/2006 after seeping on a new pillow. The pain radiates up her neck. About a month ago, the pain has started to radiate to the left scapula. The pain is worse with turning her head, writing, and lifting her arms. She has seen an orthopedic surgeon in 2006 for the above complaints. Ex-rays and MRI of the cervical spine reported no abnormalities. She had a trial of physical therapy that gave some pain relief. ..." RX 4. Right shoulder range of motion was limited due to pain on

exam. Under the diagnosis of right shoulder pain and posterior cervical neck pain Dr. Luke administered injection to the right medial mid scapular trigger point. Petitioner testified that prior to this incident she did not have any shoulder problems. Petitioner did testify to prior neck pain and carpal tunnel problems.

On 11/3/09, Petitioner returned to Dr. Luke who noted, "status post workers' compensation injury. Bilateral shoulder symptoms. Date of injury 2/13/09." Dr. Luke further noted, "Patricia Bogacki is a 41 year old established patient seen in the office today with a new condition. Patient complains of bilateral shoulder pain after an injury at work about 9 months ago. She was working at Sam's club and felt pain in both shoulders after pulling 2 shopping carts together. She had x-rays and MRI of the cervical spine and an MRI of the right shoulder in April 2009 at Alexian Brothers. She was seen by her PCP, Dr. Demke, and was given Tylenol 3 for the pain. The pain in her shoulder is worse with writing, lifting, pushing, and driving. She denies clicking or popping in her shoulders. She has not had physical therapy or cortisone injections to the shoulders. She has been working full duty since the initial injury." RX 4. Dr. Luke administered subacromial injections to both shoulders. He ordered physical therapy 2 to 3 times per week for 4 to 6 weeks. He further limited Petitioner to no lifting over 10 pounds with either arm and no over the shoulder activities.

Dr. Luke ultimately recommended right shoulder surgery under a diagnosis of shoulder impingement and adhesive capsulitis of the shoulder. Petitioner was sent for a Section 12 exam with Dr. Romeo who agreed with the need for right shoulder surgery. On 5/21/10, Dr. Luke performed a diagnostic arthroscopy of the right shoulder, debridement of superior labral fraying, arthroscopic subacromial decompression, and mini open biceps tenodesis. PX 3. After surgery, Petitioner returned to work with restrictions against lifting over 5 pounds. Petitioner worked her normal schedule and job under this restriction. Petitioner also attended physical therapy for her right and left arms post right arm surgery. Based on continued complaints of left shoulder pain Dr. Luke administered injections to Petitioner's left arm along with medication and work restrictions. However, the left arm injections only helped temporally and on 11/24/10 Petitioner underwent surgery for her left shoulder. Under a pre-op diagnosis of chronic left shoulder pain secondary to biceps tendinitis and impingement syndrome, Dr. Luke performed a diagnostic arthroscopy of the left shoulder, debridement of anterior and posterior labral fraying, arthroscopic subacromial decompression, and min open biceps tenodesis. PX 3.

Petitioner followed up with Dr. Luke in January 2011. On 1/4/11, Dr. Luke noted that Petitioner was attending post-surgical PT. He also noted that Petitioner reported a significant increase in bilateral shoulder pain resulting from a domestic assault during which both arms were pulled. Petitioner testified she had constant shoulder pain before the domestic violence but that her pain was spike by the incident and then returned to baseline constant shoulder pain thereafter. On 1/21/11, Dr. Luke noted increased continued left shoulder pain and ordered an MRI. The MRI indicated worsening rotator cuff tendinosis without tear and no evidence of biceps tear. PX 3. Petitioner was given more injections to the left shoulder and continued on work restrictions. On 3/8/11, Dr. Luke referred Petitioner to Dr. Romeo for further evaluation and treatment of the left shoulder. PX 3. In July 2011 Petitioner saw Dr. Romeo and he recommended repeat left shoulder arthroscopy, subacromial decompression, distal clavicle resection, evaluation of the rotator cuff and revision open biceps tenodesis. He also indicated that Petitioner could live with her problems undergoing conservative treatment only to control the symptoms. However, on 7/26/11, Petitioner was sent for a Section 12 exam with Dr. Atluri who recommended no further treatment and returned Petitioner to full duty work.

Dr. Atluri testified that Petitioner presented a history of bilateral upper extremity pain following the accident at work in February 2009. RX 1, p. 9. At the time he saw Petitioner she still had bilateral shoulder pain complaints and could not lift her left arm above her shoulder level and pain with rest and range of motion. RX 1, p. 11. Petitioner also reported numbness and tingling in her hands beginning in her mid-forearm. Petitioner also reported some tingling in her fingers and some neck pain before the accident but that these symptoms became worse after the accident. RX 1, p. 11. Petitioner advised that additional left shoulder surgery had been recommended following the failure of cortisone injections to alleviate the pain.

Dr. Atluri examined Petitioner and noted positive cross arm test on the right, and positive Hawkins sign on the right. RX 1, p. 14. Dr. Atluri reviewed the MRI film from the left shoulder MRI of 6/23/11 and noted that it did not show any rotator cuff tears but showed only hardware at the humeral head. After the examination and review of Petitioner's treating records covering her right and left shoulders, Dr. Atluri's impression was bilateral shoulder pain and numbness and tingling in her bilateral upper extremities. He was unable to determine the cause of her continued right shoulder symptoms but that the mechanism of injury described could have caused pain in her right biceps. With regard to the left shoulder, Dr. Atluri was similarly unable to explain the cause of Petitioner's left shoulder complaints. Dr. Atluri agreed that Petitioner's preoperative complaints could be attributed to the work accident but he could not attribute the post-operative complaints, six months after surgery, to the accident. RX 1, p. 19. Rather, he opined that Petitioner's continued complaints 6 months post-surgery were not attributable to the accident. This opinion is in part based on the record of 1/4/11 wherein Dr. Luke noted the domestic abuse incident and a worsening of her shoulder pain after that incident. RX 1, p. 34-36. Dr. Atluri further opined that any pain after 6 months post-surgery is not related to the work injury as the mechanical pain should have resolved by that time. RX 1, p. 32,47. He opined that Petitioner's pain had no organic basis.

He further opined that Petitioner did not need any additional treatment and could work without restrictions. RX 1, p. 25.

Dr. Luke also testified via deposition. He testified that he first saw Petitioner in September 2009 for an "unrelated issue." His first visit with Petitioner for her "this injury" on 11/3/09. PX 11, p. 9. With regard to the domestic violence incident noted on 1/4/11, Dr. Luke indicated that the incident caused tenderness in both shoulders but "not unusual tenderness from the fact she had her surgery,... within a six or eight-month period of time." Dr. Luke opined that the event did not interrupt his opinion on causal connection between Petitioner's continued condition and the original accident. PX 11, p. 29,41. He further testified that immediately after the 1/4/11 visit, he continued to treat Petitioner with previously ordered medical management and that the incident did not result in the need for any additional treatment. PX 11, p. 29.

Petitioner continued to complain of left shoulder symptoms worse than right so he sent her back to Dr. Romeo for evaluation of additional surgery on the left shoulder. Dr. Romeo agreed to the need for additional left shoulder surgery. PX 11, p. 31. Dr. Romeo advised that Petitioner could live with her condition and conservative management or undergo a revision surgery to the left shoulder. PX 11, p. 33.

Finally, Dr. Luke testified that he saw Petitioner in September 2009 for unrelated neck pain for which she had trigger point areas of inflammation along her medial border of her scapula or posterior left shoulder region. PX 11, p. 44. This reported pain started in August 2009. PX 11, p. 45. Dr. Luke summarized that the anterolateral shoulder pain was related to a work injury and the posterior medial scapular pain

was a pre-existing trigger point problem, "not related to a workmen's comp claim." PX 11, p. 48,63. Dr. Luke testified that the medial scapular pain is a "separate issue" from the shoulder joint. PX 11, p. 63. Dr. Luke again testified on cross exam that any exacerbation of Petitioner's symptoms after the January 2011 domestic violence incident was temporary. PX 11, p. 55. Finally, with regard to the prescribed surgery, Dr. Luke testified "It would hopefully make her better. It's not going to make all of her pain go away. I don't think all her pain is going to go away no matter what is done. The goal is to help decrease her pain and you know, that's a decision she has to make if she wants to take that chance that she could potentially be unchanged with surgery." PX 11, p. 62. Dr. Luke also testified that if Petitioner does not have surgery, pain management is an option. PX 11, p. 66.

Lastly, on the issue of causal connection, Dr. Luke testified, "She came to see me back in November of 2009 for what she claims is a work injury that occurred back in February of 2009. Prior to that, I have no other recollections of any other injuries so I go by what I was told and my documentation and records state she came in for a work injury that occurred at Sam's Club by pulling these two carts together. That was again verified multiple times along the way independently by Dr. Anthony Romeo, by myself, by her work comp carriers who approved surgery for that so I am not sure what the issue is." PX 11, p. 66.

Following the Section 12 exam with Dr. Atluri, all benefits were denied. Petitioner has not been released to full duty work at any time by her treating doctors. Petitioner's last day working for Respondent was 11/11/11. Petitioner's last visit to Dr. Luke was in 2012. At that time he again recommended surgery on both shoulders to be performed Dr. Romeo. Petitioner testified that her option is to live with the pain if tolerable or have the recommended surgery. Petitioner wants to undergo the recommended surgery. Petitioner currently notices continued pain in both shoulders has difficulty sleeping. She requires help at home doing laundry and lifting groceries. Her inactivity has resulted in a weight gain. During pain flare ups she takes Tramadol once per day and rests her arms to reduce the pain and swelling. Petitioner testified that she continues to work her desk job at Harley.

CONCLUSIONS OF LAW

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

Based upon a preponderance of the credible evidence at trial, the Arbitrator finds that the record does not support a finding that Petitioner sustained an accident arising out of and in the course of her employment for Respondent on 2/13/09. In this case, Petitioner's contemporaneous medical histories are not consistent with her testimony at trial and fail to support allegations of a February 13, 2009 work accident. In so finding, the Arbitrator initially notes that Petitioner repeatedly testified that her injury occurred at work on 2/13/09. Ms. Romero testified that she recalls Petitioner's report of shoulder pain while pulling carts but that she did not recall the exact date of accident. Ms. Romero testified that she submitted the accident information on the day she received the report of accident from Petitioner which is reflected on RX 2 as 3/13/09. RX 2 appears to have been completed retrospectively as the notice date to Respondent is listed as 7/25/09.

Petitioner continued to work full duty between 2/13/09 and 3/13/09. Petitioner testified that she waited to seek treatment for one month after 2/13/09 to see if her symptoms would subside. Petitioner's first visit

for the alleged shoulder injury was on 3/14/09 when she appeared at Alexian Brothers. PX 1. The medical records and written notes from that visit indicate chronic/inactive conditions including "shoulder blade pain x – yrs." The number of years is not discernable on the records. The date of onset is listed at 3/10/09. The written history reads, "right ant shoulder pain upon awakening 5 d ago. Throbbing ant R shoulder pain with rad to arm and hand, exac by movement, improved with ice, constant 2/10. Patient admits to heavy lifting at work." PX 1. Exam showed tenderness and impingement on the right shoulder and trapezius. Petitioner was diagnosed with right shoulder sprain and prescribed a heating pad, massage and Tylenol. PX 1. No work restrictions were provided. The Arbitrator notes that no mention of pain while moving carts at work or of a specific work incident was made to Alexian Brothers.

Petitioner next saw Dr. Demke for her right shoulder complaints on 4/2/09. On 4/2/09, Dr. Demke's records note that Petitioner reported a sprain to her right shoulder 3 weeks earlier, which is again in March 2009. Petitioner testified that she told Dr. Demke that she had shooting pain in her shoulders when lifting. No mention of moving carts or of a specific work incident is made to Dr. Demke. Petitioner testified that Dr. Demke prescribed pain medication and advised Petitioner that her right shoulder complaints could heal with medication but that she should return to see him if she did not improve. Petitioner testified that her pain did not improve so Dr. Demke referred her to Dr. Luke for further treatment in September 2009. Petitioner did not seek treatment between April and September 2009 while waiting for the pain to subside on its own. During this period, Petitioner worked full duty.

When Petitioner did resume treatment on 9/3/09, she saw Dr. Luke who noted "Patient complains of right posterior shoulder pain along the medial border of her scapula since 12/2006 after seeping on a new pillow. The pain radiates up her neck. About a month ago, the pain has started to radiate to the left scapula. The pain is worse with turning her head, writing, and lifting her arms. She has seen an orthopedic surgeon in 2006 for the above complaints. Ex-rays and MRI of the cervical spine reported no abnormalities. She had a trial of physical therapy that gave some pain relief. ..." RX 4. Dr. Luke testified emphatically that this visit was for an "unrelated" condition and not for Petitioner's alleged bilateral shoulder injury at work. The Arbitrator further notes that Petitioner did not even mention an alleged work incident in connection with her "separate" shoulder complaints to Dr. Luke at this 9/3/09 visit. The Arbitrator would expect to see this mention given that Dr. Demke sent Petitioner to Dr. Luke allegedly for her alleged work related right shoulder injury.

Finally, the Arbitrator notes that the first mention of any specific work related accident or injury contained in the medical records is 10 months after the alleged accident date on 11/3/09. Petitioner returned to Dr. Luke who noted, "status post workers' compensation injury. Bilateral shoulder symptoms. Date of injury 2/13/09." Dr. Luke further noted, "Patricia Bogacki is a 41 year old established patient seen in the office today with a new condition. Patient complains of bilateral shoulder pain after an injury at work about 9 months ago. She was working at Sam's club and felt pain in both shoulders after pulling 2 shopping carts together." The Arbitrator notes that this accident mention is made 10 months after the alleged accident and after several medical visits for shoulder and/or scapular pain complaints where no work accident is mentioned. As such, this single reference does not buttress Petitioner's testimony on the issue of accident and does not provide a sufficient basis for a finding of accident in this matter in light of the record as a whole.

Based on the Arbitrator's foregoing findings on the issue of accident, the Arbitrator needs not make findings on the remaining issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH WYSE,

Petitioner,

vs. NO: 12 WC 6426

GSI TECHNOLOGIES, LLC,

Respondent.

15IWCC0163

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

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. Based on the totality of the evidence, the Commission finds that the Petitioner is entitled to TTD benefits from February 27, 2013 through August 28, 2013, and Section 19(l) penalties of $1,020.00. All else is affirmed and adopted.

The facts establish that Petitioner returned to work on February 25, 2013 and worked part of the next day, February 26, 2013, before leaving due to pain. Petitioner presented to Dr. Thomas McGivney on February 26, 2013 complaining of pain. Dr. McGivney provided Mr. Wyse with restrictions of no lifting over 5 pounds, no repetitive or forceful grasping with the right arm, and no reaching or pushing or pulling with the right arm. The February 26, 2013 restrictions were more restrictive than the previous restrictions outlined in the January 23, 2013 FCE.

On March 4, 2013, Kelli Franks sent Petitioner an e-mail indicating that GSI Technologies could not accommodate the new restrictions. The Respondent obtained a Section 12 examination from Dr. Babak Lami on April 1, 2013. Dr. Lami found Petitioner to be at MMI and gave him no work restrictions.

Petitioner was then seen by Dr. Gregory Milani of Rush Copley on April 11, 2013. Petitioner was informed about the addictive/sedative nature of the medication and instructed not to "drink/drive/work" while taking medication. Petitioner reported that the pain interfered with his work. It was noted that secondary gains included a workers' compensation claim. Petitioner was referred to pain management and physical therapy. Ms. Franks testified that the Respondent never consulted a doctor to see if Petitioner could perform his job duties without pain medication.

The Commission finds that the Respondent offered no plausible reason as to why TTD benefits were not paid effective February 27, 2013. The Respondent admitted, in its e-mail dated March 4, 2013, that they could not accommodate the new restrictions. They did not obtain a medical opinion disputing the reasonableness of the February 26, 2013 restrictions until April 1, 2013. The Respondent's subjective belief that the February 26, 2013 restrictions were unreasonable is vexatious given the restrictions could not be accommodated and Respondent had no medical opinion to the contrary.

The Commission further finds the opinions of Dr. McGivney's more persuasive than the opinion of Dr. Lami. Dr. McGivney's opinion is supported by the opinions of all the other doctors and the medical evidence. The doctors have recommended continued medical treatment in an attempt to determine the cause of Petitioner's ongoing symptoms including a cervical MRI to determine whether a non-union of the fusion exists.

The Commission, therefore, awards Petitioner TTD benefits from February 27, 2013 through August 28, 2013.

The Commission finds the non-payment of TTD benefits between February 27, 2013 and April 1, 2013 was unreasonable and vexatious. While the Respondent may have not agreed with the February 26, 2013 restrictions, they did not obtain a medical opinion disputing the reasonableness of the restrictions until April 1, 2013 despite acknowledging on March 4, 2013 that they could not accommodate the restrictions. Therefore, the Commission awards Petitioner

Section 19(l) penalties of $1,020.00 for the non-payment of TTD benefits between February 27, 2013 and April 1, 2013. The Commission declines to award penalties pursuant to Section 19(k) and Section 16.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 29, 2014, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $567.51 per week for a period of 101-1/7 weeks, December 7, 2011 through December 16, 2011, April 25, 2011 through February 24, 2013, February 27, 2013 through August 28, 2013, and August 28, 2013 through March 28, 2013, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,070.53 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for the prospective MRI and CT scans of the cervical spine pursuant to Section 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $1,020.00 as provided in Section 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.

15IWCC0163

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,900.00. 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: MAR 9 - 2015

Michael J. Brennan

MJB/tdm
O: 1-6-15
052

Thomas J. Tyrrell

Kevin W. Lamborn

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

WYSE, JOSEPH
Employee/Petitioner

Case# **12WC006426**

GSI TECHNOLOGIES LLC
Employer/Respondent

15IWCC0163

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:

2986 PAUL A COGHLAN & ASSOC PC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

2284 LAW OFFICES OF COZZI & GOGGIN-WARD
KATRINA ROBINSON
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

15IWCC0163

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)

Joseph Wyse
Employee/Petitioner

v.

GSI Technologies LLC
Employer/Respondent

Case # 12 WC 6426

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of Chicago, on **March 10, 2014 and March 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. ☐ 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, **12/7/2011**, 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 $**44,265.60**; the average weekly wage was $**851.26**.

On the date of accident, Petitioner was **37** 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 $**27,726.92** for TTD, $**.00** for TPD, $**.00** for maintenance, and $**.00** for other benefits, for a total credit of $**27,726.92**.

Respondent is entitled to a credit of $**.00** under Section 8(j) of the Act.

ORDER

See attached decision.

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

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

25 April 2014
Date

ICArbDec19(b)

APR 29 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH K. WYSE,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 12 WC 06426
	)	
GSI TECHNOLOGIES, LLC,	)	
	)	15IWCC0163
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Sections 8(a) and 19(b) of the Act.

STATEMENT OF FACTS

The petitioner, 37 years old on the accident date of December 7, 2011, has been a press operator since the age of 18. He worked for the respondent for approximately six years before the date of loss. On December 7, 2011, he injured his neck while moving dies and performing an inventory check. He reported the injury to his supervisor. Accident and notice were not disputed.

On December 7, 2011, the petitioner presented to his family physician at Rush-Copley Medical Center. He reported a history of a work accident a week prior to that point with worsening pain since, which had become severe two days before with burning into the right shoulder. X-rays were normal. He was prescribed muscle relaxants, no heavy lifting and physical therapy. On December 16, 2011, he reported improved pain and was diagnosed with a resolving trapezius and cervical strain. He was released to work at his request. See PX3.

On January 24, 2012, he presented to Dr. McGiveny at Castle Orthopedics. He described pain over the last two months following several days of moving boxes during an inventory process. He reported pain radiating down the right arm into the hand. Dr. McGiveny recommended an MRI and physical therapy. PX3.

On February 2, 2012, a cervical MRI demonstrated disk dessication and spondylosis at C5-6 with an associated right-sided disk protrusion, and a small central herniation at C4-5 without cord effacement or stenosis. See PX3.

On March 5, 2012, Dr. McGiveny reviewed the MRI and noted the C5-6 disk. He noted some relief of symptoms and recommended pain injections; Dr. McGivney advised

he did not think the petitioner was presently a surgical candidate. PX3, PX5.

On March 19, 2012, the petitioner was discharged from physical therapy with instructions to follow up with Dr. McGiveny. PX5.

On March 27, 2012, the petitioner presented at Fox Valley Pain Management. He received a cervical epidural steroidal injection that day. PX4.

On April 25, 2012, Dr. McGiveny saw the petitioner, who reported no relief from the injection. Dr. McGiveny prescribed him off work for three weeks and renewed his physical therapy prescription. Dr. McGiveny noted that if symptoms persisted he would recommend fusion at C5-6. Dr. McGiveny renewed those recommendations on May 15, 2012. The petitioner began another course of physical therapy thereafter. See PX5.

On June 19, 2012, the petitioner saw Dr. McGiveny, who recommended four additional weeks of physical therapy. Dr. McGiveny recommended fusion from C5 through C7 absent improvement in physical therapy; it is not clear why the additional level was recommended at this time. PX5.

On August 1, 2012, the petitioner returned to Dr. McGiveny with persistent complaints and Dr. McGivney recommended surgery. The petitioner reported that he was scheduled to go to court and Dr. McGiveny noted there were some dates of service that had been paid for by workers' comp and some dates paid by the petitioner's group health provider. Dr. McGiveny maintained the claimant off work pending surgery. PX5.

On August 21, 2012, the petitioner presented for a pre-surgical appointment with Dr. McGivney. He was noted to be scheduled for surgery at the C5-6 level only. PX5.

The petitioner underwent anterior C5-6 fusion surgery on August 29, 2012. No complications were noted. On September 4, 2012, Dr. McGivney noted good placement of the hardware and the petitioner was prescribed off work pending follow-up.

On September 25, 2012, Dr. McGivney noted the petitioner was "doing pretty well" and prescribed physical therapy, which began that day. See PX5. On October 2, 2012, the petitioner contacted his physician requesting a crossbow permit form for hunting purposes, which required a physician signature. PX5. The petitioner underwent physical therapy thereafter. PX5.

On October 23, 2012, the petitioner followed up with Dr. McGiveny. X-rays showed the hardware in good position. Dr. McGiveny maintained him in physical therapy. PX5. On November 20, 2012, the petitioner told Dr. McGiveny that he had difficulty with weight and Dr. McGiveny opined "I think at this point it is time to push him" and that "at 10 weeks, he is really exceeding the time frame that I had put on for him." Dr. McGiveny recommended a work conditioning program and an FCE. PX5.

The petitioner entered a work conditioning program on November 26, 2012.

PX5. On November 30, he called Dr. McGiveny complaining of more pain, now radiating down the left arm rather than the right; Dr. McGiveny prescribed the petitioner additional medication. PX5.

On December 18, 2012, Dr. McGiveny saw the petitioner, who complained of left neck muscle cramps and additional pain in the right arm. Dr. McGiveny opined the left neck "is unrelated to anything we were dealing with" and that the right hand symptoms were "all non-physiological findings from a cervical disk" but noted the petitioner was concerned of "another disk going bad." Dr. McGiveny opined he could not explain the pain from a physiological standpoint as the x-rays looked solid with no pathology. He prescribed a new MRI to ensure nothing was being missed in the neck. See PX5.

The MRI was performed on January 8, 2013. It demonstrated the C5-6 fusion. C6 through T3 were normal. At C4-5 there was a "very small" central protrusion with no canal or foraminal stenosis. A very small syrinx was noted which had decreased in diameter compared to the presurgical MRI. PX5, RX6. Dr. McGiveny reviewed the MRI on January 11, 2013 and noted no new disk pathology, concluding that the symptoms were muscular only. In his report of January 15, 2013, Dr. McGiveny noted the MRI was normal and did not agree with the interpretation of the C4-5 bulge. Dr. McGiveny opined he did not have any objective evidence to correlate the petitioner's subjective symptoms and referred him for a FCE, noting the petitioner would likely be discharged thereafter. PX5, RX6.

The petitioner underwent the FCE on January 23 and 30, 2013. The petitioner ceased participation during the first day due to pain complaints, and the FCE was positive for multiple Waddell's non-organic signs and symptom magnification. The petitioner was rated at between light and medium physical work levels; however, the petitioner subjectively rated his ability to work as "none." See PX5, PX6, RX2. The petitioner testified he was taking prescription pain medication when he underwent the FCE, and therefore the FCE only revealed what he could do while on his pain medication, which is why his restrictions were later reduced below the FCE level; however, the medical records reveal that he was not taking pain medication at the time of the FCE. PX5.

On February 7, 2013, Dr. McGiveny saw the petitioner and reviewed the FCE. He opined the petitioner would not benefit from therapy and suggested possible job retraining given the restrictions on the FCE (20 pounds overhead, 37 pounds floor to waist, occasional carrying 20 to 50 pounds). He believed there was nothing left he could recommend and placed the petitioner at MMI at that time. PX5, RX6. He later faxed the FCE restrictions to the respondent on February 18, noting those would be the petitioner's prescribed restrictions. PX5, RX6.

On February 26, 2013, the petitioner presented to Dr. McGiveny complaining of increased pain after returning to work; Dr. McGiveny wrote a new work restriction note for the petitioner, reducing him to five pounds lifting and no use of the right arm or hand. He opined the petitioner might benefit from a pain specialist but physical therapy and work conditioning would not be of benefit. PX5, RX6.

The petitioner returned to work for the respondent on February 25, 2013. He underwent sedentary safety training that day. RX8. On February 26, 2013, he worked for approximately two hours in the morning, then complained of pain and left. He has not worked for the respondent since.

On April 1, 2013, the petitioner was seen for a Section 12 examination by Dr. Lami, who had previously seen the petitioner on August 1, 2012, prior to the fusion surgery. No sign of muscle atrophy was present and reflexes were symmetric. Following examination, Dr. Lami noted the postoperative MRI was benign and the x-rays showed no pathology. Dr. Lami noted signs of symptom magnification on the FCE and noted the petitioner complained of pain in the right arm in a non-anatomic distribution which did not correlate to any objective findings. He concluded the petitioner was at maximum medical improvement and could work at his regular job. He did not believe further medical care was required. See RX3.

On April 11, 2013, the petitioner presented to his primary care physician, Dr. Milani at Rush-Copely, with persistent neck pain. Dr. Milani recommended a diagnostic EMG test and referred the petitioner for a pain management consultation. PX3.

On May 13, 2013, the petitioner saw Dr. McGiveny again. Dr. McGiveny noted he did not have the results from the EMG, but spoke to the physician who performed the EMG, "who did not find much of anything." RX6. Dr. McGiveny spoke with the patient at length and noted "I think there are definitely secondary issues going on with Joe." He opined the other disk was not causing the symptoms of which the petitioner complained, that he did not feel any further surgery would be of benefit, and suggested the petitioner seek another opinion. See RX6.

On June 5, 2013, the petitioner saw Dr. Ruban, a neurosurgeon, on referral from his family physician. The petitioner asserted there had been no change in his symptoms from before the surgery. Dr. Ruban reviewed the MRI, opined the instrumentation appeared to be in good position, and noted that while there was a small bulging disk above the fusion, it was not causing any stenosis. Dr. Ruban noted the EMG suggested a mild C6 radiculopathy on the left side. Dr. Ruban opined that the pain asserted by the petitioner was not coming from the cervical spine, that the MRI was unremarkable, and recommended against further intervention for the neck. He suggested consideration of a pain specialist or a rheumatologist for evaluation, as "I do not see any anatomic explanation for [the pain] at least on the basis of his cervical MRI." RX6.

On August 22, 2013, the petitioner sought another neurosurgical assessment, with Dr. Erickson. The petitioner reported bilateral hand paresthesias and pain in the forearm. Dr. Erickson noted the fusion appeared solid on the MRI and opined the petitioner might be suffering from RSD. He recommended against surgery as the C4-5 disk appeared small and the C6-7 disk did not show any significant disruption. RX6.

The respondent terminated the petitioner on August 28, 2013. RX10.

On October 31, 2013, the petitioner underwent a cervical spine MRI without contrast. It noted mild disk degeneration at C4-5 without significant canal stenosis or foraminal narrowing. The C6-7 level was assessed as benign. RX6.

On January 28, 2014, the petitioner saw Dr. Sheri Dewan, Dr. Erickson's colleague. She reviewed the October 31, 2013 MRI and noted mild degeneration at C4-5 and C6-7 without stenosis, but with a possible syrinx at the C-6 level. She recommended another cervical MRI, this time with contrast, and a CT of the cervical spine to evaluate possible nonunion of the fusion. She prescribed the petitioner off work, instructed him to cease hydrocodone, and told him to follow up after the imaging studies. See PX2.

The respondent had originally disputed the MRI and CT scans as not medically necessary pursuant to a utilization review. See RX4, RX5. However, following appeal of that finding, the utilization review reversed its position and the respondent agreed to authorize the cervical MRI and CT scans. See PX10, RX14.

ANALYSIS

On February 26, 2013, the petitioner apparently worked with Eric Knack, and the petitioner's job duties that day were a matter of some dispute, as the petitioner asserted to Dr. McGiveny that his restrictions had been exceeded. Mr. Knack did not testify; the respondent introduced printouts of the petitioner's Facebook posts which show an Eric Knack plays in a musical band with the petitioner away from work (see RX11, pp. 4, 12). The Arbitrator concludes this is the same person.

The respondent's HR Manager, Kelli Frank, testified she had requested that the petitioner bring in prescription medication so she could review what restrictions on his activities might be needed based on it. The petitioner admitted he never gave it to her.

The petitioner's Facebook posts further show him to be capable of using his right arm to lifting and holding in excess of five pounds without apparent difficulty. See RX11, pp 3, 10. While he made assertions of inability to drive at trial, he acknowledged driving to band practices during his testimony and admitted that no doctor prescribed him unable to drive. The petitioner testified he lives with his parents in Wedron, Illinois. He asserted that this is based in part on the financial and medical burdens from his case and that the increased driving based on that caused him difficulty. However, documents showed he actually moved in with his parents a year before the injury occurred. RX12. The petitioner then testified that moving had nothing to do with the work accident, but he had remained there because of the litigation and post-surgical difficulties. The Arbitrator finds his earlier testimony to be deliberately misleading.

The petitioner further testified that his symptoms never really abated following surgery and that the first few weeks were especially hard. The Arbitrator finds this testimony at the very least inconsistent with the petitioner's request for a hunting permit

on October 2, barely five weeks postoperatively. At worst, it is further evidence of a deliberate attempt to exaggerate his disability or engage in deception. This is entirely in line with Dr. McGiveny's assessment of the claimant's motives of secondary gain.

The respondent sent multiple documents to the petitioner, some of which were overtures of light duty work availability, others were FMLA and insurance information, and others of which were offers of job severance agreements. See PX11, RX10. The Arbitrator has considered each of these letters as well as the respective counsels' arguments towards how they should be interpreted. The petitioner did not act with any motivation towards any of the possibilities of a return to work; he asserted that he did not understand the offers. While the jobs were not well detailed, the petitioner did not act in good faith to clarify them, such as by presenting to observe the potential duties. He asserts that he wanted to go through his attorney, but did not actually attempt to take the respondent up on potential offers of light duty work. The Arbitrator does not find the respondent's actions deceptive or malicious, but rather due to understandable frustration.

The Arbitrator has fully considered the medical records as well as the substance and manner of the petitioner's testimony. The petitioner has demonstrated a serious lack of motivation towards a return to work and his own physicians have repeatedly noted a lack of clinical or objective evidence to substantiate his complaints. The petitioner asserted to Dr. Lami in 2013 that he could not hunt, but had sought a crossbow permit at the beginning of bow hunting season following the surgery. The Arbitrator notes multiple instances where the petitioner demonstrated a lack of forthrightness in his testimony, such as his assertion of using pain medication at the time of the FCE and his assertion of driving difficulties. The Arbitrator finds the petitioner has a serious credibility deficit. This informs the Arbitrator as to all issues in dispute.

OPINION AND ORDER REGARDING DISPUTED ISSUES

Causal Connection to the Injury

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim. *See, e.g., Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1993). While the initial accident was not disputed, and there appears to be a general consensus that the 2012 fusion surgery was causally related to the injury, the credibility of any residual complaints is highly suspect. The claimant's own doctors have advised that they cannot relate the extent of the ongoing description of symptoms to the observed pathology. While the right to recover benefits cannot rest upon speculation or conjecture (see *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977)) a casual relationship to the cervical spine and the original fusion surgery, at least, has been established. Causation to any other condition does not appear to have been so established, but requested additional benefits at this time based on the fusion surgery will be addressed in each individual section, below.

Medical Benefits Pursuant To Section 8(a)

In accordance with the causal assessment above, and supported by the medical records and reports, the petitioner has established that the medical bills contained in PX1 are reasonable and causally related to the injury. The majority of the medical costs have already been satisfied. The respondent is directed to satisfy the remaining $6,897.22 in outstanding medical bills and reimburse the claimant for $1,173.31 in out of pocket expenses, all subject to the limits of Sections 8(a) and 8.2 of the Act; the Arbitrator notes the largest single outstanding expense is Castle Orthopedics, to whom substantial sums were already paid by the WC provider, and may represent fees exceeding the fee schedule, which should be eliminated. The respondent shall receive credit for any and all amounts previously paid, but shall hold the petitioner harmless, pursuant to 8(j) of the Act, for any group health carrier reimbursement requests for such payments.

Prospectively, the respondent shall authorize and pay for the prospective MRI and CT scans of the cervical spine within the limits of Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

The respondent submits the petitioner would be eligible for TTD only from April 25, 2012, through February 24, 2013. The petitioner submits for TTD eligibility for various individual dates in 2011 and 2012, as well as April 24, 2012 through February 24, 2013, and requests TTD from February 26, 2013 through March 24, 2014 (trial). See generally Arb.Ex.I.

The petitioner has substantiated TTD eligibility from December 7 through 16, 2011, and the Arbitrator awards this period.

The various individual dates in March 2012 as well as April 14, 2012, do not appear sufficiently corroborated by the credible medical records and are further contradicted by the petitioner's earning statement (RX13). Those are denied.

The petitioner was prescribed off work by Dr. McGiveny on April 25, 2012, and was released on February 24, 2013; this period is stipulated to and is awarded.

The petitioner worked the morning of February 26, 2013, and then returned to Dr. McGiveny. At that time, the petitioner's restrictions were significantly tightened despite no apparent change in his medical condition. Moreover, while Dr. McGiveny appears to base these restrictions on the petitioner's subjective complaints, he himself noted there was no objective evidence to substantiate those, and that the petitioner had motives of secondary gain. The Arbitrator views these restrictions very skeptically and further believes that the work offered at that time by the respondent was in good faith. The petitioner never followed up with regard to the overtures, though nebulous, of further employment as an evaluator which could have accommodated even more limited restrictions than the FCE would have emplaced. Dr. Lami is likely correct in his

assessment that the petitioner, from a purely physically objective point of view, would presently be capable of working his regular job, and that the current restrictions are more probably due to the claimant's subjective limitations. However, the Arbitrator concurs with Dr. Dewan that the objective evaluations to ensure that the fusion has solidified would be required before making a conclusive determination. As such, the petitioner cannot be reliably assessed at maximum medical improvement.

The respondent elected to terminate the claimant as of August 28, 2013. Despite the possibility that the claimant requires no further invasive care or therapy, and further despite the aforementioned lack of motivation and credibility of the claimant, he is not yet at MMI. As such, this case falls within the holding of *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 266 Ill.2d 132, 923 N.E.2d 266 (2010). The Arbitrator is left with no option but to award TTD from August 28, 2013, through the date of hearing, March 24, 2014.

In sum, the petitioner is entitled to TTD for 525 days, or 75 weeks. At the appropriate TTD rate of $567.51, a total liability of $42,563.25 results. Against this amount the respondent shall have credit for $27,726.92 previously paid, resulting in present liability of $14,836.33.

Penalties and Fees

The Illinois Supreme Court has long recognized the imposition of penalties is a question to be considered in terms of reasonableness. *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 297 (1980); *Smith v. Industrial Commission*, 170 Ill.App.3d 626 (3rd Dist. 1988). In the *Avon* case, the Court looked to Larson on Workmen's Compensation for guidance, noting that penalties for delayed payment are not intended to inhibit contests of liability or appeals by employers who honestly believe an employee is not entitled to compensation. 3 A. Larson, Workmen's Compensation sec 83.40 (1980). In addition, when the employer acts in reliance upon responsible medical opinion, or where there are conflicting medical opinions, penalties are not ordinarily imposed. 3 A. Larson, Workmen's Compensation sec 83.40, at 15 – 636 (1980).

The respondent questioned a serious increase in the level of restricted activity despite no objective rationale for it and immediately secured a Section 12 evaluation. The Arbitrator believes the respondent's dispute was within the bounds of reasonableness and was not vexatious in its character. Penalties and fees are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES CONNER,

Petitioner,

15IWCC0164

vs.

NO: 09 WC 042380

AT&T,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission finds the permanent disability experienced by Petitioner as a result of his September 10, 2009, injury to be more severe than was found in the Decision of the Arbitrator. Petitioner, while working for Respondent as an installation-repair technician on September 10, 2009, was assaulted at gunpoint and was forced to surrender the money from his wallet. He reported the incident to both the Chicago Police Department and his supervisor, Adam Howsey. No medical treatment was offered at that time but such treatment began on September 17, 2009, when he sought treatment from his primary care physician at Christian Community Health Center where he diagnosed as suffering from posttraumatic stress disorder and was removed from work. Petitioner eventually came under the care of Dr. Daniel Kelley, a psychologist, and, in conjunction with his treatment with Dr. Kelley, Dr. Joseph Beck. Petitioner, at the suggestion of Dr. Kelley, was also seen by a neuropsychologist, Dr. Nancy Landre. It was through his treatment with Dr. Landre that it was learned Petitioner began carrying weapons for protection. The weapons are a handgun and a knife. Petitioner continues to carry these weapons. Petitioner's belief to needing to carry these weapons was seen by the vocational specialist from Vocomative as an impediment to his successfully returning to the work force.

In addition to Petitioner's continuing belief that he needs to carry weapons for protection, the Commission also takes notice that Petitioner continues to treat his posttraumatic stress disorder through medication taken on about a weekly basis.

15IWCC0164

For trauma experienced by Petitioner on September 10, 2009, and the lingering aftereffects from it, the Commission finds it appropriate to increase the permanent disability award to 30% loss of a man as a whole.

The Commission finds, in the Decision of the Arbitrator, that the parties agreed that Respondent had made temporary total disability payments to Petitioner in the amount of $140,902.35 for which Respondent did not receive credit. Accordingly, the Commission modifies the Decision of the Arbitrator further so that Respondent receives credit for these payments.

All other findings and orders contained within the Decision of the Arbitrator are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $830.06 per week for a period of 59-3/7 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 $664.72 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 the 30% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner for medical expenses incurred for treatment with Drs. Fredrick and Moolayil.

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

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

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

DATED: MAR 6 - 2015
KWL/mav
O: 01/06/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CONNER, CHARLES
Employee/Petitioner

Case# **09WC042380**

AT&T
Employer/Respondent

15IWCC0164

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:

1067 ANKIN LAW OFFICES LLC
DEREK S LAX
101 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

2337 INMAN & FITZGIBBONS LTD
G STEVEN MURDOCK
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

CHARLES CONNER
Employee/Petitioner

Case #09 WC 42380

v.

AT&T
Employer/Respondent

15IWCC0164

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on May 29, 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 September 10. 2009, 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 $64,799.68; the average weekly wage was $1,245.09.
- At the time of injury, the petitioner was 56 years of age, *married* with no children under 18.
- The parties agreed that the respondent paid $140,902.35 in temporary total disability benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for 29-6/7 weeks, from September 17, 2009, through April 13, 2010.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $830.06/week for 59-3/7 weeks, from September 17, 2009, through November 6, 2010, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $664.72/week for a further period of 100 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 20% loss of use of the man as a whole.

- The respondent shall pay the petitioner compensation that has accrued from September 10, 2009, through May 29, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his psychological symptoms by Drs. Fredricks and Moolayil were reasonable and necessary. The cost of the petitioner's care provided by Dr. Kelley and his referrals, including Drs. Beck and Landre, is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

June 11, 2014
Date

JUN 11 2014

FINDINGS OF FACTS: 15IWCC0164

The petitioner, an installation and repair technician, was robbed at gunpoint on September 10, 2009. The petitioner was afraid that he would be shot and complied with the robber's orders. He filed a report immediately afterward with the Chicago Police Department. The petitioner did not seek any immediate medical attention. On September 17, 2009, the petitioner saw Dr. Earl Fredericks at Christian Community Health Center for a three-month checkup and reported back pain and psychological trauma subsequent to the robbery. Dr. Fredericks felt the petitioner had PTSD. The petitioner told his doctor on October 1st that he felt he could no longer work for the respondent. The petitioner received care for his psychological problem with Dr. Kumar Moolayil from October 21st through November 19th. The doctor's treatment notes are not clearly legible.

On October 31, 2009, Dr. Daniel Kelley, a clinical psychologist, evaluated the petitioner and administered the Minnesota Multiphasic Personality Inventory, the Trauma Symptom Inventory, the Beck Depression Inventory and the Beck Anxiety Inventory tests. Dr. Kelley's diagnosis was depression and anxiety for which he recommended cognitive-behavioral therapy to address the petitioner's significant level of emotional distress and to facilitate his coping skills and return to work. A psychiatric consultation and no work activity were also recommended. On December 10th and 21st, Dr. Kelley noted modest progress in the petitioner's emotional and psychological functioning with episodic exacerbations of symptoms. It was noted on February 5, 2010, that the petitioner had progress in his emotional and psychological functioning and reported a significant decrease in depressive symptoms. After consulting with Dr. Beck, Dr. Kelly prescribed Xanax for the petitioner's panic symptoms in loud, crowed public environments. On

November 6th, Dr. Kelly noted that Dr. Nancy Landre opined that the petitioner may never be able to resume his prior work duties. Dr. Kelly terminated his goal of returning the petitioner to his previous work position and opined that he was at maximum psychological improvement. Dr. Kelley reported on July 29, 2011, that the petitioner had limited psychological progress due to continued anxiety symptoms and dysphoria.

An IME was started by Dr. Alexander Obolsky at Health & Law Resource on April 13, 2010, and concluded on January 6, 2012. Dr. Obolsky reported on November 26, 2012, that the incident of September 10, 2009, resulted in a temporary exacerbation of the petitioner's pre-existing anxiety, that the petitioner had reached MMI as of April 13, 2010, and was capable of working full-duty and that there was no permanent mental disability.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The petitioner's first choice of physicians was Dr. Fredericks at Christian Community Health Center and his second choice of physician was Dr. Kumar Moolayil. The medical care rendered the petitioner for his psychological condition by Drs. Fredricks and Moolayil were reasonable and necessary and is awarded. Pursuant to Section 8(a) of the Act, the petitioner's treatment with Dr. Kelley and his referrals, including Drs. Beck and Landre, were not within the two-physician choice allowed under the Act and the cost of their care 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 psychological condition of ill-being is causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY AND MAINTENANCE BENEFITS:

The petitioner did not seek treatment and was not advised to stop working until September 17, 2009. Dr. Obolsky opined that the petitioner was fit to return to gainful employment on April 13, 2010. Dr. Nancy Landre opined on October 8, 2010, that the petitioner may never be able to resume his prior work duties. On November 6, 2010, Dr. Kelly opined that he was at maximum psychological improvement.

The respondent shall pay the petitioner temporary total disability benefits of $830.06/week for 59-3/7 weeks, from September 17, 2009, through November 6, 2010, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

The petitioner failed to prove that he is entitled to maintenance benefits after November 6, 2010. The petitioner did not look for any employment after November 6, 2010, or since the robbery on September 10, 2009. All claims for maintenance benefits are denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that he is obviously incapable of employment or that he 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 his health or life.

Although he did not conduct any type of job search, due to the robbery, the petitioner is unwilling and unable to return to his former employment duties of an installation and repair technician. The respondent shall pay the petitioner the sum of

$664.72/week for a further period of 100 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 20% loss of use of the man as a whole.

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

JUAN CARLOS HERNANDEZ,

Petitioner,

15IWCC0165

vs.

NO: 12 WC 11499

DAVIS STAFFING,

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

Based upon a review of the record, the Commission modifies the Decision of the Arbitrator, finding that Petitioner failed to prove his current cervical and left shoulder conditions of ill-being are causally related to his March 12, 2012 work-related injury, based upon the numerous initial treating medical records documenting symptoms and complaints confined to the left upper mid back, Petitioner's admission the onset of neck complaints occurred on approximately May 07, 2014, and the more persuasive opinion of Dr. Zelby on the issue of causal connection.

Petitioner sought initial medical care on March 12, 2012, at which time he was seen at Advocate South Suburban Hospital and reported left upper back pain from heavy lifting at work. Petitioner examination was negative for neck spinal tenderness, reproducible tenderness to palpation of the back, subscapular bursitis, or musculoskeletal abnormalities. The Advocate South Suburban Hospital records contain no reference to shoulder or cervical complaints He was

diagnosed with back pain without radiation. (PX1). On March 14, 2012, Petitioner sought treatment with Chicago Pain & Orthopedic Institute. He completed a Patient Questionnaire, reporting sharp pain in his left upper back as a result of turning to his left and feeding cartons in to a machine. The pain diagram Petitioner completed at that time reflected pain in the left mid-thoracic region. At the time of that initial office visit to Chicago Pain & Orthopedic Institute, Petitioner was examined by Dr. Jain. Dr. Jain recorded complaints of sharp pain in the left side of his upper back, and a denial of any complaints of numbness or tingling. Petitioner's examination indicated tenderness to palpation along the left parascapular area, left sided upper back pain, and he was diagnosed with a thoracic strain/sprain. Dr. Jain recommended physical therapy, an MRI of the thoracic spine, and that Petitioner remain off work. On March 19, 2012, Petitioner completed an additional pain diagram during his follow-up office visit with Dr. Jain, again reporting only pain on the left side of his back, mid-line vertically. Dr. Jain documented continued complaints of left sided thoracic paraspinal pain, and his records contain no reference to shoulder or cervical complaints. He recommended physical therapy, and discussed possible left-sided thoracic facet injections should Petitioner continue to have pain. On April 16, 2012, Petitioner sought follow-up treatment at Chicago Pain & Orthopedic Institute, at which time he was seen by Dr. Morgan. Petitioner continued to complain of left-sided mid to upper back pain, and completed a pain diagram which reflected complaints of pain in the left mid to upper back and parascapular pain. Dr. Morgan diagnosed thoracic strain/sprain and thoracic facet syndrome, and recommended continued physical therapy. (PX2).

Petitioner began a course of physical therapy at Chicago Pain Center on March 20, 2012, at which time he complained of upper left back pain. The pain diagram completed on that date reflected symptoms of stabbing and aching in his left upper back. His cervical exam was noted to be within normal limits, and his compression test was noted as negative. His examination was significant for muscle spasm and tenderness in left upper trapezius and mid trapezius and he was diagnosed with a thoracic sprain/strain. Petitioner underwent approximately ten sessions of physical therapy, from March 20, 2012 through April 11, 2012, during which time treatment was directed to his left upper/mid thoracic complaints. The physical therapy records from April 19, 2012 reflect that Petitioner was performing light car repair, replacing a battery, and had left arm/shoulder weakness with increased pain. Petitioner underwent continued physical therapy then through May 01, 2012. On May 01, 2012, Petitioner reported that for the prior two days he had felt increased neck and left upper back pain. Petitioner reported that with reaching, pushing or pulling the left arm he felt increased muscle cramping in the mid left scapular region and in the left side of the neck. Petitioner further reported that when he performed certain therapy exercise to his left upper trapezius he had a feeling of pain radiating down his left arm. (PX3). Although Petitioner reported his symptoms started two days prior to May 01, 2012, a review of the physical therapy notes reflects no visits in the four days prior to that May 01, 2012 physical therapy visit. Furthermore, the May 01, 2012 physical therapy note contains no history of Petitioner injuring his left shoulder or neck while performing a pulley exercise in physical therapy. On May 02, 2012, the physical therapist recorded a history of complaints of continued muscle soreness in neck and left mid scapular region. Although the therapist noted "continued" complains of muscle soreness in Petitioner's neck, a review of Petitioner's physical therapy records fails to indicate any documented cervical complaints or significant cervical findings prior to Petitioner's May 01, 2012 visit. (PX3).

On May 14, 2012, Petitioner was seen in follow up with Dr. Jain. At that time, Dr. Jain noted that Petitioner "complains of new onset of left neck and shoulder pain which started approximately 1 week ago. He complains of crepitus in the left shoulder when his arm is raised overhead and he is doing pulley exercises in physical therapy." Petitioner further complained of occasional numbness in his left hand fingers. Petitioner reported his left thoracic pain had improved, with pain rated at 3 on a scale of 1 to 10. On examination, Dr. Jain documented left shoulder pain with forward flexion, abduction, and adduction. He also noted full cervical ROM, with complaints of left paracervical and trapezius pain with rotation to contralateral side and with cervical extension. Dr. Jain repeated his diagnosis of thoracic facet syndrome, but further made new diagnoses of cervicalgia and a left shoulder strain. He recommended continued physical therapy, and MRI studies of the cervical spine and left shoulder. Petitioner questionnaire reflects he "started getting pain on my left shoulder & neck," and his pain diagram for that office visit reflects only pain in the left side of the neck and left shoulder. (PX2).

From the date of accident until May 14, 2012, the Petitioner's symptoms and pain complaints recorded in the records and reports of Advocate Hospital, Dr. Jain, and Dr. Morgan appear to be limited to the left shoulder blade and left upper back, without mention of any left shoulder or cervical complaints. After May 14, 2012, Petitioner's complaints thereafter were confined to his cervical spine and his left shoulder, with indication his original thoracic complaints had resolved.

The Commission finds the Arbitrator improperly concluded on page three of the Decision that the May 14, 2012 office visit note of Dr. Jain indicates that "his left shoulder and left side of his neck had begun hurting while performing pulley exercises in physical therapy." Instead the doctor stated that Petitioner "complains of new onset of left neck and shoulder pain which started approximately 1 week ago. He complains of crepitus in the left shoulder when his arm is raised overhead and he is doing pulley exercises in physical therapy." The Commission also notes that Petitioner testified on direct examination that while performing physical therapy pulley exercises, he felt pain "in the same place, on my back, on my upper left quarter back." Petitioner offered no testimony this pulley exercise brought on his neck or left shoulder symptoms. (T46-47). Furthermore, Petitioner admitted on cross examination that this was a new complaint of neck pain on May 14, 2012, which had started about a week prior, on May 7, 2012. (T40-41).

The Commission further finds the causal connection opinion of Dr. Zelby most persuasive with regard to Petitioner's cervical and left shoulder conditions of ill-being. Dr. Zelby conducted a Section 12 examination of Petitioner on August 10, 2012, reviewed treating records, and diagnosed a thoracic strain as a result of Petitioner's March 12, 2012 work-related injury. Dr. Zelby testified Petitioner provided a history that a week after his March 12, 2012 left posterolateral thoracic work injury he developed a sharp pain along the left side of his neck, and then a while after that he had some pain in his left shoulder. (T10-12). Dr. Zelby testified that the May 14, 2012 office visit note of Dr. Jain reflected Petitioner made a complaint of a new onset of left neck and shoulder pain that started a week earlier, at which time Dr. Jain added the diagnosis of neck pain, and referred Petitioner for MRI studies of his cervical spine and left shoulder. Dr. Zelby opined based upon his review of the treating medical records, Petitioner's cervical and shoulder complaints began two months after his work-related injury, and that those cervical and shoulder complaints and the modest degenerative changes seen on his cervical MRI

study were not caused, aggravated, exacerbated, or made symptomatic as a consequence of his reported work injury. (T18-19).

Based upon the above, the Commission finds Petitioner failed to prove his current condition of ill-being with respect to his cervical spine and left shoulder are causally connected to his March 12, 2012 work-related injury.

With regard to the issue of medical expenses, the Commission vacates the Arbitrator's award of medical expenses related to Petitioner's cervical and left shoulder conditions of ill-being, those medical services rendered after May 14, 2012, through June 18, 2012. The Commission vacates the Arbitrator's award of the following medical expenses: Metro Milwaukee Anesthesia Associates, D.O.S. 06/12/12, $1,400.85; Accredited Ambulatory Care, D.O.S. 06/12/12, $14,105.10; Dr. Ernesto Padron, D.O.S. from 05/21/12 through 06/20/12, $3,590.80; Archer Open MRI, D.O.S. 05/18/12, $3,600.00; Chicago Pain & Orthopedic Institute, D.O.S. 05/14/12 through 07/16/12, $2,169.28. In so finding, the Commission affirms the Arbitrator's award of the following medical expenses: Oaklawn Radiology Imaging Consultants, D.O.S. 03/13/12, $43.00; Chicago Pain & Orthopedic Institute, D.O.S. 03/14/12 through 05/14/12, $493.92; Archer Open MRI, D.O.S. 03/15/12, $1,800.00; and, Dr. Ernesto Padron, D.O.S. from 03/21/12 through 05/11/12, $7,332.00.

Based upon the Commission's finding that Petitioner failed to prove a causal connection between his March 12, 2012 work-related injury and his current condition of ill-being with regard to his cervical spine and left shoulder, the Commission vacates the Arbitrator's award of temporary total disability benefits from May 14, 2012 through June 18, 2012. In so doing, the Commission finds that as of May 14, 2012, Petitioner's medical treatment and off work status was solely related to his cervical and left shoulder conditions of ill-being.

The Commission further modifies the temporary total disability rate from $319.00 per week to $312.67 per week, based upon Section 8(b)1 of the Act. Under Section 8(b)1, the compensation rate for temporary total disability shall not exceed 100% of the state minimum wage calculation, nor the Petitioner's average weekly wage, whichever is less. A review of the record indicates the parties stipulated to an average weekly wage of $312.67 at the time of hearing, as evidenced by the Request for Hearing (ARB EX1), and based upon the parties failure to raise the issue of average weekly wage at the time of hearing. (T7-8). Petitioner alleged he had three dependents under age of 18 at the time of his March 12, 2012 date of accident. Although the statutory minimum temporary total disability rate for accidents on March 12, 2012 is $319.00, based upon three dependents, the temporary total disability rate may not exceed 100% of the statutory minimum temporary total disability rate, nor the Petitioner's average weekly wage, whichever is less. Based upon Petitioner's average wage of $312.67, the Commission modifies the temporary total disability rate from $319.00 to $312.67 per week.

With regard to the issue of permanent partial disability rate, the Commission affirms the Arbitrator's award of 4% loss of use of the man as a whole under Section 8(d)2. However, the Commission modifies the permanent partial disability rate from $319.00 per week to $312.67 per week, pursuant to Section 8(b)2 of the Act. As stated above, the parties stipulated to an average weekly wage of $312.67 at the time of hearing. Petitioner alleged he had three dependents under

age of 18 on the March 12, 2012 date of accident. Although the statutory minimum permanent partial disability rate for a date of accident of March 12, 2012 is $319.00, based upon three dependents, under Section 8(b)2 of the Act, the permanent partial disability rate may not exceed the lesser of statutory minimum permanent partial disability rate or Petitioner's average weekly wage. Based upon Petitioner's average wage of $312.67, the Commission modifies the permanent partial disability rate from $319.00 to $312.67 per week.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 23, 2014 Decision is modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $312.67 per week for a period of 9 weeks, from March 12, 2012 through May 14, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits from May 14, 2012 through June 18, 2012 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $312.67 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 4% man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,668.92 for medical expenses under §8(a) and pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses in the amount of $24,866.03 is hereby vacated.

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

15IWCC0165

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 $17,600.00. 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: MAR 6 - 2015
KWL/kmt
01/06/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0165

HERNANDEZ, JUAN CARLOS
Employee/Petitioner

Case# **12WC011499**

DAVIS STAFFING
Employer/Respondent

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

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN & MACIARIELLO
DAVID VanOVERLOOP
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
MATTHEW IGNOFFO
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

15IWCC0165

Juan Carlos Hernandez
Employee/Petitioner

v.

Davis Staffing
Employer/Respondent

Case # 12 WC 11499

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 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 _____

FINDINGS

On **March 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 $; the average weekly wage was **$312.67**.

On the date of accident, Petitioner was **28** 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 **$1,250.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,250.68**.

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$319.00/week** for **20** weeks, because the injuries sustained caused the **4%** 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 $319.00 / week for 14 weeks commencing March 12, 2012 through June 18, 2012, as provided in Section 8(b) of the Act as Petitioner was Temporarily Totally Disabled from March 12, 2012 through the June 18, 2012.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received including:

Oaklawn Radiologogy Imaging Consultants	$43.00
Chicago Pain & Orthopedic Institute	$2,663.20
Archer Open MRI	$5,400.00
Pain Center of Chicago	$10,922.80
Accredited Ambulatory Care	$14,105.10
Metro Milwaukee Anesthesia Associates	$1,400.85

pursuant to the medical fee schedule or by prior agreement, whichever is less, as stated in 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.

15IWCC0165

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

Juan Carlos Hernandez,	)	15IWCC0165
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 11499**
	)	
Davis Staffing,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on March 12, 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.

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; (5)Is the Respondent due any credit; and (6) What is the nature and extent of the injury.

STATEMENT OF FACTS

It is undisputed Petitioner was employed by Respondent Davis Staffing on Monday, March 12, 2012 and was placed at Accord Carton working as a machine operator on that date. Petitioner testified that his job duties at this assignment were to feed cardboard boxes into a machine. Petitioner was required to unload piles of flattened boxes from a pallet behind him onto a table to his right, and then feed the boxes into a machine for further processing. Petitioner testified that it was necessary to keep the cardboard boxes going into the machine, and that he was urged to work rapidly to keep up with the feeder. Petitioner further testified that the entry into the machine was at about chest level, the table where he staged the boxes was at about waist level and that the stack of flattened boxes on the pallet would start around chest level, but work down to almost the floor. Due to the setup, Petitioner was required to quickly and continuously lift the stacks of flattened boxes up and to the left, either to go from the pallet to the table, or

from the table up to the feeder in the machine. The machine would fold the boxes and apply adhesive forming the boxes for certain food products. A picture of the boxes was submitted into evidence as RX #6 and actual samples of the cardboard boxes were submitted into evidence as RX #7. Petitioner testified such samples were the boxes he was working with.

Petitioner's first day working this position was Wednesday, March 7, 2012. He worked third shift starting at 9:00 p.m. March 7, 8, and 9, 2012. He was off on March 10 and 11, 2012. Thirty minutes into his shift on March 12, 2012, at approximately 9:30 p.m., while he was twisting and lifting the stacks of boxes he felt a sharp pain in his upper left back. Petitioner stopped working and reported to third shift supervisor Rito Sandoval that he could not continue to work due to pain. Upon advising his supervisor that he was experiencing pain, Petitioner was directed to go to a hospital. Petitioner testified he transported himself to the emergency room at Advocate South Suburban Hospital. At the hospital Petitioner reported pain in his left upper back and left shoulder blade at a level of 3 out of a possible 10 at rest, and 10 out of a possible 10 with activity. X-rays taken came back negative, and Petitioner was diagnosed with back pain without radiation. He was discharged from the hospital with instruction to take medications and follow up with his primary care physician.

Petitioner testified he merely had pain at work. Petitioner did not testify that he reported to Sandoval that the pain was due to his work.

On cross examination Petitioner testified it was up to the worker how large of a stack of cardboard to feed into the machine. He further testified on re-direct examination the stacks weighed between 3-5 pounds.

Mr. Sandoval testified for Respondent. Mr. Sandoval testified Petitioner merely reported he had pain and that he did not report to Mr. Sandoval the pain was related to work. Mr. Sandoval testified Petitioner was complaining of pain in his back prior to March 12, 2012. Mr. Sandoval testified that during a break on Friday, March 9, 2012 Petitioner complained of back pain. During this discussion Sandoval learned Petitioner performed car mechanic work. Sandoval testified it was his impression, based on this conversation he had with Petitioner, that Petitioner injured his back while performing car mechanic work.

On cross examination Mr. Sandoval admitted he was responsible for overseeing the entire third shift, and that it was frequently staffed by staffing agencies. The temporary workers would be there anywhere from a few weeks to a few months and had a fairly high turnover. However, Mr. Sandoval claimed to have a specific independent recollection of Petitioner and this passing conversation, despite Petitioner only having worked for him for four days over a year prior to the date of hearing.

On March 13, 2012, Petitioner presented to Advocate South Suburban Hospital. Petitioner complained of left upper back pain which began 10 hours previously while doing heavy lifting at work. PX #1 at 1of 20. The pain began in his left shoulder blade. Id.

On March 14, 2012, Petitioner presented to Dr. Neeraj Jain at Chicago Pain and Orthopedic Institute. Petitioner stated his job required lifting cardboard boxes weighing

approximately 20-30 pounds. PX #2. Dr. Jain diagnosed a thoracic strain/sprain and ordered a thoracic MRI. Id.

On March 19, 2012, Petitioner followed up with Dr. Jain. Id. He completed a pain diagram on this date. Id. The pain diagram indicates the pain is on the left side in the very middle of his back vertically. Id. On cross examination Petitioner confirmed he prepared this diagram on March 19, 2012 and that it accurately reflected where his pain was on that date. Dr. Jain noted minimal disc bulging at T12-L1 and an otherwise normal thoracic MRI. Dr. Jain noted the possibility of performing left-sided thoracic facet injections. Id.

On April 16, 2012, Petitioner followed up at Chicago Pain with Dr. Christopher Morgan noting decreased pain. Id. The diagnosis was thoracic strain/sprain and thoracic facet syndrome. Id. There is no mention of the possible left-sided thoracic facet injections in this record. Id.

On May 14, 2012, Petitioner returned to Dr. Jain. This record indicates, "He complains of new onset of left neck and shoulder pain which started approximately 1 week ago." Id. It was noted the thoracic pain had improved and Petitioner testified his thoracic pain had resolved by this time. Petitioner informed Dr. Jain on this day that although his thoracic pain had improved, his left shoulder and left side of his neck had begun hurting while performing pulley exercises in physical therapy. He further reported occasional numbness in the fingers of his left hand. Dr. Jain again diagnosed thoracic facet syndrome and added diagnoses of cervicalgia and left shoulder strain. He recommended MRIs of his left shoulder and cervical spine, as well as again opining that Petitioner may benefit from possible thoracic facet injections. Petitioner was to continue physical therapy and remain off work. Cervical and left shoulder MRIs were ordered. Id.

A pain diagram dated May 14, 2012 does not identify pain anywhere on the back. Id. The pain diagram identifies pain on top of the left shoulder and the left side of the neck. Id.

On June 4, 2012, Petitioner followed up with Dr. Jain reporting left sided neck pain and shoulder pain. Id. Thoracic pain is not noted in this record. Id. The recommendation regarding injections changed from thoracic injections to cervical injections in this record. Id.

On June 12, 2012, Petitioner presented to Dr. Jain who performed left C4-5, C5-6, and C6-7 facet joint injections. Id. The diagnosis in this record is cervical facet syndrome, cervical discogenic pain, and cervical radiculopathy. Id.

On June 15, 2012, Petitioner presented to Dr. Steven Sclamberg at Chicago Pain. Id. This record indicates a cervical spine and low back injury in April 2012. Id. On cross examination Petitioner testified he was not aware of such an injury. This record indicates the shoulder pain had resolved. Id.

On June 18, 2012, Petitioner presented to Dr. Morgan noting complete relief of the neck and left shoulder pain. Id. The pain diagram on this date indicates a zero pain level. Id. Petitioner was released to full duty work and discharged from care. Id.

On July 16, 2012, Petitioner followed up with Dr. Jain. Id. He was not reporting any pain, but occasional cramping in the left shoulder which would last for 5-10 seconds. Id. Petitioner was again released to full duty work.

Petitioner presented for 42 physical therapy or chiropractic sessions at Chicago Pain Center from March 20, 2012 through June 20, 2012. PX #3. On April 19, 2012, the therapy record indicates Petitioner was performing light car repair. Id.

On August 10, 2012, Petitioner presented to Dr. Andrew Zelby for a Section 12 examination at Respondent's request. Dr. Zelby's evidence deposition was taken on March 4, 2013. RX #1. The August 10, 2012 report of Dr. Zelby is attached to the deposition transcript as Zelby Exhibit #2.

Dr. Zelby opined Petitioner's problem was a thoracic strain and nothing more. (RX #1 at 18, Zelby Report at 6). He indicated based on the onset of pain, symptoms, and an exam and diagnostic finding, Petitioner's treatment was prolonged and excessive for no medical reason. (RX #1 at 19, Zelby Report at 6). Petitioner required no more than six chiropractic visits. Such treatment would only warrant an additional twelve visits if there was objective functional improvement. Id. Dr. Zelby pointed out how Petitioner's cervical and shoulder complaints began two months after the alleged work injury date. Id. These complaints and the modest findings on the cervical MRI were not caused, aggravated, exacerbated, or even made symptomatic as a consequence of the reported work injury. Id.

Regarding the cervical facet injections Dr. Zelby indicated they were not reasonable or necessary irrespective of cause since Petitioner did not have any objective medical condition to be treated with such injections. (RX #1 at 20, Zelby Report at 6).

According to Dr. Zelby based on the injury and diagnostic findings Petitioner would have been qualified to return to modified duty within 0-4 days of incident, manual labor within 14-18 days of incident, and heavy physical labor within 42 days of incident, although the job at Accord Carton was not a heavy manual job. (RX #1 at 21, Zelby Report at 6). Maximum medical improvement would have been reached within 8-12 weeks of the incident at the most. Id.

Dr. Zelby provided an impairment rating based on the AMA Guides to the Evaluation of Permanent Impairment 6th Edition. The final whole person impairment rating for Petitioner is zero. (RX #1 at 22-23, Zelby Report at 6).

On cross-examination Dr. Zelby admitted that his examination of the Petitioner did not take place until one month after he had been released full duty by his treating physicians. Although diagnosing Petitioner solely with a thoracic strain, Dr. Zelby further admitted that the type of accident described by Petitioner could cause a similar injury to the cervical spine. Moreover, Dr. Zelby affirmed that neck pain could be clinical indication for facet injections.

On June 4, 2012, Gary Polizzotto, D.C. authored a utilization review report. Gary Polizzotto's evidence deposition was taken on March 21, 2013. (RX #2). The June 4, 2012 report of Gary Polizzotto is attached to the deposition transcript as Polizzotto Exhibit #2.

Dr. Polizzotto reviewed the records of Chicago Pain and Orthopedic Institute and Chicago Pain Center. (RX #1 at 12-15, Report at 1). He noted there were no periodic re-exams to substantiate ongoing therapy beyond what would be appropriate for a simple soft tissue injury of the sprain/strain type which is all the objective testing supported. (RX #1 at 17, Report at 2). Dr. Polizzotto noted there are two levels of proof of medical necessity, reasonableness, and appropriateness of care a provider must satisfy:

1. Services must result in significant progressive improvement in the patient's functional level relative to treatment goals, and
2. The clinical documentation must demonstrate this improvement for services, and the need as well as goals for specific services, to be deemed necessary, reasonable and reimbursable. As such, a provider typically should re-examine the patient every 10-12 visits or each 30 days of treatment, whichever comes first.

(RX #1 at 18-19, Report at 2.)

Dr. Polizotto noted the medical records did not support the medical necessity of 17 therapy sessions based on the lack of re-examinations as well as the orthopedic evaluations of March 19, 2012 and April 16, 2012 which simply state the examination is unchanged. (RX #1 at 21, Report at 2-3). Based on Official Disability Guidelines (ODG) ten therapy sessions were all that could be recommended and the cervical MRI was entirely premature as evidenced by the normal findings. (RX #1 at 21-23, Report at 3). A patient should be allowed one month of conservative care before an MRI is medically necessary. (RX #1 at 23, Report at 3).

On cross examination Dr. Polizzotto explained that there is no such thing as chiropractic medicine, it is just chiropractics and that is what he is licensed to practice. (RX #2 at 28-29) Although he is licensed to practice chiropractics in several states, his license to practice chiropractics did not extend to Illinois. (RX #2 at 28-29) He works for Zurich, for the past twelve years as an independent contractor, doing utilization reviews. Dr. Polizzotto also admitted that he did not review the entirety of Petitioner's medical records. Dr. Polizzotto acknowledged that Petitioner was reporting subjective improvement with the physical therapy.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No

single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

An injury 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).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course and scope of her employment with Respondent and the date of the accident, the Arbitrator makes the following conclusions of law:

The Arbitrator finds Petitioner did sustain accidental injuries on March 12, 2012 that arose out of and in the course of employment with Respondent. In doing so, the Arbitrator notes Petitioner's consistent history of the accident provided in his oral testimony and corroborated by the records of his treating physicians, as well as the consistent history in the report of Respondent's own IME Dr. Zelby. Petitioner testified credibly that prior to beginning his shift on March 12, 2012 he was in a stable, healthy condition. Throughout his oral testimony and as recorded in the records of the treating and examining physicians, Petitioner consistently described performing his job tasks involving twisting to the left and lifting stacks of cardboard boxes when he began to feel pain in his left upper back.

The Arbitrator affords more weight to these consistent histories than the testimony of Respondent's witness Rito Sandoval. Mr. Sandoval admitted to supervising dozens of different employees in the year since Petitioner's four days of work, yet claimed to have a specific independent recollection of a passing comment made during a break on Petitioner's third day of work. The Arbitrator finds Mr. Sandoval's testimony that Petitioner came to him three days before the date of accident and reported an injury occurring completely unrelated to his employment with Mr. Sandoval to be not credible. As such, the Arbitrator finds Petitioner did

sustain accidental injuries on March 12, 2012 arising out of and in the course of employment with Respondent.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator finds Petitioner's current condition of ill-being to be causally related to the work accident of March 12, 2012. Petitioner testified credibly that although he was released to full duty work, he continues to experience the effects of his work injury. Petitioner testified that he can no longer play with his children like he could before the accident, and that he can no longer perform the same house work that he used to perform.

While Petitioner's treating physicians and Dr. Zelby both placed Petitioner at MMI in 2012, it is clear any complaints of aching or soreness Petitioner continues to have are related to the March 12, 2012 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:

At trial, Petitioner introduced the following unpaid medical bills:

Oaklawn Radiologogy Imaging Consultants	$43.00
Chicago Pain & Orthopedic Institute	$2,663.20
Archer Open MRI	$5,400.00
Pain Center of Chicago	$10,922.80
Accredited Ambulatory Care	$14,105.10
Metro Milwaukee Anesthesia Associates	$1,400.85

The Arbitrator finds the x-rays taken in the emergency room visit as well as the medical treatment ordered and rendered by Drs. Jain and Morgan to be both reasonable and necessary, and that Respondent has not paid all appropriate charges. In doing so, the Arbitrator notes the consistent improvements documented in the contemporaneous treating records, as well as the testimony of Petitioner that the treatment provided notable benefit; specifically, that he felt 100% better and experienced lasting relief following the injections.

The Arbitrator further notes that Dr. Zelby agreed with treatment by way of physical therapy, although he opined that Petitioner should not need more than 18 visits. It is not clear whether he took into account the Petitioners statement that he injured his neck and shoulder while participating in the physical therapy for his back. Also, Dr. Zelby did not examine

Petitioner during the course of his treatment, but after the treatment had successfully been completed and Petitioner had been discharged by his physicians.

The Arbitrator finds the testimony and report of Dr. Polizzotto to not be credible. Dr. Polizzotto never examined Petitioner and based his entire opinion off a review of incomplete records. Furthermore, Dr. Polizzotto is not licensed to practice medicine, and even his chiropractic license is not valid in Illinois.

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998). An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n,* (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

In support of the Arbitrator's decision regarding whether Petitioner is entitled to Temporary Total Disability Benefits, the Arbitrator concludes the following:

The Arbitrator finds Petitioner to have been Temporarily Totally Disabled from March 12, 2012 through the June 18, 2012 release to return to work, a period of 14 weeks. Again, the Arbitrator notes the credible opinions of Petitioner's treating physicians, as the records and recovery show that the treatment Petitioner was receiving resulted in a near 100% recovery from his injury.

Moreover, the Arbitrator notes that Dr. Zelby even agreed that a period of 6 weeks off of work would be expected with an injury such as Petitioner sustained, and full duty would not be anticipated until 8-12 weeks out. As before, the Arbitrator notes Dr. Zelby did not examine Petitioner until after the successful completion of Petitioner's treatment. As such, the Arbitrator affords more weight to the contemporaneous records of Petitioner's treating physicians and finds Petitioner entitled to 14 weeks of Temporary Total Disability Benefits. Respondent is entitled to a credit for any benefits paid.

In support of the Arbitrator's decision regarding what is the nature and extent of Petitioner's injury, the Arbitrator concludes the following:

Petitioner testified at trial that although he was released full duty he continues to experience the effects of his work injury even through to the date of hearing. He testified that he has lingering difficulties with his current work, as well as with daily activities such as playing with his children and performing household chores.

Respondent submitted the report and testimony of their IME Dr. Zelby, wherein Dr. Zelby opined that in suffering a thoracic strain Petitioner warranted a 0% impairment rating. However, impairment does not equate to permanency, and the Arbitrator must consider the other factors of section 8.1(b).

Petitioner is currently working in a manual labor position. However, Petitioner noted that in returning to manual labor he continues to feel the effects of the work injury with repeated use of his arms and lifting overhead.

The Arbitrator notes Petitioner to have been of age 28 at the time of the injury, and finds that being such a young age Petitioner will have to live and work with the permanent effects of the injury for a long time.

As for the employee's future earning capacity, Petitioner was able to return to full-duty employment with a new employer.

As for permanent effects corroborated by the treating records, the Arbitrator notes that at the time of his release Petitioner claimed to be feeling almost 100% with occasional cramping. This is consistent with Petitioner's testimony that the treatment improved his condition, but that he experiences pain and soreness on an occasional basis when playing with his children, performing household tasks, and working at his new job. The Petitioner underwent a course of physical therapy and injections. He had a virtually complete resolution of his symptoms, was released to work full duty with no restrictions but suffers an occasional flare up while at work or when playing with his children.

The Arbitrator finds the factors of Petitioner's age, occupation and permanent effects to carry more weight than the impairment rating and, when combined with years of precedent established by the Commission, finds that Petitioner suffered thoracic and cervical strains resulting in **4%** loss of use of the person as a whole.

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 **$319.00/week** for **20** weeks, because the injuries sustained caused the **4%** 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 $319.00 / week for 14 weeks commencing March 12, 2012 through June 18, 2012, as provided in Section 8(b) of the Act as Petitioner was Temporarily Totally Disabled from March 12, 2012 through the June 18, 2012.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received including:

Oaklawn Radiologogy Imaging Consultants	$43.00
Chicago Pain & Orthopedic Institute	$2,663.20
Archer Open MRI	$5,400.00
Pain Center of Chicago	$10,922.80
Accredited Ambulatory Care	$14,105.10

Metro Milwaukee Anesthesia Associates	$1,400.85

pursuant to the medical fee schedule or by prior agreement, whichever is less, as stated in the Act.

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

Michael Cioffi,

Petitioner,

vs.

NO: 06 WC 45302

15IWCC0166

Personal Transportation Corp.,

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

Procedural History

This case was initially tried before Arbitrator Hagan on May 4, 2010. In her decision, dated June 22, 2010, Arbitrator Hagan found that Petitioner's condition of ill-being with respect to Petitioner's lumbar spine was not causally related to the August 20, 2006 work accident. On April 12, 2011, the Commission affirmed and adopted the Arbitrator's Decision.

The case was appealed to the Circuit Court and on March 15, 2012, the court affirmed the Commission's finding with respect to the L3 disc level, but found that the "finding of the Arbitrator that the L5 disc herniation is not related to the Petitioner's accident is against the manifest weight of the evidence." The Circuit Court reversed the decision and remanded the case back "for further proceedings."

As a result of the Circuit Court's Order, on November 19, 2012, in a Decision and Opinion on Remand, the Commission reversed the Arbitrator's decision regarding Petitioner's

lumbar disc herniation at L5, found that Petitioner's current condition of ill-being regarding the L5 is causally related to the August 20, 2006 work accident, and remanded the case back to the Arbitrator for proceedings consistent its decision.

The case proceeded to trial, before Arbitrator O'Malley, on June 11, 2013, pursuant to the aforementioned remand order. The Arbitrator found that Petitioner's L5 disc herniation was causally related to the August 20, 2006 accident. Based upon this finding, the Arbitrator awarded temporary total disability benefits from August 21, 2006 through May 4, 2010, medical expenses, and permanent partial disability benefits.

Respondent filed a Petition for Review on October 29, 2013 and the Commission heard arguments regarding the review on January 6, 2014.

Findings of Fact and Law

After reviewing the facts of the matter, both from a legal and medical/legal perspective, and considering all of the testimony, exhibits, pleadings, orders and arguments submitted by the parties, the Commission finds that, based on the Circuit Court's Order that Petitioner's L5 condition is causally related to the August 20, 2005 accident, Petitioner is entitled to the payment of medical expenses totaling $52,642.23 and to temporary total disability benefits from October 2, 2006 through May 4, 2010, the date of the original arbitration hearing.

Petitioner claimed entitlement to $57,382.29 in medical expenses. However, a complete review of the bills shows that not all of the bills claimed are related to Petitioner's L5 disc herniation. The bills from August 28, 2006 and August 31, 2006 are for treatment of a hernia ($1,994.95 & 463.00). The bill from September 9, 2006 was for removal of a cyst ($1,357.20). The bill from January 23, 2007 was for treatment of a sore throat ($287.36). Finally, the bill from July 12, 2007 was for right arm treatment ($637.55).

The Commission finds that the rest of the medical bills presented deal specifically with treating Petitioner's ongoing low back pain. It is, as the Arbitrator explained, "essentially impossible to separate the above medical expenses based on whether they were incurred relative to the L3 or the L5 herniations." (Ard.Dec.5) Therefore, based on the medical bills presented and the Circuit Court's Order, the Commission awards medical expenses in the amount of $52,642.23, the total of the remaining medical bills associated with the treatment of Petitioner's low back condition.

On the issue of temporary total disability benefits, the Commission notes that the first indication in the medical records that a doctor actually kept Petitioner off work was on October 3, 2006, when Dr. Belen noted that Petitioner remained disabled from his employment "at the present time." (PX6) The Commission notes that there is nothing in the record to indicate that Petitioner has been released to return to work. Therefore, based on the totality of the evidence and, again, on the Circuit Court's Order, the Commission finds that Petitioner is entitled to temporary total disability benefits from October 3, 2006 through May 4, 2010, for a total of 187-1/7 weeks.

15IWCC0166

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $210.01 per week for a period of 187-1/7 weeks, from October 3, 2006 through May 4, 2010, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $199.32 per week for a period of 150 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 30% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $52,642.23 for medical expenses under Section 8(a) of the Act.

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

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

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

DATED: MAR 9 - 2015
MJB/ell
o-01/06/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CIOFFI, MICHAEL
Employee/Petitioner

Case# **06WC045302**

PERSONAL TRANSPORTATION CORP
Employer/Respondent

15IWCC0166

On 9/25/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0212 LAW OFFICE OF MICHAEL D GERSTEIN
800 LEE ST
SUITE 3
DES PLAINES, IL 60016

2709 MICHAEL L SHEPHERD
155 N MICHIGAN AVE
SUITE 613
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
MARK F VIZZA
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

15IWCC0166

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

Michael Cioffi,
Employee/Petitioner

v.

Professional Transportation Corp.,
Employer/Respondent

Case # **06** WC **45302**

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 **Chicago**, on **6/11/13 & 7/15/13**. 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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **8/20/06.**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being with respect to L5 herniation ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$16,381.04**; the average weekly wage was **$315.02**.

On the date of accident, Petitioner was **44** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$15,295.50** for other benefits, for a total credit of **$15,295.50**.

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 $210.01 per week for 193-2/7 weeks, commencing 8/21/06 through 5/4/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 8/21/06 through 6/11/13, 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.

Respondent shall pay reasonable and necessary medical services of $57,382.29, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $199.32 per week for 150 weeks, because the injuries sustained caused the 30% 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

9/24/13
Date

SEP 25 2013

STATEMENT OF FACTS:

By way of procedural history, this matter was originally tried before Arbitrator Kathleen Hagan on May 4, 2010. In a decision dated June 22, 2010, Arbitrator Hagan determined that Petitioner's present condition of ill-being with respect to his lumbar spine was not causally related to the accident on August 20, 2006, and compensation was denied. The Commission eventually affirmed and adopted the arbitrator's findings in a decision dated April 12, 2011. Thereafter, the matter was appealed to the circuit court. In an order dated March 15, 2012, Judge Robert Lopez Cepero affirmed the Commission's finding with respect to the L3 disc level but determined that "[t]he finding of the Arbitrator that the L5 disc herniation is not related to the petitioner's accident is against the manifest weight of the evidence and reversed; this cause is remanded for further proceedings." (Arb.Ex.#2). Thereafter, in a Decision and Opinion on Remand dated November 19, 2012 (12IWCC1266), the Commission on Review ordered that "[i]n accordance with and pursuant to the order from the Circuit Court, the Commission reverses the Arbitrator's decision regarding Petitioner's lumbar disc herniation, finds that Petitioner's current lumbar condition of ill-being at L5 is causally related to the August 20, 2006 accident and remands the case back to the Arbitrator for proceedings consistent with this decision." (Arb.Ex.#3).

The matter was eventually assigned to Arbitrator Peter O'Malley and proceeded to trial pursuant to the aforementioned remand order on June 11, 2013, with the close of proofs on July 15, 2013.

Petitioner testified that he was employed by Respondent from 2004 until he was injured on August 20, 2006. His job was to move railroad employees from one location to another. On August 20, 2006, he was driving his Astro-Van on the way to pick up a railroad crew. He was on the I-94 expressway and traffic in front of him stopped. When he was doing about 2 miles an hour, as he was stopping, the car behind him struck his rear end. The impact was heavy. There was damage to the back bumper of the Astro-Van. Both drivers went to the police and ultimately made out a report. He did not work the rest of that day but instead went back to Detroit. (R.5-10).

On September 3, 2006, he was triaged at the Wyandotte Henry Ford Hospital Emergency Room. The emergency room record shows his chief complaint of back pain. (PX1; RX3). The history obtained from the patient was "Patient presents for the evaluation of bi-lateral, lower, back pain." He did not describe any mechanism of the injury and reported the symptoms as gradual, onset two days ago. His symptoms complaint was persistent. He located the symptoms as the left side of his back and left thigh. He described the quality as sharp, the describer wrote paresthesias of left leg. Numbness is present. At Wyandotte Henry Ford Hospital he was prescribed pain medication.

His employer had him fill out a work related accident/injury report. (RX2). In that report he describes a motor vehicle collision of August 20, 2006. He describes "torn, ligaments and cyst"; part of body affected "groin".

Junction Health Care Center records show that Petitioner was treated there on September 5, 2006 for a chief complaint of back pain. (PX2). He followed up at the Clinic on September 6, 2006, September 15, 2006 when he was sent for an MRI. He again followed up with treatment September 20, 2006 through November 2, 2006.

Petitioner was also seen at Oakwood Hospital and Medical Center Emergency Department on October 19, 2006 for back pain. He was prescribed Anaprox 550 mgs; Prednisone 20 mgs and Skelaxin 400 mgs. (PX4; RX5).

Petitioner testified that in the 1990's he had also suffered a herniated disc. An MRI performed on March 21, 2004 at Harper-Hutzel Hospital described a herniated disc to the right at L3-L4 with bulging discs and mild stenosis at multiple levels. (R.41; PX3).

The medical records show that Petitioner underwent two MRIs after the August 20, 2006 motor vehicle collision. The first MRI was performed on September 13, 2006 at MNA MRImaging Services and revealed a large left L5 disc herniation with compression as well as a disk herniation on the right at L3. (R.41; PX3). A repeat MRI on May 20, 2008 revealed that the L5-S1 level was the worst of the two herniations and that it had increased in severity since the September 13, 2006 MRI. (Id).

The petitioner testified that he has an 8th grade education. (R.12).

On October 3, 2006, Petitioner was seen by Dr. Jack Belan at Spine Sports & Occupational Medicine, P.C. Dr. Belan continued to treat him through April of 2010. At the time of this initial visit, the following history of illness was recorded: "The patient reports that his problem began while working in Chicago. He was the driver of an Astro-Van while on his job on August 20, 2006 when he was rear ended by another vehicle. He was shaken up severely. 8 days later, he went to Wyandotte Henry Ford Hospital Emergency Room where x-rays were taken. He was told that there were no fractures. He was having groin pain and he was told he had a cyst that came about as a result of the accident. This was cut and drained and has completely healed. He was treated at Junction Clinic. The patient also was referred to a chiropractor, however, did not go through treatment. He indicates that the Junction Clinic is sending him to see a physician on North Line Road who is a surgeon." Petitioner gave Dr. Belan a past medical history which included the herniated disc to which he previously testified occurred in the 1990s. Following his examination and review of the records, Dr. Belan noted that "[i]t is my opinion that the patient has developed a new disc herniation with radiculapathy on the left side as a result of his MVA on August 20, 2006. The patient's progress is guarded at this time." (R.44,48,56;PX6, PX10;RX7).

Dr. Belan described Petitioner's condition as quite severe and to the point where he would have surgery if the surgery would provide him good results. He also said Mr. Cioffi remains disabled from his employment at the present time. He also said he requires assistance with household chores. (Id).

Throughout the years, Petitioner continued regular treatment with doctors at Spine Sports & Occupational Medicine, P.C. as well as doctors at Orthopedic Associates, P.C. (R.48; PX11). During that period, Petitioner had continuing pain and the doctors gave him various injections in his low back. Dr. Belan has kept Petitioner off work since the date he first saw him on October 3, 2006. Likewise, Dr. Michael Baghdoin, at Orthopedic Associates, P.C., has continually kept Mr. Cioffi off work and has variously described Petitioner as being "fully disabled." (R.48; PX11). The records also reflect that as of March 31, 2010, Dr. Baghdoin noted that "[c]linical presentation reveals lumbar pain and flattening of the lumbar spine, difficulty in walking. Truncated mobility patterns. Peripheral vascularity is intact with bounding pulses for posterior tibial and dorsalis pedis." In addition, Dr. Baghdoin has recommended surgery, which he noted Mr. Cioffi does not want to have.

At the request of Respondent, Petitioner was examined by Dr. Scott T. Monson on March 19, 2009. Dr. Monson agreed that Petitioner had a large herniated disc at L5-S1 and noted that Mr. Cioffi should follow up with an orthopedic surgeon. In addition, Dr. Monson stated that a herniated disc could occur from trauma, but was of the opinion that the MRI from 2004 suggested the disc herniation pre-dated the 2006 motor vehicle accident. However, it does not appear that Dr. Monson acknowledged that the MRI of March 21, 2004 only indicated a disc herniation to the right at L3-L4. Dr. Monson also did not express an opinion regarding the large compressive left posterolateral L5 disc herniation found on the September 13, 2006 MRI.

Currently, Petitioner testified that he is in a great deal of pain and that he can barely move around as a result, requiring him to stop for a minute to catch his breath. He noted that his wife and his grandkids help him get dressed and that he is unable to make his own breakfast or do household chores such as cut the grass or take out the trash.

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

As previously noted, Arbitrator Hagan determined, in a decision dated June 22, 2010, that Petitioner's present condition of ill-being with respect to his lumbar spine was not causally related to the accident on August 20, 2006. The Commission eventually affirmed and adopted the arbitrator's decision in a decision dated April 12, 2011. Thereafter, the matter was appealed to the circuit court. In an order dated March 15, 2012, Judge Robert Lopez Cepero affirmed the Commission's finding with respect to the L3 disc level but determined that "[t]he finding of the Arbitrator that the L5 disc herniation is not related to the petitioner's accident is against the manifest weight of the evidence and reversed; this cause is remanded for further proceedings." (Arb.Ex.#2). Thereafter, in a "Decision and Opinion on Remand" dated November 19, 2012, the Commission on Review ordered that "[i]n accordance with and pursuant to the order from the Circuit Court, the Commission reverses the Arbitrator's decision regarding Petitioner's lumbar disc herniation, finds that Petitioner's current lumbar condition of ill-being at L5 is causally related to the August 20, 2006 accident and remands the case back to the Arbitrator for proceedings consistent with this decision." (Arb.Ex.#3).

Based on the above remand order, and the clear language of said order, the Arbitrator finds that Petitioner's current lumbar condition of ill-being with respect to the L5 disc herniation is causally related to the August 20, 2006 accident.

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

Petitioner submitted into evidence the following medical bills:

	Medical Provider	Service Date		Amt. Billed
1)	Henry Ford Wyandotte Hospital	08/28/06 to 07/12/07		$ 5,821.29
2)	MNA MRImaging Service	09/13/06 to 09/13/06		$ 1,000.00
3)	Orthopedic Associates	01/12/07 to 01/15/10		$ 28,486.00
4)	Spine Sports Occ. Medicine	10/03/06 to 10/28/09		$ 22.075.00
			Total	$ 57,382.29

The medical bills are supported by the medical records of the providers. (R.39-49; PX1-PX12). Respondent offered no opinion into evidence which would call into question the reasonableness of the bills. Petitioner testified he was provided the services while.

Therefore, based on the above, and the record taken as a whole, including the Commission's remand order finding that the L5 disc herniation is causally related to the accident, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses in the amount of $57,382.29 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. Along these lines, the Arbitrator notes that as a practical matter, it is essentially impossible to separate the above medical expenses based on whether they were incurred relative to the L3 or the L5 herniations. Accordingly, all of the claimed bills are awarded.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The record shows that Petitioner continued to be off work following the accident on August 20, 2006 through the date of arbitration on May 4, 2010. Dr. Baghdoin continued to treat Petitioner for his injuries and to restrict him from work through that date. Likewise, Respondent's §12 examining physician, Dr. Monson, conceded that "[a]t this time I would concur that he should not be doing any heavy lifting and bending. I would also consider surgical intervention based upon the degree of complaints, the duration, and the failure of other conservative treatments."

Based on the above, and the record taken as a whole, and in light of the Commission's finding to the effect that Petitioner's current condition of ill-being with respect to the L5 disc herniation is causally related to the accident, the Arbitrator finds that Petitioner is entitled to temporary disability benefits from August 21, 2006 through May 4, 2010, for a period of 193-2/7 weeks. Once again, it being a practical impossibility to separate any time off work due to the L3 versus the L5 herniation, the entire claimed period is awarded.

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

An MRI performed on September 13, 2006 revealed an L5 disc herniation compressing on the L5 nerve root. Petitioner's treating physicians have said throughout his medical records that the herniated disc at L5 is large and compressive. Petitioner's condition was described as producing radiculapathy on the left side. Dr. Belan also noted that surgery at one point was an option. However, Petitioner has not undergone any such surgical procedure and testified that he has not seen any physician since Dr. Belen's retirement and since he last testified in May of 2010.

Currently, Petitioner testified that he is in a great deal of pain and that he can barely move around as a result, requiring him to stop for a minute to catch his breath. He noted that his wife and his grandkids help him get dressed and that he is unable to make his own breakfast or do household chores such as cut the grass or take out the trash.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% person-as-a-whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

The parties agreed that Respondent is entitled to a credit under §5(b) in the amount of $15,295.50 as a result of the third party action. Said credit is hereby awarded.

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

LAWRENCE WILLIAMS,

Petitioner,

vs.

NO: 11 WC 37451

15IWCC0167

ILLINOIS CEMENT COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

The Petitioner alleged two separate work-related incidents. The first incident occurred July 29, 2010 (11 WC 37451) and the second on May 9, 2011 (11 WC 34038). The cases were consolidated at hearing and a single decision was issued. The Arbitrator found the July 29, 2010 accident compensable and also found that Petitioner failed to prove a work-related accident occurring on May 9, 2011.

15IWCC0167

The Commission affirms and adopts the Arbitrator's decision relating to case 11 WC 37451. The evidence establishes that the Petitioner developed left lateral epicondylitis as a result of his injury. He underwent conservative treatment including a series of injections. He subsequently returned to work full-duty and does not require any further medical treatment. The Petitioner demonstrated no loss of earning capacity as a result of his injury. The Arbitrator's award of 10% loss of use of the left arm pursuant to Section 8(e) of the Act is therefore affirmed.

The Commission has issued a separate decision for case 11 WC 34038.

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 Respondent pay to Petitioner the sum of $661.54 per week for a period of 25.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related solely to the left epicondylitis under §8(a) of the Act and subject to the medical fee schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,800.00. 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: MAR 9 - 2015

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 2-17-15
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, LAWRENCE
Employee/Petitioner

Case# **11WC034038**
11WC037451

ILLINOIS CEMENT COMPANY LLC
Employer/Respondent

15IWCC0167

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:

1824 STRONG LAW OFFICES
TODD STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

Lawrence Williams
Employee/Petitioner

v.

Illinois Cement Company LLC
Employer/Respondent

Case # **11** WC **34038**

Consolidated cases: **11 WC 37451**

15IWCC0167

An *Application for Adjustment 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 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 **7/29/10 & 5/9/11**, 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 **7/29/10**, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
On **5/9/11**, 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 in part causally related to the 7/29/10 accident.

In the year preceding the injury, Petitioner earned **$57,333.86**; the average weekly wage was **$1,102.57**.

On the date of accident, Petitioner was **67** 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** in nonoccupational indemnity disability benefits, and **$0** in 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 TTD / Maintenance benefits is denied based on the Arbitrator's finding of no accident on 5/9/11 and no causation with regard to the Petitioner's cervical condition.

Respondent shall pay reasonable and necessary medical services limited only to treatment of Petitioner's left epicondylitis, as provided in Section 8(a) of the Act. Petitioner's claim for medical expenses related to his cervical condition is denied based on the finding with regard to causation and accident.

Respondent shall pay Petitioner permanent partial disability benefits of $661.54/week for 25.3 weeks, because the injuries sustained caused the 10% loss of the left arm , as provided in Section 8(e) of the Act.

The Petition for Penalties and Attorneys Fees is denied based on the findings on the issues of accident and causation.

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

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

6/30/14
Date

JUL 2 - 2014

15IWCC0167

FINDINGS OF FACT

Petitioner originally filed four Applications for Adjustment of Claim. which were consolidated at the time of this arbitration hearing. On Petitioner's motion. the Arbitrator dismissed the Application for Adjustment of Claim on case number 11 WC 33849 and 11 WC 37475. The remaining claims are for 11 WC 37451 regarding a date of accident of May 9. 2011 and 11 WC 37451, which regards a date of accident of July 29. 2010. The parties have also indicted to this Arbitrator that there are overlapping issues of causal connection between the remaining two alleged accident injuries. For purposes of judicial economy and because of the overlapping issue of causation. there will be one arbitration decision issued for the two remaining claims.

Although the parties indicated at the beginning of the arbitration hearing. that the issues in dispute are accident, causation. TTD/maintenance. medical expenses. credit, penalties/attorney fees. and permanency - the central issue in dispute is whether or not the petitioner's condition of ill-being with respect to his alleged cervical injuries are causally connected to the alleged accident injuries he sustained on July 29. 2010 and/or the alleged accident of May 9. 2011. or a combination of both.

The parties have stipulated that the Petitioner sustained an accident on July 29, 2010. The Petitioner testified that he slipped and fell while in the course of his employment on that day with an outstretched left arm when he tripped and fell on a concrete riser on the sidewalk leading into the employer's administrative office. Petitioner's job duties at include driving a truck as well as manual labor at Respondent's mining operation. He does not perform over-the-road truck driving duties, but rather drives a truck in a quarry operation driving loads of limestone back and forth between the quarry entrance and a processing plant. The Petitioner described his job duties and specifically described the driving conditions that he is frequently asked to be exposed to up to and including large ruts in the gravel and limestone surfaces of the roadway as well as an extreme vibratory nature of the truck in which he operates.

Following the incident on July 29, 2010. Petitioner reported to Illinois Valley Community Hospital Occupational Health Clinic on September 7. 2010. His initial diagnosis was left elbow epicondylitis. Petitioner continued to work without restrictions.

On February 15, 2011, Petitioner underwent an IME with Dr. John Fernandez, who confirmed the diagnosis of Left elbow lateral epicondylitis. Dr. Fernandez opined that the condition was causally related to the event from July 29, 2010. Dr. Fernandez indicated Petitioner could return to truck driving, but had restrictions of 10 to 20 pounds of force and restrictions from significant amounts of repetition or use of tools with his hands. Dr. Fernandez further added that he believed there would be no permanent impairment due to the Petitioner's epicondylitis.

On March 1, 2011, Petitioner began treatment with Dr. Robert Mitchell. Dr. Mitchell confirmed the diagnosis of lateral epicondylitis. Dr. Mitchell gave Petitioner a cortisone injection in the elbow and prescribed physical therapy. On March 2, 2011, Petitioner was also placed on light duty restrictions of lifting greater than 10 pounds. On March 29, 2011, Petitioner was released to return to regular work by Dr. Mitchell.

Petitioner testified that on May 9, 2011, he was using a shovel at work when his left elbow began to swell and experienced pain in his neck, with pain radiating down to his fingers. Petitioner testified that he provided notice to his co-workers regarding this incident. Petitioner continued to work. He testified that he then went on vacation from May 31, 2011 through June 12, 2011. Petitioner then saw Dr. Mitchell on June 28, 2011, whose records indicate the Petition complained of a heavy, burning sensation in his lateral epicondyle and pain with

15IWCC0167

soreness and swelling. Dr. Mitchell's records from June 28, 2011 indicate Petitioner had full active and passive range of motion of his left shoulder with tendness over the lateral epicondyle with a small amount of swelling. Dr. Mitchell gave Petitioner work restrictions of no lifting greater than 10 pounds and provided Petitioner with another cortisone injection. On July 19, 2011, Dr. Mitchell notes continued pain in Petitioner's left elbow with numbness shooting down to his fingers. Dr. Mitchell continued Petitioner's light duty work restrictions and ordered an EMG. On August 11, 2011, Dr. Mitchell notes that the Petitioner's EMG was positive for double crush with C-7 radiculopathy, left carpal tunnel syndrome and mild left cubital tunnel syndrome. At this time, Dr. Mitchell's records indicate Petitioner was complaining of paraesthesias in his left upper extremity and radiating pain from his shoulder and neck. At that time, Dr. Mitchell refers Petitioner to follow up with a spine surgeon for an evaluation of Petitioner's neck. Dr. Mitchell later testified via evidence deposition that the Petitioner's left arm epicondylitis was related to his alleged accidents, but that these conditions had resolved and he had no permanent restrictions as a result of these conditions. Dr. Mitchell did not give any opinion regarding Petitioner's alleged neck condition and deferred to the spine specialists on that matter.

Petitioner followed up his neck treatment with Dr. Richard Kube at the Prairie Spine and Pain Institute on August 30, 2011. Dr. Kube's records indicate an assessment of cervicalgia, degenerative disc disease, spinal stenosis and brachial neuritis. Dr. Kube noted that an MRI indicated an annular tear at C5-C6. Dr. Kube ultimately recommended surgery for Petitioner's cervical condition. According to Petitioner's testimony, any further treatment for his cervical condition was denied by Respondent. Dr. Kube testified via evidence deposition that he believed the incident from May, 2011 was either a causative factor or an aggravation of Petitioner's underlying cervical condition.

On December 1, 2011, Dr. Kern Singh performed an IME at the request of Respondent. In his initial report, he indicated that he believed the Petitioner sustained an aggravation of his underlying degenerative cervical condition as the result of his alleged work injuries. On December 19, 2011, Dr. Singh prepared an addendum report essentially retracting his opinion with regard to the issue of causation based on his review of the Petitioner's medical records. Dr. Singh subsequently testified via evidence deposition that his opinion on causation changed because of the gap in the Petitioner's complaints of neck pain, which began in July, 2011.

On February 16, 2012, Petition saw Dr. Mark Lorenz of Hinsdale Orthopaedics on referral from Dr. Kube. Dr. Lorenz diagnosed a herniation at C5-C6. Dr. Lorenz ultimately performed surgery on March 20, 2012 involving a diskectomy and fusion at C5-C6. Dr. Lorenz testified in his evidence deposition that he believed the Petitioner's cervical condition was a result of his injury from July 29, 2010. Following Petitioner's surgery, Dr. Lorenz had Petitioner off work through July 9, 2012. On July 9, 2012, Dr. Lorenz released Petitioner to light duty work and Petitioner worked light duty for Respondent from September 21, 2012 through November 28, 2012.

In November, 2012, Petitioner's restrictions were increased to restrict him from quarry driving, no lifting more than 30 pounds and no exposure to vibration. Petitioner testified that he has been unsuccessful in looking for work within those restrictions. He underwent a vocational assessment by Bob Hammond – a vocational counselor selected by Petitioner's attorney. Mr. Hammond did not believe the Petitioner could find work given his restrictions. Respondent retained Natalie Maurin as their vocational expert. Ms. Maurin believed that the Petitioner was capable of finding work within his restrictions.

The medical records and Petitioner's testimony during cross examination revealed that the Petitioner has been working at the Cedar Creek Ranch, where he had been observed painting. Petitioner also testified that he has ridden all terrain vehicles, and can load/unload, ride and operate a boat without problems to his neck.

15IWCC0167

CONCLUSIONS OF LAW

1. The Arbitrator finds that the Petitioner has not met his burden of proof regarding the issue of whether he sustained an accident on May 9, 2011. This finding is based primarily on the medical records on or around that date. The parties stipulated that the Petitioner sustained an accident on July 29, 2010 involving his left elbow and that is supported by the contemporaneous medical records. However, the Arbitrator notes that there are no medical records contemporaneous with Petitioner's alleged incident from May 9, 2011. In closely reviewing the Petitioner's treating medical records from Dr. Mitchell, the first time Petitioner complained of any neck condition was after his MRI results were reviewed by Dr. Mitchell on August 11, 2011. This is over 3 months after the alleged incident from May, 9, 2011. The Arbitrator finds it highly incredible that the Petitioner injured his neck on May 9, 2011, took a 12 day vacation, continued to work, but had no neck complaints until 3 months later. At most, the records support that the incident on May 9, 2011 was a continuation of the Petitioner's complaints from his July 29, 2010 incident involving his left arm. For these reasons, the Arbitrator finds that the Petitioner did not sustain an accident on May 9, 2011.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has proven that he sustained a left lateral epicondylitis injury, which is causally related to his July 29, 2010 accident. However, Petitioner has not met his burden of proof with regard to the issue of whether his cervical condition is causally related to either the alleged incident on July 29, 2010 or his alleged accident from May 9, 2011. In support of this finding, the Arbitrator again refers to a close analysis of the Petitioner's treating medical records, which do not document any complaints of neck pain until August 11, 2011 – the date Dr. Mitchell reviewed Petitioner's MRI results. This notation of neck complaint is almost a year following the July 29, 2010 incident and 3 months following the alleged May 9, 2011 incident. Given the notable gap in time with regard to the Petitioner's neck complaints and his alleged accident dates, the Arbitrator finds no causal connection between the neck condition and the Petitioner's alleged accidents.

3. Based on the Arbitrator 's findings on the issues of accident and causation, the Petitioner's claim for TTD and maintenance benefits are denied. In support of this finding, the Arbitrator notes that the Petitioner was taken off work due to his cervical condition, which is not causally related to his alleged accidents.

4. Based on the Arbitrator's findings above, the Arbitrator finds that the Petitioner's medical treatment limited to his left epicondylitis was reasonable and necessary. Respondent shall pay for any medical expenses related to treatment of the Petitioner's left epicondylitis, subject to the fee schedule and in accordance with Section 8 of the Act. Petitioner's request for payment of expenses related to the treatment of his cervical condition is denied.

5. With regard to the issue of permanency, the Arbitrator finds that as a result of his accident from July 29, 2010, the Petitioner sustained an injury to his left arm resulting in left laterally epicondylitis. Petitioner underwent conservative treatment and a series of injections in his arm for this condition. Petitioner was able to return to work full duty following his treatment for this condition. Accordingly, the Arbitrator awards the Petitioner 10% loss of use of his left arm pursuant to the Act. Furthermore, the Arbitrator notes that the Petitioner's inability to return to work and his current physical restrictions are due to his unrelated cervical condition.

6. Based on the findings above and the issues in dispute, the Petition for Penalties and Attorney Fees is denied.

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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY CAPUA,

Petitioner,

vs. NO: 10 WC 10042

LISLE-WOODRIDGE FIRE PROTECTION DISTRICT,

Respondent.

15IWCC0168

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability benefits and permanent partial disability benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Arbitrator's findings of fact as set forth in his September 24, 2013, Decision, are attached hereto.

The Arbitrator found Petitioner failed to prove he suffered an accident arising out of and in the course of his employment with Respondent and that his condition was not causally connected to the alleged work injury. The Commission reverses the Arbitrator and finds Petitioner proved he suffered a work related injury and his condition of ill being is causally connected to his work injury. Additionally, we award medical expenses and permanent partial disability benefits.

The Workers' Compensation Act provides Petitioner with a rebuttable presumption that he suffered a work injury and that there is a causal connection. Section 6(f) states in relevant part:

> Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), ... which results directly or indirectly from any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT, EMT-I, A-EMT, or paramedic. ... The changes made to this subsection by Public Act 98-291 shall be narrowly construed.

The Petitioner proved he suffered a work related injury on November 15, 2009. There is no dispute that Petitioner was at the location and involved with fighting the fire. He testified that he felt a pain in his abdomen after pulling the 35 foot ladder out of about 5 inches of mud. We note that Petitioner had previously complained of some abdomen pain earlier that summer. Petitioner testified credibly and carefully distinguish how he felt and what he noticed from the summer of 2009 until November and then after the November 15, 2009, accident. Petitioner explained his medical records contain a history of slight swelling in his abdomen in the summer of 2009 because he wanted to honestly tell his physicians about his complete history. Petitioner then testified that it was only after the November 15, 2009, accident that he noticed much larger swelling and sought medical treatment. While Petitioner did not immediately seek medical treatment, he is not faulted for waiting a few weeks to see his physician as he already knew he had the December 2, 2009, appointment scheduled with Dr. Link at the time of the accident. We also do not fault Petitioner for not immediately connecting the hernia to the work incident. Petitioner did not know what the swelling in his stomach was and testified that he did not want to report an accident or tell his chief until he found out what it was and how it would be treated.

While Respondent presented some evidence, Respondent was not able to overcome the statutory rebuttable presumption that Petitioner suffered a work injury.

Additionally, we find that Petitioner's current condition of ill being is causally connected to his work related injury. Again, there is a statutory rebuttable presumption that Petitioner's hernia is causally connected to his work accident. Dr. Link diagnosed Petitioner with a hernia on December 2, 2009. Once Petitioner realized he had a hernia, he immediately sought further medical treatment and then eventually underwent surgery. This is the first time in Petitioner's extensive medical history that he sought medical treatment specifically for a hernia and the first time he underwent surgery for the condition. Petitioner submitted extensive medical records

dating back to 2003. None of those records contain any history or indication that he had swelling or any other issues with his abdomen.

Further, we find Dr. Gross, Petitioner's Section 12 examiner, more credible than Dr. Kale, Respondent's Section 12 examiner. Dr. Kale opined there is no evidence Petitioner sustained a hernia as a result of the November 15, 2009, work accident. At the same time, Dr. Kale testified that it was possible that one hernia developed over the summer and one developed in November 2009 and it was impossible to tell which hernia developed first or when. He also said it was possible both occurred at the same time and evidence for any of the scenarios is lacking. On the other hand, Dr. Gross opined there was a causal connection and Petitioner's history of moving a ladder that was stuck in mud could have led to either one of Petitioner's hernias. He pointed out that even though Petitioner did notice some swelling over the summer, he continued to work and never sought medical attention for it. While Respondent was able to present some evidence, it was not enough to rebut the presumption that Petitioner's hernia is causally connected to his work.

The Commission awards Petitioner his outstanding medical bills of $8,918.75 per the fee schedule. Petitioner medical treatment was reasonable and necessary, and not excessive.

Finally, we award Petitioner permanent partial disability benefits of 5% loss of the person as a whole. Petitioner has suffered two hernias in the course of performing the strenuous job duties of a firefighter/paramedic. He has since returned to his position full duty. Petitioner testified he notices the mesh when his stomach rubs against something and it causes him some discomfort. While Petitioner testified he experiences discomfort during almost every work shift, he has fully returned to his heavy duty employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 25 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,918.75 for medical expenses per the medical fee schedule under §8(a) of the Act.

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

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

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

DATED: MAR 9 - 2015
TJT: kgg
R: 1/6/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAPUA, TIMOTHY
Employee/Petitioner

Case# **10WC010042**

LISLE-WOODRIDGE F P D
Employer/Respondent

15IWCC0168

On 9/24/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0728 LAW OFFICES OF THOMAS W DUDA
3125 N WILKE RD
SUITE A
ARLINGTON HTS, IL 60004

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MICHAEL E RUSIN
10 S RIVERSIDE PLZ SUITE 1520
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Timothy Capua
Employee/Petitioner

v.
Lisle-Woodridge F.P.D.
Employer/Respondent

Case # 10 WC 10042

Consolidated cases:

15IWCC0168

An *Application for Adjustment 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 Kurt Carlson, Arbitrator of the Commission, in the city of Wheaton, on 9/16/13. 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 _____

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY CAPUA,	)	
	)	
Petitioner,	)	15IWCC0168
	)	
v.	)	No. 10 WC 10042
	)	
LISLE-WOODRIDGE F.P.D.,	)	
	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner claims an accident date of November 15, 2009 resulting in a hernia. The claim is disputed. Disputes involve the issues of accident, causal connection, wages, medical, TTD and permanent partial disability.

Petitioner testified that he is employed as a firefighter/paramedic for Respondent. He was hired September 11, 1989 as a firefighter/EMT. He was promoted to lieutenant February 28, 2008 and was working in that position on November 15, 2009.

Petitioner testified that as a lieutenant he still did firefighting/EMT activities. Petitioner testified the work is strenuous. It involves pulling dry hoses off of engines in bundles. The dry hoses are pulled into structures then filled with water and carried. Petitioner testified the hoses are heavier once filled with water. Petitioner testified that he is required to wear full gear including pants, coat, hat, tools and an air tank. The gear weighs approximately 80 pounds. Petitioner testified that while fighting fires, he will be required to lift and carry ladders of varying weights from 80 pounds to a couple of hundred pounds.

Petitioner testified that while working as an EMT he was required to carry heavy gear including bags weighing about 40 pounds. He was also required to lift patients of

varying weights. He testified that about 60% of his calls were for EMS and 40% for fires.

Petitioner testified that he worked 24 hour shifts from 7:00 a.m. to 7:00 a.m. He would then be off for 48 hours.

Petitioner testified that prior to November 15, 2009 he had noticed soreness in his lower abdomen. He never reported any type of injury and did not seek any medical treatment. Petitioner testified that on November 15, 2009 he was working a regular shift. During the early morning hours of November 15, 2009, he was called out to respond to a fire at a single family residence at approximately 3:40 a.m. Petitioner testified that his crew was the third engine on scene. He testified that other firemen were already fighting the fire. His engine was assigned a support role as an RIT or Rapid Intervention Team. He was required to collect tools and equipment. He was to assist in providing ingress and egress to the house. Petitioner testified that his crew removed a 35 foot ladder from the truck and positioned it on the roof. He testified that three people carried the ladder and they positioned it on the roof. He testified the fire started burning through the roof and they needed to reposition the ladder. Petitioner testified that the heel of the ladder had sunk in the mud and he and a fellow firefighter lifted the ladder out of the mud. As Petitioner lifted the ladder to move it, he felt a pull in his lower abdomen. He testified that he repositioned the ladder and he finished the call.

Petitioner admitted that he did not report any accident or injury on November 15, 2009. However, he claims that he noticed a bulge in his abdomen near his belly button. Petitioner admitted that he did not seek any medical treatment on or about November 15,

2009. Petitioner stated that he knew he had a department physical coming up December 2, 2009 and he did not seek any medical treatment prior to that department physical.

Petitioner admitted that he did not report any accident or injury to his employer over the next two weeks. Petitioner testified that he continued to work his regular shifts.

On December 2, 2009, Petitioner attended an annual department physical at Edward Corporate Health with Dr. Williamson-Link. Petitioner testified that he had known Dr. Williamson-Link for over 20 years. Petitioner stated that he told Dr. Link that he had something in his abdomen. He testified that he told Dr. Link that he first noticed something in his abdomen over the summer. Petitioner testified that Dr. Link then found that Petitioner had a hernia and suggested that he follow up with his family doctor, Dr. Czepiel.

Petitioner testified that he saw Dr. Czepiel December 4, 2009 and Dr. Czepiel diagnosed a hernia. Dr. Czepiel referred Petitioner to Dr. Ward, a surgeon.

Petitioner testified that he saw Deputy Chief Burke on December 5, 2009 and told him "what happened." Petitioner testified that he first submitted a written report claiming a work injury on December 8, 2009. (Rx. 1).

Petitioner was examined by Dr. Ward on December 17, 2009 and diagnosed with a hernia. Dr. Ward recommended surgery. Surgery was performed on February 8, 2010. Petitioner admitted that from November 15, 2009 through February 8, 2010 he continued to perform his regular work duties. After surgery, Petitioner was off work until March 23, 2010 when he was given a full duty release and returned to his regular work duties. Petitioner testified that he saw Dr. Ward in follow up on February 16, 2010 and March 22, 2010 at which time he received a full duty release.

Petitioner testified that while he was off work from February 8, 2010 to March 22, 2010 he received his regular, full salary under PEDA. Petitioner testified that since returning to work March 23, 2010 he has not received any further medical treatment for his hernia. He has performed all of his regular work duties for the past three and a half years since March 23, 2010. Petitioner testified that he has received regular wage increases pursuant to union contract over the past three and a half years.

Deputy Chief Keith Krestan testified that he was the officer in charge of the fire call on November 15, 2009. He stated that Petitioner did not report any accident or injury on or about November 15, 2009. He testified that Petitioner was in charge of his crew and issued a report detailing the crew's activities. Chief Krestan stated petitioner completed a report for his crew's activities and that no report was made of any injury having been incurred by petitioner. (Rx. 7). Chief Krestan testified that he issued a report on the fire and similarly that report showed no reported injuries. (Rx. 8).

Chief Krestan stated that the first he was aware that Petitioner was reporting any type of injury was December 8, 2009 when petitioner completed an accident report. (Rx. 1). Chief Krestan stated that all firefighters are instructed to report any injuries immediately. He testified that if injuries are reported, employees are immediately sent to Corporate Health for evaluation.

MEDICAL RECORDS

Petitioner did not offer any medical records documenting any contemporaneous medical treatment on or about November 15, 2009. Petitioner did not seek any ER treatment. The first medical treatment record documents a physical examination on December 2, 2009 at Edward Corporate Health. Petitioner saw Dr. Williamson-Link for

his annual executive history and physical examination. (Rx. 3). Petitioner reported noticing some swelling around his bellybutton and thinking he had a hernia. A physical examination showed a small umbilical hernia. Dr. Williamson-Link found it was reducible and asymptomatic. Dr. Williamson-Link questioned Petitioner about his hernia condition. Dr. Williamson-Link noted "He (petitioner) does not recall any specific injury where he might have developed a hernia or had acute onset of abdominal pain and he just noted it casually over the summer while going to the bathroom and noted a little bit of swelling in that region." (Rx. 3).

Dr. Czepiel examined Petitioner December 4, 2009. Dr. Czepiel notes that he received a call from Dr. Williamson-Link concerning an umbilical hernia as well as abnormal blood work. Dr. Czepiel found a left-sided umbilical wall hernia. He diagnosed Petitioner with diabetes type II, uncontrolled, an umbilical hernia and obesity. He referred Petitioner to Dr. Ward, a general surgeon, for an umbilical wall hernia repair. There is nothing in the records of Dr. Czepiel which indicate that Petitioner suffered a work injury or more specifically a work injury on November 15, 2009. (Rx. 2).

Petitioner next sought medical treatment with Dr. Gregory Ward on December 17, 2009. (Rx. 4). Petitioner complained of a hernia. Dr. Ward's notes state "The onset of the hernia has been gradual and has been occurring in a persistent pattern for months. The course has been increasing." (Rx. 4). The records of Dr. Ward do not document a work injury and specifically do not document any type of work accident or injury on November 15, 2009.

Petitioner had surgery at Edward Hospital on February 8, 2010. According to the history and physical examination report of February 8, 2010, Petitioner presented a

history of "Patient has had an umbilical hernia since summer 2009 per patient." (Rx. 3, Pg. 8).

The records of Dr. Ward document that after surgery Petitioner was last seen on February 16, 2010. No records document any office visits after that date. As of that date, Petitioner's wound was healing well. He was given a release to return to work at full duty effective March 23, 2010. (Px. 3).

At Respondent's request, Petitioner was examined by Dr. Scott Kale on January 18, 2011. Dr. Kale, after examination and medical record review, concluded there was no causal relationship between Petitioner's alleged accident of November 15, 2009 and his umbilical hernia and surgery. (Rx. 5).

Subsequently, on August 10, 2011, Petitioner was examined at his attorney's request by Dr. Michael Gross. Dr. Gross concluded there was a causal relationship between Petitioner's hernia and his alleged accident of November 15, 2009. (Px. 5, 6). Dr. Gross admitted in his deposition that the history Petitioner gave to Dr. Gross was not consistent with the history of onset of symptoms documented in the medical records.

WAGES

Petitioner alleged an average weekly wage of $2,211.89. Respondent alleged an average weekly wage of $1,549.21.

Petitioner did not testify as to wages. The only evidence offered as to wages were payroll records by Respondent. (Rx. 6). Based on those wage records, Petitioner's average weekly wage for Respondent was $1,549.21. The Arbitrator therefore finds that Petitioner's average weekly wage is $1,549.21.

CONCLUSIONS OF LAW

After considering all of the testimony and medical records, the Arbitrator finds that Petitioner failed to prove that he sustained an accident which arose out of and in the course of his employment November 15, 2009. The Arbitrator finds that Petitioner failed to prove a causal relationship between his alleged accident of November 15, 2009 and his condition of ill-being involving his umbilical hernia.

Although Petitioner testified that he sustained an accident on November 15, 2009, Petitioner admitted that he did not report any accident or injury on that date. Deputy Chief Krestan confirmed that no accident or injury was reported by Petitioner on or about November 15, 2009. The documentary evidence also confirms that no accident or injury was reported by Petitioner on or about November 15, 2009. Petitioner's report of the fire call does not document any injury and no injury is recorded in the Station's daily log.

Contrary to Petitioner's testimony, the contemporaneous medical records do not document any accident or injury on or about November 15, 2009. The records from Dr. Williamson-Link and Dr. Ward both contain histories which conflict with Petitioner's testimony and indicate Petitioner's onset of symptoms was in the summer of 2009. Further, the records of Petitioner's family doctor, Dr. Czepiel, do not indicate any accident at work as the cause of his condition.

The Arbitrator adopts the findings and conclusions of Dr. Scott Kale. Dr. Kale's report is predicated on the contemporaneous medical records. Based on the above analysis, the Arbitrator denies the claim for compensation. The claim for TTD, medical bills and PPD is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Zachariah Holoman,

15IWCC0169

Petitioner,

vs.

NO: 12 WC 25076

Kraft Foods/ Mondelez 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, temporary total disability, causal connection, medical expenses, prospective medical expenses, 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 May 27, 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.

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: MAR 9 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 3/5/15
45

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

HOLOMAN, ZACHARIAH
Employee/Petitioner

Case# **12WC025076**

15IWCC0169

KRAFT FOODS/MONDELEZ INTERNATIONAL
Employer/Respondent

On 5/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2553 LAW OFFICES OF JAMES P McHARGUE
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CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
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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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED DECISION
19(b)

15IWCC0169

Zachariah Holoman
Employee/Petitioner

v.

Kraft Foods/Mondelez International
Employer/Respondent

Case # 12 WC 25076

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 **March 21, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0169

FINDINGS

On the date of accident, **06-28-12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** 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 **$41,892.76**; the average weekly wage was **$805.63.**

On the date of accident, Petitioner was 52 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 $N/A for TTD, $N/A for TPD, $ N/A for maintenance, and **$7,794.40** for medical benefits, for a total credit of **$7,794.40**.

Respondent is entitled to a credit of **$1,695.50** under Section 8(j) of the Act.

ORDER

No benefits awarded.

- The Arbitrator finds that the Petitioner has failed to prove an accident arising out of and in the course of his employment.
- The Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to the alleged work accident and that Petitioner is not entitled to medical or TTD benefits, prospective medical care, or compensation for permanent partial disability.

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

05.23.14
Date

ICArbDec19(b)

MAY 27 2014

FINDINGS OF FACT

The petitioner, Mr. Zachariah Holoman, is a 53-year-old male employed with Kraft Foods since July 28, 1997. The petitioner testified that he began his employment with Kraft Foods as a line attendant, but has most recently worked in sanitation. (Tr. 9).

The petitioner reports a work accident involving a slip and fall on a bathroom floor, resulting in injuries to his cervical and lumbar spine and the right shoulder. Different dates for this accident have been provided by the petitioner. The petitioner's Application for Adjustment of Claim lists an accident date of June 27, 2012. At trial, the petitioner testified that the accident occurred on June 28, 2012. (Tr. 10). To his doctors, the petitioner has described the accident as occurring at different points at the end of June 2012.

The petitioner testified on direct examination that he slipped while going into a stall in the restroom on June 28, 2012. He testified that he fell backwards, hitting his shoulder and the side of his face, and falling to the ground. (Tr. 10). On cross examination, when questioned about reporting to his doctors that he struck a urinal, the petitioner stated that he did not reference a urinal, but rather said he hit a divider on the side of a urinal. (Tr. 38-41). The petitioner testified on re-direct examination that when he fell, he struck the divider that would be located to the left when facing the urinal. (Tr. 54). When questioned regarding the positioning of the divider, the petitioner testified on re-cross examination that when facing the urinal, the divider was on the right. (Tr. 57).

The petitioner testified that prior to the accident, he had not had any problems with his right shoulder, neck, or his back beyond back spasms. (Tr. 23-24).

The petitioner's prior medical history includes an August 22, 2008 visit to the his primary care physician, Dr. Catherine McGinness, when the petitioner complained of tense pain in the back of the head and neck areas, blurred vision, and an irritable left lower back. (RX2, p. 971). On January 26, 2009, the petitioner was seen at Anchor Oak Park Medical Office, where he stated his back went out and he took a week off of work. He took an additional week off and then called the doctor's office in order for her to "change the date in his work statement as to extending days." (RX2 p.975) He also reported a stiff neck. (Id.) At trial, the petitioner testified that he could not recall the visits of August 22, 2008 or January 26, 2009. (Tr. 31-32). On February 27, 2009, the Petitioner was sent home from work last night. When offered to come in for an appointment, the Petitioner's wife stated that she wanted to take him to ER because she knew he was dehydrated. (RX2 p.979) Petitioner spent more time off work in March. (RX2 p.980)

On January 29, 2010, the Petitioner was admitted to Rush Oak Park Hospital for severe right flank pain, nausea, and vomiting where it was noted that "he had a nearly decade-long history of these events which have defied medical diagnosis. Some of the events were associated with the consumption of alcohol, some were not. Some were associated with the use of marijuana, some were not.....This could only be consoled with the use of morphine to attenuate the pain." The physical exam, radiographic, laboratory, ultrasonographic and endoscopic findings were all negative. The doctor finally wrote, "My suspicion, however, is that

the endoscopy will not add significant information as the etiology of this pain, which looks to be psychodynamic in origin as I can find no structural anatomic cause for this...." (PX2 p.1236)

On February 8, 2010, the Petitioner told his doctor that he gets pain in his neck "too often." (RX2 p.991) On February 16, 2010, x-rays of the lumbar spine were completed at Rush Oak Park Hospital. The x-rays noted grade 1 retro-spondylolisthesis at L5-S1, moderate degenerative disc disease at the two lower levels, greatest at L5-S1, and spondylotic changes of the lower lumbar spine. (RX2, p. 1146).

The petitioner was seen on September 27, 2010 for left lower back pain. X-rays showed mild degenerative change that appeared to be stable from February 16, 2010. (RX2, p. 1132). Two days later, he received FMLA forms for lower back pain and abdominal pain. (RX2 p.1008) Dr. Carpenter of Rush Oak Park Physicians Group evaluated the petitioner for low back pain on September 28, 2010 and recommended monitoring the issue. (RX2, p. 1008-1009). The petitioner also saw Dr. Carpenter on October 5, 2010 with complaints of back and neck pain. (RX2, p. 1011-1012).

On February 2, 2011, the Petitioner was admitted to Rush Oak Park Hospital for abdominal pain, nausea and vomiting. The records state the following; "Of note, he is somewhat abstract in his description of the time of events. This is not unusual for Mr. Holoman,...this is very much a typical physical presentation for him....He rates it as a 10/10 and states that the only thing that has given his relief is morphine. He received a small amount of this currently though is significantly less than what he usually gets when he comes in....It should be noted that Mr. Holoman has presented with similar symptoms in the past. In fact, he has had approximately 1 admission or ER visit per month over the last 18 months or so. He has had approximately 15 ER visits for this complaint since 2009. About half of these have resulted in inpatient hospitalizations...He has had 9 CTs since he first began having these problems. None of the CTs have shown any significant abnormalities." The Petitioner's exam that day was (markedly benign." (Id. p.1189)

The petitioner presented to Dr. McGinness on October 3, 2011 reporting a sore throat, headaches, and back discomfort. (RX2, p. 47). The petitioner complained of low back pain at a follow up visit on October 27, 2011. (RX2, p. 93).

At a visit with Dr. McGinness on January 31, 2012, the petitioner reported that his back pain "comes and goes." (RX2, p. 125). The petitioner was seen at the emergency room of Rush Oak Park by Dr. Navtej Sandhu on March 8, 2012, complaining of left mid back/flank area pain for two days. The petitioner stated that he had chronic low back pain, but said his current pain was higher up and "feels different." The petitioner stated that this pain was severe. He said he had tried NSAIDS in the past for his symptoms with no relief. The doctor noted that the etiology of the symptoms was likely musculoskeletal. He recommended treatment with morphine and Valium. (RX2, p. 238-241). The petitioner also complained of back and neck pain at a visit to Dr. McGinness at Rush Oak Park on March 21, 2012. (RX2, p. 287). The petitioner testified on cross-examination that he could not recall the visits that occurred in March 2012. (Tr. 33-34).

On April 2, 2012, the petitioner was returned work after being off for gastritis of unknown etiology. His prescription for norco and flexerile were refilled. The Petitioner's group disability claims department needed the diagnosis and treatment plan for the next day of treatment. (RX2 p. 542) On June 14, 2012, the Petitioner was treating for left flank pain and receiving flexerile and norco for neck and back pain. He was taken off work for a week.

The petitioner testified that on June 28, 2012, he was going from one job to the other when he had to go to the restroom. He said when he went to go to the stall, he slipped, falling backwards. The petitioner testified that he hit his shoulder and the side of his face, and fell to the ground. He testified that the restroom had just been mopped, but there was no wet sign down. (Tr. 10). After he fell, the petitioner testified that he noticed numbness in his shoulder and face, along with dizziness. (Tr. 11). He testified that he remained on the floor for a few minutes, then sat on a bench but was still woozy. The petitioner testified that he then went to speak to a supervisor about the incident. (Tr. 11-12). The petitioner testified that he finished out his shift, but still felt woozy and nauseated. (Tr. 13). He worked the following day, and tried to finish his week out. (Tr. 13-14). The petitioner testified that he continued to feel nauseous, and was having a problem with his stomach. The petitioner testified said his shoulder was kind of numb and he had pain in the side of his jaw. (Tr. 14).

The petitioner testified that he had been in and out of the hospital for many years due to gastritis. (Tr. 14). He was seen on several occasions for abdominal pain, including on June 14, 2012, when he was given a note off work for June 8, 2012 through June 18, 2012. (RX1, p.558-561).

The petitioner testified that he did not go to work on July 31, 2012, as he was still sick. (Tr. 15). On July 1, 2012, he was hospitalized with complaints of dry heaving that morning with doubling over and abdominal cramping. (RX2, p. 582). The hospital recommended an x-ray or CT scan of the abdomen to rule out acute pathology, but the petitioner refused, saying he "had too many of them." He was given some medication for relief. (RX2, p. 584).

While hospitalized, the petitioner reported to medical personnel that he slipped and fell in a washroom at work the day prior and bruised the right jaw area. The petitioner reported some headaches for the next 2 days. He stated there was no loss of consciousness or neck pain. (RX2, p. 586). His head was atraumatic and he was negative for back pain. (Id. p.588) The petitioner testified that this history was given to Dr. McGinness, who told him they would deal with his nausea and vomiting first and that he should bring his other complaints to her attention when he followed up. (Tr. 16). The petitioner testified that he did not return back to work at any time after his stay at the hospital. (Tr. 16).

On July 13, 2012, the petitioner followed up with Dr. McGinness, reporting a sore throat, left sided neck pain, and pain at the back of his head. He said his pain had been continuous for two days. The petitioner reported that his abdominal pain was now better. At this visit, the petitioner said he fell at work three weeks ago and hit is left neck and lower back. (RX2, p. 857). On cross-examination, the petitioner testified that this medical record was incorrect as to the statements he made to Dr. McGinness on July 13, 2012. (Tr. 36).

Dr. McGinness's assessment on July 13, 2012 was back pain, neck pain, pharyngitis, and hypokalemia. She ordered x-rays of the cervical and lumbar spine, a metabolic panel, and recommended heat application and medication. (RX2, p. 859).

X-rays of the cervical spine showed mild osseous and disc degenerative changes, particularly at C3-C4 and to a lesser degree at C4-C5, C5-C6, and C6-C7. There was no evidence of fracture. (RX2, p. 893). X-rays of the lumbar spine showed mild osseous and degenerative change at the L4-L5 and L5-S1 levels. The impression was no acute lumbar spine abnormality with osseous and stable degenerative disc changes in the lower lumbar distribution as compared to the September 27, 2010 study. (RX2, p. 910). The petitioner was advised to follow up if he had any additional pain. (RX2, p. 925).

The petitioner was evaluated by Dr. Igor Russo of Advanced Physical Medicine on July 17, 2012 for an initial evaluation of complaints stemming from a work-related injury on June 27, 2012. (PX3, p. 16). The petitioner testified that he was referred to this clinic by a friend (Tr. 18). The petitioner reported to Dr. Russo that he was "trying to use the washroom when he slipped on the floor and hit the urinal with his lower jaw." (PX3, p.16). At trial, the petitioner denied referencing a urinal to Dr. Russo, stating that he referenced the divider. (Tr. 38).

The petitioner reported to Dr. Russo that a couple of days after his fall, he started feeling headaches and neck pain. He also complained of symptoms with his jaw. (PX3, p. 16). In addition to bilateral headaches, the petitioner reported to Dr. Russo aching, spasm, throbbing and cramping pain in the neck and low back bilaterally. (PX3, p. 16). Dr. Russo assessed a lumbosacral sprain/strain with accompanying vertebral subluxation. He recommended ultrasound, massage therapy, spinal manipulation, and intersegmental traction. (PX3, p. 17).

The petitioner presented to Dr. Goldvekht at Advanced Physical Medicine on July 23, 2012. (PX3, p. 18). He reported that on June 27, 2012, he was working at his job when he went to the washroom and slipped and fell, sliding under the urinal and hitting his low back on the ground and his neck, right shoulder, and right side of his face on the urinal. (PX3, p. 18). When this history was reviewed with the petitioner on cross-examination, he testified that he did not say "urinal" to Dr. Goldvekht, but instead said "the divider." (Tr. 40).

Dr. Goldvekht diagnosed a sprain/strain of the cervical and lumbar spines. He recommended medication and a course of physical therapy. Dr. Goldvekht authorized the petitioner off work. (PX3, p. 18).

The petitioner initiated a course of physical therapy for cervicalgia and lumbalgia at Advanced Physical Medicine on July 25, 2012. (PX3, p. 24). On August 27, 2012, the petitioner returned to Dr. Goldvekht stating that he was doing better, but still experiencing severe pain in his neck and low back. He said his neck pain radiated into his right shoulder. (PX3, p. 19). Dr. Goldvekht's assessment at this visit was a sprain/strain of the cervical and lumbar spine. He advised petitioner to continue with his medication and physical therapy. The doctor also ordered a MRI of the cervical and lumbar spine. The petitioner was kept off work. (PX3, p. 19).

A lumbar spine MRI was performed on August 28, 2012 and showed spondylotic changes with disc desiccation of the lower lumbar spine. (PX2, p. 43). On August 31, 2012, a cervical spine MRI showed spondylotic changes and changes of facet arthropathy. (PX2, p. 44).

On October 8, 2012, Dr. Goldvekht recommended continued therapy and a MRI of the right shoulder due to complaints of neck pain radiating into the shoulder. (PX3. p.20). The petitioner underwent a MRI of the right shoulder on October 9, 2012 for "right shoulder pain status post work related injury of June 28, 2012." The MRI showed a small focal interstitial tear involving the supraspinatus tendon and Type II acromion. (PX2, p. 49). Based upon the results of the MRI, the petitioner testified he was referred by Dr. Goldvekht to Dr. Ronald Silver. (Tr. 20).

On February 1, 2013, the petitioner presented for an initial evaluation with Dr. Ronald Silver of Orthopaedic Specialists of the North Shore. (PX2, p. 37). The petitioner reported to Dr. Silver that was he was going into a restroom at work when he slipped on a recently washed floor and crashed his right shoulder into the stall separators and injured his neck, back, and other body parts. He reported that prior to the accident at work his shoulder was normal without any treatment or symptoms in the past. (PX2, p. 37).

Dr. Silver noted that the MRI of the right shoulder demonstrated a partial thickness tear of the rotator cuff. (PX2, p. 37). It was noted the petitioner had a severe reaction to a cortisone injection in the past. Therefore, he deferred any further injections. Dr. Silver recommended proceeding with arthroscopic surgery for the right shoulder. (PX2, p. 38).

The petitioner was evaluated by Dr. Ronald Michael of The Illinois Neural Spine Institute on February 12, 2013. The petitioner reported a work-related injury of June 27, 2012. He reported that he entered a restroom at work, stating that the floor had been mopped. The petitioner said he slipped and fell forward into the divider between the two urinals and then fell backward onto his lower and upper back areas, and the right shoulder. (PX5). At trial, when this history was reviewed on cross-examination, the petitioner indicated that this was not the description he provided to Dr. Michael. (Tr. 41).

As a result of the fall at work, the petitioner reported dizziness, low back pain, and jaw numbness. He said that he also had neck pain. Dr. Michael's assessment was herniated discs at L4-L5 and L5-S1 and C3-C4 and C5-C6. For the lumbar spine, Dr. Michael recommended physical therapy and a set of three lumbar steroid injections. The petitioner was not interested in undergoing the recommended injections. Regarding the cervical spine, Dr. Michael said the petitioner should continue physical therapy. Dr. Michael said he was discharging the petitioner back to the care of Dr. Goldvekht as he had nothing further to offer him as he was not interested in surgery or injections. (PX5).

The petitioner returned to Dr. Silver on March 6, April 3, May 17, June 26, and July 31, 2013. The recommendation continued for arthroscopic surgery, and the petitioner was kept off work. (PX2, p. 29-36).

At trial, the petitioner testified that he attended physical therapy at Advanced Physical Medicine from July 2012 to July 2013. (Tr. 18). The petitioner's treatment at Advanced Physical Medicine was submitted to Utilization Review, with a report issued by Dr. Jay Roberts on March 20, 2014. The services reviewed included 58 physical therapy visits for the neck and back between July 25, 2012 and December 28, 2012, a functional capacity evaluation on January 23, 2013, six office visits to a physiatrist between July 23, 2012 and January 28, 2013, and 62 physical therapy visits for the neck, back, and right shoulder from January 2, 2013 through June 24, 2013. (RX5, p. 1). Pursuant to his review, Dr. Roberts certified 6 of the physical therapy visits for the neck and back through August 8, 2012, 1 office visit with a physiatrist on July 23, 2012, and 6 physical therapy visits for the right shoulder through January 14, 2013. (RX5, p. 10). At trial, the petitioner acknowledged that the Utilization Review was recently completed and indicated a waiver of any right to appeal the determination. (Tr. 70-71).

On July 11, 2013, the petitioner was evaluated at the respondent's request by Dr. Peter Hoepfner of the Illinois Bone and Joint Institute regarding the right shoulder. The petitioner reported to Dr. Hoepfner that on June 28, 2012, he was on his way into the washroom at work when he slipped on a wet floor. He said that he was on his way into a stall when both of his feet went out from underneath him. He said he landed onto his back and buttocks. The petitioner also said that his right shoulder and arm hit the dividers in the stall and that his right jaw and ear hit the stall. (RX1, p. 1)

Dr. Hoepfner reviewed the medical records from July 1, 2012 through April 3, 2013, including Dr. Silver's recent recommendation for a right shoulder arthroscopic surgery. (RX1, p. 1-3). Dr. Hoepfner diagnosed a partial right rotator cuff tear with low grade impingement syndrome. (RX1, p. 5). Dr. Hoepfner stated that the exam and objective findings as documented by Dr. Silver were consistent with right shoulder impingement syndrome, which Dr. Hoepfner felt to be a common condition in the middle aged, male population. (RX1, p. 6).

Dr. Hoepfner's noted the petitioner first reported right shoulder pain when evaluated by Dr. Goldvekht on July 23, 2012. At that time, however, Dr. Hoepfner noted that the focus was on the petitioner's low back and neck complaints. Dr. Hoepfner noted that visits with at least three practitioners, including the petitioner's primary care doctor, between July 1, 2012 and July 23, 2012, did not reflect any specific complaints related to the right shoulder. (RX1, p. 6).

Dr. Hoepfner stated that it was his opinion that the petitioner's delay in reporting right shoulder pain or injury was significant. He opined that the alleged incident at work when the petitioner slipped and fell in a restroom was not a reliable cause for the petitioner's current right shoulder condition, based on the records and history provided. Dr. Hoepfner opined that there were too many inconsistencies with respect to the dates of the injury and the reported mechanism of the injury to reliably state that the petitioner's current right shoulder condition was caused by that specific alleged incident at work. (RX1, p. 6).

Dr. Hoepfner said that there were examination findings consistent with symptom magnification during the petitioner's examination on July 11, 2013. Dr. Hoepfner said that petitioner displayed a level of feigned hand grip weakness with grip strength testing. He also noted that the rapid exchange grips were specifically better than static grip strength. Dr.

Hoepfner's said that considering all the information available in the case, he did not believe the petitioner's current right shoulder condition was causally related to the alleged work accident. Dr. Hoepfner said that since the petitioner refused cortisone injections, arthroscopic surgery would be a reasonable next step. (RX1, p. 6).

Regarding the petitioner's work abilities, Dr. Hoepfner the petitioner was capable of productive, although not unrestricted, work. He said that the petitioner would require work restrictions including no over-the-shoulder work and a 10 pound lifting restriction. Dr. Hoepfner stated that these restrictions were unrelated to the work incident of June 28, 2012. (RX1, p. 7).

On August 28, 2013, Dr. Silver issued a letter to ESIS Insurance regarding the report of Dr. Hoepfner. Dr. Silver stated that the report was ludicrous at best. Dr. Silver stated that the petitioner reported pain in the right shoulder at the time of June 28, 2012 and stated that slowly over the next few weeks the pain increased to where he sought medical attention. He said this was obviously directly correlated, related and causally connected to the work injury of June 28, 2012. Regarding the absence of complaints for the right shoulder from July 1 to July 23, 2012, Dr. Silver cited the petitioner's pain medication for his severe gastritis. Dr. Silver noted they were awaiting approval for right shoulder surgery stating that a delay in treatment would now most likely cause permanent disability in the right shoulder. (PX2, p. 15-16).

On September 3, 2013, a letter was issued by Dr. Saul Haskell, also of Orthopaedic Specialists of the North Shore to ESIS Insurance. Dr. Haskell indicated that he examined the petitioner for the lumbar and cervical spine on September 3, 2013 after he underwent a number of months of treatment with Advanced Physical Medicine and Dr. Aleksandr Goldvekht. Dr. Haskell stated that according to the history obtained from the patient, he had no prior history of cervical or lumbar pain until the injury of June 28, 2012 except for one episode of muscle tightness in the low back which respondent spontaneously after one visit to his primary care physician. Dr. Haskell stated he felt the petitioner had pre-existing degenerative disc problems of the cervical and lumbar spine with very minimal arthritic changes which were asymptomatic until flare-up and aggravation caused by the injury. Dr. Haskell stated he did not believe epidural injections or surgery was indicated for this and said he believed physical therapy should be resumed with attention centered on an appropriate home exercise program. (PX2, p. 25-26).

The petitioner was seen for a second time for low back pain by Dr. Haskell on December 3, 2013, at which point Dr. Haskell recommended an updated lumbar MRI. (PX2, p. 10). The petitioner did not testify at trial that he was seeking any additional care or the cervical or lumbar spine. (Tr. 7-25). He indicated that he was completing home exercises. (Tr. 44).

The petitioner was seen again by Dr. Silver for the right shoulder on November 6 and December 11, 2013. Dr. Silver continued the recommendation for arthroscopic surgery. (PX2, p. 8-11).

At trial, the petitioner testified that his right shoulder was still numb and in pain when he lifts it past a certain point. (Tr. 22). He indicated he could lift his arm to about a 90 degree

angle before feeling pain. (Tr. 23). He said he would sometimes have pain, tingling, and numbness in his legs, and that his neck "pains sometimes." At trial, the petitioner testified that he wished to have the shoulder surgery recommended by Dr. Silver. (Tr. 24).

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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

It is the burden of the claimant to prove by a preponderance of the credible evidence that the injury arose out of and in the course of the employment. *Jensen vs. Indus. Comm'n*, 305 Ill. App. 3d 274, 277, 711 N.E.2d 1129, 1132 (1st Dist. 1999). Compensation has been denied in numerous instances where the claimant's credibility was suspect and the medical histories conflicted with and/or failed to corroborate a claimant's testimony. *Elliott v. Industrial Comm'n.*, 303 Ill. App. 3d 185, 707 N.E. 2d 228 (1999); *McRae v. Indus. Comm'n.*, 285 Ill. App. 3d 448, 674 N.E. 2d 512 (1996).

The only witness testifying to the accident in this case was the petitioner. While a claimant's testimony, standing alone, can be sufficient to establish an accident, the petitioner has made numerous conflicting statements as to when and how his injuries occurred, both in the treating medical records and at trial.

The medical records contain at least four different histories of how the petitioner was injured at work. On July 1, 2012, the petitioner stated that he slipped and fell in a washroom at work "the day prior" (or on June 30) and bruised the right jaw area. On July 13, 2012, the petitioner told Dr. McGinness that he fell "three weeks ago" (or on approximately June 22) and hit his left neck and lower back. Four days later, on July 17, 2012, the petitioner reported to Dr. Russo that on June 27, he slipped and fell on a washroom floor and "hit the urinal with his lower jaw." On July 23, 2012, the petitioner stated to Dr. Goldvekht that on June 27, he slipped and fell in a restroom, sliding under the urinal and hitting his low back on the ground and his neck, right shoulder and right side of his face on the urinal. When the petitioner was seen by Dr. Michael on February 12, 2013, he said slipped and fell forward into the divider between the two urinals and then fell backward onto his lower and upper back areas and the right shoulder.

At trial, the petitioner's testified that the accident occurred on June 28, 2012. His initial testimony was that he "slipped going into the stall" and "fell backwards" hitting his shoulder and the side of his face. (Tr. 10). He stated that when he fell, he hit the divider separating the urinals, but later said that he never mentioned the word "urinal" to his doctors. (Tr. 47). The petitioner testified on re-direct examination that when he fell, he struck the divider located to the left when facing the urinal. (Tr. 54). However, when questioned regarding the positioning of the divider on re-cross examination, the petitioner stated that when facing the urinal, the divider was on the right. (Tr. 57).

When questioned about the inconstancies regarding the accident date and the mechanism of injury, the petitioner denied the accuracy of the certified treating medical records and alleged he could not recall making the statements to his doctors. The Arbitrator notes that it is assumed that one seeking medical care will be truthful regarding the nature and cause of their condition in order to receive the proper medical care. *Chi. Messenger Serv. v. Indus. Comm'n*, 356 Ill. App. 3d 843, 848, 826 N.E. 2d 1037, 1041 (1st Dist. 2005)

The petitioner has presented multiple inconsistencies to his doctors and at trial as to when and how his injuries occurred. As a result, his testimony is not credible. The Arbitrator finds that the petitioner has failed to credibly establish an accident arising of and in the course of his employment.

F. **Is the petitioner's present condition of ill-being causally related to the injury?**

In addition to his failure to establish an accident arising out of and in the course of his employment, the petitioner has failed to establish that his conditions of ill-being with respect to the cervical and lumbar spine and the right shoulder are causally related to the alleged work accident.

It is fundamental to every claim for an award under the Illinois Workers' Compensation Act that the claimant proves all elements of his claim, including causal connection as it relates to each alleged injury.

The petitioner has failed to prove by a preponderance of evidence that his condition of ill-being with respect to the cervical and lumbar spine is causally related to the work accident. In the event of a pre-existing condition, it is incumbent upon the claimant to prove an aggravation or acceleration thereof. The petitioner has failed to establish that the alleged work accident aggravated or accelerated his pre-existing degenerative conditions of the cervical and lumbar spine.

In his September 3, 2013 note, Dr. Haskell commented on causation, stating that the petitioner had pre-existing degenerative disc problems of the cervical and lumbar spine with very minimal arthritic changes which were asymptomatic until flare-up and aggravation caused by the injury. Dr. Haskell stated that according to the history obtained from the patient, he had no prior history of cervical or lumbar pain until the injury of June 28, 2012 except for one episode of muscle tightness in the low back which respondent spontaneously after one visit to his primary care physician.

As reported to Dr. Haskell, at trial, the petitioner testified that he had no problems with his neck before the accident. The Arbitrator notes that this history is inconsistent with the certified medical records. When presented on cross-examination with notes of Dr. McGinness from August 22, 2008 and January 26, 2009 with references of tense pain in the neck and neck stiffness, the petitioner testified that he could not recall these visits. The petitioner also reported neck pain and pressure on March 21, 2012, just four months prior to the alleged accident. He testified at trial that he also could not recall this visit. The Arbitrator finds that the petitioner's

testimony regarding the absence of prior complaints relating to the cervical lumbar spine is inconsistent with the certified medical records and lacks credibility.

Regarding the lumbar spine, the petitioner testified at trial that he had only back spasms in the past. He reported to Dr. Haskell that he had no history of lumbar pain until the accident except for one prior episode of low back pain that resolved after one visit to his primary care physician. This history is also inconsistent with the certified medical records. The petitioner reported low back pain to Dr. McGinness on August 22, 2008, and he was noted to have taken a week off work prior to a visit of January 26, 2009 due to his back going out. He underwent two sets of lumbar spine x-rays in 2010, and was seen twice in October 2011 with low back pain. On March 8, 2012, the petitioner went to the emergency room with pain, stating that he had chronic low back pain, but that his current pain was severe, higher up, and "felt different." The petitioner testified at trial that he could not recall the visits in 2008, 2009, 2010, or 2011 for back pain, and he could not recall being seen twice just four months before the accident with complaints of increased low back pain. The Arbitrator finds that the petitioner's testimony regarding the extent of his prior history of low back pain is inconsistent with the certified medical records and lacks credibility.

The Arbitrator notes further that the mechanism of injury as described by the petitioner to medical personnel on July 1, 2012 was that when he fell, he struck his jaw. The petitioner specially denied neck pain at that time. As he went on to treat with the various doctors, the injury described changed to include impact to the cervical and lumbar spine.

In light of the inconsistencies noted between the certified medical records and the histories provided to his doctors following the alleged accident and at trial, the Arbitrator finds that the petitioner has failed to prove by a preponderance of credible evidence that his conditions of ill-being with respect to the cervical and lumbar spine were aggravated or accelerated by the alleged accident.

The petitioner failed to establish that his current condition of ill-being for the right shoulder is causally related to the accident of June 28, 2012. The Arbitrator finds that the petitioner's delay in right shoulder complaints is significant. As noted by Dr. Hoepfner, the medical records following the accident reflect that the petitioner was seen on three separate occasions without any complaints of right shoulder pain. The petitioner first reported shoulder pain to Dr. Goldvekht on July 23, 2012, but at that point, the focus remained the neck and low back complaints. It was not until October 2012 that a MRI was prescribed for the shoulder, and the first evaluation specific to the right shoulder did not occur until February 2013.

In his report of August 28, 2013, Dr. Silver stated that the petitioner reported pain in the right shoulder at the time of June 28, 2012 and stated that slowly over the next few weeks the pain increased to where he sought medical attention. This description is inconsistent with the certified medical records.

The petitioner did not report right shoulder pain when he described the accident during the July 1, 2012 hospital admission. When he was seen two weeks later by Dr. McGinness, he said he hit his left neck and lower back, and was seeking treatment for these areas. At his visit

to Dr. Russo on July 17, 2012, the petitioner voiced several complaints, including headaches, neck, back, and jaw pain. There was no mention to Dr. Russo of any complaints relating to the right shoulder. Regarding the absence of complaints for the right shoulder from July 1 to July 23, 2012, Dr. Silver cited the petitioner's pain medication for his severe gastritis. This reasoning fails account for the petitioner's reports of various other areas of pain over that same time period, with the exclusion of the right shoulder.

The Arbitrator takes note Dr. Hoepfner's conclusion that the examination and objective findings are consistent with right shoulder impingement, a common condition in the middle-aged, male population. The Arbitrator agrees that the delay in right shoulder complaints is significant and there are too many inconsistencies with respect to the histories provided by the petitioner to conclude that the right shoulder condition is causally related to the alleged fall at work.

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

In light of the findings on issues (C) and (F) above, the petitioner's claim for an award of any amount of medical bills is hereby denied. As the Respondent is not liable for medical bills, it is entitled to a credit for $7,794.40 in medical benefit payments. Respondent is also entitled to a credit of $1,695.50 under Section 8(j) of the Act.

K. Is Petitioner entitled to any prospective medical care?

In light of the findings on issues (C) and (F) above, the Arbitrator finds that the Petitioner is not entitled to prospective medical care.

L. What temporary benefits are in dispute?

In light of the findings on the issues of (C) and (F) above, the Arbitrator finds that the Petitioner is not entitled to TTD benefits.

O. Nature & Extent

In light of the findings on the issues of (C) and (F) above, the Arbitrator finds that the Petitioner is not entitled to any compensation for permanent partial disability.

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

Salvador Vazquez,

Petitioner,

15IWCC0170

vs.

NO: 08 WC 06915

Labor Temps,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, prospective medical expenses, 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 15, 2013 is hereby affirmed and adopted.

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

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

15IWCC0170

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,000.00. 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: MAR 9 - 2015

David L. Gore

DLG/gaf
O: 3/5/15
45

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VAZQUEZ, SALVADOR
Employee/Petitioner

Case# **08WC006915**

LABOR TEMPS
Employer/Respondent

15IWCC0170

On 10/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% 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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LAKE ZURICH, IL 60047

0075 POWER & CRONIN LTD
BRIAN RUDD
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

15IWCC0170

Salvador Vazquez
Employee/Petitioner

v.

Labor Temps
Employer/Respondent

Case # 08 WC 06915

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **5/9/2013**. 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 **11/20/2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,987.88**; the average weekly wage was **$326.69**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$1,431.92** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,160.00** for other benefits, for a total credit of **$2,591.92**.

Respondent is entitled to a credit of **$6,179.50** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $300.00/week for 5-4/7 weeks, commencing 1/4/2008 and 1/24/2008 through 2/4/2008 and 2/21/2008, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to Tyler Medical Services, but only for treatment with a date of service from 11/20/2007 through 2/21/2008, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $6,179.50 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 $300.00/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 — Date: 10/14/13

OCT 15 2013

FINDING OF FACTS:

It has been stipulated that Petitioner sustained an accident on November 20, 2007. At the time of the accident Petitioner was placed at General Corporation, a warehouse that stocks automotive parts. Petitioner was operating a forklift. The particular type of forklift that Petitioner was operating was a lift tuck that not only raises material to higher levels but also carries the forklift operator with it. Petitioner testified that on November 20, 2007, he was working to retrieve automotive parts on the fifth shelving level at the warehouse and estimated this height to be approximately 30 feet above the floor. Petitioner was wearing a safety harness and was tied up to the structure at the time of the accident. According to Petitioner's testimony he was in the process of carrying boxes when the floor of the shelving rack opened up causing him to fall towards the fourth level. By the time Petitioner reached the fourth level the safety belt became tight and stopped Petitioner from falling any further. Petitioner estimated that each level was approximately 5-6 feet apart.

Petitioner testified that although he did not strike the fourth level or any other portion of the structure, he experienced pain in his lower back and legs. Petitioner did not seek immediate medical attention. The first medical treatment did not occur until 25 days later when Petitioner sought treatment at Tyler Medical Services. Medical records from Tyler Medical Services were submitted as Petitioner's Exhibit 1. The chart note from December 14, 2007 indicates that Petitioner presented for an initial evaluation and a staff member by the name of Esther acted as a Spanish interpreter during the history exam and discharge process. Petitioner claimed he suffered an injury 13 days prior. Petitioner gave a history of standing on a platform loading boxes onto a forklift when the platform broke and he began to fall. Petitioner provided that he was using a safety harness and that the belt stopped his fall. Petitioner reported that he twisted his back in the process and that boxes weighing between 30-40 pounds fell and struck him in the right lower back region. Petitioner informed the provider that he decided to seek treatment due to persistent pain and the fact that he continued to work full duty with overtime during this period. Petitioner specifically denied any prior injury to his back and that he had no history of acute or chronic medical problems. X-rays were taken and deemed negative for acute osseous pathology. Petitioner was diagnosed with thoracic and lumbar strain with spasm and bilateral leg pain and numbness. Petitioner was prescribed Naproxen and Cyclobenzaprine. He was given a home exercise program, instructed to apply moist heat to the area three times a day for 20 minutes and given work restrictions of no lifting over 30 pounds and to stoop and bend as tolerated.

Petitioner returned to Tyler Medical on December 20, 2007 and again denied any previous low back injuries or any significant past medical history. Petitioner provided that his symptoms were worsening and rated his pain at 6/10. Physical therapy began this date which Petitioner was instructed to continue for six sessions before being reevaluated by the doctor. (PX 1)

A MRI of the lumbar spine was performed on December 21, 2007. The radiologist performing the MRI concluded the findings were negative. (PX 1)

On December 24, 2007, Petitioner returned to Tyler Medical Services and complained of pain on a scale of 8/10. Petitioner was noted to be in no acute distress during the physical examination. Dr. Pappas reviewed the MRI with Petitioner noting same was negative. Physical examination on this date showed no erythema, no edema, and no ecchymosis. Petitioner had full range of motion and was able to do deep knee bend and heel toe walk. Petitioner was able to ambulate with no limp or antalgic gait and straight leg raise tests were negative. Strength was noted to be 5/5. Dr. Pappas instructed Petitioner to continue Hydrocodone at night time only and

was started on a steroid Dosepak in lieu of Ibuprofen. Dr. Pappas also advised Petitioner to follow-up with his primary care physician regarding any other reason why he may have his back pain. Petitioner's work restrictions were 30 pounds lifting while the bending and stooping as tolerated restriction remained in place. (PX 1)

Petitioner returned to Dr. Pappas on January 2, 2008 after completing six out of six physical therapy visits and complained of pain ranging from 5/10 to 8/10 depending on activity. Dr. Pappas reviewed the physical therapists notes and noted that Petitioner had not met any of the physical therapy goals. Dr. Pappas noted that the therapist commented that she did not feel he would benefit from any further physical therapy and that he demonstrated self-limiting behavior due to pain during the physical therapy sessions. On this date Petitioner began to question the results of his normal X-rays and normal MRI. Physical examination showed no objective findings and the diagnosis given was persistent lumbar strain. Dr. Pappas discussed the issues with Petitioner and noted that he was unable to attribute his pain symptoms to anything else due to the normal results of the MRI and X-ray. Dr. Pappas recommended Petitioner follow-up with his primary care physician to assure that there was no non-work related caused for the back pain. (PX 1)

On January 4, 2008 Petitioner presented to Tyler Medical Services for chiropractic evaluation. At that time he rated his pain as 10/10. Dr. Ryan Brinka noted that he was unable to perform any lumbar orthopedic testing due to pain. Petitioner's medication and exercises were continued. Petitioner returned to Tyler Medical Services on January 9, 2008 with pain complaints of 8/10. Petitioner saw Dr. Long at that visit. Dr. Long noted that baseline x-rays and MRI of the lumbar spine revealed no obvious abnormalities. The doctor diagnosed persistent lumbar back pain and strain. Again Petitioner was advised to follow-up with his primary care physician for any non-work related etiologies contributing to his symptoms. Also noted was that Petitioner wanted to proceed with the chiropractic therapy previously recommended. Petitioner was advised to remain off work. (PX 1)

On January 28, 2008, Petitioner began a course of chiropractic treatment at the Neck and Back Clinic under the direction of chiropractor, Dr. Gattas. (PX 3 & 7)

Pursuant to Dr. Gattas' referral Petitioner presented to Dr. John J. O'Keefe of Marian Orthopedics & Rehabilitation on February 4, 2008. Petitioner provided a history that he had been performing warehouse work for the last 10-12 years. He had no history of back pain, debility, sciatica or work restrictions during those years. The notes indicate Petitioner provided that on November 20, 2007, he fell vertically 9 feet before being stopped abruptly with a huge torgueing moment at the L5 junction by a safety belt. Dr. O'Keefe reviewed an x-ray taken January 28, 2008 and determined same showed diminished disc height at L5-S1. Dr. O'Keefe's impression was "films indicative of spasm with loss of normal lordosis." The doctor recommended an EMG and prescribed medication including Norco, Ultram, Mobic, Neurontin and Soma. Petitioner was also prescribed physical therapy and taken of work. (PX 4)

On February 8, 2008 an EMG was performed showing evidence of acute denervation of the left L5-S1 nerve root with no evidence of peripheral entrapment or polyneuropathy. There was also no evidence of acute denervation of the right lumbosacral nerve. (PX 4)

On February 11, 2008, Dr. O'Keefe reported Petitioner was still having high levels of low back pain, worse on the left than right. The doctor reported that the EMG revealed radiculopathy and the December 2007 MRI showed bulging disc injury. Neurontin, Soma and physical therapy were prescribed. (PX 4)

At Respondent's request, Petitioner was seen by Dr. Kern Singh for an independent medical evaluation on February 21, 2008. Dr. Singh authored a report that was submitted into evidence as Deposition Exhibit 2. Dr. Singh reported Petitioner complaining of 10/10 pain that radiated into both legs. Petitioner reported that none of the physical therapy he had undergone provided any relief. The doctor reviewed the December 2007 MRI flms and provided same demonstrated normal lordosis, no evidence of disk herniation, no evidence of spondylolisthesis and no evidence of fracture. Upon examination, the doctor noted Petitioner's strength was 5/5 and his range of motion to be self-limited. Dr. Singh opined Petitioner showed positive Waddell's signs and extreme hyper-exaggeration of symptoms especially with pain during simulated axial loading, pain with simulated percussion, pain with simulated axial rotation, and pain with simulated distracted straight leg raise. Dr. Singh opined that Petitioner suffered a lumbar strain and that his current symptoms were not causally related to the work injury. Dr. Singh opined he could return to work full duty with no restrictions. Additionally, Dr. Singh opined the Petitioner required no further treatment.

Dr. Singh's deposition was taken January 3, 2013. Dr. Singh was asked about the significance of pain with axial compression and his answer was that Petitioner was having pain that could not be anatomically objectified. Dr. Singh was asked about whether he had an opinion with regard to symptom magnification and Dr. Singh answered that Petitioner demonstrated multiple signs of somatic complaints which were non-physiologic in origin. Furthermore, Dr. Singh noted Petitioner did not present with any objective findings. Dr. Singh was asked about what if any distress Petitioner was observed to be in prior to the examination and Dr. Singh noted that he was in no distress. Ultimately, Dr. Singh found Petitioner presented with a normal exam outside of the Waddell signs and that Petitioner himself was demonstrating self-limiting behavior during the range of motion. Dr. Singh opined that Petitioner had no further casual connection between his complaints and the work injury and required no further medical treatment.

Petitioner return to Dr. O'Keefe on February 25, 2008. The doctor noted Petitioner's pain was not controlled. The doctor increased Petitioner's Norco and Neurontin. The doctor also recommended a lumbar epidural injection if no improvement. On March 10, 2008, Dr. O'Keefe expressed disagreement with the opinion of Dr. Singh. He felt that "obviously missed the evaluation of the discal injury with sciatica referring to the February 2008 EMG. Dr. O'Keefe requested authorization to perform four (4) lumbar epidural injections over a five (5) week period. (PX 4)

Also, on March 10, 2008, another lumbar MRI was performed. Same was read to demonstrate midline disc herniation at L4-5 and bulging disc at L5-S1. (PX 4)

By April 16, 2008, it was noted Petitioner underwent 33 sessions of physical therapy with no improvement and continued pain complaints of 10/10. (PX 3) On May 7, 2008, Dr. O'Keefe noted that Petitioner had increased pain and leg weakness. Petitioner took 6-8 Norco 10s in a 24 hour period. Thereafter, the pain subsided. The doctor recommended additional physical therapy and scheduled an epidural injection. The doctor also discussed the possibility of a discal decompression. (PX 4)

Throughout May and June 2008 Dr. O'Keefe performed a series of four epidural steroid injections with small improvement. On July 16, 2008, Dr. O'Keefe recommended a pain management assessment. (PX 4)

Petitioner saw Dr. Suada Spirtovic, of Marque Medicos, on July 24, 2008 for a pain management consultation. The doctor's impression was 1.) disc herniation at L4-5 and L5-S1; 2.) bilateral radiculopathy left worse than right; 3.) bilateral S1 joint dysfunction; 4.) chronic low back pain with myofascial pain syndrome; and 5.) depression. The doctor recommended bilateral L4-5 selective nerve root block, bilateral sacroiliac joint steroid injection, Lyrica and Nortriptyline. (PX 3)

On September 2, 2008, a chart noted from Margue Medicos, Dr. Chunduri, show Petitioner went to the emergency room and was given Xanax, Effexor, Ultram, and Norco. (PX 3) On September 5, 2008, Petitioner presented to Rush Copley emergency room September 5, 2008 with a pain score of 10/10. (RX 3) On September 13, 2008, another epidural steroid injection was performed. On September 16, 2008, Dr. Chunduri noted that Petitioner was using six Norco tablets per day and was also taking Xanax and Effexor. (PX 3)

On September 18, 2008, Petitioner presented to Rush Copley emergency room with complaints of nausea, vomiting, anxiety and poor pain control. His pain rating was 10/10. Petitioner was diagnosed with anxiety, panic attack, chronic pain, nausea and vomiting. Petitioner was prescribed Norco and Zofran. (RX 3)

On September 18, 2008, Petitioner also had a therapy session at Neck and Back. The therapist noted Petitioner unable to tolerate exercises, secondary to pain. The therapist noted similar documentation on September 22, September 24, September 26, October 1 and October 22, 2008. (PX 3)

On October 6, 2008 and November 3, 2008 Petitioner underwent epidural steroid injections with Dr. Chunduri. Petitioner continued in physical therapy. The therapist continued to note that Petitioner was unable to tolerate exercises, secondary to pain. On November 25, 2008, P.A. Stacy Pond of Neck and Back recommended a three-level discogram. Same was carried out on December 15, 2008 showing a positive finding at L4-5. A post CT scan carried out showed no evidence of disc herniation. There was minimal bulging at L4-5 with no stenosis. (PX 7)

By December 27, 2008 Petitioner called the ambulance to be taken to Rush Copley Emergency Room complaining of lower back pain 9/10. Petitioner was prescribed Zofran and Ibuprofen.

Pursuant to referral, Petitioner began treating with Dr. Daniel Ivankovich. Petitioner first presented to Dr. Ivankovich on January 9, 2009. The doctor noted Petitioner presented for a low back injury secondary to a fall from a forklift. It was noted that Petitioner had a negative past medical history and review of systems were noncontributory. Dr. Ivankovich assessed lumbar back pain. (PX 8)

Dr. Ivankovich ordered a CT of the lumbar spine. The scan which when carried out on January 10, 2009 described a 3-4mm protrusion/herniation at L4-5 and L5-S1 without stenosis. (PX 7) On January 16, 2009, Dr. Ivankovich ordered an EMG which when completed on January 16, 2008 was determined to show ongoing denervation at L5-S1 with some reinnervation of L5-S1 fibers. On February 27, 2009, Dr. Ivankovich recommended a lumbar laminectomy and foraminotomy at L4-5 and L5-S1. Petitioner was to continue in physical therapy and remain off work. (PX 7 and 8)

Therapy notes through March 2, 2009 show Petitioner had attended a total of 96 sessions. Therapy notes show Petitioner was "...unable to progress in program at this time..." (PX 3)

On May 29, 2009, Petitioner was taken by ambulance to the emergency room. Petitioner noted that he had run out of pain medication. On June 21, 2009, Petitioner presented to the Rush Copley Emergency Room and again complained that he had run out of pain medication.

On June 8, 2009, Dr. Spirtovic authored a report indicating that the accident was a direct cause of Petitioner's current lumbar spine injury. The doctor noted that Petitioner "had been working in a warehouse for about 10-12 years without any back pain or previous injury in this nature." The doctor also stated, " ...the patient denies any previous injury of this nature, prior to 11/20/07." (PX 7)

On September 9, 2009, another lumbar MRI was completed showing a 3-4 millimeter broad protrusion at L4-5 without stenosis and at L5-S1 and 2-3 millimeter broad protrusion without stenosis. On September 15, 2009, Dr. Ivankovich performed a lumbar laminectomy and foraminotomy at L4-S1. (PX 9 and 10) Petitioner commenced physical therapy thereafter.

On October 3, 2009, Dr. Ivankovich noted Petitioner had been on narcotic medications for two (2) years. The doctor provided that he wanted "to start a weaning/maintenance protocol ASAP."

By November 19, 2009, Petitioner returned to Rush Copley emergency room complaining of lower back pain 10/10 and was given Vicodin, Ativan, and Ambien. On November 24, 2009, Dr. Chunduri referred Petitioner to a methadone clinic. On December 3, 2009, Petitioner was taken to Rush Copley Emergency Room. Petitioner was administered Fentanyl intravenously by the ambulance personnel. Petitioner's pain description was 10/10.

On December 8, 2009, Petitioner called the ambulance once again to be taken to Rush Copley. He was given intravenous Fentanyl on the way to the hospital by paramedics and complained of 10/10 back pain again. The emergency room prescribed Norco at the time of discharge.

On Decemeber 11, 2009, an EMG/NCV was completed that showed progressive reinnervation of L5-S1.

On December 20, 2009, Petitioner presented to Rush Copley Emergency Room complaining of 10/10 back pain after falling out of bed three times. (PX 6)

On December 25, 2009, Petitioner called the ambulance to be taken to Rush Copley Emergency Room again. Here he was given intravenous Fentanyl by the paramedics. A CT of the lumbar spine was completed that showed postoperative changes from the L5 laminectomy. There was severe stenosis at L4-5 and moderate stenosis at L2-3 and L3-4. (PX 6)

On January 15, 2010, Petitioner requested the ambulance once again and was given Fentanyl intravenously by the ambulance paramedics. Here he reported twisting his back while getting out of bed.

On January 16, 2010, Petitioner called the ambulance to take him to Rush Copley Emergency Room and was once again given Fentanyl by the paramedics. On January 18, 2010, Petitioner called the ambulance and attempted to obtain Fentanyl intravenously however the paramedics refused to administer the narcotics on this occasion. The emergency room diagnosed Petitioner with lower back pain and narcotic dependence. The following day January 19, 2010, Petitioner attempted to obtain narcotics from the ambulance paramedics again however they refused. The emergency room staff consulted the Illinois prescription monitoring program website and noted that Petitioner obtain 180 tablets of Norco between January 5 and January 10. Records show that when the staff questioned Petitioner regarding the number of pills, Petitioner responded that "he doesn't remember picking up all these scripts and he has no pain meds." (PX 6)

Petitioner saw his orthopedic surgeon Dr. Ivankovich that same day January 19, 2010 and was prescribed methadone. On February 2, 2010, Petitioner presented to Rush Copley Emergency Room for what was diagnosed as chronic low back pain with right lower extremity. Petitioner was given a prescription for Darvocet and Tylenol. (PX 6)

On April 3, 2010, a myelogram and CT scan of the lumbar spine was performed and the report indicated no disc herniation but found postoperative changes from a fusion from the L3 to the sacrum.

On July 8, 2010, Petitioner underwent a FCE conducted at Elite Physical Therapy. The results were deemed valid with Petitioner demonstrating the physical capability to function at the sedentary physical demand level. (PX 5)

On October 3, 2010, Petitioner returned to Rush Copley Emergency Room complaining of chronic pain related to previous back surgery. Petitioner reported that he ran out of pain medication. A MRI was taken showing mild central canal stenosis at L2-3, L3-4 and L4-5; there was multilevel bilateral neural foraminal narrowing, most severe at L4-5 and L5-S1; also indicated was asymemetric clumping of the nerve roots at L4-5 and L5-S1. (PX 6)

With respect to Petitioner's prior medical history, Respondent obtained medical records dating back to April 23, 2001 when Petitioner presented to the Rush Copley Emergency Room after being involved in a motor vehicle accident and complained of pain in his entire back. All X-rays were negative however Petitioner was given Vicodin. (RX 3)

Petitioner presented to the Rush Copley Emergency Room once again on January 13, 2004 complaining of pain with no objective findings; however, he was given Vicodin.

On August 28, 2004, the Rush Copley Emergency Room performed an MRI of the lumbar spine that showed mild diffuse disc bulging at L4-5 and L5-S1.

On November 11, 2004, Petitioner presented to Provena Mercy Center Occupational Health complaining of back pain after being struck with a 100 pound box. Physical examination was negative and Petitioner was given Toradol and Demerol. (RX 4)

On November 12, 2004, Petitioner presented to Provena Mercy. The medical note refers to the 100 pound box incident as "allegedly" taking place. Petitioner was given Vicodin in addition to Robaxin.

On November 15, 2004, Petitioner presented to Provena Mercy reporting 10/10 back pain and demonstrated increased pain even to light touch. A medical note states that Petitioner demonstrated signs of symptoms magnification and that the examination revealed no objective findings.

Two days later, Petitioner presented to Provena Mercy Center on November 17, 2004 complaining of 10/10 back pain. Petitioner gave a history of a prior MRI showing a herniated disc. Petitioner related his pain to work; however, the doctor noted in the chart that he did not agree and did not feel that the back pain was work related. Petitioner was discharged from care on this date.

One week later, Petitioner presented to Provena Mercy on November 24, 2004 and complained of 10/10 back pain. On this date Petitioner showed positive Waddell signs for symptoms magnification and a CT of the head was noted to be normal. Petitioner was returned to work with no restrictions.

On November 30, 2004, Petitioner underwent an MRI of the lumbar spine that showed no disc herniation.

On January 26, 2005, Rush Copley performed an MRI of the Petitioner's cervical spine that showed degenerative changes but no stenosis.

On April 29, 2005, Petitioner presented to Provena Mercy complaining of foot and knee pain in addition to back pain that was noted at 8/10. Also noted was that he was not in no acute distress. Petitioner was prescribed Darvon.

On May 3, 2005, Provena Mercy noted a history of pain at 7-8/10. Also noted was that Petitioner was in no acute distress. Medication was continued.

On May 11, 2005, another MRI of the lumbar spine was performed that showed no evidence of significant disc protrusion but there was some bulging at various levels with stenosis at L4-5 and L3-4.

On May 19, 2005 Petitioner complained of 10/10 back pain but was noted to be in no acute distress. Vicodin was given.

On May 27, 2005, Provena Mercy noted a history of 10/10 back pain. There was no acute distress found. Petitioner had no objective findings and significant nonorganic findings this date. The doctor opined that no further treatment was necessary. It was noted that Petitioner became angry and refused to sign the discharge papers.

On September 13, 2005, Petitioner presented to Rush Copley Emergency Room complaining that he fell on 4-5 stairs at work and injured his low back. He reported chronic back pain since 2005. Petitioner claimed his back pain was 10/10 and he was given Hydrocodone and Diazepam.

On October 10, 2005, Petitioner was being treated at the Anesthesia Pain Clinic at Hinsdale Hospital by Dr. Goodman where he underwent a bilateral facet injection. On November 14, 2005, Dr. Goodman noted Petitioner's pain of 10/10. Duragesic was prescribed. (RX 4)

On December 6, 2005, Dr. Goodman again noted a history of 10/10 back pain. An increase in Duragesic was prescribed to a new patch every 48 hours instead of one every 72 hours. Petitioner was also prescribed Roxicodone and Zofran.

On January 24, 2006, Dr. Goodman again noted pain being 10/10 and that Petitioner was taking the Duragesic (Fentanyl) also Skelaxin, Zofran, and Vicodin. An epidural steroid injection was administered this date.

On May 4, 2006, an EMG showed no signs of nerve damage or degeneration with no denervation.

On December 15, 2006, Petitioner presented to Rush Copley Emergency Room and was given Vicodin for abdominal pain.

At Respondent's request Petitioner underwent a Section 12 examination with Dr. Jessie Butler on December 10, 2010. The doctor was deposed on January 18, 2013. His report was submitted as Deposition Exhibit No. 2. Dr. Butler described the medical history involving Petitioner's low back between 2001 and when he was examined in 2010. Specifically, Dr. Butler described the narcotic medication usage and the fact that the prescriptions were larger than what he is used to seeing. Additionally, Petitioner told Dr. Butler that he occasionally used alcohol and Dr. Butler noted that a mixing alcohol with the regiment of medications would be

dangerous. With regard to a diagnosis, Dr. Butler opined Petitioner suffered a pseudoarthrosis of his fusion from the L4 to the sacrum. Petitioner had persistent spinal stenosis particularly at the L4-5 level. That level had been reported to have been decompressed but the imaging studies confirmed that decompressing did not exist though L4. The other impressions were severe narcotic dependency and drug seeking behavior.

With regard to casual connection Dr. Butler opined that Petitioner's condition was a long-standing issue that was unrelated to any work injury. Dr. Butler noted several instances whereby Petitioner denied any prior back problems. With regard to the accident on November 20, 2007, Dr. Butler opined that Petitioner did suffer a work accident but it was limited to a lumbar strain. With regard to maximum medical improvement Dr. Butler opined Petitioner reached maximum medical improvement for the lumbar strain on February 21, 2008.

With regard to (F) is the Petitioner's current condition of ill-being causally related to the injury? The Arbitrator finds the following:

Based on the evidence submitted, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the injury. Petitioner began medical treatment several weeks after the accident with Tyler Medical Services and specifically denied any prior back problems or chronic medical conditions. (The Arbitrator notes that the December 14, 2007 chart note from Tyler Medical Services notes that a staff member by the name of Esther acted as a Spanish interpreter during the entire office visit. Therefore any communication difficulty has been reduced.) These statements are contradictory to the medical records submitted as Respondent's Exhibit 3, Respondent's Exhibit 4, and the thorough history documented by Dr. Butler in Respondent's Exhibit 2.

The medical records taken as a whole demonstrate that Petitioner engaged in a pattern beginning in 2001 wherein Petitioner would complain of severe low back pain obtaining narcotic medication. Petitioner began treatment with Rush Copley Emergency Room on April 23, 2001 complaining of pain throughout his entire back and was given Vicodin. Petitioner returned to Rush Copley Emergency Room in 2004 once again complaining of back pain; however, the treatment providers found no objective findings in support of Petitioner's complaints. The Arbitrator notes that frequently Petitioner was prescribed narcotic pain medication to include Vicodin and Norco. By the end of 2004 Petitioner began treatment at Provena Mercy Center and specifically claimed he suffered a herniated disc. However, the MRI performed August 28, 2004 show Petitioner did not suffer from a disc herniation. Doctors at Provena Mercy Center on November 17, 2004 suspected Petitioner's complaints were not related to any work accident.

Petitioner continued to treat with Provena Mercy Center, Rush Copley Emergency Room, and Dr. Goodman at Hinsdale Hospital throughout 2004, 2005, and 2006. Petitioner continued to complain of back pain at the level of 10/10; however, the medical providers did not note any objective findings and specifically stated on numerous occasions that Petitioner was in no acute distress. The Arbitrator finds it to be incredible that Petitioner demonstrated no signs of being in distress if he was in fact suffering from pain at the level of 10/10. The Arbitrator also notes the medications prescribed to Petitioner throughout 2004, 2005, and 2006 increased in strength as Petitioner sought further treatment. Dr. Goodman at Hinsdale Hospital prescribed a patch of Duragesic with the active ingredient Fentanyl, an extremely strong pain medication. Petitioner continued to complain of increased pain and Dr. Goodman increased the dosage from one patch every 72 hours to one patch every 48 hours.

By the time Petitioner began treatment with Tyler Medical for the work injury that is the subject matter of this claim, Petitioner had an extensive medical background involving his lumbar spine between 2001 and

2006. Despite this long history Petitioner denied that he had ever experienced any prior back problems. Based on the records submitted, it is obvious Petitioner was less than truthful.

Petitioner's entire medical history, including the timeframe from the date of injury through 2010, shows a pattern where Petitioner complained of extreme back pain with no objective findings in support of his pain. Petitioner would present to various treatment providers complaining 10/10 pain but also being described as being in no acute distress. Several providers document that Petitioner was demonstrating symptom magnification sometimes to the level of being extreme. Dr. Singh, during his independent medical evaluation, noted that Petitioner demonstrated several positive Waddell's findings. Dr. Butler opined that Petitioner was engaged in drug seeking behavior. The Arbitrator is persuaded by Dr. Butler. Petitioner obtained narcotic pain medication from the emergency room on numerous occasions and had even convinced paramedics to administer intravenous Fentanyl on several occasions.

Based upon Petitioner's demonstrated symptom magnification, positive Waddell's signs, and drug seeking behavior the Arbitrator finds that Petitioner's condition of ill-being after February 21, 2008 was no longer related to the accident on November 20, 2007.

With regard to the issues of (J) where the medical services provided to the Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? The Arbitrator finds the following:

The Arbitrator finds that medical services provided to Petitioner were no longer reasonable, necessary, or related to the work accident after February 21, 2008. Respondent has paid $6,179.50 toward medical services. Petitioner submitted a total charged amount of $505,851.98. This amount when reduced pursuant to the fee schedule is $340,911.02. The Arbitrator finds that Respondent is responsible and shall pay for any unpaid medical expenses with the date of service between November 20, 2007 and February 21, 2008. Said bills are to be paid pursuant to the medical fee schedule.

With regard to (K) what temporary benefits are in dispute TTD? The Arbitrator finds the following:

Based on the Arbitrator's finding in Issue F., Petitioner is entitled to TTD benefits from January 4, 2008 through January 24, 2008 and also from February 4, 2008 through February 21, 2008, or period of 5-4/7 weeks.

With regard to issue (L) what is the nature and extent of the injury? The Arbitrator finds the following:

Based upon the above and in addition to the testimony given at trial and the exhibits submitted into evidence the Arbitrator finds Petitioner suffered a lumbar strain on November 20, 2007. Based upon these findings the Arbitrator awards 5% loss of use of the person as a whole.

With regard to issue (M) should penalties or fees be imposed on the Respondent or upon the Respondent? The Arbitrator finds the following:

Based upon the Arbitrator's findings in Issues, F., J. and K., Petitioner's request penalties and fees are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julita Hart,
Petitioner,

vs.

No: 04 WC 04782
No: 04 WC 04923

15IWCC0171

Walgreens Distribution Center,
Respondent.

DECISION AND OPINION PURSUANT TO SECTION 8(a)

This matter comes before the Commission on Petitioner's Motion Pursuant to Section 8(a) for Medical Benefits and for Penalties and Attorney's Fees, filed on June 24, 2013. The underlying claim, numbered 04 WC 004923, arises out of an acute trauma to Petitioner's lumbar spine suffered on October 28, 2003, while Petitioner was lifting a tote at work. The Commission notes that the 04 WC 004923 claim was consolidated with claim number 04 WC 004782, which also alleged injury to Petitioner's lumbar spine, with an injury date of December 3, 2003. Prior to the Arbitration Hearing, Petitioner elected not to proceed on the 04 WC 004782 claim. The cases remained consolidated and were tried before Arbitrator Tobin in Mount Vernon, Illinois on September 22, 2006 on the sole issue of the nature and extent of Petitioner's permanent disability. By Decision issued on October 9, 2006, Arbitrator Tobin found Petitioner permanently and totally disabled under the "odd lot" theory as a result of her October 28, 2003 work injury. No appeal was taken from that decision.

On or about June 24, 2013, Petitioner filed her Motion Pursuant to Section 8(a) for Medical Benefits and for Penalties and Attorney's Fees, requesting that the Commission order Respondent to comply with Arbitrator Tobin's Decision requiring payment for medical care and medication expenses. Petitioner also sought penalties and attorney's fees under Sections 19(k), 19(l) and 16 of the Act for Respondent's failure to provide payment for these medical expenses.

The parties proceeded to hearing before Commissioner Donohoo on August 18, 2014 in Collinsville, Illinois. Prior to the hearing, Petitioner stipulated that she was not moving forward with her claim for penalties and fees and was not seeking additional permanency under Section

19(h) of the Act. The parties also stipulated that Respondent would authorize and pay for three medications that were not in dispute and are marked by asterisks on Petitioner's Exhibit 5. Respondent disputed its liability for the four other medications.

After considering the entire record, including the transcripts of the original September 22, 2006 arbitration hearing, the August 18, 2014 review hearing, the parties' briefs, and oral arguments presented on January 28, 2015, the Commission finds that Petitioner's post-arbitration treatment and medications listed in Petitioner's Exhibit 5 are causally connected to her October 28, 2003 work injury and grants her Section 8(a) petition for additional medical expenses. No penalties, attorney fees, or additional permanency are ordered.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On October 28, 2003, Petitioner, a 35 year old split case picker for Respondent, was lifting a tote at work when she developed low back pain.

2. Petitioner immediately reported the injury and was seen the following day in the Emergency Room of Good Samaritan Hospital for back pain radiating into her leg. The hospital doctor diagnosed her with acute myofascial strain.

3. Petitioner was evaluated in the work center at Respondent's plant, performed physical therapy, and remained on light duty in November and December 2003. A January 7, 2004 MRI showed degenerative changes and narrowing at L4-5.

4. Dr. George Schoedinger examined Petitioner on January 16, 2004 for pain radiating into both buttocks and referred her to Dr. Kumar for pain management.

5. A February 10, 2004 myelogram revealed disc bulges at L4-5 and L5-S1 without stenosis, and a discogram performed the following day revealed that Petitioner's low back and hip pain reproduced at L5-S1. Petitioner agreed to epidurals and surgery, and Dr. Schoedinger performed an anterior discectomy and instrumented inner body fusion at L5-S1 with a post-operative diagnosis of herniated disc at L5-S1 on April 23, 2004. Dr. Schoedinger noted a retroperitoneal hematoma as a post-operative complication.

6. Dr. Schoedinger referred Petitioner to Dr. Douglas Dripps, an internist, for evaluation and treatment of her high blood pressure, which Dr. Schoedinger believed was associated with her work injury. Petitioner reached maximum medical improvement on November 2, 2004, and a January 4, 2005 FCE found her capable of working at the sedentary duty level.

7. At the September 22, 2006 arbitration hearing, Petitioner testified that she still had daily pain radiating down her leg, problems with lifting, bending and stooping, tingling in her left foot, and pain down both legs. She testified that she had performed 500-700 job searches without success.

8. Petitioner's native language is Visiya, a Philippine dialect, and Petitioner received language instruction in English. However, the Arbitrator concluded that Petitioner was unable to secure employment and was permanently and totally disabled under the "odd lot" theory.

9. At the Section 8(a) hearing before Commissioner Donohoo, Petitioner offered the transcript of Dr. Dripps' deposition. Dr. Dripps testified that each of the disputed medications is causally related to Petitioner's work injury.

    a. **Pantoprazole/Protonix:** for prevention of gastrointestinal ulcers and gastric stress. Dr. Dripps testified that Petitioner's gastroesophageal reflux was related to stress, which she didn't have prior to her injury.

    b. **Rosuvastatin/Crestor:** to help lower cholesterol. Dr. Dripps testified by deposition that Petitioner was a slender woman of Asian descent. Without provocation, it is unlikely she would suffer from high cholesterol.

    c. **Toprol/Metoprolol**: to help keep blood pressure down, control heart rate. Chronic pain can affect blood pressure.

    d. **Avapro:** for high blood pressure. Petitioner takes both Toprol and Avapro to help control her blood pressure.

    e. ***Oxazepam/Serax:** anti-anxiety. Respondent did not dispute that this medication was causally related to Petitioner's work injury.

    f. ***Ultracet:** pain medication. Respondent did not dispute that this medication was causally related to Petitioner's work injury.

    g. ***Zolpidem/Ambien:** to help with insomnia due to ongoing stress. Respondent did not dispute that this medication was causally related to Petitioner's work injury.

10. Dr. Russell Cantrell performed a Section 12 exam of Petitioner on August 7, 2013 and testified by way of deposition on November 6, 2013. Dr. Cantrell testified that Petitioner's use of Zolpidem, Oxazepam and Tramadol was appropriate, reasonable, and necessary for treatment of her work injury. However, he did not believe that Petitioner's use of Avapro and Toprol for high blood pressure or Crestor for cholesterol control was work-related. Although he agreed that pain can cause an acute increase in blood pressure, he opined that chronic pain and chronic high blood pressure were not causally related. The doctor noted that Petitioner's sedentary work restrictions did not prevent her from walking or exercising, and she had gained no weight since her injury. Dr. Cantrell agreed that a weight gain might have affected Petitioner's blood pressure and cholesterol. He further agreed that a number of medications, including some of those taken by Petitioner for treatment of her work injury, could have caused gastric distress and that Petitioner's inactivity could have exacerbated a pre-existing cholesterol problem.

Petitioner stipulated prior to the review hearing before Commissioner Donohoo that she was not seeking additional permanent partial disability or penalties and fees. The sole remaining issue is whether Petitioner's prescription costs and doctor visits are causally related to her 2003 work injury. Dr. Dripps testified by deposition that Petitioner's petite size (4'9") and Asian descent would not predispose her to the development of high blood pressure or high cholesterol. Dr. Dripps attributed those conditions to Petitioner's forced inactivity and stress, both the results of her work accident and the ongoing battles with Respondent to obtain treatment and medications.

Respondent offered Dr. Cantrell's contrary medical testimony as to causation. Dr. Cantrell noted that Petitioner had evidenced some pre-existing gastric complaints. Prior to her accident, Petitioner did suffer from gastric reflux and, according to the Emergency Room records, was treating for that condition with medication at the time of her accident. However, Dr. Cantrell admitted that some of the medications that were required to treat Petitioner's work injury might have increased her pre-existing gastric problems. There was no evidence that Petitioner suffered from pre-existing high blood pressure, and she testified that the pain and stress caused her hypertension. There was no other possible cause mentioned at trial.

Petitioner suffered a low back injury at work. The credible medical opinion in evidence found the medications that she took to treat that condition could have caused increased her gastric or intestinal problems. Further, the stress and inactivity that could have resulted in higher cholesterol counts and hypertension stemmed from her pain and the aggravation of fighting for additional treatment and medications. Based upon these causal connections, the Commission concludes that Respondent is liable for the treatment and medications required for treatment of Petitioner's gastric problems, hypertension, and raised cholesterol counts. Petitioner's Motion for Section 8(a) relief is granted.

The Commission, after considering the entire record, including the transcripts of the Arbitration Hearing on September 22, 2006 and the Review Hearing before Commissioner Donohoo on August 18, 2014, finds Petitioner has proved she is entitled to medical expenses pursuant to Section 8(a) of the Act for the reasons set forth above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Prospective Medical Pursuant to Section 8(a) of the Act is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses related to the treatment of her lumbar condition, pursuant to Sections 8(a) and 8.2 of the Act, as found in Petitioner's Exhibit 5.

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

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

15IWCC0171

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 10 2015

o-01/28/15
jdl/dak
68

Charles J. DeVriendt

Ruth W. White

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on 1/28/2015 before a three member panel of the Commission including members Dan Donohoo, Charles DeVriendt and Ruth White, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of member Dan Donohoo on 2/23/2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued while former member Dan Donohoo still held his appointment.

Although I was not a member of the panel in question at the time Oral Arguments were heard, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how the departing member voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 342, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dawn Bergman,
Petitioner,

vs.

NO: 13 WC 19068

15IWCC0172

Addus Healthcare,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering Petitioner's issues of penalties and attorneys' fees and Respondent's issues of accident, medical expenses and prospective medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof..

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 24, 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.

15IWCC0172

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: MAR 10 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/03/15
drd/wj
68

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

BERGMAN, DAWN
Employee/Petitioner

Case# **13WC019068**

ADDUS HEALTHCARE
Employer/Respondent

15IWCC0172

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:

1539 DRUMMOND LAW OFFICE
PETE DRUMMOND
PO BOX 130
LITCHFIELD, IL 62056

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Dawn Bergman
Employee/Petitioner

Case # 13 WC 19068

v.

Consolidated cases: n/a

Addus HealthCare
Employer/Respondent

15IWCC0172

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 15, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0172

FINDINGS

On the date of accident, January 3, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $13,065.00; the average weekly wage was $251.25.

On the date of accident, Petitioner was 41 years of age, single with 2 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as 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 authorize and make payment prospective medical treatment including, but not limited to, the right knee arthroscopic surgery as recommended by Dr. Brett Wolters.

Petitioner's petition for Section 19(k) and Section 19(l) penalties and Section 16 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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

June 17, 2014
Date

JUN 24 2014

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on January 3, 2013. According to the Application, Petitioner fell and sustained an injury to her right knee. Respondent disputed liability on the basis of accident and causal relationship. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and prospective medical treatment. Petitioner also filed a petition for Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees.

Petitioner worked for Respondent as a home caregiver and her job required her to go to the homes of the Respondent's clients and provide home health care to them. Petitioner's job duties included such things as bathing them, doing laundry, housework, preparing meals, giving them medication, etc. Petitioner would drive her own vehicle to the homes of the various clients.

On January 3, 2013, Petitioner went to the home of one of Respondent's clients, Cindy Ginnis, and parked her car in front of the house. Petitioner testified that it was extremely cold that day and there was packed snow on the ground. None of the areas adjacent to the residence including the driveway, walkway and sidewalk had been shoveled. Petitioner stated that she worked at the residence for approximately five hours and, as she was in the process of walking to her vehicle, she slipped and fell on the packed snow and sustained an injury to her right knee. Petitioner contacted her supervisor that same day and reported the accident.

At trial evidence was presented by counsel for both Petitioner and Respondent regarding the location of where Petitioner sustained the fall. Petitioner introduced into evidence four photographs which showed the location of the client's residence, a dead end street in Irving, Illinois (Petitioner's Exhibit 5, 6, 7 and 8). One of the exhibits was of the Petitioner standing a short distance from her car (Petitioner's Exhibit 8). Petitioner testified that this was the approximate location of where she fell, but that she could not be certain of the precise location because of the fact that the entire area was covered with snow on the day of the accident.

At trial, Carl Nail, a land surveyor, testified on behalf of the Respondent. Nail was hired by Respondent to conduct a survey of the property lines of the Respondent's client, Cindy Ginnis. Nail identified the plat of the survey he conducted which showed the property lines of the Ginnis residence (Respondent's Exhibit 3). He reviewed the photograph of Petitioner standing in the approximate area where she sustained the fall (Petitioner's Exhibit 8) and testified that Petitioner fell on public property approximately seven feet from the property line of Respondent's client, Cindy Ginnis.

The following day, Petitioner was seen by Virginia Behrhorst, a nurse practitioner. Her record noted that Petitioner fell yesterday afternoon while leaving work on a patch of snow/ice and that Petitioner twisted her leg and fell backwards. The assessment was knee joint pain, an x-ray was ordered and Petitioner was directed to take ibuprofen (Respondent's Exhibit 1; Deposition Exhibit 4).

Petitioner subsequently sought medical treatment from Dr. Brian Cady, her family physician. Dr. Cady's records for this treatment immediately following the accident were not tendered into evidence; however, Dr. Cady apparently ordered an x-ray of the right knee which was taken on January 4, 2013, at Hillsboro Area Hospital. According to the radiologist's report, the x-ray revealed no acute bony abnormality and mild osteoarthritis. It also made reference to a comparison film of the right knee taken on January 4, 2012 (Petitioner's Exhibit 1).

A Doppler evaluation of Petitioner's right lower extremity was performed at Hillsboro Area Hospital on January 25, 2013. The test was negative for DVT. According to the radiologist's report, the procedure was ordered by Dr. Cady (Petitioner's Exhibit 1).

On February 22, 2013, Petitioner was seen in the ER of Hillsboro Area Hospital where she was seen by Dr. J. Peterson. The record prepared by Dr. Peterson noted that Petitioner initially injured her right knee on January 3, 2013, when she slipped on ice and kicked her knee upwards. The record stated that the mechanism of the injury occurred during twisting and a slip on the ice. The symptoms were thought to be "arthritic" and that Petitioner had a similar problem in the past. Dr. Peterson ordered an x-ray and CT scan of the right knee. The x-ray was negative for any fractures and the CT scan revealed degenerative changes in the patellofemoral compartment. Report also noted that the menisci were "inadequately evaluated." (Petitioner's Exhibit 1).

An MRI scan was performed on Petitioner's right knee on April 17, 2013, at Hillsboro Area Hospital, at the direction of Dr. Cady. According to the radiologist, the MRI revealed tears of both the medial and lateral meniscus as well as patellofemoral osteoarthritis (Petitioner's Exhibit 1).

Petitioner testified that Dr. Cady referred her to Dr. Matthew Gardner who subsequently referred her to Dr. Brett Wolters, an orthopedic surgeon. Dr. Gartner saw Petitioner on May 10, 2013, and his record of that date noted that Petitioner had sustained an injury to her right knee on January 3, 2013, while walking to her car when she slipped on some packed snow. Dr. Gartner examined Petitioner and noted tenderness and a decreased range of motion. He reviewed the x-rays, CT and MRI scans and opined that Petitioner had an OCD lesion in the right knee. He recommended physical therapy and referred Petitioner to Dr. Brett Wolters (Petitioner's Exhibit 2).

Dr. Wolters saw Petitioner on May 21, 2013, and his record of that date also contained the history of the accident of January 3, 2013. On clinical examination, Dr. Wolters noted pain and patellar crepitus. He reviewed the x-rays and CT and MRI scans. Dr. Wolters opined that Petitioner had patellofemoral osteoarthritis versus OCD lesion and a possible medial meniscus tear. He recommended Petitioner have physical therapy but if did not relieve her pain, that she should have an arthroscopy (Petitioner's Exhibit 2).

Petitioner received physical therapy at Hillsboro Area Hospital from May 30, 2013, through July 3, 2013. Those records also contained the history of Petitioner injuring her right knee on January 3, 2013. The record also noted that Petitioner discontinued physical therapy because of limited visits being authorized by insurance (Petitioner's Exhibit 1).

Petitioner was again seen by Dr. Wolters on July 16, 2013. Petitioner still had right knee complaints and Dr. Wolters noted that she was injured at work approximately six months prior. Dr. Wolters opined that Petitioner had a patellofemoral OCD lesion and a possible torn medial meniscus, noting that it was difficult to say due to the quality of the MRI scan. Dr. Wolters noted that Petitioner had completed physical therapy, used over-the-counter medication and had continued to wear her knee brace. He observed that Petitioner's symptoms had remained constant and that he had nothing else to offer her except a right knee arthroscopic medial meniscectomy and chondroplasty. In regard to the OCD lesion, he stated that sometimes a cartilage replacement procedure is performed; however, a diagnostic arthroscopy needed to be performed to determine if that condition existed and if there was a need for that procedure (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Michael Nogalski, an orthopedic surgeon, on September 10, 2013. Petitioner informed Dr. Nogalski that she had right knee pain but had continued to work full time using a knee brace for support. She also advised that she had no prior right knee problems but that she had sustained a severe left knee injury approximately 20 years prior. Dr. Nogalski examined Petitioner and reviewed medical records and the diagnostic studies that were provided to him by Respondent. Dr. Nogalski's findings on clinical examination were benign. He opined that Petitioner's right knee complaints were not causally related to the work injury of January 3, 2013, and his diagnosis was osteoarthritis versus osteochondritis dissecans lateral trochlea without findings of either patellofemoral dislocation or medial meniscus tear (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Nogalski was deposed on February 10, 2014, and his deposition testimony was received into evidence at trial. Dr. Nogalski's testimony was consistent with his medical report of September 10, 2013, and he reaffirmed his opinion that Petitioner's right knee condition was not related to the accident of January 3, 2013, and that his diagnosis was osteoarthritis versus osteochondritis dissecans. He explained that either of these conditions would be compatible with Petitioner's complaints and the imaging findings. He further opined that Petitioner's right knee condition was not aggravated, accelerated or exacerbated by the accident of January 3, 2013 (Respondent's Exhibit 1; pp 13-15).

On cross-examination, Dr. Nogalski was asked whether Petitioner's twisting of her knee was a traumatic event which could have exacerbated or aggravated an underlying condition. Dr. Nogalski did not respond to the question stating that it was "compound" and "complex." This was followed by an exchange between Petitioner's counsel and Dr. Nogalski in which Dr. Nogalski did not give a specific answer but simply commented that the questions were "long" or needed additional specifics. Dr. Nogalski seemed to be focusing on differences in the histories contained in the medical records and the history provided to him by Petitioner. Dr. Nogalski did reaffirm his opinion that the findings on clinical examination and the MRI scan did not reveal any meniscal pathology (Respondent's Exhibit 1; pp 16-19, 21-29).

On cross-examination, Dr. Nogalski reviewed Dr. Wolters' medical record of July 16, 2013, when Dr. Wolters recommended that Petitioner undergo arthroscopic surgery. When questioned about whether he agreed or disagreed with Dr. Wolters' proposed course of treatment, Dr. Nogalski stated "From a diagnostic standpoint, if someone complains long enough, it's reasonable to perform a diagnostic arthroscopy, so in that sense, I have no argument with Dr.

Walters [Wolters'] position." In the next answer given by Dr. Nogalski, he then stated "I'm not convinced that she has an issue that would be clearly amenable to arthroscopic treatment." (Respondent's Exhibit 1; pp 31; Deposition – Petitioner's 3).

At trial Petitioner testified that she had no prior knee injuries or symptoms. Petitioner complained of pain and swelling in the knee primarily on the right side of the middle of the knee cap. She testified that she has not lost any time from work; however, she has continued to wear her knee brace that was prescribed for her by Dr. Cady. Petitioner testified that she wants to proceed with the treatment as recommended by Dr. Wolters and wants to have her knee "fixed."

Conclusions of Law

In regard to disputed issue (C) 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 her employment for Respondent on January 3, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that she sustained a slip and fall on ice/snow on January 3, 2013, was unrebutted.

It was undisputed that Petitioner's job duties required her to travel to the homes of Respondent's clients so that she could provide home health care to them. Generally, when an employee is required by the employer to travel, an injury that occurs during this time is within the course of employment. Bradford Supply Co. v. Industrial Commission, 277 N.E. 2d 854 (Ill. 1971). In the case of Mlynarczyk v. Illinois Workers' Compensation Commission, 999 N.E. 2d 711 (Ill. App. 3rd Dist 2013) Petitioner work for the employer as a janitor and she was required to travel to various clients of the employer that included homes, churches and offices. Petitioner sustained a slip/fall on snow on a public sidewalk that was adjacent to the driveway of her residence while she was walking to a vehicle used to transport her to the employer's clients. The Court held that this accident was compensable because Petitioner was a "traveling employee" and that the employee was subject to the hazards of the street to a greater degree than the general public. Mlynarczyk at 718.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of January 3, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that she injured her right knee when she sustained the fall on January 3, 2013, and that she had no prior right knee symptoms was unrebutted. In spite of the fact that the record from Hillsboro Area Hospital of January 4, 2013, made reference to a comparison x-ray film of the right knee being taken on January 4, 2012, and when seen at Hillsboro Area Hospital

by Dr. Peterson on February 22, 2013, there was a reference that Petitioner had a similar problem in the past; however, no medical records of any prior right knee symptoms were tendered into evidence at trial.

Dr. Wolters, an orthopedic surgeon, noted that Petitioner has had right knee complaints since the accident, has examined Petitioner, reviewed the MRI scan and has recommended arthroscopic surgery. Further, the history of the accident of January 3, 2013, is noted by the other treating medical providers.

The Arbitrator is not persuaded by the opinion of Respondent's Section 12 examiner, Dr. Nogalski. When cross-examined about the etiology of Petitioner's right knee condition and whether it could be aggravated or exacerbated by the accident, Dr. Nogalski was evasive and non-responsive. Accordingly, the Arbitrator gives little weight to his opinion regarding causal relationship.

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

The Arbitrator concludes that the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 4 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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, right knee arthroscopic surgery recommended by Dr. Wolters.

In support of this conclusion the Arbitrator notes the following:

Dr. Wolters has opined that arthroscopic surgery is indicated.

When deposed, Respondent's Section 12 examiner, Dr. Nogalski, initially stated that it was reasonable to perform diagnostic arthroscopy but then, in his next answer, attempted to change his opinion. The Arbitrator finds Dr. Nogalski's testimony to be inconsistent and is not persuaded by same.

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

The Arbitrator concludes Petitioner is not entitled to Section 19(k) and Section 19(l) penalties or Section 16 attorneys' fees.

In support of this conclusion the Arbitrator notes the following:

While it is clear that Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent, the Arbitrator does note that Respondent had a medical opinion

that there was not a causal relationship between the Petitioner's condition and the accident. As stated herein, the Arbitrator was not persuaded by Dr. Nogalski's opinions; however, the Arbitrator does not find that Respondent's reliance on Dr. Nogalski's opinion in denying liability in this case was either vexatious or in bad faith.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cuahtemoc Betancourt,
Petitioner,

vs. NO: 12 WC 12841

Oxy Dry Corporation,
Respondent.

15IWCC0173

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 disability, medical expenses, and penalties and fees, and being advised of the facts and law, affirms, adopts, and provides additional reasoning in support of 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).

After considering the entire record, including video surveillance, the Commission affirms the Arbitrator's finding that Petitioner did sustain an accident that arose out of and in the course of employment on March 26, 2012 and that his current condition of ill-being with regard to the left foot is causally related to the accident, but Petitioner's alleged CRPS and lumbar spine/hip conditions are not causally related to the accident.

In addition to the findings of the Arbitrator in his March 18, 2014 Decision, the Commission makes the following findings of fact and conclusions of law:

No question exists as to whether Petitioner suffered a contusion and laceration to his left ankle that arose out of and in the course of employment on March 26, 2012 when a circular piece of metal fell and struck him near the Achilles tendon. However, the parties dispute whether Petitioner suffers from CRPS, and, if so, whether that condition is causally related to the March 26, 2012 work accident. The parties also dispute whether Petitioner suffered a low back injury that is casually related to the March 26, 2012 work accident. The arbitrator outlined in great detail the evidence as contained in the record and his interpretation of that evidence as it related

to credibility of Petitioner and the opinions of the medical experts. The Commission affirms and adopts the opinions of the Arbitrator and adds additional findings.

Several medical experts provided opinions regarding Petitioner's condition of ill-being. Dr. Kane, a podiatrist, noted on July 10, 2012 that Petitioner presented with antalgic gait, as well as excessive weakness in the left lower extremity and, given those symptoms, Petitioner should be evaluated by a neurologist in order to determine if he were suffering from CRPS. Petitioner was referred to Dr. Thurston, a chiropractic neurologist, who examined Petitioner on July 16, 2012 after review of an EMG/NCV the same date. Dr. Thurston opined there was evidence, both clinically and electrodiagnostically, to support *possible* CRPS (emphasis added). Petitioner also saw Dr. Kelikian, an orthopedic foot specialist, on one occasion, October 22, 2012. After that visit, Dr. Kelikian noted Petitioner's symptoms of pain and numbness in his left foot, reviewed MRI results, and opined Petitioner should present to a pain clinic for evaluation of CRPS. Petitioner then presented to Dr. Dasgupta, a specialist in pain medicine, on January 29, 2013. Dr. Dasgupta noted Petitioner presented with burning and tingling pain in the left foot, weakness in the left lower extremity, and pain that was worsened by weight bearing activities, including walking and standing. Dr. Dasgupta opined it was *possible* that Petitioner was suffering from early stage CRPS (emphasis added). Dr. Dasgupta authored a note on May 28, 2013 that stated he agreed that Petitioner did not meet the objective criteria for CRPS, but he still felt Petitioner was most likely suffering from CRPS Type I, based on his subjective complaints.

The Respondent entered two surveillance videos into evidence as RX3 and RX4. The videos depicted Petitioner performing various activities on March 3, 2013, March 7, 2013, March 26, 2013, August 17, 2013 and August 18, 2013. On March 3, 2013, Petitioner is repeatedly filmed walking without a cane or limp with no outward signs of pain or discomfort and also seen bending at the waist and loading various items into a car without any signs of discomfort or favoring of his left leg. Petitioner was also filmed on March 7, 2013, the same day as a Section 12 examination with Dr. Holmes, a board certified foot and ankle surgeon. Petitioner was seen using a cane and limping as he entered and exited Dr. Holmes office. At that visit, Petitioner complained of constant pain with increased symptoms with walking and standing. However, he was filmed later that same day walking through a parking lot carrying a cable box without a limp or the assistance of cane and without any outward signs of pain or discomfort. Dr. Holmes, after examination of Petitioner and review of relevant medical records, rendered an opinion report on March 7, 2013 that Petitioner did have subjective complaints of pain, but there was no objective data to support his complaints. He further opined Petitioner did not suffer from CRPS and did not require pain management.

Petitioner then met with Dr. Konowitz, a board certified internist, anesthesiologist, and pain management physician, for a Section 12 examination on March 26, 2013. On that date, surveillance footage of Petitioner was obtained both before and after the examination. Petitioner is filmed prior to arriving at Dr. Konowitz's office using a cane and relying on the hand railings when entering the building. At the appointment, Petitioner presented with a limp and complained of decreased strength in the lower extremities but did not meet the diagnostic criteria for CRPS. After leaving Dr. Konowitz's office, surveillance of Petitioner continued and he was filmed getting out of his vehicle without the use of a cane and walking without any outward signs of pain or discomfort. He placed items in to the back of his vehicle and entered and exited the car without the need to brace himself. He also transferred his weight to the left foot.

Additional surveillance was obtained of Petitioner in August of 2013. On August 17, 2013, Petitioner was filmed walking at a brisk pace with his wife without a cane or limp. For approximately 30 minutes, Petitioner was filmed walking on sidewalks, crossing streets and walking through a field. Later that day, Petitioner was filmed entering a Wal-Mart and emerging approximately an hour later with a shopping cart full of groceries. He was viewed placing a large case of beer in his car trunk without any visible distress. After placing items in his car, he was seen pushing his cart to the parking lot corral, and pushing other carts into the corral as well, without any signs of pain. Surveillance was again obtained on August 18, 2013, and Petitioner was filmed walking without a cane or outward signs of distress through a park.

The Commission resolves the difference of expert opinion regarding the diagnosis of CRPS and treatment recommendations with its determination regarding the persuasiveness of each doctor's opinions when coupled with its determination regarding Petitioner's credibility. The Commission finds Petitioner incredible regarding his subjective complaints, based in part on the surveillance footage in evidence. The Commission affirms the Arbitrator's finding that the opinions of Dr. Holmes, a board certified foot and ankle surgeon, and Dr. Konowitz, a board certified internist, anesthesiologist and pain management physician, are more persuasive then those of Dr. Kane, a podiatrist, Dr. Thurston, a chiropractic neurologist, Dr. Kelikian, an orthopedist, and Dr. Dasgupta, a pain management physician.

The Commission, after review of the record as a whole, including surveillance evidence contained in RX3 and RX4, finds Petitioner proved by a preponderance of the credible evidence that he sustained a contusion and laceration to the left foot and/or ankle as a result of the March 26, 2012 accident, and that he failed to prove that he currently suffers from CRPS as a result of the accident. Petitioner reached maximum medical improvement regarding the foot contusion as of August 3, 2012. Furthermore, the Commission finds that Petitioner failed to prove that his current condition relative to his lower back is causally related to the accident.

All else is affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $296.03 per week for 18 4/7 weeks, commencing March 27, 2012 through August 3, 2012, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $4,052.84 for TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $17,640.46, as provided in Section 8(a) and 8.2 of the Act.

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

15IWCC0173

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 10 2015

o-01/13/15
jdl/adc
68

Charles J. DeVriendt

Ruth W. White

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on 1/13/2015 before a three member panel of the Commission including members Dan Donohoo, Charles DeVriendt and Ruth White, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of member Dan Donohoo on 2/23/2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued while former member Dan Donohoo still held his appointment.

Although I was not a member of the panel in question at the time Oral Arguments were heard, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how the departing member voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 342, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

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

BETANCOURT, CUAUHTEMOC
Employee/Petitioner

Case# **12WC012841**

BALDWIN OXY-DRY CORPORATION
Employer/Respondent

15IWCC0173

On 3/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JEFFREY T RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

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

Cuauhtemoc Betancourt,
Employee/Petitioner

v.

Baldwin Oxy-Dry Corporation,
Employer/Respondent

Case # **12** WC **12841**

Consolidated cases: **none**

15IWCC0173

An *Application for Adjustment 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 **Wheaton**, on **11/18/13**. 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, **3/26/12**, 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 relative to his left foot/ankle ***is*** causally related to the accident, but that Petitioner's alleged CRPS and lumbar spine/hip conditions ***are not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**$23,090.08**; the average weekly wage was $**444.04**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **no** dependent children.

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

Respondent shall be given a credit of $**4,052.81** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**2,250.80** for other benefits (advance), for a total credit of $**6,303.64**.

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 $296.03 per week for 18-4/7 weeks, commencing 3/27/12 through 8/3/12, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 3/27/12 through 11/18/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $4,052.84 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$17,640.46**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner penalties of **$0.00**, as provided in Section 16 of the Act; **$0.00**, as provided in Section 19(k) of the Act; and, 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.

Peter M. Finley
Signature of Arbitrator

3/6/14
Date

ICArbDec19(b)

MAR 18 2014

15IWCC0173

STATEMENT OF FACTS:

Petitioner, a 50 year old blender operator, testified that he had worked for the Respondent for 9 years leading up to the date of the accident. He indicated that his duties involved operating a machine called a blender which mixes between 5,000 and 7,000 pounds of food. He noted that he empties boxes and bags of material into the mixer and pushes buttons to operate the machine. He stated that the boxes/bags weighed from 50 to 80 pounds each and that they would do 7 runs per day using about 50 boxes/bags per run. He indicated that he had a helper while performing this job.

Petitioner testified that on March 26, 2012 he was washing the blender when a circular piece of metal, which a helper had placed on one of the mixers, fell and hit him on his leg. He indicated that he told his boss and was sent to Concentra on the date of the incident. Petitioner testified that he had never hurt his left leg before the accident in question. He did acknowledge, however, that he had previously suffered an injury involving the upper middle back.

Concentra Medical Center records dated March 26, 2012 contain he following history: "[t]he patient states that 20 lb piece of metal fell on his posterior left ankle injuring the Achilles tendon and left heel. The pain began immediately. The pain is located on the left heel and and [sic] left Achilles tendon area. The pain is described as mild, moderate, sharp and intermittent. The pain did not radiate. The symptoms are exacerbated by pressure, walking or standing. He is able to bear weight and wear shoes. He currently is unable to stand for an extended length of time. Associated bruising and limited movement. Denies sensory loss and paresthesias of the left foot. He feels the pattern of symptoms is stable…" (PX1). A 1.5 cm superficial laceration of the posterior aspect of the left ankle was treated, and x-rays of the ankle revealed no fracture or dislocation. (PX1). Petitioner was diagnosed with an ankle laceration and contusion and prescribed an aluminum cane. (PX1). He was released to modified activity with instructions to avoid prolonged standing/walking longer than tolerated, to sit 80 percent of the time and to refrain from the climbing of stairs or ladders. (PX1).

Petitioner testified that Respondent did not have a job for him within his restrictions, so he did not work at that time. He also testified that he used the cane for some time after the accident, and that he stopped using it a few months prior to his testimony.

Petitioner testified that he continued to treat at Concentra and to attend therapy thereafter. Petitioner noted that Concentra continued to send copies of his restrictions to his boss but that Respondent refused to provide him with a light/sedentary duty job. Instead, he indicated that they placed him in an area where he would be standing all day.

In a Concentra office note dated April 2, 2012 it was recorded that Petitioner "… feels the pattern of symptoms is improving. The patient has been working within the duty restrictions. Patient has been taking prescribed medications as needed. His pain is located on left heel, left Achilles tendon and medial ligaments. The pain is described as mild, moderate, sharp and intermittent. The symptoms are exacerbated by pressure, standing, walking up stairs or walking down stairs. Associated limited movement. Denies swelling, popping, sensory loss and paresthesias of the left foot." (PX1). Petitioner was diagnosed with an ankle contusion and instructed to undergo therapy three times a week for one to two weeks. (PX1). Once again, Petitioner was released to modified activity involving no prolonged standing/walking longer than tolerated and no climbing of stairs or ladders with instructions to sit 80 percent of the time. (PX1).

Concentra records show that Petitioner was initially evaluated in physical therapy on April 3, 2012 and that he attended five (5) sessions through April 12, 2012. (PX1). In a progress note dated April 9, 2012 it was noted

that Petitioner "... feels the pattern of symptoms is improving. The patient states that on April 5 [2012] while at work he did a lot of lifting up to '50 lb' and felt more pain to his left ankle. Today he feels the pain is less. The patient has been working within the duty restrictions..." (PX1). Petitioner was diagnosed with an ankle contusion and sprain and released to modified activity with instructions to the effect that he should be sitting 80 percent of time and that he should not lift over 10 lbs., push/pull over 10 lbs of force or climb stairs or ladders. (PX1).

Petitioner testified that his condition was getting worse so he eventually sought treatment on his own at New Life Medical Center on April 12, 2012. In an "Initial Exam Report" on that date, chiropractor Dr. Aldrin Carrion recorded a history of injury on March 26, 2012 when a piece of metal weighing approximately 35 pounds fell and struck the posterior portion of Petitioner's left ankle, causing severe pain and bleeding. (PX2). Following his examination, Dr. Carrion diagnosed Petitioner with 1) an ankle contusion, 2) ankle pain, 3) ankle sprain and 4) difficulty walking. (PX2). Petitioner was taken off work at that time. (PX2). He continued to treat at New Life Medical Center, receiving various modalities to both his left ankle and lumbar spine, through February 9, 2013. (PX2).

Petitioner underwent an MR of the left ankle on April 20, 2012 which was interpreted as evidencing a small joint effusion in the tibiotalar and subtalar articulations, but was otherwise unremarkable. (PX2).

In a "Physician's Report/Employee Work Status" form filled out by Dr. Carrion on May 22, 2012, it was noted that Petitioner could return to restricted work on that date, with no lifting/carrying over 10 pounds, no pushing/pulling and no squatting/kneeling/stooping. (PX2). Dr. Carrion specifically noted that sedentary or clerical work was "OK." (PX2).

Petitioner testified that he was subsequently referred to a specialist, podiatrist Dr. John F. Kane, whom he saw on May 4, 2012. In an "Initial Consultation" report on that date, Dr. Kane recorded a history of a heavy ring weighing approximately 50 pounds falling from a shelf onto the posterior aspect of Petitioner's left calf and Achilles tendon. (PX3). Following his examination, Dr. Kane diagnosed 1) a contusion on the posterior aspect of the left foot and ankle at the insertion of the Achilles tendon with associated laceration that is healing, and 2) erythematous change along the posterior aspect of the left Achilles tendon and muscle body in watershed area which may be an impending infection. (PX3). Dr. Kane recommended continued physical therapy and the use of a fracture boot in addition to a one-prong cane. (PX3). Finally, Dr. Kane opined that "... *this patient's clinical findings and radiographic results on a recent MRI of his left ankle are consistent with the work injury described on March 24, 2012, and are directly related to that injury.* Furthermore, the mechanism of action this action appeared to be directly related to the patient's symptoms and clinical findings. Moreover, with appropriate physical therapy and immobilization and oral medications the patient should resolve these symptoms soon." (Emphasis added) (PX3).

Petitioner returned to Dr. Kane on May 10, 2012 at which time it was noted that use of the fracture boot had "helped significantly in decreasing the symptoms in the area of the posterior aspect of his calf and ankle." (PX3). Upon examination, Dr. Kane noted continued swelling along the area of the laceration as well as "some erythematous changes along the posterior aspect of the ankle representing typical contusion type changes." (PX3). Dr. Kane's diagnosis was 1) contusion on the posterior aspect of the left foot and ankle and 2) rule out infection along the posterior aspect of the left foot and ankle near the Achilles tendon. (PX3). Dr. Kane recommended continued physical therapy and use of the fracture boot and prescribed antibiotics. (PX3).

Petitioner returned to Dr. Kane on May 17, 2012 at which time it was noted that Petitioner presented with significant improvement in swelling and erythematous changes. (PX3). Dr. Kane also indicated that the

infection along the posterior aspect of the left ankle appeared to be resolved with no open lesion noted. (PX3). In addition, Dr. Kane stated that Petitioner's range of motion had also improved and that a recommendation to upgrade to a surgical shoe had been made on that date. (PX3). Once again, Dr. Kane's diagnosis was contusion and infection of the posterior aspect of the left ankle. (PX3). Finally, with respect to work status, Dr. Kane noted that "[i]t is likely this patient is capable of returning to sedentary work duties, but that should be determined by Dr. Carrion." (PX3).

In a progress note dated May 31, 2012, Dr. Kane indicated that removal of the fracture boot revealed an erythematous area along the posterior aspect of the left calf similar to the previous erythema, but not quite as advanced. (PX3). Dr. Kane opined that the apparent cause may be the boot and that Petitioner was taken out of the boot and given an AFO device for support. (PX3). Besides some swelling of the posterior aspect of the calf, Dr. Kane noted that his symptoms appeared to be improving slightly. (PX3). Petitioner was instructed to continue with physical therapy and use a 4-pronged cane in conjunction with the AFO support. (PX3). He was also asked to call the office if his erythematous changes within the next few days. (PX3).

At the request of the Respondent's insurance carrier, Petitioner visited Dr. George Holmes on June 5, 2012 for purposes of a §12 examination. Dr. Holmes' report from this visit as well as three (3) additional reports were referenced during the course of Dr. Konowitz's deposition and attached thereto. (RX1, Exhibit 3-6). The Arbitrator notes that while it does not appear that any of these reports were officially offered into evidence at the time of Dr. Konowitz's deposition (RX1), the following conversation took place when the deposition was offered into evidence at the time of trial (T.67).

> ***Respondent's attorney:*** Respondent's first exhibit is the deposition transcript of Dr. Howard Konowitz taken on August 30, 2013. I will add a caveat, attached to it are exhibits that were submitted at the deposition and I request that all exhibits attached to the deposition be admitted at trial here today.
>
> ***Petitioner's attorney:*** Your Honor, during the course of the deposition counsel did refer the doctor to various medical records that he had used. I made comments and objections on the record, and I would just assume you would rule on those individually as they appear in the transcript.

The Arbitrator notes that he has ruled on any and all objections made during the course of Dr. Konowitz's deposition, and that at no time was any objection raised as to the reports of Dr. Holmes. Accordingly, the reports attached to Dr. Konowitz's deposition were likewise admitted into evidence.

In his report dated June 5, 2012, Dr. Holmes noted upon physical examination that the circumference measurements of the calf, ankle and foot were all .5 cm greater on the left than the right. (RX1, Exhibit 3). Dr. Holmes also related multiple levels of pain including pain over the dorsal aspect of the foot and an area of hotness over the posterolateral aspect of the foot. (RX1, Exhibit 3). In addition, Petitioner complained of burning fire at the posterior aspect of the calf radiating from the ankle upwards into the calf, leg and further. (RX1, Exhibit 3). He also noted some posterior heel pain with no pain over the medial aspect of the foot. (RX1, Exhibit 3). Following his examination and review of left ankle x-rays, Dr. Holmes' diagnosis was "… sprain or contusion of the ankle with no real evidence of any significant injury as a result of the reported injury on 03/26/2012. There does appear to be a cause relationship with the accident and the onset of discomfort. I do not see any evidence of any prior injuries to the ankle in the records review today." (RX1, Exhibit 3). Dr. Holmes went on to state that he had "… no data as to if there is any neurologic cause of his current symptomatology as it relates to the radiating pain to the calf and into the knee and hip." (RX1, Exhibit 3). In addition, Dr. Holmes indicated that "[i]n light of the fact that his measurements are relatively symmetrical, it is my opinion that he does not require any active ongoing treatment at this time. It may actually be helpful to get

an FCE to get some more objective data with regard to his capabilities. From a structural standpoint, his ankle should be capable of returning to his usual position as a machine operator. It appears that the neurologic complaints are the main impediment to his return to work. At this point, I am unable to causally connect the neurologic complaints with the injury itself. This issue or question may be resolved with the EMG nerve conduction velocity study." (RX1, Exhibit 3). Dr. Holmes felt that in the interim Petitioner could perform light duty and/or medium duty work with restrictions of refraining from walking on uneven surfaces, lifting greater than 30 pounds and working from heights or from ladders. (RX1, Exhibit 3).

In a progress note dated June 12, 2012 Dr. Kane indicated that both the erythematous changes and swelling had resolved, but that Petitioner continued to have pain in the posterior aspect of his left calf and the lower part of his ankle. (PX3). The diagnosis was 1) contusion left foot and ankle, and 2) local infection left foot and ankle subsequent to the contusion. (PX3). An Unna wrap was applied, and it was noted that Petitioner's work status was to be determined by Dr. Carrion. (PX3).

In a New Life Medical Center work status report dated June 12, 2012 it was noted that Petitioner was able to do clerical or sedentary work but that "[p]atient [was] not working because he was not allow[ed] to go back with restrictions." (PX2). The same release and explanation as to why he was not working can be found in similar status reports dated July 3, 2012, July 24, 2012, August 22, 2012, September 12, 2012 and October 3, 2012. (PX2). He was also released to sedentary work in New Life Medical Center status reports dated December 15, 2012, January 19, 2013 and February 9, 2013. (PX2). Petitioner testified that his employment with Respondent was eventually terminated in a letter effective May 20, 2013.

Petitioner returned to Dr. Kane on June 26, 2012 at which time it was noted that Mr. Betancourt had been participating in physical therapy and wearing his AFO on a regular basis whenever walking or standing. (PX3). Dr. Kane noted some mild-to-moderate erythema with some irritation upon examination of the posterior aspect of the Achilles tendon, but indicated that it had improved significantly since the last visit and was no longer taking antibiotics. (PX3).

In a progress note dated July 10, 2012, Dr. Kane indicated that "[t]he patient had suffered a contusion of the left foot and has had excessive symptoms which have been prolonged and appeared to be plateauing in regard to recovery with his physical therapy and conservative treatments." (PX3). Dr. Kane also reported that Petitioner now complained of "burning sharp shooting pain along the lateral aspect of the ankle" and that "[p]alpation of the lateral dorsal cutaneous nerve also reveals a sharp shooting pain, which the patient states is present when walking and standing." (PX3). In addition, Petitioner presented with an antalgic gait as well as excessive weakness of the affected limb. (PX3). Given that these symptoms appeared excessive for the type of injuries involved, Dr. Kane recommended that Petitioner be evaluated by a neurologist in order to determine if Mr. Betancourt was suffering from early stages of complex regional pain syndrome ("CRPS"). (PX3). Dr. Kane also recommended an EMG study, and "[d]epending on results from the EMG study, an FCE would be a good option." (PX3).

Petitioner subsequently visited chiropractic neurologist Dr. Gregory D. Thurston who examined him and performed an EMG/NCV on July 16, 2012. (PX2). Following his examination and testing, Dr. Thurston's impression was as follows: "Clinical findings as well as lower extremity NCV studies showed sensory/motor changes that suggest mild-moderate L5, S1 neuropathy. Additionally, there is also sensory and particularly, motor evidence to suggest nerve conduction block type neuropathy involving the left sural nerve and the left posterior tibial/plantar nerve associated with left ankle trauma. *Clinically and electrodiagnostically, there is evidence supporting a possible complex regional pain syndrome (CRPS) as a result of the work comp injury trauma in addition to a previous chronic low back injury producing a lumbar disc disorder with lumbar*

neuropathy. Patient's low back and left hip symptoms were likely aggravated at the time of the injury and have progressed because of the patient's altered gait as a result of his ankle injury. EMG study was negative." (Emphasis added) (PX2). Dr. Thurston recommended a lumbar MRI to rule out possible soft tissue or osseous pathology. (PX2).

Petitioner testified that he began feeling pain traveling up to his back and was sent for an MRI on July 26, 2012. He noted that he was still using a cane at that time. The results of that lumbar MRI were interpreted as revealing subligamentous posterior disk bulges measuring approximately 2-3 mm at L4-L5 and L5-S1 without spinal stenosis or significant neuroforaminal narrowing. (PX2).

In a supplemental report dated August 3, 2012, Dr. Holmes noted that the overall impression of the EMG Petitioner underwent on July 16, 2012 was "… moderate left sural nerve and posterior tibial nerve neuropathy as a result of the work injury trauma to the Achilles calcaneal junction of the left ankle. CRPS in the left ankle peripheral nerves is a likely diagnosis. Mild-to-moderate left L5-S1 neuropathy. This report was interpreted by a chiropractic neurologist, Gregory Thurston, DC." (RX1, Exhibit 4). Dr. Holmes went on to state that "*[t]he findings of the EMG nerve conduction velocity study do not appear to be consistent with the area of this gentleman's pain*. The chiropractor indicated on the EMG that there was a posterior tibial nerve neuropathy and plantar nerve neuropathy. These areas did not correspond with this gentleman's area of pain as reported and photographed in the office. There could be some overlap with a sural nerve neuropathy. However, *the mechanism of the injury is unlikely to cause the area of pain that is noted in this gentleman's examination.*" (Emphasis added) (RX1, Exhibit 4). Dr. Holmes went on to add that "… on his examination, there was *no evidence of any asymmetry or atrophy* indicating that both lower extremities are being used equally which would also be inconsistent with a profound neuropathy involving all the nerves that were listed in the report. Additionally, *the distribution of pain would also be inconsistent with any underlying CRPS*. Therefore, *my final diagnosis would be that this gentleman has suffered a contusion*." (Emphasis added) (RX1, Exhibit 4). Dr. Holmes recommended use of a Lidoderm patch and possible repeat EMG, this time by a university neurologist or physiatrist. (RX1, Exhibit 4). Finally, Dr. Holmes indicated that "[t]here is no structural impairment at this point that would restrict him from full duty work, but at a minimum, he still should be able to perform at least a medium duty level of work at this time without any restrictions or limitations within that medium duty level. From a structural standpoint, this gentleman appears to be MMI. This is based upon the lack of any swelling or atrophy in comparing the right and left lower extremities." (RX1, Exhibit 4).

In a progress note dated August 7, 2012, Dr. Kane recorded "mild-to-moderate swelling with moderate degree of skin temperature difference between the left and right limb. The patient noted a significant difference in the temperature of his left foot as it is sometimes colder or sometimes warmer than the opposite side. The patient states that the foot can also [feel] clammy and at night appears to be increasingly swollen and red." (PX3). The diagnosis was 1) left foot and ankle contusion and 2) rule out CRPS. (PX3). Petitioner was instructed to continue with physical therapy and see a pain specialist for evaluation and treatment. (PX3). Finally, Dr. Kane indicated that he was of the opinion that "… *this patient's clinical findings and radiographic results have a direct relationship to the work injury that occurred on March 26, 2012. Furthermore, after recent neurological studies it is becoming more apparent that the patient's symptoms are related to complex regional pain syndrome.* Moreover, these symptoms should be treated by a pain control specialist for relief of those symptoms to help the patient recover from his injuries." (Emphasis added) (PX3).

Petitioner noted that he continued to treat with Dr. Kane and at New Life Medical, and that he was eventually sent to Dr. Krishna C. Chunduri at Metro Pain Management on August 21, 2012. In a consultation report on that date, Dr. Chunduri noted a history of work related injury on March 28 [sic], 2012 when something dropped on his left foot. (PX4). Dr. Chunduri noted that Petitioner presently complained of pain in the left side of his

back radiating down his left lower extremity to his foot. (PX4). Following her examination and review of the lumbar MRI results, Dr. Chunduri diagnosed Petitioner with L4-5, L5-S1 disk bulge with left radiculitis and lumbago. (PX4). Dr. Chunduri opined that "*Mr. Betancourt was injured on 03/28/2012 [sic] at work directly resulting in his current symptoms and diagnosis.*" (Emphasis added) (PX4). Dr. Chunduri went on to state that since Petitioner's condition had failed to improve in spite of a significant amount of conservative treatment and time, "… it is my opinion based on a reasonable degree of medical certainty that we advance his care to include epidural steroid injections." (PX4). Petitioner subsequently underwent a left L4 and L5 transforaminal epidural steroid injection under fluoroscopic guidance on September 5, 2012. (PX4).

Petitioner indicated that he then returned to Dr. Kane before seeing Dr. Chunduri a second time. In addition, he continued to undergo physical therapy at New Life Medical Center, including chiropractic manipulation of the lumbar spine. (PX2).

Petitioner returned to Dr. Kane on September 25, 2012. (PX3). In an office note on that date, Dr. Kane indicated that Petitioner continued to present with symptoms similar to and consistent with CRPS. (PX3). Dr. Kane also noted that he disagreed with Dr. Holmes' opinion that Petitioner was capable of full duty work. (PX3). Instead, Dr. Kane felt that Mr. Betancourt was not at MMI and "continues to suffer significant swelling and pain in the area of his left foot and ankle." (PX3). Dr. Kane continued to diagnose Petitioner with a contusion of the left foot and ankle and CRPS. (PX3). Dr. Kane recommended the continued use of the Unna wrap for the next two to three days as well as the continued use of the ankle support, physical therapy and the services of a pain control specialist. (PX3). Dr. Kane also noted that Petitioner was capable of sedentary work duties only. (PX3).

In a report dated October 9, 2012, Dr. Holmes indicated that he reviewed the additional records forwarded to him by defense counsel and that "[f]rom an orthopedic standpoint, this patient does not require additional orthopedic input in terms of physical therapy, operative intervention, braces, or other orthopedic supports." (RX1, Exhibit 5). Dr. Holmes was of the opinion that Petitioner could return to full duty work, and if he was unable or unwilling to do so, then he "… should be capable of returning to work according to a medium to light duty level of work; however, the imposition of such potential restrictions would not have an underlying structural or orthopedic basis." (RX1, Exhibit 5). As a result, Dr. Holmes felt that Petitioner had reached MMI, and that any "… ongoing pain may be accounted for by the lumbosacral spine issues more so than any localized issue in the foot or ankle." (RX1, Exhibit 5).

Petitioner testified that Dr. Kane referred him to Dr. Matthew Ross for consultation with respect to his back. Dr. Ross examined Petitioner on October 10, 2012. On that date Dr. Ross recorded that Petitioner presented with a history of left back, leg and foot pain of approximately 6-1/2 months duration. (PX5). He noted that Petitioner was injured when a heavy metal piece fell off a blender onto the back of his left foot on March 26, 2012. (PX5). Dr. Ross related that Petitioner had had extensive therapy and reported that his foot pain was feeling better. (PX5). However, he noted that Petitioner was still experiencing pain up to his left lower back and buttock area, and that he notices a feeling of numbness over his lateral thigh. (PX5). Dr. Ross also noted that Petitioner had suffered a back injury at work 2 to 3 years earlier but that that injury had resolved with physical therapy and he had been able to resume his heavy physical demand job. (PX5). Following his examination and review of both the lumbar MRI as well as the EMG/NCV study, Dr. Ross stated that "Mr. Betancourt appears to have sustained a primary injury to his left foot and ankle. He may have developed some secondary plantar fasciitis. The pain higher in his leg and left buttock area is most likely muscular due to the altered gait mechanics. He may be developing a little trochanteric bursitis. *I do not detect any injury to the lumbar spine as a consequence of the work accident of March 26, 2012.* I have recommended that the patient obtain an opinion regarding his foot and ankle from a premier orthopedic foot ankle specialist, such as Dr. Armen Kelikian at

Northwestern University Medical Center. The patient will not require any type of surgical intervention for his low back." (Emphasis added) (PX5).

Petitioner visited Dr. Kelikian on October 22, 2012. In a report on that date, Dr. Kelikian noted that Petitioner was a machine operator and that he had "sprained his ankle at work." (PX6). Dr. Kelikian indicated that Dr. Cann [sic] had sent the patient to therapy and that "[h]e has pain going up and down his leg at this point." (PX6). Upon evaluation, Dr. Kelikian noted that the patient "… has stocking glove numbness throughout the left foot. CMS intact. No ankle instability. Sensory, motor intact. Full range of motion." (PX6). Dr. Kelikian then recorded that "[o]utside MRI, no report was available, but did not see any abnormalities." (PX6). Based on this, Dr. Kelikian opined that "I think he has a complex regional pain syndrome at this point, and he should basically go to a pain clinic at this point." (PX6). In a separate letter, addressed to no one and dated November 7, 2012, Dr. Kelikian indicated that "I have recommended that Cuauhtémoc Betancourt be seen by a pain clinic for complex pain syndrome. I had recommended Dr. Ira Goodman but patient can attend consultation near his home or as covered within his workman's comp claim." (PX6).

Petitioner indicated he saw both Dr. Ross and Dr. Kelikian on only one occasion. All the while, Petitioner continued to receive physical therapy at New Life Medical Center. On cross examination, Petitioner testified that the therapy was only making it worse.

Petitioner testified that following the recommendation of Dr. Kelikian he began treating with Dr. Sunavo Dasgupta at Premier Pain Specialists on January 29, 2013. On that date, Dr. Dasgupta recorded a history of chronic left foot pain following a work related injury on March 26, 2012 wherein a heavy steel disc weighing approximately 35 pounds fell and ended up hitting him on the back of the foot near the heel area as well as the lateral and medial aspects of the left foot. (PX7). Dr. Dasgupta noted that Petitioner was diagnosed with an ankle contusion and underwent physical therapy before eventually developing low back and left hip pain in addition to left ankle pain and being diagnosed with probable CRPS of the left foot. (PX7). On that date, Dr. Dasgupta recorded that Petitioner presented with complaints of significant left foot pain that he rated as approximately 8/10 and which he described as a constant, burning, tingling type of pain located all around the left foot and extending upwards to about the mid tibial point. (PX7). *Petitioner described the pain as being worsened by weight-bearing activities, including walking and standing, and noted numbness in the foot as well as weakness in the left lower extremity*. (Emphasis added) (PX7). In addition, Petitioner complained of left-sided back pain with some radiation into the left buttock region which he described as an intermittent, sharp and shooting type of pain. (PX7). Following examination and review of the left ankle and lumbar spine MRIs, as well as the EMG, Dr. Dasgupta noted that Petitioner "… does exhibit objective findings of sensory changes, vasomotor changes as well as motor changes in terms of weakness. He also endorses some pseudomotor changes in terms of increased sweatiness of the foot at times as well. *Objectively, he meets criteria for CRPS*. Subjectively, he also complains of all of these sensory vasomotor, pseudomotor, and more changes. *At this point, I will leave it as entirely possible that he is suffering from early stages of CRPS*..." (Emphasis added) (PX7). Dr. Dasgupta went on to recommend medication as well as left lumbar sympathetic blocks, noting that if there was no change thereafter Petitioner would be a candidate for a trial of spinal cord stimulation. (PX7).

In a progress report dated February 9, 2013, Dr. Carrion noted that Petitioner's condition "has improved nearly 50-55% since his first evaluation … *It is my professional opinion that the patient has reached MMI and will continue care with pain management specialist*." (Emphasis added) (PX2).

In a progress note dated March 5, 2013, Dr. Dasgupta noted that Petitioner responded well to Lyrica but that he had been experiencing some abdominal pain that his primary care physician would need to evaluate. (PX7). In the interim, until he was cleared with respect to the Lyrica, Petitioner was to continue with the Lidoderm patch.

(PX7). Dr. Dasgupta also recommended the aforementioned lumbar sympathetic block and possible trial spinal cord stimulator if his symptoms do not improve. (PX7). Finally, Dr. Dasgupta noted that he would "continue his previous work restrictions," indicating in a separate fax that Petitioner was restricted from lifting greater than 10 pounds, and should not stand for more than one hour or engage in any bending, carrying, squatting, climbing, pushing, pulling twisting, kneeling or overhead reaching. (PX7).

Respondent submitted surveillance video footage taken on March 3, 2013 during a period extending from approximately 10:11 am through a little before 5:00 pm. (RX3). During this period Petitioner is repeatedly seen walking without the use of a cane and without a limp, and evidencing no outward signs or manifestations of pain or discomfort, while walking through parking lots and pushing a shopping cart. (RX3). Petitioner is also seen bending at the waist and loading various items into a car and getting into the passenger seat of said vehicle with no outward signs of pain or discomfort, or even the need to compensate or favor one foot/leg/hip over the other. (RX3).

Petitioner saw Dr. Holmes for a second time on March 7, 2013. In his report on that date, Dr. Holmes recorded that Mr. Betancourt presented with continued pain in his left leg which shoots up from the left lateral aspect of the foot, ankle through the lower leg to the hip and buttocks and sometimes crossing to the right buttocks. (RX1, Exhibit 6). In addition, Dr. Holmes noted complaints of stinging pain with tingling and increased sensitivity near the foot. (RX1, Exhibit 6). Dr. Holmes recorded that Petitioner "... *states his pain is constant in nature*..." and that "[h]e *currently has increased symptoms with walking, standing activities*... He does use a cane on occasional basis and he currently is not working." (Emphasis added) (RX1, Exhibit 6). Dr. Holmes' physical examination revealed circumference measurements of the ankle and foot that were 1 cm greater on the left compared to the right. (RX1, Exhibit 6). Dr. Holmes also noted that the ankle was grossly stable to anterior drawer testing and that the color and turgor were normal. (RX1, Exhibit 6). In addition, Dr. Holmes recorded that Petitioner had increased sensitivity to light touch over the lateral aspect of the ankle, dorsum of the foot and plantar aspect of the foot, and that patient reported that the pain radiated proximally into the knee, past the knee proximally into the hip and lower back. (RX1, Exhibit 6). Dr. Holmes diagnosed Petitioner as having sustained a contusion of the lower extremity, noting that "[i]t is *my impression from my review of the records and his examination that he does not have a CRPS. This does not deny that he has subjective complaints but I do not believe that there is any validation of these subjective complaints or secondary to CRPS*...." (Emphasis added) (RX1, Exhibit 6). Dr. Holmes also noted that he found "... no objective data to indicate this gentleman would not be able to return to his full duties without limitations or restrictions." (RX1, Exhibit 6). Finally, Dr. Holmes opined that Petitioner "... has reached maximal medical improvement for the aforementioned injuries. It is my opinion that he does not require pain management at this point as well." (RX1, Exhibit 6).

Respondent submitted surveillance video footage taken on March 7, 2013, or the date of the above examination by Dr. Holmes, showing Petitioner limping and using a cane as he enters and later leaves an office building. (RX3). Later that day, Petitioner is seen walking through a parking lot while carrying what appears to be a cable box. The Arbitrator notes that Petitioner is seen walking at that time without a limp, and without the assistance of a cane, and showing no outward signs or manifestations of pain or discomfort before he getting into the passenger side of a vehicle. (RX3).

At the request of Respondent, Petitioner visited Dr. Howard Konowitz on March 26, 2013 for purposes of a §12 examination. Dr. Konowitz testified by way of evidence deposition on August 30, 2013. (RX1). He indicated that he is board certified in internal medicine, anesthesiology and pain management. (RX1, p.5). Dr. Konowitz noted that Petitioner presented with a limp or antalgic gait – which he later described as a "multifactorial gait abnormality" -- as well as significant musculoskeletal overlay. (RX1, p.11). He noted decreased strength in the right lower extremity, decreased sensation and vibratory sense in the right and left extremities as well as

decreased light touch in the right and left lower extremities. (RX1, p.11). In addition, he indicated that reflexes were decreased but symmetric, that the patient had a negative Babinski's with toes downgoing and no long tract signs. (RX1, p.11). He also noted that Mr. Betancourt was consistent with response to behavioral stimulation and that pulses were normal throughout the upper and lower extremities. (RX1, p.11). Furthermore, Dr. Konowitz noted that "*[s]pecific exams looking for allodynia, temperature asymmetry, skin color changes, edema, sweating changes, specific non-motor or tremor related weakness or trophic changes of the hair and nails were not present*." (Emphasis added) (RX1, p.11). Dr. Konowitz testified that based upon his examination, as well as a review of the medical records – including the reports of Dr. Holmes as well as the records of Dr. Kane, New Life Medical Center, Concentra, Dr. Ross, Dr. Kelikian, Dr. Chunduri and Dr. Dasgupta – he was of the opinion that Petitioner "… *did not meet the clinical diagnostic criteria for complex regional pain syndrome or suffer from it*."(Emphasis added) (RX1, pp.18-19). Furthermore, while Dr. Konowitz believed that Petitioner's ankle-related complaints were related to the March 26, 2012, and that he was presently unable to return to full duty work, he was unable to comment on any current restrictions given the confluence of what he described as Mr. Betancourt's work and non-work related issues. (RX1, p.19-20). Finally, Dr. Konowitz opined that Petitioner had reached MMI with respect to the ankle trauma, although he indicated that he would not have an issue with Dr. Dasgupta's recommendation for the use of Lyrica, or its equivalent, as well as a diagnostic lumbar sympathetic block and repeat EMG. (RX1, pp.21-23). He indicated, however, that relief as the result of such a block would not confirm a diagnosis of CRPS. (RX1, p.23).

On cross examination, when questioned about the lumbar MRI finding of small joint effusion in conjunction with Petitioner's complaints of intermittent pain in his butt, Dr. Konowitz testified that he "… interpreted those complaints as his piriformis was so irritable and his gluteus muscles were so irritable on the chiropractor's exam, I could see some residual of that when I examined him that I suspect we had a functional irritation from piriformis syndrome causing leg discomfort." (RX1, p.26). With respect to the antalgic gait, Dr. Konowitz noted that "… the gait abnormality can relate to some of his myofascial pain complaints that were documented in the chart. I suspect a significant proportion of his peripheral complaints relate to the pelvic musculature... But from a gait abnormality, you don't want to jump that that's the only cause of his pain complaints. It sometimes is, but you need to work it up." (RX1, pp.44-45). When asked directly whether this piriformis problem could have been caused by the event on March 22 [sic], 2012, Dr. Konowitz indicated that he "… would need to work up the pelvis as a secondary problem … But from an ankle standpoint, the ankle is healed…" (RX1, p.54). On re-direct, Dr. Konowitz indicated that Petitioner "… clearly had gait abnormalities and extremity pain that would preclude putting him in the work environment at the time I saw him. Again, I don't have a workup of a cause for that part." (RX1, p.56). Finally, Dr. Konowitz noted that he did not agree with the EMG report's finding of CRPS given that "[t]here is no EMG criteria for complex regional pain syndrome that have been developed to date." (RX1, p.58).

Respondent submitted surveillance video footage taken on March 26, 2013, or the morning of his visit to Dr. Konowitz, wherein Petitioner is seen at approximately 10:30 am walking without the use of a cane and exhibiting no outward signs or manifestations of pain or discomfort. (RX3). Petitioner is also seen placing an item in the back seat of a car at that time, then getting into the passenger side of said vehicle, even transferring his weight to his left foot as he gets in, all without any apparent difficulty or need to brace himself. (RX3). Later that same day, at approximately 12:18 pm, Petitioner is seen using a cane as he walks towards and eventually enters an office building, presumably Dr. Konowitz's. (RX3). Petitioner is likewise seen using a cane and holding onto a railing as he exits the same office building at approximately 3:10 pm. (RX3). Interestingly enough, Petitioner is then seen at 4:06 pm getting out of the passenger side of his vehicle and walking without the use of a cane. (RX3).

In a progress note dated May 28, 2013, Dr. Dasgupta noted that Petitioner's continued left foot pain "… was *most likely secondary to CRPS type I as subjectively his pain complaints are consistent with CRPS. Although I agree he does not meet many objective criteria at this time as [sic] could represent very early CRPS*. Atrophic changes[,] muscle wasting[,] etc. do not appear until the disease is well progressed into its end-stage. It is unlikely that he would exhibit such symptoms at this point." (Emphasis added) (PX7).

In a progress note dated July 22, 2013, Dr. Dasgupta noted that over the past few visits Petitioner has started to complain of more proximal pain in the left lower extremity and that there appeared to be some worsening in the distribution of his pain. (PX7). Dr. Dasgupta indicated that "[t]his could possibly represent worsening of the symptomatology if it is truly related to underlying CRPS." (PX7). Dr. Dasgupta once again recommended a left-sided sympathetic block, noting that if the benefits of such a shot were profound, even if merely transient, "… *then it would probably support a diagnosis of CRPS for this patient*." (Emphasis added) (PX7). Dr. Dasgupta also noted that he had discussed the case with the patient's attorney on that date. (PX7).

Dr. Dasgupta subsequently administered three left-sided sympathetic blocks to Petitioner on August 6, 2013, September 17, 2013 and October 14, 2013. Petitioner testified on cross examination that these injections have not done anything for him. However, on re-direct he indicated that he gets some relief from these injections, but that it only lasts for a few days.

Respondent submitted surveillance video footage taken on August 17, 2013 wherein Petitioner is seen walking without the assistance of a cane and without a limp, and at a relatively brisk pace, with a woman presumably his wife. (RX4). During a period encompassing approximately 30 minutes, from about 10:35 am through 11:07 am, Petitioner is seen walking down the sidewalk, crossing streets and even walking through a field. (RX4). Later that same say, Petitioner is seen walking through the parking lot of a Wal-Mart, emerging more than an hour later pushing a shopping cart and showing no signs of pain or discomfort as he rearranges items in the trunk of his car and places various purchases in the vehicle, including what appears to be a large case of beer. (RX4). After he finishes loading his trunk, Petitioner is seen returning his shopping cart to the designated drop off area in the parking lot, even going so far as to insert his cart in the line of carts and pushing the lot of them (probably 10-15 carts in all) forward in the pen. (RX4). Once again, Petitioner exhibits absolutely no outward sign or manifestation of pain or discomfort while doing so, and returns to his car without any sign of a limp. (RX4).

Finally, Petitioner is seen on August 18, 2013 once again walking without the aid of a cane and without a limp or outward sign of pain or discomfort. (RX4). Indeed, Petitioner is seen at one point holding his wife's hand as they walk through what appears to be a park and smiling and waving to someone as he walks towards his car. (RX4).

Petitioner last visited Dr. Dasgupta on November 5, 2013. (PX7). On that date, Dr. Dasgupta noted that Petitioner "… reported improvement after LSB x2 but reports no improvement after his third LSB. Continues with numbness in allodynia of the left lower extremity. The most relief he has gotten since onset of symptoms has been the [sic] with the LSB's." (PX7). Dr. Dasgupta recommended a spinal cord stimulator trial, stating that Petitioner "… notes improvement with lumbar sympathetic block but unfortunately benefit is transient. Likely for more durable pain control he will require spinal cord stimulation to help address his lower extremity neuropathic pain." (PX7).

Petitioner indicated that he would like to go ahead with the treatment recommended by Dr. Dasgupta. Petitioner also testified that since he began treatment at New Life Medical Center no doctor had released him to return to full duty work.

Petitioner was shown the bills submitted at PX8. He indicated that some of these bills had been paid but that some had not. The parties subsequently prepared an agreed stipulation setting forth the amount of medical expenses that would be due and owing in the event this matter is found compensable. (Arb.Ex.#2). Petitioner also testified that he had paid $166 in out-of-pocket expenses and that to date he had not been reimbursed for same.

Petitioner testified that currently his condition is "very bad" and that he has been depressed. He noted that his wife has had a hard time dealing with him and that his hair is falling out. He testified that he has intense pain in his left leg, where he cannot feel his entire leg, and that parts of his back and forehead hurt. Specifically, he claimed that his forehead feels numb and "falls asleep." He noted that the injections do not help his back and leg complaints; hence the recommendation for a new form of treatment. All in all, he stated that he is always feeling bad. On cross examination, Petitioner indicated that he is not able to perform activities of daily living activities and that he cannot go grocery shopping or perform similar chores. In fact, he testified that he spends the entire time in his house, other than those times he goes with his wife to visit his mother-in-law. He also indicated that he can only walk less than a mile, given that the pain starts right away. On redirect, Petitioner agreed that he sometimes goes with his wife to the store for short periods of time, and that he has tried to do things around the house. He indicated that the treatment provided very little relief and within one to two days he would feel the same. He presently takes medication prescribed by Dr. Dasgupta. He noted that he continues to have significant pain in his left leg and that he cannot stand for a long time. He also indicated that he was having trouble sitting at the time of his testimony.

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

The question here is two-fold – whether Petitioner suffers from CRPS and if so whether his current condition of ill-being with respect to said condition, including his claimed inability to work and need for ongoing medical treatment, is causally related to the accident on March 26, 2012.

By its very nature, CRPS is a complicated disease process that is oftentimes as difficult to diagnose as it is to treat. It is a condition that is more or less a diagnosis of exclusion, one that is characterized by a seemingly random constellation of symptoms that may emanate, as in this case, from a relatively minor trauma, and then progress to other parts of the body. The symptoms themselves may seem overly subjective, drawing criticism from those who prefer a more empirical and quantifiable approach to medicine. And yet the condition exists, recognized by medical science, and all too real for the many sufferers who deal with the disease day in and day out.

Over the years, the medical community has attempted to define the condition, to develop diagnostic tools and a uniform set of criteria to help us better understand and treat the disease. Even then, arriving at such a diagnosis seems almost as much an art as science. Open to interpretation and debate. Practitioners piecing together pieces of the puzzle, and arriving at their best estimate of what truly is going on with a particular individual.

Such is the case here. One set of chiropractors and physicians saying Petitioner is suffering from what his current pain management doctor refers to as "very early CRPS", while Respondent counters with two §12 examining physicians who question the diagnosis, given what they view as a lack of correlation between his symptoms and the criteria used to diagnose CRPS.

The evidence is not so clear cut. Petitioner was injured when a circular piece of metal, weighing somewhere between 20 to 50 pounds, based on the various histories, fell and struck his left ankle, near the Achilles tendon and heel. A rather minor incident, by all accounts. He goes to the company clinic and is diagnosed with a contusion and laceration. He's given a cane and released to modified duty. He receives physical therapy and eventually seeks treatment on his own at New Life Medical Center where he comes under the care of chiropractor Dr. Carrion on April 12, 2012. The diagnosis remains ankle contusion and ankle pain. He continues to treat conservatively at New Life Medical Center, receiving various chiropractic and other modalities, through February 9, 2013. During that period, New Life records note that his condition is improving and that he is capable of working with restrictions.

In any event, Petitioner continues to have symptoms. He is then referred to Dr. Kane, presumably a podiatrist, whom he sees for the first time on May 4, 2012. Dr. Kane diagnoses a contusion on the left foot/ankle. He also notes an erythematous area on the foot, and later another, which he blames on the fracture boot Petitioner had been wearing, and which eventually resolves. Dr. Kane likewise notes improvement in Petitioner's condition during the course of his treatment.

Then, on July 10, 2012, or almost four (4) post accident, Dr. Kane notes that Petitioner was complaining of a burning sharp pain along the lateral aspect of the ankle as well as a sharp shooting pain along the lateral dorsal cutaneous nerve upon palpation. Dr. Kane also notes an antalgic gait and excessive weakness in the affected limb. Since these symptoms appeared excessive, Dr. Kane decided to send Petitioner to a neurologist to determine if he was suffering from the early stages of CRPS.

Petitioner then sees chiropractic neurologist Dr. Thurston who notes that "[c]linically and electrodiagnostically, *there is evidence supporting a possible complex regional pain syndrome (CRPS) as a result of the work comp injury trauma in addition to a previous chronic low back injury producing a lumbar disc disorder with lumbar neuropathy. Patient's low back and left hip symptoms were likely aggravated at the time of the injury and have progressed because of the patient's altered gait as a result of his ankle injury*. EMG study was negative." (Emphasis added) (PX2). Dr. Thurston recommends a lumbar MRI which eventually reveals subligamentous posterior disk bulges measuring approximately 2-3 mm at L4-L5 and L5-S1 without spinal stenosis or significant neuroforaminal narrowing. (PX2).

Thereafter, Dr. Kane opines that "… *this patient's clinical findings and radiographic results have a direct relationship to the work injury that occurred on March 26, 2012. Furthermore, after recent neurological studies it is becoming more apparent that the patient's symptoms are related to complex regional pain syndrome*…" (Emphasis added) (PX3).

Petitioner is subsequently sent to Dr. Chunduri at Metro Pain Management on August 21, 2012. Dr. Chunduri notes Petitioner's complaints of pain in the left side of his back radiating down his left lower extremity to his foot. Dr. Chunduri opines that "*Mr. Betancourt was injured on 03/28/2012 [sic] at work directly resulting in his current symptoms and diagnosis.*" (Emphasis added) (PX4).

Dr. Kane eventually refers Petitioner to Dr. Ross for his back complaints. In a report dated October 10, 2012, Dr. Ross noted that "Mr. Betancourt appears to have sustained a primary injury to his left foot and ankle. He may have developed some secondary plantar fasciitis. The pain higher in his leg and left buttock area is most likely muscular due to the altered gait mechanics. He may be developing a little trochanteric bursitis. *I do not detect any injury to the lumbar spine as a consequence of the work accident of March 26, 2012."* (Emphasis added) (PX5). Dr. Ross then refers Petitioner to a foot and ankle specialist, namely Dr. Kelikian.

Petitioner visits Dr. Kelikian on October 22, 2012. Dr. Kelikian issues a report that is noticeably lacking in exam findings. Specifically, Dr. Kelikian notes that Petitioner "…has pain going up and down his leg at this point" and that upon evaluation he exhibited "… stocking glove numbness throughout the left foot. CMS intact. No ankle instability. Sensory, motor intact. Full range of motion." (PX6). Dr. Kelikian then notes "[o]utside MRI, no report was available, but did not see any abnormalities." (PX6). Based on this rather limited set of facts, Dr. Kelikian opines that "*I think he has a complex regional pain syndrome at this point*, and he should basically go to a pain clinic at this point." (Emphasis added) (PX6).

Petitioner then begins treating with a pain management specialist, Dr. Dasgupta, on January 29, 2013. At that time, Dr. Dasgupta notes that Petitioner "… *does exhibit objective findings of sensory changes, vasomotor changes as well as motor changes in terms of weakness. He also endorses some pseudomotor changes in terms of increased sweatiness of the foot at times as well. Objectively, he meets criteria for CRPS. Subjectively, he also complains of all of these sensory vasomotor, pseudomotor, and more changes. At this point, I will leave it as entirely possible that he is suffering from early stages of CRPS*..." (Emphasis added) (PX7).

In a subsequent office note dated May 28, 2013, Dr. Dasgupta noted that Petitioner's continued left foot pain "… was *most likely secondary to CRPS type I as subjectively his pain complaints are consistent with CRPS. Although I agree he does not meet many objective criteria at this time as [sic] could represent very early CRPS*. Atrophic changes[,] muscle wasting[,] etc. do not appear until the disease is well progressed into its end-stage. It is unlikely that he would exhibit such symptoms at this point." (Emphasis added) (PX7).

At this point, it is sounding like there is probably enough to find that Petitioner is suffering from the early stages of CRPS, based on the opinions of Drs. Kane, Thurston, Kelikian and Dasgupta.

But then there are the opinions of Drs. Holmes and Konowitz, Respondent's §12 examining physicians. Along these lines, Dr. Holmes opines, in his report dated August 3, 2012, that "*[t]he findings of the EMG nerve conduction velocity study do not appear to be consistent with the area of this gentleman's pain*…" and that "… *the distribution of pain would also be inconsistent with any underlying CRPS*. Therefore, *my final diagnosis would be that this gentleman has suffered a contusion*." (Emphasis added) (RX1, Exhibit 4). In his final report, dated March 7, 2013, Dr. Holmes notes that "[i]t is *my impression from my review of the records and his examination that he does not have a CRPS. This does not deny that he has subjective complaints but I do not believe that there is any validation of these subjective complaints or secondary to CRPS*…." (Emphasis added) (RX1, Exhibit 6).

For his part, Dr. Konowitz points out that "*[s]pecific exams looking for allodynia, temperature asymmetry, skin color changes, edema, sweating changes, specific non-motor or tremor related weakness or trophic changes of the hair and nails were not present*." (Emphasis added) (RX1, p.11). Dr. Konowitz goes on to opine that based upon his examination, as well as a review of the medical records, that Petitioner "… *did not meet the clinical diagnostic criteria for complex regional pain syndrome or suffer from it*."(Emphasis added) (RX1, pp.18-19).

Thus, there would appear to be a difference of opinion as to whether the findings were sufficient to warrant a diagnosis of CRPS. Obviously, Petitioner has made certain complaints and exhibited certain signs that are commonly associated with CRPS, even though he apparently does not presently meet many of the objective criteria for the condition.

Which brings us to the surveillance tapes. Given that the diagnosis of CRPS in this case would appear to be based to a large extent on Petitioner's subjective complaints, its stands to reason that the accuracy of that diagnosis will be greatly dependent upon the credibility of the patient along these lines. And where those subjective complaints are brought into question by evidence such as the surveillance footage in this case – which shows Petitioner walking without any noticeable limp or outward signs of pain or discomfort, and without the assistance of a cane, unless he happens to be going to an examination set up by the insurance company -- one cannot help but question the soundness of the CRPS diagnosis itself. The Arbitrator notes that none of the physicians who opined that Petitioner is suffering from CRPS were shown the videos in question or otherwise asked to reconcile what is depicted in those videos with Petitioner's ongoing complaints of constant, debilitating pain. Without sufficient objective findings, and without reconciling what is plainly apparent in the videos, a diagnosis of CRPS at this stage would seem to amount to little more than a well-intentioned attempt on the part of his treaters to but a label on Mr. Betancourt's growing list of complaints. And with nothing more, the Arbitrator is not willing to make such an assumption, particularly in light of surveillance tapes that appear to show Petitioner limping and needing a cane only when he is visiting the insurance company's §12 examining physicians.

Accordingly, the Arbitrator finds that Petitioner suffered a contusion and laceration of his left foot and/or ankle as a result of the accident on March 26, 2012, and that he failed to prove that he currently suffers from CRPS as a result of said accident. Along these lines, the Arbitrator finds the opinions of Drs. Holmes and Konowitz to be more persuasive than those offered by Drs. Kane, Thurston, Kelikian and Dasgupta.

Furthermore, the Arbitrator finds that Petitioner failed to prove that his current condition relative to his lower back is causally related to the accident on March 26, 2012. In support of this finding, the Arbitrator relies on the opinion of Dr. Ross who noted that he did not detect any injury to the lumbar spine as a consequence of the work accident of March 26, 2012 and that Petitioner would not require any type of surgical intervention for his low back. (PX5). Furthermore, the Arbitrator notes that the video surveillance footage fails to show any sign of a limp or antalgic gait, other than on those occasions that Petitioner is seen visiting Respondent's §12 examining physicians. As a result, the Arbitrator once again questions Petitioner's credibility as to his alleged altered gait and any relation it may have to his hip or low back complaints.

Finally, the Arbitrator finds that Petitioner's condition of ill-being with respect to his left foot and/or ankle reached maximum medical improvement as August 3, 2012, or the date Dr. Holmes opined that Petitioner was not suffering from CRPS, was capable of returning to full duty, or at a minimum medium duty, and from a structural standpoint was at MMI. (RX1, Exhibit 4).

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

The parties submitted into evidence an agreed stipulation setting forth the amount of medical expenses that would be due and owing pursuant to the fee schedule in the event this matter was found to be compensable, with Respondent maintaining any objection to liability as well as reasonableness and necessity. (Arb.Ex.#2).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses incurred through August 3, 2012, or the date Dr. Holmes opined that Petitioner did

have suffer from CRPS and had reached MMI, said expenses totaling $17,640.46 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act, and as set forth in Arb.Ex.#2.

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

Petitioner is requesting prospective medical treatment recommended by Dr. Dasgupta, including a trial spinal cord stimulator, based on her diagnosis of early stage CRPS.

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to prospective care and treatment relative to his alleged condition of CRPS. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that following his release by Concentra to return to work with light or sedentary restrictions, Respondent attempted to have him return to work in a position that was outside his restrictions. Thus, he indicated that he did not work. New Life Medical Center work status reports likewise reflect the fact that Petitioner had not been allowed to return to work by his employer. (PX2).

On April 12, 2012, Dr. Carrion took Petitioner off work completely. Dr. Carrion eventually indicated, in work status note dated May 22, 2012, that Petitioner could return to sedentary or clerical work involving no lifting/carrying over 10 pounds, no pushing/pulling and no squatting/kneeling/stooping. (PX2). Petitioner testified that Respondent did not provide work within his restrictions throughout this period.

In a report dated August 3, 2012, §12 examining physician Dr. Holmes opined that Petitioner did not suffer from CRPS and that "[t]here is no structural impairment at this point that would restrict him from full duty work, but at a minimum, he still should be able to perform at least a medium duty level of work at this time without any restrictions or limitations within that medium duty level. From a structural standpoint, this gentleman appears to be MMI. This is based upon the lack of any swelling or atrophy in comparing the right and left lower extremities." (RX1, Exhibit 4).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from March 27, 2012 through August 3, 2012, for a period of 18-4/7 weeks.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, 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's conduct in the defense of this claim was neither unreasonable nor vexatious so as to warrant the imposition of penalties. Therefore, Petitioner's request for additional compensation pursuant to §19(l) and §19(k) and attorneys' fees pursuant to §16 of the Act is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Betty Yandell,
Petitioner,

vs.

No. 12 WC 06370

15IWCC0174

State of Illinois,
Shawnee Correctional Center
Respondent.

DECISION AND OPINION ON REVIEW

Petition for Review having been timely filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and permanent disability, and being advised of the facts and law, modifies the March 17, 2014 decision of Arbitrator Zanotti, as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On July 15, 2011, Petitioner was 52 years old and employed as an administrative specialist for Respondent. On that date, the parties stipulate she sustained an accident that arose out of and in the course of her employment when she slipped on a wet floor and fell on her left shoulder and arm.

Section 12 examiner, Dr. Johnson, opined Petitioner suffered a left shoulder strain, impingement syndrome, bursitis and biceps tenosynovitis. The medical records in evidence show Petitioner sustained a contusion to the anterior aspect of the left shoulder, and an MRI on July 28, 2011 revealed medial subluxation of the biceps out of the bicipital groove, likely from lesion, as well as tendinitis and a likely bursal sided rotator cuff tear. An MRI of the left elbow on

December 22, 2011 revealed mild edema involving the common flexor tendon, medial collateral ligament and flexor carpi ulnaris muscle. Petitioner underwent a course of physical therapy and corticosteroid injection in the left AC joint, and the medical records show a recommendation for subacromial decompression, distal clavicle excision and rotator cuff repair and biceps tenodesis, but Petitioner opted to undergo only conservative treatment for her complaints. Petitioner was found by her treating physician, Dr. Kern, to be at maximum medical improvement on May 29, 2012.

Petitioner testified at arbitration regarding her current complaints in her left shoulder and arm. She testified she is right hand dominant and continues to experience episodic tingling in her left arm and hand, as well as tinges of pain and weakness when reaching overhead to perform tasks of daily living. She further testified her ability to work on her family cattle farm has been adversely affected, as she experiences pain when driving her four-wheeler with her arms outstretched. Petitioner testified she does not take any regular medication for her complaints, but occasionally takes Tylenol, as needed.

With regard to permanent partial disability, the Arbitrator found Petitioner sustained a 7.5% loss of use of the person as a whole, referable to the left shoulder, and 7.5% loss of use of the left arm, referable to the elbow, due to the injuries sustained in the July 15, 2011 accident. The Commission affirms the Arbitrator's award of 7.5% loss of use of the body as a whole, but views the evidence differently regarding left arm permanent partial disability. The Commission finds that Petitioner sustained a 5% loss of use of the left arm pursuant to Section 8(e) of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the March 17, 2014 Decision of the Arbitrator is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses as outlined in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained to the left shoulder caused the 7.5% loss of use to the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 12.65 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained to the left elbow caused the 5% loss of use to the arm.

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

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

15IWCC0174

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: MAR 10 2015

Charles J. DeVriendt

o-01/27/15
jdl/adc
68

Ruth W. White

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on 01/27/2015 before a three member panel of the Commission including members Dan Donohoo, Charles DeVriendt and Ruth White, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of member Dan Donohoo on 02/23/2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued while former member Dan Donohoo still held his appointment.

Although I was not a member of the panel in question at the time Oral Arguments were heard, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how the departing member voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 342, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

YANDELL, BETTY
Employee/Petitioner

Case# **12WC006370**

15IWCC0174

STATE OF ILLINOIS/SHAWNEE CC
Employer/Respondent

On 3/17/2014, 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 0.08% 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:

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
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 17 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

BETTY YANDELL
Employee/Petitioner

v.

STATE OF ILLINOIS/SHAWNEE C.C.
Employer/Respondent

Case # 12 WC 6370

15IWCC0174

An *Application for Adjustment 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 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

FINDINGS

On **July 15, 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 **$66,069.50**; the average weekly wage was **$1,270.57**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD (all TTD benefits owed were paid by Respondent), **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for all medical bills paid under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as outlined in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent is entitled to a credit for all medical bills paid under Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 37.5 weeks, because the injuries sustained to her left shoulder caused the 7.5% loss of use to the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 18.975 weeks, because the injuries sustained to her left elbow caused the 7.5% loss of use to the arm, 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

03/06/2014
Date

MAR 17 2014

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BETTY YANDELL
Employee/Petitioner

v.

Case # 12 WC 6370

STATE OF ILLINOIS/SHAWNEE C.C.
Employer/Respondent

15IWCC0174

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On July 15, 2011, Petitioner, Betty Yandell, was employed as an Administrative Specialist for Respondent, the Shawnee Correctional Center. The parties stipulated that she sustained accidental injuries on July 15, 2011, when she slipped on a wet floor and fell on her left shoulder and arm. Petitioner testified to no prior claims or treatment with respect to her left shoulder, elbow or arm.

On the day of the incident, Petitioner reported to Redi-Care Center, who referred Petitioner to Lourdes Hospital and Western Baptist Hospital for imaging studies. (Petitioner's Exhibit (PX) 3; PX 4). The initial physical examination showed that Petitioner was unable to move her left arm above hip level. (PX 3, 7/15/11). The clinical impressions noted suspicion of a rotator cuff tear in addition to left shoulder strain. *Id.* Petitioner was noted to have significant bruising and swelling of the left elbow on follow-up and received a Medrol Dosepak prescription. (PX 3, 7/20/11). Petitioner was subsequently referred to an orthopedist. (PX 3, 7/28/11).

Petitioner saw Dr. Brian Kern on August 22, 2011. Dr. Kern took the history of Petitioner's slip and fall at work and noted her complaints of pain, swelling in the shoulder and tingling in her hand. Petitioner exhibited weakness during physical examination and several positive orthopedic tests. After reviewing the films and appreciating a rotator cuff tear, Dr. Kern informed Petitioner that her shoulder condition would likely require surgery. Petitioner wished to try conservative treatment first. (PX 6, 8/22/11). Petitioner derived some benefit from therapy until Respondent no longer approved her treatment. Dr. Kern ordered an MRI of Petitioner's elbow due to the fact that she consistently experienced elbow pain since her accident, which was somewhat overshadowed by her shoulder problems. (PX 6, 12/12/11). Following review of Petitioner's elbow MRI and her previous studies, Dr. Kern diagnosed a known partial thickness rotator cuff tear with medial subluxation of the biceps tendon, biceps tendinosis, and ongoing pain and weakness, as well as medial epicondylitis of the left elbow. (PX 6, 1/3/12). Dr. Kern repeatedly stated his belief Petitioner would benefit from surgery. (PX 6).

Respondent had Petitioner examined pursuant by Dr. Richard Johnston on February 10, 2012, pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). Dr. Johnston stated that Petitioner's rotator cuff tear was the direct result of her July 2011 work injury and stated that Petitioner had appropriate treatment to date. He also noted that Petitioner had

pathology which contributed to her ongoing left shoulder impingement and evidence of medial epicondylitis. He also believed that Petitioner was a candidate for shoulder surgery. (PX 8; RX 8).

Petitioner continued to treat conservatively and received an injection. (PX 6, 4/27/12). Petitioner continued to express a desire to avoid surgery on follow-up despite continued symptoms, and reported that she could live with her current symptoms if her condition did not worsen. Dr. Kern advised Petitioner that her condition may deteriorate in the future and require surgery. He placed her at maximum medical improvement without surgery. (PX 6, 5/29/12).

Petitioner testified that despite the improvement she received from physical therapy and injection, she continues to have pain and tenderness in her shoulder and arm. She testified that her pain increases with activity and lingers at times until the following day. She has difficulty driving for long periods of time, and cannot sleep in her natural position with her left arm under her pillow. She continues to experience tingling in her left arm and hand as well as a twinge of pain and weakness when reaching to perform simple tasks such as taking plates out of her cabinet or removing something from her oven and setting it on her stovetop. Her ability to work on her family farm has been adversely affected. She must ride four-wheelers when working on her farm, and uses the four-wheelers to shepherd animals on the farm. Operating these vehicles on her family farm is now more difficult due to her injuries. She also has difficulty performing basic activities of personal hygiene. She occasionally takes Tylenol for her symptoms.

CONCLUSIONS OF LAW

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

In order to obtain compensation under the Act, a claimant bears the burden in proving that her current condition of ill-being is causally related to her accidental work-related injury. Circumstantial evidence, especially when entirely in favor of the claimant, 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, 728 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 93 Ill.2d 59, 63-64, 442 N.E.2d 908, 910-911 (1982).

Here, the medical records and objective diagnostic studies show a clear chain between Petitioner's ill-being and the undisputed accident of July 15, 2011. Petitioner had no prior claims or treatment with respect to her left shoulder, elbow or arm. On the same day of her accident, Petitioner presented for medical care for her swollen and painful left shoulder and arm, and obtained shoulder, elbow and humerus imaging studies. Respondent's examiner, Dr. Johnston, opined that Petitioner's shoulder condition was directly related to her July 2011 fall. Although Respondent contends that Petitioner's conditions enumerated thereafter are not related to the fall because Dr. Johnston did not specifically delineate these conditions as related, the Arbitrator notes that Dr. Johnston did not in any portion of his report indicate that any of Petitioner's conditions were not caused or aggravated by her July 2011 fall, and implied by reference that her condition as a whole was related to the fall by virtue of his statement that Petitioner "has had appropriate treatment to date," after discussing Petitioner's condition as a whole and indicating that Petitioner had not reached maximum medical improvement for these conditions. (PX 8, p. 3 of 4). Although Petitioner has evidence of degeneration on her films, this was asymptomatic prior to her accident, and notwithstanding same, a claim is not to be barred simply because of a pre-existing condition.

Even when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in her current condition of ill-being. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665 (2003). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Id.* If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Id.* Since Petitioner did not require any treatment for her pathology prior to the accident, the subsequent treatment rendered for these pre-existing conditions would be resultant from an aggravation of these conditions on account of the undisputed fall that occurred on that day.

Based upon the foregoing, the Arbitrator finds that Petitioner has met her burden in establishing that her current condition of ill-being is causally related to her work accident, and that she is entitled to benefits under the Act.

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

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for their employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of a claimant's injury. *Plantation Mfg. Co. v. Industrial Comm'n,* 294 Ill. App. 3d 705, 691 N.E.2d 13 (2d Dist. 1997). Based upon the above finding regarding causal connection and the acknowledgement of the reasonableness and necessity of Petitioner's treatment made by Respondent's examiner, Dr. Johnston, the Arbitrator awards the medical expenses contained in Petitioner's Exhibit 1 as follows:

Redi-Care Center	$ 637.00
Lourdes Hospital/Paducah Diagnostic Ctr.	$ 1,697.42
Western Baptist Hospital	$ 2,012.00
Dr. Brian S. Kern/Ortho. Inst. of Western Kentucky	$ 8,540.00
Paducah Magnetic Resonance Imaging	$ 740.00
TOTAL:	**$ 13,626.42**

Respondent shall have credit for any amounts paid by it or through its group carrier. However, it shall indemnify and hold Petitioner harmless from any claims made by any healthcare provider for which it is receiving this credit, pursuant to Section 8(j) of the Act.

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

Petitioner sustained a partial thickness rotator cuff tear and developed symptomatic medial epicondylitis. Petitioner testified that despite the improvement she received from physical therapy and injection, she continues to have pain and tenderness in her shoulder and arm. She testified that her pain increases with activity and lingers at times until the following day. She has difficulty driving for long periods of time, and cannot sleep in her natural position with her left arm under her pillow. She continues to experience tingling in her left arm and hand as well as a twinge of pain and weakness when reaching to perform simple tasks such as taking plates out of her cabinet or removing something from her oven and setting it on her stovetop. She was since retired, but her ability to work on her family farm has been adversely affected. She also has difficulty performing basic activities of personal hygiene. She occasionally takes Tylenol for her symptoms.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 7.5% loss of use to the person as a whole for the injury sustained to her left shoulder pursuant to Section 8(d)2 of the Act, and the 7.5% loss of use to her left arm for the injury sustained to her left elbow pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin P. Oswald,

Petitioner,

vs. NO: 13WC 18472

B. Garcia Trucking,

15IWCC0175

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical, evidentiary issues 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 19, 2014, is hereby affirmed and adopted.

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

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

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

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

DATED: MAR 10 2015
o030415
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

OSWALD, KEVIN P
Employee/Petitioner

Case# **13WC018472**

15IWCC0175

B GARCIA TRUCKING
Employer/Respondent

On 8/19/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1775 JOHN H HUSTAVA PC
ANDREW NALFESKI
101 ST LOUIS RD
COLLINSVILLE, IL 62234

3150 JAMES M KELLY
4801 N PROSPECT RD
SUITE 832
PEORIA HEIGHTS, IL 61616

15IWCC0175

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)

KEVIN P. OSWALD
Employee/Petitioner

v.

B. GARCIA TRUCKING
Employer/Respondent

Case # 13 WC 018472

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 **Collinsville, IL**, on **06/25/14**. 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 _____

15IWCC0175

FINDINGS

On the date of accident, **03/13/13**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$29,831.36**; the average weekly wage was **$584.93**.

On the date of accident, Petitioner was **41** years of age, *married* with **2** dependent children.

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

Respondent shall be given a credit of **$7,966.15** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,083.85** for other benefits, for a total credit of **$10,050.00**.

Respondent is entitled to a credit of **$2,083.85** under Section 8(j) of the Act.

ORDER

Respondent is liable for bills as outlined in the attached decision.

Respondent shall be given a credit of $2,083.85 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 is liable for temporary total disability benefits of $389.95/week for 4 weeks, commencing 03/17/13 through 04/20/13, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $7,966.15 for temporary total disability benefits that have been paid.

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

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

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

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

Edward Lee
Signature of Arbitrator

8/13/14
Date

ICArbDec19(b)

AUG 19 2014

STATE OF ILLINOIS)
) ss.
COUNTY OF MADISON)

15IWCC0175

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATOR'S DECISION

KEVIN P. OSWALD,

Petitioner,

vs. Case No.: 13-WC-018472

B. GARCIA TRUCKING,

Respondent.

STATEMENT OF FACTS

Petitioner is employed by Respondent as a truck driver. On 03/13/13, Petitioner was unloading a semi-truck trailer of blocks that had been strapped down for transport. Petitioner was operating a ratchet binder to loosen the straps. Petitioner was standing by the flatbed using a cheater bar when the bar used to operate the ratchet mechanism struck him in the chest. Petitioner testified that he was operating the ratchet with an outstretched left hand while holding the bar with his right hand close to his chest. Petitioner's right hand was no further from his body than 1 inch when the bar struck him in the chest. Petitioner offered an example of a bar which is similar to the one which he alleges stuck him; however, it was not the bar in question. (P.E.23) After the accident, Petitioner continued working full duty the remainder of the day. Petitioner did not seek medical care or notify his employer on 3/13/13 of any accident. Petitioner continued to work full duty for two days after 3/13/13. Petitioner testified that he is a big guy and, because of that, he tried to deal with the injury without seeking medical care.

Petitioner first sought medical care at Highland Priority Care on 3/17/13, four days after he alleges that he was struck by a bar. Petitioner's history was that he lost his footing while applying pressure and a bar popped and hit him in the right side of the anterior chest and ribs. Upon physical examination, Petitioner was found to have clear lungs, full chest expansion, and was in no distress. Petitioner did have tenderness of the right anterior ribs, but there was no bruising of the outside of the skin. There were no rashes, lesions, or other skin markings noted. X-rays of the chest and ribs were noted as showing no fractures. (P.E.1) The radiologist's interpretation of the 03/17/13 X-rays confirmed there were no fractures—only mild degenerative changes of the spine and shoulders were noted. (P.E.2) Petitioner's diagnosis was rib contusion. Petitioner made no complaints of shoulder or cervical spine pain and no tracheal injuries were noted. (P.E.1)

Petitioner followed up at Highland Priority Care on 3/19/13, again only complaining of rib pain. Faint bruising was noted from the medial right rib cage to midline in the 11-12 rib area. Petitioner's diagnosis continued as a right chest contusion. No complaints of shoulder or cervical spine pain were made and no tracheal injuries were noted. Petitioner was taken off work 03/19/13 through 03/22/13. (P.E.1)

Petitioner's only diagnosis remained a right chest contusion in follow up on 04/01/13. It was noted that Petitioner attempted to return to work, but Petitioner felt it was too soon. No shoulder or cervical spine complaints were made and no tracheal injuries were noted. The review of symptoms noted a normal musculoskeletal condition with only tenderness of the 10-11 ribs. Petitioner was released to light duty until 04/04/13 when he was released for full activity. (P.E.1)

On 04/04/13, Petitioner reported to the St. Joseph Hospital emergency room complaining of continued chest pain. No shoulder pain was noted. Petitioner denied neck pain. On exam, the neck was non-tender and supple. There was a normal range of motion of the extremities in the musculoskeletal review. (R.E.3) A 04/04/13 chest CT demonstrated a mediastinal gas collection at the level head of the clavicles. It was postulated that a tracheal tear could have been the cause. (P.E.3) Petitioner was transferred to Barnes-Jewish Hospital on 04/04/13 for further diagnostics regarding this mediastinal gas collection. It was noted that Petitioner moved all extremities well. Petitioner denied this possible tracheal injury was work related on this date. An X-ray of the chest on 04/04/13 again demonstrated no acute injury. It was again noted on this date that Petitioner's description of his alleged accident was a bar hitting him on the right chest below the breast. (P.E.4)

On 04/05/13, Petitioner underwent a diagnostic bronchoscopy. There was very good visualization of the entire trachea and there was no injury or sign of trauma. Petitioner was discharged with no diagnosis of tracheal tear or injury. (P.E.5)

Petitioner's first complaint of neck pain was on 04/08/13 at Highland Priority Care. Although on exam Petitioner was found to have tenderness in the neck below the shoulder level, Petitioner's diagnosis remained only right chest contusion. (P.E.1)

On 04/12/13, further diagnostic testing of Petitioner's chest complaints was undertaken. A chest X-ray on this date showed no acute findings and there was no finding of an area of pneumomediastinum as indicated on the 04/04/13 CT. (P.E.6)

Petitioner followed up with Dr. Freeman at Barnes-Jewish Hospital on 04/16/13 for his chest complaints. Dr. Freeman noted that Petitioner's imaging and bronchoscopy were negative for tracheoesophageal injury. On this date, over a month after his alleged injury, Petitioner first complained of right arm and shoulder pain. Dr. Freeman noted "in retrospect, it (the accident) caused somewhat of a trauma to his right arm and shoulder." However, on exam Petitioner demonstrated full strength in his upper extremities bilaterally and had no deformity in his right shoulder. It was noted in Petitioner's self-assessment on 4/16/13, Petitioner admitted to no functional difficulties and had no problems getting dressed, bathing, grooming, eating, cooking, cleaning, shopping, or driving. Shoulder films showed no acute injury to Dr. Freeman's review.

(P.E.7) The radiologist's impression of the 04/16/13 X-ray of the right shoulder also only demonstrated mild acromioclavicular joint osteoarthritis. (P.E.8)

On 4/20/13, Petitioner's treating doctor, Dr. Aryal, released Petitioner at MMI and returned Petitioner to full duty work doing his regularly scheduled work duties. (P.E.1)

On 05/28/13, Petitioner was seen by Dr. Tang for a 1-1/2 month history of right shoulder pain—which is inconstant with the history on the same date which stated the shoulder bothered Petitioner immediately after the accident. X-rays demonstrated mild acromioclavicular joint osteoarthritis and an ultrasound exam demonstrated an intact rotator cuff. Petitioner was referred for an MRI and taken off work until 06/10/13. (P.E.10)

On 06/06/13, Petitioner returned to Dr. Aryal now complaining of shoulder pain. The only complaint on this date was right shoulder pain. It was noted Petitioner was scheduled for a right shoulder MRI. (P.E.1) On 06/07/13 a right shoulder MR arthrogram demonstrated moderate to severe acromioclavicular joint osteoarthritis and mild glenohumeral joint osteoarthritis. Also demonstrated was tendonopathy of the supraspinatus with question of a linear full thickness extension into the bursal surface of the supraspinatus. There was some tendonopathy of the infraspinatus and subscapularis as well as some focal irregularity of the glenoid labrum at the junction of the posterior and superior aspects. Dr. Tang performed a right shoulder injection on this date. (P.E.11)

On 06/10/13, Petitioner had an X-ray of the cervical spine which demonstrated only degenerative conditions of cervical disc disease and resulting mild diffuse cervical osseous central canal stenosis. (P.E.12) A 06/14/13 MRI of the cervical spine confirmed the impression of the X-ray—degenerative disc disease at multiple levels resulting in spinal canal stenosis. (P.E.13) A CT of the neck performed on 08/02/13 identified a stable small air collection adjacent to the trachea. There was no change noted relative to the 04/04/13 CT of the same area. (P.E.14) Further diagnostic testing was undertaken on 08/05/13 with a barium and water-soluble esophagram which demonstrate no acute findings. (P.E.15) Another consulting physician, Dr. Patterson, opined on 08/05/13 that Petitioner required a repeat bronchoscopy despite no findings in the 08/05/13 exam or contrast swallow testing. (P.E.17) Upon checking in for his repeat bronchoscopy, Petitioner complained of 10/10 pain. The 08/06/13 bronchoscopy did demonstrate a congenital tracheal diverticulum 6 cm below the vocal cords at the 6th tracheal ring. (P.E.16) On 08/09/13, Dr. Patterson opined that the tracheal defect was congenital and believed the questionable air pocket was present prior to the alleged accident—not as a result of the accident. Dr. Patterson opined that the congenital tracheal defect was not responsible for Petitioner's subjective pain complaints. (P.E.17)

On 08/16/13, Petitioner was seen by Dr. Paletta for a Section 12 exam. Dr. Paletta is a board certified orthopedic surgeon, licensed to practice in 4 states. Dr. Paletta is a well published surgeon in the field of orthopedic surgery and has, in fact, been the medical director/team physician for the St. Louis Cardinals baseball team since 1998. In his history to Dr. Paletta, Petitioner stated he was holding the bar with his right hand close to the chest and his left hand was abducted out to the side at the end of the four foot bar. Petitioner told Dr. Paletta that he was unstrapping his load when the strap gave way causing the bar to hit him in the chest under the right pectoralis. Dr. Paletta noted that Petitioner had ongoing right shoulder pain complaints of

uncertain etiology. Dr. Paletta opined that Petitioner had underlying tendonopathy that would not be caused by Petitioner's alleged mechanism of injury, as the blow to the anterior chest was without injury to the shoulder. Dr. Paletta noted that although Petitioner claimed he had shoulder pain from the beginning of his treatment, that complaint was not supported by the medical records as Petitioner's first complaint of shoulder pain was documented a month after the injury. Dr. Paletta also noted that Petitioner's exam was limited by subjective pain which was out of proportion with the objective findings. Dr. Paletta stated that Petitioner's degenerative fraying of the labrum, and any potential rotator cuff injury, would not be consistent with the mechanism of injury. Dr. Paletta's review of the diagnostic studies revealed there was no full thickness rotator cuff tear. Dr. Paletta concluded Petitioner's right shoulder pathology was not related to an alleged work accident on 3/13/13. Dr. Paletta stated that the mechanism of injury would not be consistent with a traumatic rotator cuff tear and Petitioner had evidence of tendonopathy that appeared to be moderately advanced. While Dr. Paletta stated he believed Petitioner would benefit from a diagnostic ultrasound of the shoulder to further delineate the extent of the rotator cuff pathology, it was Dr. Paletta's opinion that the tendonopathy was not related to the work injury, and there was not enough evidence by the MRI scan to support a diagnosis of full thickness rotator cuff tear. Dr. Paletta opined that Petitioner suffered no permanent disability as a result of his employment. (R.E.1)

On 9/9/13, Dr. Kennedy performed a records review of Petitioner's treatment. Dr. Kennedy is a board certified neurosurgeon. Dr. Kennedy stated that at no point did the Petitioner have any finding compatible with cervical radiculopathy, and further noted that Petitioner was found on multiple examinations to have a normal neurological examination. Dr. Kennedy found that the records demonstrated no evidence of injury to the cervical spine, shoulder, or tracheal-bronchial tree as a result of the alleged accident. Dr. Kennedy stated Petitioner had findings on the radiographic reports of cervical degenerative disc disease which pre-existed his work injury, were not aggravated by the work injury, and would not require any type of treatment. Dr. Kennedy reviewed the totality of Petitioner's medical records and Dr. Kennedy found that Petitioner could work full duty without restriction and did not suffer any permanent injury. (R.E2)

On 11/21/13, Petitioner first saw Dr. Felix Ungacta for right shoulder pain. Dr. Ungacta recited a history in which Petitioner had right shoulder pain for 8 months. In his history, Dr. Ungacta stated the bar forced Petitioner's arm backwards and since that time Petitioner has had significant pain. Dr. Ungacta's ultrasound exam was negative for acute injury which lead Dr. Ungacta to diagnose a right rotator cuff strain versus tendonitis. Petitioner was taken off work for 4 weeks. On 01/15/14, Dr. Ungacta saw Petitioner for a follow up with Petitioner noting a pop in his right shoulder during therapy. It was noted since that time, Petitioner could not lift his right arm. In his history, Dr. Ungacta relates another new version of accident events in which Petitioner was hit in the chest by the bar and tried to brace himself. Dr. Ungacta stated Petitioner related that he used his right arm to brace himself by grabbing onto the truck. Based on this history, Dr. Ungacta opined that the "patient's report of the mechanism of his injury at which time a bar hit him across his chest and he attempted to brace himself by grabbing onto the truck" led Dr. Ungacta to believe that Petitioner's complaints were related to his alleged work accident. Dr. Ungacta's ultrasound on this date suggested a rotator cuff tear. (P.E.18) A 01/21/14 MRI demonstrated moderate to severe degenerative changes along with a complex partial tear of the rotator cuff tendon. (P.E.20)

Petitioner returned to Dr. Ungacta on 01/27/14. In his history on this date, Dr. Ungacta relates a new version of events in which Petitioner was struck in the chest by the bar which then slipped up underneath Petitioner's right arm and caused his right arm to abduct. Dr. Ungacta stated again Petitioner tried to brace himself and in this way pinned the bar underneath his right arm. Dr. Ungacta stated "he (Petitioner) clearly stated to me today that he attempted to brace himself at that time with the bar underneath his arm." Dr. Ungacta, based on this history, stated it was conceivable that this mechanism of injury could cause a rotator cuff tear. Dr. Ungacta kept Petitioner off work until 02/17/14. (P.E.20)

On 02/17/14, Petitioner followed up with Dr. Ungacta. On this date Dr. Ungacta recommended a right shoulder arthroscopic rotator cuff repair. Petitioner was kept off work for an additional 4 weeks. (P.E.20) Petitioner underwent right shoulder arthroscopic rotator cuff repair and subacromial decompression and bursectomy by Dr. Ungacta on 03/20/14. (P.E.21) Petitioner followed up with Dr. Ungacta on 03/27/14 in which he was prescribed physical therapy and kept in a sling for 5 weeks. Petitioner was kept off work for 6 weeks for his shoulder surgery. Petitioner followed up again with Dr. Ungacta on 04/21/14 when his sling was discontinued and Petitioner was prescribed further physical therapy and kept off work for another 6 weeks. Petitioner followed up again on 05/29/14 and Dr. Ungacta continued Petitioner's physical therapy and no work for another 6 weeks. (P.E.18) Petitioner has attended physical therapy at Apex Physical Therapy from 01/15/14 through 05/21/14. (P.E.19)

On cross-examination, Petitioner admitted to not seeking medical care or notifying his employer until the week after the alleged accident. (A.T.33) Petitioner testified that he failed to notify his employer or seek medical care because he was over 6' tall and 275 pounds and thought he could "rub it off." (A.T.30) However, medical records from 01/24/13 demonstrate prior shoulder pain. (R.E.4) Medical records from 02/05/13 also demonstrate prior treatment for shoulder pain. (R.E.5) When asked to qualify his prior diagnosed shoulder pain, Petitioner testified it was just shoulder soreness which was not attributed to any accident. (A.T.39)

Petitioner also testified on cross-examination that the position he was in during the alleged accident was with his left arm extended to the end of the bar in question, and his right hand within an inch or two of his body. (A.T.37) Petitioner's testimony was consistent with the history given to Dr. Paletta. (R.E.1) However, Petitioner's testimony contradicted other medical records. Dr. Ungacta, on 01/15/14, reported that Petitioner was unstrapping a load when the bar hit Petitioner in the chest and Petitioner tried to brace himself with his right arm. Dr. Ungacta further stated that Petitioner attempted to brace himself by grabbing onto the truck with his arms. (P.E.18) Petitioner's testimony contradicted Dr. Ungacta's history of 01/15/14 and 01/27/14. Petitioner refuted Dr. Ungacta's history of events, denying that he ever grabbed his truck to brace himself and affirmed that his testimony as to the mechanism of the injury was the correct version of events. (A.T.43)

On cross-examination, Petitioner also admitted to certifying to the Illinois Department of Employment Security that he was ready, willing, and able to work when he applied for unemployment benefits. (A.T.45) Petitioner received unemployment benefits from 3/24/13 through 6/1/13. (R.E.6)

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

In support of the Arbitrator's Decision relating C: "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?," the Arbitrator reaches the following legal conclusions:

The Arbitrator finds that Petitioner provided evidence that while he was attempting to loosen the straps to unload the concrete blocks from a flatbed trailer, the strap gave way and the bar hit him in the chest. Petitioner's testimony was unrebutted. Therefore, Petitioner has proven that he suffered an accident on 3/13/13.

In support of the Arbitrator's Decision relating F: "Is Petitioner's current condition of ill-being causally related to the injury?," the Arbitrator reaches the following legal conclusions:

The Arbitrator finds that Petitioner's condition of ill-being as it relates to his chest contusion is causally related to the injury. The Arbitrator finds that Petitioner's condition of ill-being as it relates to his cervical spine, right shoulder, and tracheal-bronchial tree are not causally related to the injury.

The unrefuted evidence demonstrates Petitioner was struck in the chest by a bar while unloading his truck on 03/13/13. Petitioner's diagnosis was a chest contusion. Specifically, the Arbitrator finds Petitioner was struck by the bar on the right, anterior side of the chest in the area of the 11-12 ribs based on the unrefuted medical evidence. The contusion did not result in bruising or swelling. The Arbitrator finds Petitioner's chest contusion symptoms were resolved by 04/20/13—the date Petitioner's treating doctor, Dr. Aryal released Petitioner from care to return to full duty work.

As to Petitioner's alleged tracheal injury, the Arbitrator finds the medical records from the 08/06/13 bronchoscopy, Dr. Patterson's record of 08/09/13, and Dr. Kennedy's 09/09/13 report to be unrefuted—Petitioner had a congenital tracheal defect which was neither aggravated or accelerated by Petitioner's work accident. The Arbitrator finds that the mechanism of injury, a bar striking the anterior right chest in the area of the 11-12 ribs, could not have caused, aggravated, or accelerated Petitioner's congenital tracheal defect which was 6cm below the vocal cords. The medical opinions from Dr. Patterson, a treating doctor, and Dr. Kennedy are consistent, credible, and unrefuted. The Arbitrator finds Petitioner's tracheal condition is not causally related to the accident and Respondent is not responsible for Petitioner's treatment for his congenital tracheal condition.

As to Petitioner's cervical spine complaints, the Arbitrator finds that Petitioner's complaints are not causally related to Petitioner's work accident. Petitioner made no complaints of neck pain until 04/08/13—approximately 1 month after Petitioner's accident. Moreover, Petitioner specifically denied neck pain on 04/04/13. The Arbitrator finds Petitioner did not

introduce evidence which causally related Petitioner's cervical complaints to his work-related accident and no causation opinion from any physician. The Arbitrator finds Dr. Kennedy's opinion to be credible that the medical records demonstrate no relation between Petitioner's cervical complaints and the work accident. The medical records demonstrate Petitioner suffers from degenerative conditions to his cervical spine. Based on Petitioner's testimony, and the history he related to various doctors, up to and including Dr. Paletta, the Arbitrator finds the mechanism of injury does not support an injury, aggravation, or acceleration of Petitioner's cervical spine.

As to Petitioner's shoulder complaints, the Arbitrator finds that Petitioner's complaints are not causally related to Petitioner's work accident. Petitioner's testimony regarding his work accident does not support a mechanism of injury which would cause right shoulder injury. Petitioner's placement of his right hand within 1 to 2 inches of his chest would not support an injury to the right shoulder when it hit Petitioner's chest. Additionally, the Arbitrator finds Petitioner's testimony incredible that he suffered shoulder injury on 03/13/13. Petitioner made no shoulder complaints until 04/16/13. The Arbitrator finds, in light of Petitioner's testimony that he sought medical care prior to his work accident for non-traumatic shoulder soreness, Petitioner would have sought medical treatment for a shoulder injury if a shoulder injury was incurred on 03/13/13.

The Arbitrator finds Dr. Paletta's opinion specifically regarding Petitioner's alleged shoulder injury to be more credible than Dr. Ungacta. Dr. Paletta is a credible orthopaedic surgeon who, upon hearing a description of the mechanism of injury consistent with Petitioner's testimony, found that Petitioner's injuries would not have been the result of this alleged accident. Dr. Ungacta, seeing Petitioner for the first time 8 months after the alleged accident, is unable to provide a consistent history on which to base a credible opinion. Dr. Ungacta's history is not supported by the unrefuted medical evidence. In fact, Petitioner's own testimony refuted Dr. Ungacta's history to the extent that it contradicted Petitioner's version of events which was the same as given by Dr. Paletta. Dr. Ungacta's version of events, which is not corroborated by any of the prior medical records or Petitioner's testimony, is flawed and, as such, Dr. Ungacta's opinion relying on a flawed history is equally flawed. The Arbitrator finds Petitioner was struck by the bar in the right anterior chest in the area of the 11-12 ribs. Dr. Ungacta's history in which he describes Petitioner being hit by the bar and the bar driving under Petitioner's right arm while Petitioner braced himself by grabbing onto the truck does not correlate with Petitioner's testimony, the medical records, or the Arbitrator's findings. As such, Dr. Ungacta's opinion is discounted.

In summary, the Arbitrator finds that Petitioner's chest contusion is causally related to Petitioner's work accident and was resolved by 04/20/13. The Arbitrator finds that Petitioner's tracheal, cervical, and shoulder complaints are not causally related to Petitioner's work accident and, therefore, are not the responsibility of Respondent.

In support of the Arbitrator's Decision relating to J: "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?," the Arbitrator reaches the following legal conclusions:

The Arbitrator's findings with respect to accident and causal connection are incorporated herein. The Arbitrator finds that Petitioner's medical care up to and including 04/20/13 was reasonable and necessary, except any medical care related to Petitioner's tracheal, cervical, and shoulder complaints. Specifically, the Arbitrator finds Respondent is responsible for the following bills, pursuant to the fee schedule amounts, which Petitioner entered into evidence:

HSHS Medical
DOS: 03/17/13—Amount $135.00
DOS: 03/19/13—Amount $233.00
DOS: 04/01/13—Amount $81.00
DOS: 04/08/13—Amount $135.00

St. Joseph Hospital
DOS: 03/17/13—Amount $716.00
DOS: 04/04/13—Amount $2545.75
DOS: 04/12/13—Amount $360.00

Mid-America Radiology
DOS: 03/17/13—Amount $41.82
DOS: 03/17/13—Amount $44.08
DOS: 04/12/13—Amount $41.82

The Arbitrator finds Respondent's total liability for bills, prior to applying the fee schedule, is $4,333.47. The Arbitrator finds that Respondent is entitled to an 8(j) credit in the amount of $2,083.85 as an offset to the amount owed by Respondent.

In support of the Arbitrator's Decision relating to L: "What temporary benefits are in dispute," the Arbitrator reaches the following legal conclusions:

The Arbitrator's findings with regard to accident and causal connection are incorporated herein. Based on those findings, Petitioner is entitled to TTD from 3/17/13–4/20/13 when petitioner was released at MMI by his treating physician, Dr. Aryal. While the Arbitrator finds that being off work completely for a minor chest contusion which resulted in no bruising is unreasonable, the unrefuted evidence shows Petitioner was not offered a light duty job during this time period. At Petitioner's TTD rate of $389.95 based on the stipulated average weekly wage of $584.93, Respondent is liable for $1,559.80 representing 4 weeks of TTD.

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

Sonya Sylvester,
Petitioner,

15IWCC0176

vs.

NO: 11WC 1865

Winners Lounge,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical, 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 23, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,700.00. 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: MAR 10 2015
o030315
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

SYLVESTER, SONYA
Employee/Petitioner

Case# **11WC001865**

WINNERS LOUNGE
Employer/Respondent

15IWCC0176

On 4/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0564 WILLIAMS & SWEE LTD
JEAN SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
JAMES J MANNING
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sonya Sylvester
Employee/Petitioner

v.

Winners Lounge
Employer/Respondent

Case # 11 WC 01865

15IWCC0176

An *Application for Adjustment 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 **February 27, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0176

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

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

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

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

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

In the year preceding the injuries, Petitioner earned **$2,009.07**, respectively; and the corresponding average weekly wages were **$160.00.**

On the date of the first accident, Petitioner was **38** years of age, ***single*** with **3** dependent children.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $160/week for 10 weeks, because the injuries sustained caused the 2% 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

4/21/14
Date

ICArbDec p. 2

APR 23 2014

FINDINGS OF FACT

Petitioner, a 38 year old part-time bartender/waitress, sustained an accidental injury that arose out of and in the course of her employment by Respondent on December 6, 2008. Prior to this date, Petitioner had worked 1 ½ years for Respondent. Petitioner testified that her job duties included stocking, filling glasses of beer, washing glasses, filling ice bins, cooking on a grill, changing garbage, and cleaning up spills. Petitioner denied any cervical or left arm pain prior to December 6, 2008.

Petitioner testified that on December 6, 2008, she was lifting a keg of beer that weighed approximately 100 pounds when she felt an immediate shooting pain into her left arm. Petitioner said that it felt as though the upper part of her left arm was broken.

Petitioner presented to Eastland Chiropractic Center on December 8, 2008 where she came under the care of Chiropractor Chris Hoelscher. Petitioner completed a patient intake form as well as a Pain Drawing which documents severe pain in the front and back of her upper left shoulder going down to the left elbow. In the intake form Petitioner also checked that she was experiencing neck pain, neck stiffness, arm/shoulder pain, numbness in her hands/fingers, back pain and leg pain. Dr. Hoelscher records show x-rays were taken of Petitioner's cervical area which demonstrated decreased disc space at C5, hypocervical lordosis and a reversal of the cervical lordosis. Dr. Hoelscher's working impression as of December 8, 2008 was cervicobrachial syndrome and disc involvement C5. (PX 2)

Dr. Hoelscher provided chiropractic treatment through January 23, 2009. During that period x-rays of the cervical and thoracic spine were taken on January 12, 2009 which relevant findings demonstrated spondylosis at the C4 and C5 disc levels. (PX 2)

Petitioner testified that she did not notice improvement while treating with Dr. Hoelscher. As a result, she stopped treating with Dr. Hoelscher and continued to work. Petitioner provided that while working she continued to experience cervical pain and developed numbness into her hands. She continued to work for Respondent through August 2009.

On November 2, 2009, Petitioner presented to the emergency room at St. Joseph Medical Center with complaints of right leg pain which had developed over the prior two weeks. Petitioner was diagnosed with right radicular pain and prescribed medication. A MRI was also recommended which when performed on November 5, 2009 revealed disc desiccation at L4-L5 and L5-S1. There was minimal central spinal canal and bilateral neural foraminal narrowing at L4-5. Also noted was an annular tear at L5-S1 without neural compression. (PX 6)

Petitioner returned to the emergency room at St. Joseph Medical Center on November 19, 2009 for symptoms of low back pain and numbness down her right lower extremity with a sudden onset. Noted in the records was that the November 5th MRI showed a mild annular tear without any evidence of disc herniation or spinal stenosis. Petitioner was assessed with right lower extremity numbness of unknown etiology. (PX 6)

Petitioner again returned to the emergency room at St. Joseph Medical Center on January 4, 2010. The triage screening states that the chief complaint was a ruptured disc in the lower back with complaints of numbness in the right arm and leg. Petitioner was diagnosed with "pain to right side of back – down right arm." MRIs of the cervical and lumbar lumbar spine were ordered. (PX 6)

Petitioner underwent a cervical MRI on January 7, 2010 which the radiologist read as showing a small focal right paracentral disc herniation at C3-4 which produced a mild degree of central stenosis; a moderate sized broad based central disc herniation with mild to moderate central stenosis and partial effacement of the ventral thecal sac at C4-C5; and a moderate to large sized focal left paracentral disc herniation with indentation of the ventral aspect of the left side of the cord at C5-C6. (PX 6)

Petitioner was next seen by her primary care physician, Dr. Shilpa Mehta, on January 11, 2010. Dr. Mehta's office note of January 11, 2010 documents that Petitioner presented as a new patient to get established for emergency room follow up on her neck pain and back pain. She provided a history of excruciating back pain and neck pain for the last two or three months with radiating pain to the right arm and right lower extremity with some numbness and tingling. The office note documents that Petitioner provided that she previously worked as a bartender and would occasionally perform heavy lifting, but, other than that, she did not remember any major trauma or injury. Petitioner also reported that she had similar symptoms and had gone to a chiropractor. She stated that initially it didn't get better, but subsequently got better on its own in 3 or 4 months later. Dr. Mehta noted that Petitioner was going to nursing school as a CNA at Heartland and did not want any major procedures or surgeries. Dr. Mehta stated that Petitioner had Sisters charity and was not looking for surgery at this point. Dr. Mehta stated that Petitioner wanted to finish her nursing school and that neurosurgeons do not take Sisters charity. Dr. Mehta stated that clinically, Petitioner was stable and that she could try non-surgical options. Dr. Metha assessed 1.) moderate C5-C6 disc herniation and L4-5 disc herniation with moderate spinal stenosis; and 2.) cervical and lumbar radiculopathy. The doctor referred Petitioner to Millenium Pain Center for possible epidural injections. (PX 3, RX 4)

On January 20, 2010, Petitioner presented to Millenium Pain Center where she came under the care of Dr. Benyamin. Petitioner gave a history of low back pain radiating into her right lower extremity as well as a six month history of pain into her left and right upper extremities. Dr. Benyamin assessed Petitioner with a right cervicalgia and arm pain; left sided herniated disc at C5-6 and C6-7; right sided herniated disc at C4-5; right sided low back and leg pain; and SI degenerative disc disease. The doctor ordered an EMG of both extremities. (PX 8)

Pursuant to Dr. Benyamin's request, Petitioner underwent the ordered EMG on February 9, 2010. Same revealed mild bilateral carpal tunnel, slightly worse on the right side. Mild radiculopathy was noted at L5. Also noted was that there was no evidence of peripheral neuropathy (PX 5)

Petitioner returned to Dr. Benyamin on February 24, 2010. At that time, the doctor administered an interlaminar cervical epidural steroid injection. Petitioner underwent a subsequent cervical epidural injection administered by Dr. Benyamin on March 24, 2010. (PX 6)

In the interim, Petitioner saw Dr. Mehta on February 26, 2010. Petitioner referenced the epidural from Dr. Benyamin the previous week and told Dr. Mehta that she was not having any pain and felt great. On follow up examination with Dr. Mehta on March 29, 2010, April 29, 2010 for a recheck of her hypertension, Petitioner voiced no complaints for concerns with her neck pain, back pain, or upper extremity problems.

Petitioner next received medical treatment in the emergency room at St. Joseph Medical Center on May 4, 2010 for complaints of back pain. Petitioner gave a history that she was working in her yard over the previous weekend and was planting flowers. While performing that activity, Petitioner felt that she had pulled something in her back and/or right hip. (PX 6) Petitioner testified that the occurrence caused such excruciating pain it brought her to tears.

Petitioner resumed treating with Dr. Benyamin and underwent a further series of cervical epidural steroid injections on May 12, 2010 and July 14, 2010. She later underwent a right sacroiliac joint injection on September 29, 2010.

Petitioner's last documented medical treatment came on November 12, 2010 when she was seen at the Millenium Pain Clinic with complaints of mid thoracic pain which radiated to the posterior neck and low back pain with radiation into the bilateral lower extremities. She also complained of weakness in her right hand. Since that time, Petitioner has not undergone any further medical treatment. (PX 6)

At Respondent's request, Petitioner underwent a Section examination with Dr. David J. Fletcher on September 20, 2011. Petitioner gave a history that her symptoms first began on December 8, 2008 while lifting a keg of beer. After performing an examination and reviewing medical records, Dr. Fletcher diagnosed right rotator cuff pathology, cervical and lumbar disc pathology-no neurological deficit-age-related degenerative changes. Dr. Fletcher stated that he did not believe that a causal relationship existed between Petitioner's current condition of ill-being and her accident. The doctor based his opinion on the gap in treatment, the mechanism of injury, the limited work hours, and the failure to report improvement in symptoms after she was no longer employed by Respondent in August of 2009. Dr. Fletcher also noted there was evidence that Petitioner had symptomatology and chiropractic treatment in Florida prior to this accident. (RX 1)

Dr. Fletcher also testified via deposition in this matter. Dr. Fletcher did not believe there was a causal connection based on the his review of the medical records, the gap in treatment, and the mechanism of injury (RX 2) Dr. Fletcher felt that Petitioner sustained more of a shoulder strain type of injury based on a localizing of the symptoms as depicted in the pain drawing from the chiropractor and also the mechanism of injury which was devoid of any kind of axial loading or violent jerking type of injury to the cervical spine (RX 2, pp. 9-11, 24) Dr. Fletcher testified as to his interpretation of the cervical MRI report as showing multi-level degenerative changes and some stenosis. According to Dr. Fletcher, there was no obvious evidence of a major disc protrusion or herniation that was impinging on the C5 nerve root and that the findings on MRI were consistent with somebody of Petitioner's age to have these age-related degenerative changes. (RX 2, pp. 18-20) The doctor further provided that upon his examination of Petitioner on October 6, 2011, the neurological examination of her cervical spine was completely normal. There was no evidence of any decreased cervical nerve root reflexes (RX 2, p. 18) Dr. Fletcher could find no evidence of any kind of cervical radiculopathy (RX 2, p. 20)

Dr. Fletcher testified that he also performed a functional capacity evaluation on Petitioner which reflected a consistent effort. The FCE demonstrated that Petitioner could perform light to medium work restrictions (RX 2, pp. 24-25) Dr. Fletcher opined that Petitioner was at MMI for the December 6, 2008 accident after she completed treatment with the chiropractor (RX 2, p. 27) On cross-examination, Dr. Fletcher was posed as to whether the results of the MRI could explain Petitioner's left and arm pain, Dr. Fletcher stated that the findings would be of long standing nature and would not be related to an acute traumatic event. He went on to state that an acute injury could aggravate a condition which could make one symptomatic and cause some pinched nerve or radicular type of complaints that could be similar to what Petitioner manifested when she initially treated with the chiropractor. (RX 2, pp. 29, 30) Dr. Fletcher also testified that based on Petitioner's description of accident, same would be more typical of causing shoulder pathology rather than neck pathology. The doctor added that if there were some kind of turning or jerking the neck involved, same could cause a disc herniation. (RX 2, p. 34) On re-direct examination, the doctor opined that there was no causality between keg incident and Petitioner's right arm symptoms. The doctor noted that it was clear Petitioner had no right arm complaints after her initial treatment. (RX 2, p. 35)

Dr. Hoelscher testified by deposition of October 31, 2012. Dr. Hoelscher testified that he treated Petitioner on December 8, 2008 for cervical pain and left arm pain which occurred after she lifted a keg in the cooler. (PX 1, p. 5) Dr. Hoelscher stated that Petitioner reported the pain radiated down to her left elbow and that it was a 9

out of 10 on a pain scale. (PX 1, p. 6) Dr. Hoelscher testified on examination Petitioner had limited flexion and extension in her cervical spine as well as limited lateral flexion both left and right. Dr. Hoelscher said that the foraminal compression test was positive centrally and laterally and that distraction was positive with shoulder decompression. Dr. Hoelscher opined that his testing indicated that Petitioner had some nerve involvement in her neck. (PX 1, p. 7)

Dr. Hoelscher testified that when he treated Petitioner, he thought that she had an irritation of nerves that was possibly due to a cervical disc involvement. Dr. Hoelscher said that the x-ray he took showed a reduced disc space at C5-6 which was indicative of disc involvement. Dr. Hoelscher testified that as of December 8, 2008 he diagnosed Petitioner with a cervical radiculopathy due to C5 disc involvement Dr. Hoelscher testified that he met with Petitioner's counsel and reviewed an MRI from January, 2010. Dr. Hoelscher stated that it was his opinion that the MRI confirmed his initial diagnosis of disc involvement at C5. Dr. Hoelscher opined that Petitioner's disc herniation was responsible for her arm pain that she presented to him with on December 6, 2008. Dr. Hoelscher opined that the work accident caused the disc herniation. After January, 2009, Petitioner was lost to treatment and she did not come back (PX 1, pp. 8-11)

On cross examination, Dr. Hoelscher testified that Petitioner did not complain of right shoulder pain. He added, however, the disc herniation was centrally located and could have given symptoms to either side. Dr. Hoelscher testified that he did not think Petitioner had a shoulder problem and that it seemed more like a radicular problem that stemmed from the neck area. (PX 1, p. 15) He added that she did not provide a history of any jerking of her neck or forceful twisting or hyperextension the neck. (PX 1, pp 14-16)

Petitioner testified at arbitration that she had completed her nursing program, but had not obtained employment as a nurse. Other than a one week attempt at working as a bartender at a different place of employment, Petitioner has not worked. Petitioner provided that she has continued to experience cervical pain with radiation into both arms. She has not treated for her ongoing symptoms since 2010.

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

It is axiomatic that Petitioner bears the burden of proving all of the elements of her claim by a preponderance of the evidence. Petitioner did not meet that burden here. There is no competent evidence from which to conclude that there is a causal relationship between Petitioner's present myriad of symptoms to her neck, back, and upper and lower extremities.

It is undisputed that Petitioner sustained an accident on December 6, 2008 when she was lifting a keg of beer that weighed approximately 100 pounds. Petitioner presented to Eastland Chiropractic Center on December 8, 2008 where she came under the care of Chiropractor Chris Hoelscher. Chiropractor Hoelscher saw Petitioner on four occasions: December 8 for a consultation and exam and subsequently on December 9, December 16, and January 23, 2009 for treatment. Petitioner completed a patient intake form as well as a Pain Drawing which documents severe pain in the front and back of her upper left shoulder going down to the left elbow. Although Petitioner checked on the intake form that she was experiencing neck pain, neck stiffness, arm/shoulder pain, numbness in her hands/fingers, back pain and leg pain, Chiropractor Hoelscher provided that she was only complaining of problems with her left shoulder from the left scapular area to the front, upper left shoulder. She was not having any problems with her right upper extremity that were reported to Chiropractor Hoelscher and Petitioner was not having any actual pain in her neck or cervical spine. Furthermore, Petitioner did not report any problems with her low back or the lower extremities involving pain or numbness.

Dr. Hoelscher records show x-rays were taken of Petitioner's cervical area which demonstrated decreased disc space at C5, hypocervical lordosis and a reversal of the cervical lordosis. Dr. Hoelscher's working impression was was cervicobrachial syndrome and disc involvement C5. During the period of treatment x-rays of the cervical and thoracic spine were taken on January 12, 2009 which relevant findings demonstrated spondylosis at the C4 and C5 disc levels. Chiropractor Hoelscher diagnosed a cervical brachial syndrome with C5 nerve root involvement which the chiropractor said could possibly explain the upper left arm pain the Petitioner was experiencing.

Petitioner testified that she did not notice improvement while treating with Dr. Hoelscher. As a result, she stopped treating with Dr. Hoelscher and continued to work. Petitioner provided that while working she continued to experience cervical pain and developed numbness into her hands. She continued to work for Respondent through August 2009.

Between the date of the last chiropractic visit on January 23, 2009 and her emergency room visit at St. Joseph Medical Center on November 2, 2009, Petitioner did not seek any medical treatment for any condition of ill-being that she related to the alleged accident on December 6, 2008.

On November 2, 2009, Petitioner presented to the emergency room visit at St. Joseph Medical Center with complaints of right leg pain which had developed over the prior two weeks. A MRI was performed and showed disc desiccation at L4-L5 and L5-S1. There was minimal central spinal canal and bilateral neural foraminal narrowing at L4-5. Also noted was an annular tear at L5-S1 without neural compression.

Petitioner returned to the emergency room at St. Joseph Medical Center on November 19, 2009 for symptoms of low back pain and numbness down her right lower extremity with a sudden onset. No doctors have causally connected these symptoms to the alleged accident.

Petitioner again returned to the emergency room at St. Joseph Medical Center on January 4, 2010. The triage screening states that the chief complaint was a ruptured disc in the lower back with complaints of numbness in the right arm and leg. Petitioner was diagnosed with "pain to right side of back – down right arm." Petitioner underwent a cervical MRI on January 7, 2010 which showed multiple level degenerative changes in the cervical spine without evidence of any nerve root impingement. No medical doctors treating Petitioner have provided any opinions causally connecting any findings from the cervical spine MRI to Petitioner's claimed accident.

Chiropractor Hoelscher testified that the cervical spine MRI findings could theoretically explain the cervical radiculopathy he diagnosed due to C5 disc involvement. However, a reading of the MRI report illustrates that there was no cord impingement at C4-5, and although there was moderate stenosis at C5-6, there was no alteration of the cord signal at the C5-C6 level.

Dr. David Fletcher, Respondent's examining physician, testified as to his interpretation of the cervical MRI report as showing multi-level degenerative changes and some stenosis. According to Dr. Fletcher, there was no obvious evidence of a major disc protrusion or herniation that was impinging on the C5 nerve root and that the findings on MRI were consistent with somebody of Petitioner's age to have these age-related degenerative changes. Furthermore, upon his examination of Petitioner on October 6, 2011, Petitioner's neurological examination of her cervical spine was completely normal. There was no evidence of any decreased cervical nerve root reflexes. Dr. Fletcher could find no evidence of any kind of cervical radiculopathy. Those factors alone beg the question as to the current condition of ill being, regardless of causation.

Petitioner was next seen by her primary care physician, Dr. Shilpa Mehta, on January 11, 2010. Dr. Mehta's office note of January 11, 2010 documents that Petitioner presented as a new patient to get

established for emergency room follow up on her neck pain and back pain. She provided a history of excruciating back pain and neck pain going on for the last two or three months with radiating pain to the right arm and right lower extremity with some numbness and tingling. The office note documents that Petitioner provided that she previously worked as a bartender and would occasionally perform heavy lifting, but, other than that, she did not remember any major trauma or injury. Petitioner also reported that she had similar symptoms and had gone to a chiropractor. She stated that initially it didn't get better, but subsequently got better on its own in 3 or 4 months later. Dr. Mehta stated that clinically, Petitioner was stable and that she could try non-surgical options. Dr. Metha assessed 1.) moderate C5-C6 disc herniation and L4-5 disc herniation with moderate spinal stenosis; and 2.) cervical and lumbar radiculopathy. The doctor referred Petitioner to Millenium Pain Center for possible epidural injections. Dr. Mehta is silent on whether there was a causal relationship between the symptoms and the accident.

On January 20, 2010, Petitioner came under the care of Dr. Benyamin. Petitioner gave a history of low back pain radiating into her right lower extremity as well as a six month history of pain into her left and right upper extremities. Dr. Benyamin assessed Petitioner with a right cervicalgia and arm pain; left sided herniated disc at C5-6 and C6-7; right sided herniated disc at C4-5; right sided low back and leg pain; and SI degenerative disc disease. Dr. Benyamin subsequently administered a series of interlaminar cervical epidural steroid injections in February. Dr. Benyamin records are silent with respect to whether the need for his treatment was causally connected to the accident.

While treating with Dr. Benyamin, Petitioner saw Dr. Mehta on February 26, 2010. Petitioner referenced the epidural from Dr. Benyamin and told Dr. Mehta that she was not having any pain and felt great. On follow up examination with Dr. Mehta on March 29, 2010 and April 29, 2010, for a recheck of her hypertension, Petitioner voiced no complaints for concerns with her neck pain, back pain, or upper extremity problems. She saw the doctor again on May 7, 2010. Her complaints at that time centered around right hip and low back pain.

Petitioner next received medical treatment in the emergency room at St. Joseph Medical Center on May 4, 2010 for complaints of back pain. Petitioner gave a history that she was working in her yard over the previous weekend and was planting flowers. While performing that activity, Petitioner felt that she had pulled something in her back and/or right hip. She later underwent a right sacroiliac joint injection administered by Dr. Benyamin on September 29, 2010. Again, Dr. Benyamin is silent with respect to causation.

Petitioner's last documented medical treatment came on November 12, 2010 when she was seen at the Millenium Pain Clinic with complaints of mid thoracic pain which radiated to the posterior neck and low back pain with radiation into the bilateral lower extremities. She also complained of weakness in her right hand. Since that time, Petitioner has not undergone any further medical treatment. (PX 6)

As noted above, Petitioner was examined at Respondent's request by Dr. Fletcher. Based on his review of the medical records, the gap in treatment, and the mechanism of injury, the doctor was of the opinion that a causal relationship did not exist between her condition and the accident sustained. Dr. Fletcher felt that Petitioner sustained more of a shoulder strain type of injury based on a localizing of the symptoms as depicted in the pain drawing from the chiropractor and also the mechanism of injury which was devoid of any kind of axial loading or violent jerking type of injury to the cervical spine. Dr. Fletcher interpreted the cervical MRI report as showing multi-level degenerative changes and some stenosis. According to Dr. Fletcher, there was no obvious evidence of a major disc protrusion or herniation that was impinging on the C5 nerve root and that the findings on MRI were consistent with somebody of Petitioner's age to have these age-related degenerative changes. The doctor further provided that upon his examination of Petitioner on October 6, 2011, the neurological examination of her cervical spine was completely normal. There was no evidence of any decreased cervical nerve root reflexes. Dr. Fletcher could find no evidence of any kind of cervical radiculopathy. Dr. Fletcher specifically stated that the MRI findings would be of long standing nature and would not be related to an acute

traumatic event. He went on to state that an acute injury could aggravate a condition which could make one symptomatic and cause some pinched nerve or radicular type of complaints that could be similar to what Petitioner manifested when she initially treated with the chiropractor. Dr. Fletcher also testified that based on Petitioner's description of accident, same would be more typical of causing shoulder pathology rather than neck pathology. The doctor added that if there were some kind of turning or jerking the neck involved, same could cause a disc herniation. In this case there is no evidence suggesting the incident involved any kind of turning or jerking of the neck. Dr. Fletcher opined that Petitioner was at MMI for the December 6, 2008 accident after she completed treatment with the chiropractor.

Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being involving her neck pain, back pain, upper extremity and lower extremity pain is causally connected to the herein work injury. Relying on Dr. Fletcher, the Arbitrator finds that any symptomotology Petitioner may have had reached a state of MMI after she completed treatment with the chiropractor. Thereafter, there is a significant ten month gap in treatment from the time she last saw her chiropractor and when she presented to the emergency room on November 2, 2009 with a reported two week onset of right lower extremity 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?

Based upon the above, the Arbitrator finds that the only causally related medical services are those pertaining to the initial chiropractic treatment immediately following the alleged accident. Those bills have been satisfied. All further medical bills are hereby denied.

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

Dr. Fletcher felt that Petitioner sustained more of a shoulder strain type of injury based on a localizing of the symptoms as depicted in the pain drawing from the chiropractor and also the mechanism of injury which was devoid of any kind of axial loading or violent jerking type of injury to the cervical spine. Dr. Fletcher interpreted the cervical MRI report as showing multi-level degenerative changes and some stenosis. Dr. Fletcher specifically stated that the MRI findings would be of long standing nature and would not be related to an acute traumatic event. He went on to state that an acute injury could aggravate a condition which could make one symptomatic and cause some pinched nerve or radicular type of complaints that could be similar to what Petitioner manifested when she initially treated with the chiropractor. Dr. Fletcher opined that Petitioner was at MMI for the December 6, 2008 accident after she completed treatment with the chiropractor.

Based upon the above, the Arbitrator finds that Petitioner's condition of ill-being which resulted from the December 6, 2008 accident reached a state of permanency when she completed her treatment with the Dr. Chiropractor Hoelscher. As such the Arbitrator that as the result of accidental injuries sustained on December 6, 2008, Petitioner is permanently disabled to the extent of 2% under Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick Morgan,

Petitioner,

vs.

NO: 14WC 3166

Travel Centers of America,

15IWCC0177

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, causation, temporary total disability, medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 25, 2014, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAR 10 2015
o030315
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

MORGAN, PATRICK
Employee/Petitioner

Case# **14WC003166**

TRAVEL CENTERS OF AMERICA
Employer/Respondent

15IWCC0177

On 6/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2424 SAUTER & SULLIVAN LLC
MICHAEL L KNEPPER
3415 HAMPTON AVE
ST LOUIS, MO 63139

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

15IWCC0177

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)

Patrick Morgan
Employee/Petitioner

v.

Travel Centers of America
Employer/Respondent

Case # 14 WC 003166

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 **Mount Vernon**, on **April 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **11/25/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,160.00**; the average weekly wage was $**330.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 19 3/7 weeks commencing November 26, 2013 through the date of arbitration, and continuing thereafter until such time as Petitioner is no longer temporarily and totally disabled, 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, of $1,225.69 to Cross Roads Community Hospital, $1,322.10 to St. Mary's Good Samaritan Hospital and $900.00 to the Orthopedic Center of Southern Illinois, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the MRI and treatment recommended by Dr. David Kovalsky, to include related charges, pursuant to the Medical Fee Schedule.

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

6/20/14
Date

ICArbDec19(b)

JUN 25 2014

15IWCC0177

The Arbitrator hereby makes the following Findings of Fact:

Petitioner, Patrick Morgan is 28 years old and has worked as a porter for Travel Centers of America since January of 2013. Petitioner testified that his job as a porter involved general maintenance including cleaning restrooms, bathrooms and the showers of Respondent's truck stop in Mount Vernon, Illinois. He was also required to mop the floors and take out the trash. Prior to November 25, 2013 he testified that he was able to perform these duties without any problems and was under no medical restrictions of any kind.

On November 25, 2013, Petitioner testified that he arrived for his shift at midnight. He worked a normal day including cleaning bathrooms and other parts of the store. At approximately 5 a.m. he went outside to empty trash cans near the fuel pump portion of the truck stop. He testified that he emptied 7-8 trash bags and loaded them on to a buggy and then pushed the buggy to a dumpster where he lifted the bags over his head and put them in to the dumpster. He then went to the other side of the store to the diesel pumps to repeat the process. He approached a can near the front door of the store and had some trouble removing its lid. He testified that as he reached in to the trash can to pull out a trash bag and felt a pop in his back as he was bent over to lift it. He felt immediate severe pain in his lower back going down his left leg.

Petitioner tried to continue his job, but was unable to do so. He called the front desk and spoke with a co-worker, Alma. She sent another co-worker, Jesse Pigg out to help Petitioner. Jesse finished the process of emptying the trash cans for Petitioner. Petitioner went back inside the store with Jesse. He asked Jesse to call the supervisor, Dena Payne. Ms. Payne arrived approximately 60 minutes later. An accident form was filled out. Ms. Payne drove Petitioner to the emergency room at Crossroads Hospital.

Upon arrival at the hospital, approximately 3 hours after the injury, Petitioner was given a shot of morphine for his pain. The note from Crossroads Community Hospital states Petitioner "presents with pain that is acute, and an injury, lifting trash back [sic] at work and felt a pull in his left lower back, radiating to the left groin and left leg is numb." (PX 2, pg. 9) The doctors took him off work.

On December 1st, Petitioner presented to Good Samaritan Regional Hospital with continued low back pain. The records from Good Samaritan Hospital state that Petitioner presents

> with left low back pain since injuring self at work 6 days ago on 11/25/13 while picking up a trash bag....this is a new problem. Episode onset: 6 days ago. The problem has not changed since onset. The pain is associated with lifting and bending. The pain is present in the low back. The pain affects the left side. (PX 3, pg. 3-4)

The doctor at Good Samaritan ordered x-rays of Petitioner's low back and gave him injections of methylprednisolone and toradol. Petitioner was diagnosed with low back pain radiating to left leg, lumbosacral strain and left sided sciatica. He was advised to remain off work and to follow-up with the Orthopedic Center of Southern Illinois.

Don Kovalsky, MD examined Petitioner at the Orthopedic Center of Southern Illinois on December 4, 2013. The report from the initial exam by Dr. Kovalsky states:

> [O]n 11/25/13 he bent down to pick up some garbage sacks and felt a pop in his lower back. As he stood up he developed pain in his lower back with radiation in to his left buttock and thigh, and a feeling of tingling in his left leg. Subsequently he started developing weakness in his left leg with leg giving out on him. Denies prior back injury, prior back pain or radicular leg pain in the past. (PX 4, pg. 12)

Dr. Kovelsky reviewed lumbosacral spine x-rays and found the disc space heights to be relatively well maintained from L2 to the sacrum. (PX 4, pg. 12) Dr. Kovalsky diagnosed left lumbar radiculopathy L3/L4 with weakness. His records state "Patient needs to have an urgent MRI." (PX 4, pg. 12) Dr. Kovalsky took Petitioner completely off work until he had the MRI.

Dr. Kovalsky examined Patrick for a follow-up on December 11, 2013. At that time he renewed his recommendation for an MRI and stated that Petitioner should remain completely off work until he has the MRI. (PX 4, pg. 4, 16)

Petitioner testified that he provided his supervisor with an off-work slip. He has remained off work since the date of his accident on November 25, 2013. He has not received any temporary total disability benefits, or any other compensation. He has not had the MRI.

Jesse Pigg testified on behalf of Respondent. Mr. Pigg is an employer of the Respondent. He testified that when he and Petitioner arrived at work on November 25, 2013, Petitioner mentioned to him that his back hurt because of new shoes that he was wearing. Later in the shift, he was told by a co-worker that Petitioner had been injured and needed help. Mr. Pigg went out to assist Petitioner to finish emptying the garbage cans. He testified that he believed the garbage bag in the can where Petitioner was injured weighed around 5 lbs. He did not actually see the alleged accident.

Dena Payne, the assistant general manager of Respondent's store testified on behalf of Respondent. She testified that the day before the accident, Petitioner told her that he had pain in his back because he had new shoes. She also testified that she took an accident report and that it was in the office.

Kent Miller, the general manager of Respondent's store, testified on behalf of Respondent. Mr. Miller testified he could not recall any injury taking place. He testified he spoke with Petitioner about an incident that happened at home but he could not recall when that conversation took place and whether it was before, on, or after November 25, 2013.

On rebuttal, Petitioner testified that he did have a conversation with Jesse when their shift began but does not recall any conversations about back pain. He testified that he may have told Ms. Payne that he had back pain the day before, but it was at the end of an 8 hour shift. He testified that prior to November 25, 2013, he had never had any left leg symptoms as he had following the accident on that date.

Petitioner testified that he continues to have severe pain in his low back and left leg. He is unable to stand or walk for periods longer than 15 minutes because his leg goes numb. His leg constantly gives way and he has trouble keeping his balance.

Therefore, the Arbitrator concludes:

1) Petitioner sustained an accident resulting in injuries to his back while bending and lifting a trash bag out of a trash can during the course and scope of his employment on November 25, 2013. Petitioner's description of the accident is consistent with the histories contained throughout the medical records, although some provide more details than others. Respondent offered no evidence to rebut Petitioner's description of the accident.

2) Petitioner's injuries to the low back are causally related to the accident of November 25, 2013. This is based on the records from Cross Roads emergency room, Good Samaritan Hospital and Dr. Kovalsky. Each of the medical providers confirm that the pain in the low back and left leg started following the lifting incident of November 25, 2013. Petitioner testified that he had no previous back injuries and by all accounts, he was able to perform his job as a porter until the accident of November 25, 2013.

   The Arbitrator finds that the testimony from Respondent's employees that Petitioner complained of non-specific back pain prior to the accident on November 25, 2013 is not compelling. Petitioner was able to work without problems prior to the accident. Immediately following the accident, he was in such clear and severe pain that the doctor at the emergency room administered a shot of morphine.

3) The Arbitrator finds that the medical treatment provided by Crossroads Community Hospital, Good Samaritan St. Mary's Hospital and the Orthopedic Center of Southern Illinois, Dr. Kovalsky, was reasonable, necessary and causally related to the accident of November 25, 2013. Respondent is hereby ordered to pay the bills as outlined in Petitioner's Exhibit 1, pursuant to the medical fee schedule.

4) As a result of the accident on November 25, 2013, Petitioner has been temporarily and totally disabled through the date of Arbitration, April 10, 2014, a period of 19 and 3/7th weeks. Respondent is ordered to pay temporary total disability benefits through that date, and to continue payment of these benefits until such time as Petitioner is no longer temporarily and totally disabled as a result of his work injury.

5) Respondent is ordered to authorize and pay for the MRI as recommended by Dr. Kovalsky and to authorize and pay for treatment recommended by Dr. Kovalsky that is reasonable and necessary to cure the affects of the November 25, 2013 work injury.

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

Diane Holt,
Petitioner,

vs.

NO: 10WC 16719
15IWCC0178

Illinois Veterans Home,
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, 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 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: MAR 10 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

o030315
CJD/jrc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOLT, DIANE
Employee/Petitioner

Case# **10WC016719**

15IWCC0178

ILLINOIS VETERANS HOME
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:

0640 KINGERY DURREE WAKEMAN & RYAN
ARTHUR R KINGERY
416 MAIN ST SUITE 915
PEORIA, IL 61602

4664 ASSISTANT ATTORNEY GENERAL
SHUAIB A AHMED
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

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

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

JUL 2 - 2014

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

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

Diane Holt,
Employee/Petitioner
v.
Illinois Veterans Home,
Employer/Respondent

Case # **10** WC **16719**

15IWCC0178

An *Application for Adjustment 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 **5/28/14**. 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 15IWCC0178

On **1/12/10**, 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 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 **$50,223.50**; the average weekly wage was **$965.84**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner failed to meet her burden of proof on the issues of accident and causation. Accordingly, Petitioner's claim for benefits 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.

Gerald Granada
Signature of Arbitrator

6/25/14
Date

JUL 2 - 2014

15IWCC0178

FINDINGS OF FACT

This case involves a Petitioner claiming an injury to her right elbow due to repetitive trauma from her employment with an alleged accident date of October 1, 2009. At issue in this case are the following: 1) accident, 2) notice, 3) causal connection, 4) medical expenses, 5) TTD, 6) nature and extent, and 7) credit.

On October 1, 2009, Petitioner worked for Respondent as a a Physical Therapy Aide III. She was initially hired by Respondent on December 1, 1991 as a certified nurses aide. She testified that her job duties involved assisting patients with the following activities: bathing, dressing, feeding, ambulation, placing them on exercise equipment and sometimes picking up and rolling patients weighing on average 186 lbs. She also assisted patients with range of motion exercises. Her job duties required her to use both her hands and arms on a regular basis.

The Petitioner testified that she previously developed carpal tunnel syndrome in her right hand after an aggressive individual she was working with grabbed her hand and twisted it on March 19, 2007. She filed a workers' compensation claim for this accident and settled that claim for 17.5% loss of use of the Petitioner's right hand and 1% loss of use of the right arm. [RX 4.]

On October 1, 2009, Petitioner saw Dr. Robert Mitchell of Illinois Valley Orthopedics. The Petitioner testified that she was experiencing pain and tingling in her right arm which was worsening and she was dropping things with her right hand. Her primary care doctor, Dr. Joel Leifheit, referred her to Dr. Mitchell, an orthopedic specialist, because she was complaining of right elbow pain. The Petitioner testified that prior to her October 1, 2009 visit to Dr. Mitchell, she had not previously treated or seen a doctor for right elbow pain. Dr. Mitchell's treating note indicated that the Petitioner presented complaining of "right lateral elbow pain for several years in duration." [PX. 2.] Dr. Mitchell also noted that the Petitioner briefly wore a counter force brace on her right elbow. Dr. Mitchell's impression was right elbow lateral epicondylitis and he recommended and administered a Cortisone injection to the Petitioner's right lateral epicondylar region. Dr. Mitchell gave the Petitioner stretching exercises and recommended physical therapy. Dr. Mitchell's treating note makes no indication that her right elbow pain was caused by work related activities.

On November 10, 2009, the Petitioner visited Dr. Mitchell for follow up of her right lateral epicondylitis. [PX. 2.] The Petitioner had been going to occupational therapy. [Id.] The Petitioner indicated to Dr. Mitchell that her right lateral epicondylitis had resolved but that she now had pain over the medial epicondyle. [Id.] Dr. Mitchell's impression was resolved right elbow lateral epicondylitis with newly diagnosed right medial epicondylitis. Dr. Mitchell administered a Cortisone injection over the Petitioner's right medial epicondyle.

On December 1, 2009, the Petitioner visited Dr. Mitchell with new complaints of paresthesias in her right upper extremity in the small and ring fingers. [PX. 2.] The Petitioner indicated that she was having decreased grip strength. Dr. Mitchell's impression was right elbow medial epicondylitis with possible ulnar neuropathy and cubital tunnel syndrome. [Id.] Dr. Mitchell recommended that the Petitioner undergo an EMG for her right upper extremity. He also prescribed a Medrol dose pack and for the Petitioner to continue with therapy. [Id.]

On December 21, 2009, an EMG was conducted on the Petitioner's right upper extremity which indicated mild cubital tunnel syndrome. [PX. 2.]

On December 22, 2009, the Petitioner was discharged from physical therapy after having received 14 sessions since her initial evaluation. [PX. 1.] The discharge summary indicates that the Petitioner had little improvement in pain and decreased strength since her initial evaluation. [Id.]

On January 12, 2010, the Petitioner visited Dr. Mitchell to follow up on the results of her right upper extremity EMG. [PX. 2.] Dr. Mitchell's impression confirmed the Petitioner's mild right cubital tunnel syndrome with medial epicondylitis and possible neuralgia type symptoms. [Id.] Dr. Mitchell referred the Petitioner to an upper extremity specialist, Dr. Jerome Oakey.

On February 12, 2010, the Petitioner visited Dr. Jerome Oakey of McLean County Orthopedics for the first time. [PX. 2.] As of that date, the Petitioner was complaining of medial sided right elbow pain. [Id.] Dr. Oakey assessed the Petitioner with medial epicondylitis and cubital tunnel syndrome in the right upper extremity. [Id.] Dr. Oakey recommended six weeks of elbow splinting. [Id.]

On March 29, 2010, the Petitioner visited Dr. Oakey. Conservative treatment was not helping the Petitioner and Dr. Oakey discussed surgical intervention consisting of a medial epicondylar debridement and repair with intramuscular ulnar nerve transposition as a treatment option. [PX. 1]
]
On April 12, 2010, Dr. Oakey sent a note to Health Alliance Medical Management indicating that the Petitioner's right medial epiconylar debridement and repair and ulnar nerve transposition were not work related. [RX. 6.]

On April 13, 2010, Dr. Oakey performed surgery on the Petitioner at the Center for Outpatient Medicine in Bloomington, Illinois. [PX. 1.] The procedure consisted of a right intramuscular ulnar nerve transposition and right medial epicondylar debridement and repair. [Id.] The Petitioner's postoperative diagnosis was right cubital tunnel syndrome and right medial epicondylitis. [Id.]

On April 21, 2010, the Petitioner visited Dr. Oakey. [PX. 1.] The Petitioner was made a splint for her arm and was shown a home exercise program for her right elbow. [Id.] Dr. Oakey kept the Petitioner off work. Subsequently, Petitioner underwent physical therapy and ultimately released to return to work full duty as of August 18, 2010.

The Petitioner testified she returned to work full duty and the LaSalle VA's timesheets for the Petitioner indicate that she returned to work on August 18, 2010. The LaSalle VA's timesheets indicate that the Petitioner was paid her full wages from April 13, 2010 through May 7, 2010, during which time the Petitioner used sick and vacation time to cover her absence. [RX. 5.] The Petitioner testified that from May 8, 2010 through August 17, 2010, she was on a non-occupational leave of absence from work. Petitioner is now claiming TTD for the time period from April 13, 2010 through August 15, 2010.

On July 6, 2011, at the request of the Petitioner's attorney, Dr. Oakey wrote a narrative report regarding the Petitioner's right elbow injury. [PX. 3, Dep. Ex. 3.] In rendering his narrative report, Dr. Oakey relied on a summary of the Petitioner's job duties, which the Petitioner testified she created herself. [See PX. 3, Dep. Ex. 2.] Dr. Oakey stated that the Petitioner "states that part of her job duties include bathing, dressing, grooming, toileting, feeding, transferring, as well as performing range of motion activities. Should these range of motion activities require elbow flexion and extension on [sic] a repetitive nature, I do believe they could be causally related to the medial epicondylitis and tennis elbow for which I have treated her." [Id. (emphasis added).] Dr. Oakey's July 6, 2011 narrative report makes no mention as to whether the Petitioner's right cubital tunnel syndrome was causally related to her work activities.

On July 6, 2012, Dr. Oakey's deposition was taken. [PX. 3.] In his deposition testimony, Dr. Oakey gave his opinion that the Petitioner's work activities were "causally connected to the cubital tunnel syndrome and medial epicondylitis for which I treated her." [PX. 3, 11:22-12:9-12.] Dr. Oakey opined that the Petitioner's repetitive

work activities, which required "a repetitive elbow flexion and extension," caused the need for the Petitioner's right elbow surgery. [PX. 3, 12:13-23; 17:16-22.] Dr. Oakey did not provide an explanation for his April 12, 2010 note to Health Alliance Medical Management indicating that the Petitioner's right medial epiconylar debridement and repair and ulnar nerve transposition were not work related. [See RX. 6.]
On July 29, 2013, the Petitioner submitted to an IME with Dr. Michael Vender of Hand to Shoulder Associates at the request of the LaSalle VA. [RX. 1.] As of that date, the Petitioner had no complaints as to her right upper extremity and was status post right ulnar nerve transposition at the elbow. [Id.] When asked to opine on whether the Petitioner's right upper extremity condition was causally related to her alleged October 1, 2009 accident date, Dr. Vender stated that the Petitioner's work activities as a physical therapy aide were not sufficiently forceful in nature and would not be considered repetitive. [Id.] As such, he opined that the Petitioner's work activities were not contributory to the Petitioner's right cubital tunnel syndrome and medial epicondylitis. [Id.]

The Petitioner testified that currently, her right elbow will swell up on occasion with heavy activity and that she feels tingling once or twice per week in her arm. The Petitioner testified that she sometimes feels pain in her right arm when she uses it forcefully. The Petitioner has a scar on her right elbow which is approximately 6 inches in length and is indicative of the surgical procedure performed.

Maria Malic testified on behalf of the Respondent. Ms. Malic is currently employed by the Respondent as a Public Service Administrator which is also recognized as a Nursing Supervisor. Ms. Malic testified that as of the Petitioner's alleged October 1, 2009 accident date she was the Petitioner's immediate supervisor. Ms. Malic testified that the earliest point at which she became aware that the Petitioner was alleging her right elbow injury was work related was on July 27, 2012, the date on which the Human Resources Department at the LaSalle VA requested her to fill out a Supervisor's Report of Injury or Illness on behalf of the Petitioner. [See RX. 3.] Ms. Malic confirmed that Respondent's Exhibit 3 was an accurate copy of the report which she received on July 27, 2012 and filled out and signed on August 1, 2012. She testified that had she known about the Petitioner's alleged work related injury sooner, she would have filled out a report sooner. Ms. Malic testified that at no point prior to July 27, 2012 did the Petitioner tell her that her right elbow injury was work related.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet her burden of proof. Petitioner is claiming that she sustained injuries due to repetitive trauma. However, the evidence presented at Arbitration indicates that the Petitioner's job duties were varied in nature. In reviewing the job description prepared by the Petitioner and sent to Dr. Oakey, it appears that as of 2009, the Petitioner's job duties involved the assessment of patients or residents in their varied activities. There are other activities listed by Petitioner involving the daily care of patients that date back to the Petitioner's initial hire in 1991. However, the Arbitrator notes the lack of any evidence indicating the frequency of each of Petitioner's various activities and or the repetitive nature of any of these activities. Furthermore, there is no indication in either the testimony or the medical records that the Petitioner had any complaints contemporaneously with any particular work activitiy. This is supported by the testimony of Petitioner's supervisor, Maria Malic, who denied the Petitioner ever reporting complaints related to her arm or that Petitioner was even filing a work injury claim unti July 27, 2010. And even more telling is the Petitioner's own treating surgeon's medical record indicating that the Petitioner's right medial epiconylar debridement and repair and ulnar nerve transposition were not work related. [see PX. 1 and RX. 6.] Given the lack of evidence on this issue, the Arbitrator finds that the Petitioner failed to prove she sustained an accident on October 1, 2009.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her alleged work accident on October 1, 2009. This finding is based primarily on the Arbitrator's findings with regard to the issue of accident. However, the Arbitrator also notes that the Petitioner's own treating physician, Dr. Oakey indicated in his initial medical records that the Petitioner's right medial epiconylar debridement and repair and ulnar nerve transposition were not work related. [see PX. 1 and RX. 6.] Although Oakey later testified that he believed the Petitioner's condition in her right arm was work related, he does not explain the contradiction with his earlier medical records. Furthermore, Dr. Oakey does not provide any indication of the repetitive nature of Petitioner's job. As such, Dr. Oakey's testimony regarding causation lacks credibility. This finding is further bolstered by the opinions of Dr. Vender, whose opinions the Arbitrator finds persuasive given the evidence presented in this case.

3. Based on the Arbitrator's findings above, all other issues are rendered moot.

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

David Dunn,
Petitioner,
vs.

NO: 13WC 16842

Gingrich Enterprises, Inc.,
Respondent,

15IWCC0179

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, notice, 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 July 14, 2014, is hereby affirmed and adopted.

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

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

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

DATED: MAR 10 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

o030315
CJD/jrc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNN, DAVID
Employee/Petitioner

Case# **13WC016842**

13WC019988

GINGRICH ENTERPRISES INC
Employer/Respondent

15IWCC0179

On 7/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1824 STRONG LAW OFFICES
SEAN OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2593 GANAN & SHAPIRO PC
JESSICA BELL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

15IWCC0179

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Dunn
Employee/Petitioner

v.

Gingrich Enterprises, Inc.
Employer/Respondent

Case # **13** WC **16842**

Consolidated cases: **13 WC 19988**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **May 19, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 20, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,537.76**; the average weekly wage was **$471.88**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$4,788.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$9,101.71** for other benefits, for a total credit of **$13,890.31**.

ORDER

The Arbitrator finds that the Petitioner failed to prove that a causal relationship exists between his employment and his condition of ill-being, therefore, the Petitioner's claim for compensation is denied and 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

July 9, 2014
Date

JUL 14 2014

FACTS:

The Petitioner filed two Applications for Adjustment of Claim which were consolidated at the time of hearing. Both Applications allege an accident date of March 20, 2013. The first Application, case number 13 WC 16842, alleges an injury to both upper extremities and the second Application, case number 13 WC 19988, alleges an injury to the right arm and hand.

On March 20, 2013 the Petitioner was employed by the Respondent as a welder, having been so employed since September 9, 2012. The Petitioner testified that in addition to his welding duties, his job duties included assembling various parts for tractors. The Petitioner described his assembly duties as including the bolting of "tines" weighing three to five pounds each onto a bar using a pneumatic gun. The Petitioner testified that there were eight to twelve tines per bar and he was required to move the tines into position on the bar then bolt them to the bar and then move the assembled bar about three feet. The Petitioner testified that his job also included assembling trailers or "tenders" and assembling "spring packs".

The Petitioner testified that moving and assembling the tines caused "pressure" in his right arm and caused a "pop" and shooting pain from his wrist to his elbow in his right arm. The Petitioner testified that he would also occasionally experience "popping" in his left arm. The Petitioner testified that he never experienced any "popping" in his arms prior to working for the Respondent and that the "popping" began sometime after he started working for the Respondent. The Petitioner testified that, after the first time it happened, he would experience the "popping" about three times each week. The Petitioner testified that he told the Respondent's plant manager about the "popping" in his arm the first time it occurred but no accident report was completed at that time and he continued to work.

The Petitioner testified that on March 20, 2013 he was assembling "spring packs" which required him to twist a bolt into a piece of iron. The Petitioner testified that this was the first time he had assembled "spring packs" for the Respondent and that, as he was assembling a "spring pack", his right arm "popped" and he experienced severe pain in his right arm. The Petitioner testified that he reported the incident to Ross Gingrich, the Respondent's owner and an accident report was completed by Eric Sieben, the Respondent's operations manager. The Petitioner testified that Eric Sieben then took him to IWIN for medical treatment. The Petitioner testified that he followed up with his primary physician, Dr. Alexander Crowe and he was then referred to and treated with Dr. Joseph Newcomer.

The March 20, 2013 IWIN Soap Note reflects that the Petitioner presented there on that date "for initial evaluation of bilateral wrist and bilateral eye injuries." The Petitioner was noted to report that "his right wrist popped again today", and that his wrists began popping while at work approximately 3-4 months before that "with any heavy lifting" and that he also began to have numbness/tingling in the right 3rd & 4th digits and the left 4th digit which was worse with any heavy lifting and radiated up the forearm into the elbow. Following examination of the Petitioner's right and left hands and his eyes, the Petitioner was diagnosed with bilateral wrist tendonitis and vision changes. It was noted that the Petitioner's wrist

symptoms were not consistent with carpal or cubital tunnel syndrome, and that the vision changes were not work related.

The records of Dr. Alexander Crowe demonstrate that the Petitioner was seen by Dr. Crowe on March 26, 2013 and reported that "he was lifting a heavy weight several weeks ago at which time he felt a snap in his right wrist. Since that time he has had numbness in his right index finger and his long finger and he has had some numbness on the ulnar border of his left ring finger." The Petitioner also reported a lot of pain and worsening numbness "when he does any activity with his wrists". The Petitioner was also noted to have reported that "he never had this problem before" and that he had no other injury. Dr. Crowe diagnosed the Petitioner as having "a carpal tunnel syndrome which is much worse on the right arm than on the left". Dr. Crowe took the Petitioner off work "for a period of time" and referred the Petitioner to Dr. Edward Pegg for EMG testing.

The Petitioner underwent the prescribed EMG testing on April 2, 2013 and Dr. Pegg reported that the EMG showed evidence of "severe right ulnar nerve entrapment at the elbow" and no abnormalities of the left upper extremity. Dr. Pegg noted that the right ulnar nerve entrapment "could explain the pains the patient is having that radiate down from the elbow into the hand" and "may also explain some of the symptomatology the patient notes in the right hand".

On April 18, 2013 the Petitioner saw Dr. Joseph Newcomer at McLean County Orthopedics. Dr. Newcomer noted that the Petitioner reported history of a right elbow injury which "occurred about three months ago". Dr. Newcomer noted that the Petitioner reported that he was having to lift 300-pound coil tines with a fellow employee and when he was pulling one of these tines, he felt a pop in his right elbow and had tingling immediately and numbness that never got better. Dr. Newcomer noted that the Petitioner reported that he first felt the discomfort in his wrist but it then settled in his elbow.

Dr. Newcomer's impression was that the Petitioner had a subluxing ulnar nerve which he opined was traumatic in nature and "occurred at the time when he was lifting these 300-pound coil tines." Dr. Newcomer further indicated; "I don't think there is any question that that type of heavy manual lifting, pushing, pulling certainly could have caused the condition of ill-being for which he has been diagnosed with ulnar nerve entrapment at the elbow." Dr. Newcomer also noted that the Petitioner "also has carpal tunnel syndrome as a manual laborer" and he opined; "I don't think there is any question that that type of activity could have aggravated a condition of ill-being".

Dr. Newcomer's recommendation was that the Petitioner undergo right carpal tunnel release, right ulnar nerve decompression and transposition of the right ulnar nerve. Dr. Newcomer reiterated that he believed that "the ulnar nerve is directly related to this incident when he felt a pop and pain shoot down to his wrist" and that "the carpal tunnel is certainly an aggravation".

At the request of the Respondent, the Petitioner was seen and examined by Dr. James

Williams on May 1, 2013. Dr. Williams noted that the Petitioner reported a history of injury in December of 2012 when he was attaching coils to long metal bars with screws and plates and he felt a pop in his right wrist and numbness in his fingers thereafter. After reviewing the Petitioner's medical records and performing a physical examination, Dr. Williams' impression was that the Petitioner did appear to suffer from right-sided median nerve neuritis, as well as right cubital tunnel syndrome secondary to subluxation, as well as subluxation on the left side. Dr. Williams indicated that subluxation is not something caused by injury but it is something one is born with, and that 10% to 15% of the population, including himself, have that condition. Dr. Williams opined that the Petitioner's subluxation was not related to any work-related injury but was something he always had. Dr. Williams recommended a 4 to 6 week trial of elbow extension splinting but acknowledged that the Petitioner could need surgery to resolve the cubital tunnel syndrome which could have been aggravated by lifting the bar with tines if it weighed 200 to 300 pounds as the Petitioner indicated it did.

On May 23, 2013 the Petitioner underwent a right anterior ulnar nerve transposition and decompression and right carpal tunnel release as prescribed by Dr. Newcomer.

The Petitioner testified that the surgery helped his right arm and that he currently has no more tingling in the arm. The Petitioner testified that he does notice some loss of strength in his right arm and that lifting heavy objects is difficult due to that loss of strength. The Petitioner testified that he did return to his regular work for the Respondent and he testified that he continued to do that work until he was laid off "a couple of weeks ago".

The testimony of Dr. Newcomer was admitted into the record as Petitioner's Exhibit 10. Dr. Newcomer testified as to the care and treatment he rendered to the Petitioner and he testified that he last saw the Petitioner on October 10, 2013. Dr. Newcomer testified that at that last visit he determined that the Petitioner was at maximum medical improvement and he released the Petitioner to return to regular work without restrictions as of October 14, 2013. Dr. Newcomer opined that the incident described by the Petitioner could have caused the ulnar nerve subluxation in the Petitioner's right arm and that it caused the ulnar neuritis which ultimately required decompression and transposition. Dr. Newcomer also opined that the Petitioner's work activities aggravated the Petitioner's carpal tunnel syndrome.

The testimony of Dr. Williams was admitted into the record as Respondent's Exhibit 7. Dr. Williams testified as to his examination of the Petitioner and the records he reviewed. Dr. Williams testified that the Petitioner did have right median nerve neuritis consistent with carpal tunnel syndrome and he did have right cubital tunnel syndrome secondary to subluxation. Dr. Williams indicated that the Petitioner's subluxation was something he was born with and he noted that it was also present, although not symptomatic, in the Petitioner's left arm. Dr. Williams opined that the work activities performed by the Petitioner neither caused, aggravated, or contributed to his carpal tunnel or cubital tunnel syndrome.

15IWCC0179

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that at some point after he began his employment with the Respondent, he experienced a "pop" in his right arm and then developed numbness and tingling. The Petitioner testified that he continued to work after that event and that, thereafter, he would experience the same "popping" in his right arm three times a week and in his left arm "occasionally". The Petitioner testified that on December 20, 2013 he was assembling "spring packs" when his right arm popped and became painful. The Petitioner reported an injury and an injury report was apparently completed. A Form 45 was also completed.

The Petitioner was taken by the Respondent's operations manager, Eric Sieben, to IWIN that same day "for initial evaluation of bilateral wrist and bilateral eye injuries." The Petitioner was noted to report that "his right wrist popped again today", and that his wrists began popping while at work approximately 3-4 months before that "with any heavy lifting" and that he also began to have numbness/tingling in the right 3rd & 4th digits and the left 4th digit which was worse with any heavy lifting and radiated up the forearm into the elbow. Following examination of the Petitioner's right and left hands and his eyes, the Petitioner was diagnosed with bilateral wrist tendonitis and vision changes. It was noted that the Petitioner's wrist symptoms were not consistent with carpal or cubital tunnel syndrome, and that the vision changes were not work related.

The Petitioner testified to a specific incident, a "pop" followed by pain in his right arm, while he was performing the duties of his employment, assembling "spiral packs", that occurred on a specific date, March 20, 2012. The incident was reported that same day and the Petitioner was taken for medical treatment that same day by the Respondent's operations manager.

Based upon the foregoing, the Arbitrator finds that on December 20, 2012 an accident occurred that arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that timely notice of that accident was given to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

While the Petitioner testified to a specific event that occurred on December 20, 2012, it is clear from the Petitioner's testimony and the histories contained in the medical records that this was not the first time he experienced a "pop" in his right arm followed by pain and

numbness. The Petitioner testified that he first experienced popping, pain and numbness in his right arm at some point after he commenced his employment with the Respondent and that he would experience the popping and pain in his right arm three times a week, and occasional popping in his left arm, thereafter. The Petitioner did not testify as to a specific date that this occurred but he testified that he first experienced the "popping" when he was moving "tines". While the Petitioner testified in some detail about the "tines" and the process of affixing the "tines" to a bar, he gave little detail as to the other aspects of his job and he testified that his December 20, 2012 injury occurred while he was assembling "spring packs".

The Petitioner came under the care of Dr. Newcomer and was ultimately diagnosed as having right ulnar nerve subluxation, ulnar neuritis, and carpal tunnel syndrome. Dr. Newcomer performed surgery on the Petitioner consisting of a right ulnar nerve decompression and transposition and a carpal tunnel release.

Dr. Newcomer opined that the incident described by the Petitioner could have caused the ulnar nerve subluxation in the Petitioner's right arm and that it caused the ulnar neuritis which ultimately required decompression and transposition. Dr. Newcomer opined that the Petitioner's subluxing ulnar nerve was traumatic in nature and "occurred at the time when he was lifting these 300-pound coil tines." Dr. Newcomer also opined that the Petitioner's work activities "as a manual laborer" aggravated the Petitioner's carpal tunnel syndrome.

Dr. Williams, the Respondent's examining physician, agreed that the Petitioner did have right median nerve neuritis consistent with carpal tunnel syndrome and he did have right cubital tunnel syndrome secondary to ulnar nerve subluxation. Dr. Williams even agreed that surgery might be appropriate for the Petitioner. Dr. Williams opined, however, that the Petitioner's subluxation was something he was born with and he noted that it was also present, although not symptomatic, in the Petitioner's left arm. Dr. Williams opined that the work activities performed by the Petitioner neither caused, aggravated, or contributed to his carpal tunnel or cubital tunnel syndrome.

While the Arbitrator notes the opinions of Dr. Newcomer, the Arbitrator finds the opinions of Dr. Williams to be more reliable and persuasive in the instant matter. In so finding, the Arbitrator notes that Dr. Newcomer is an orthopedic surgeon specializing in shoulder and knee ailments while Dr. Williams is a board certified surgeon specializing in hand and upper extremity surgery. More importantly, the Arbitrator notes that Dr. Newcomer had limited information with respect to the Petitioner's actual job duties while Dr. Williams had job descriptions which he reviewed with the Petitioner. Dr. Williams clearly had a more complete picture of the Petitioner's job and his job duties, than did Dr. Newcomer.

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 his present condition of ill-being is causally relate to the injury of March 20, 2013.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Despite finding that the Petitioner failed to prove a causal relationship with respect to his right arm injury, it is undisputed that the Petitioner underwent medical care by Dr. Newcomer, ultimately resulting in a surgery. Although the Arbitrator found the opinions of Dr. Williams to be more persuasive than those of Dr. Newcomer, the Arbitrator notes that Dr. Williams did indicate it was possible the Petitioner could need surgical intervention to address his subluxing ulnar nerve if he did not respond to conservative care. Although Petitioner did not appear to exhaust conservative care before moving forward with surgical intervention, the Arbitrator finds Dr. Newcomer's treatment, including the surgery, reasonable and necessary. The Arbitrator further notes that the Petitioner was released from care by Dr. Newcomer and determined to be at maximum medical improvement. Despite finding the Petitioner's medical care to be reasonable and necessary, the Arbitrator still finds it is not related to his employment with Respondent based on Petitioner's failure to prove a causal connection. It follows then that the Arbitrator finds the Respondent is not responsible for any of the Petitioner's outstanding medical charges, or reimbursement for any payments made to or on behalf of Petitioner for the provided medical care.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, and (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions with regard to the issues of accident and causation are adopted and incorporated herein.

As the Arbitrator has found that the Petitioner failed to prove his injury was causally related to his employment with the Respondent, the Arbitrator finds that the Petitioner is not entitled to any Temporary Total Disability benefits or an award of Permanent Partial Disability 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrew Magana,

Petitioner,

vs.

No. 13 WC 06231

MEP Auto Service, LLC d/b/a A-Team Tire & Auto,

Respondent.

15IWCC0180

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, expands, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a master mechanic, testified that he worked for Respondent for approximately two years. He characterized his job as generally medium duty and occasionally heavy duty. Petitioner admitted a prior work accident, following which Dr. Hennessy performed a fusion surgery at L3-L4 in 2007. Petitioner returned to work in 2008. Petitioner stated he was able to work full duty and denied having any back problems between 2008 and February 6, 2013. On February 6, 2013, Petitioner reinjured his low back while lifting heavy truck tires.

The medical records in evidence show Petitioner underwent chiropractic treatment with Dr. Lovell from February 8, 2013, through July 15, 2013, reporting no significant improvement. On February 19, 2013, Petitioner saw Nurse Pietrowski, an advanced practice nurse at Loyola Medical Center (Loyola), complaining of severe left-sided low back pain radiating to the thigh and calf, with numbness and tingling. On physical examination, straight leg raise test was

positive on the left, with left-sided weakness. Nurse Pietrowski prescribed medication and physical therapy, and took Petitioner off work. On March 26, 2013, Petitioner followed up with Nurse Pietrowski complaining of persistent left-sided symptoms and reporting no improvement. Physical examination was unchanged. Nurse Pietrowski ordered an MRI. The MRI, performed April 2, 2013, showed postoperative changes at L3-L4 and "[m]ultifactoral, multilevel degenerative changes of the lower lumbar spine *** greatest at L4-L5 where there is borderline spinal canal stenosis and L5-S1 where there is mild-moderate left and mild right neural foraminal stenosis." On April 5, 2013, Petitioner followed up with Nurse Pietrowski complaining of worsening symptoms. Physical examination was unchanged. Nurse Pietrowski noted the MRI findings and recommended epidural steroid injections. On April 9, 2013, Dr. Bajaj performed a left lumbar epidural steroid injection at L5-S1. On May 7, 2013, Petitioner followed up with Nurse Pietrowski reporting only temporary improvement. Physical examination was unchanged. Nurse Pietrowski recommended a repeat injection and continuing physical therapy. On May 31, 2013, Dr. Bajaj performed a second left lumbar epidural steroid injection at L5-S1. In the meantime, Petitioner underwent physical therapy at Accelerated Rehabilitation Centers from February 25, 2013, through March 25, 2013, reporting no significant improvement, and physical therapy at Loyola from April 22, 2013, through June 10, 2013, reporting no improvement and failing to progress.

On June 6, 2013, Petitioner saw Dr. Ghanayem, a spine surgeon, reporting no lasting improvement from the injections. Dr. Ghanayem stated: "[The patient] has had weakness in the L5 distribution in [the] left leg with about 4/5 strength. ¶ At this point, considering it has been over four months since his injury which aggravated his foraminal stenosis at L5-S1 on the left and he has failed to improve with time, physical therapy, and two injections, I have recommended to him an L5-S1 left-sided laminotomy and foraminotomy." Dr. Ghanayem kept Petitioner off work.

On June 19, 2013, Petitioner consulted Dr. Hennessy for a second opinion. Dr. Hennessy noted that in 2007 he performed a laminectomy and fusion at L3-L4, and Petitioner did well after the surgery. On June 19, 2013, Petitioner complained of back pain and left S1 radiculopathy. He reported his back felt fine until the work accident on February 6, 2013. Physical examination findings were as follows: "[The patient's] physical exam showed symmetrically diminished reflexes with no atrophy of the thighs or calves. He had 5/5 strength. A questionably positive straight leg raise for radiculopathy in the left leg. He was able to toe walk and heel walk. He had no numbness today. Vascular function was good distally. He could only flex to 40 degrees with tenderness in the central lumbar spine as well as the left gluteal notch." Dr. Hennessy performed X-rays, which showed grade I spondylolisthesis with some instability at L4-L5. He also reviewed the report from Dr. Ghanayem and the MRI, noting "degenerative disc disease with nearly bone on bone in the L5-S1 disc. L4-5 had the spondylolisthesis nearly reduced in the supine position which again indicates instability." Dr. Hennessy diagnosed spondylolisthesis with evidence of instability at L4-L5 and degenerative disc disease at L5-S1. He recommended a decompression and fusion surgery from L4 to S1, telling Petitioner it would not be unreasonable to try the decompression alone first.

Dr. Hennessy testified via evidence deposition on November 13, 2013, that in January of 2009 he released Petitioner to return to work with a 30 pound lifting restriction and instructed him to follow up. Petitioner did not return to Dr. Hennessy until June 19, 2013. Dr. Hennessy did not think Petitioner was magnifying his symptoms, noting that Petitioner's subjective complaints matched the objective findings. Dr. Hennessy further testified Petitioner could not return to work until he underwent appropriate treatment. Dr. Hennessy provided the following causal connection opinion: "[T]he degenerative disc disease at L5-S1 preexisted the accident but was asymptomatic at the time of his work injury and was made symptomatic. His L4-5 spondylolisthesis *** most likely also preexisted but, again, was asymptomatic and made symptomatic by the accident. The mechanism of injury as described by him lifting tires is capable of causing aggravation to those preexisting conditions." Dr. Hennessy maintained Petitioner failed non-operative treatment and required surgery. On cross-examination, Dr. Hennessy testified that Petitioner's recovery after the 2007 surgery was complicated by delayed fusion. In August of 2008, Petitioner underwent an FCE. The physical therapist questioned the validity of the FCE. Dr. Hennessy noted that Petitioner did not ask to be kept off work.

On July 1, 2013, Dr. Bernstein, a spine surgeon, examined Petitioner at Respondent's request. Dr. Bernstein testified via evidence deposition on April 9, 2014, that Petitioner complained of pain radiating from the left buttock down the left leg and gave a history consistent with his testimony. Dr. Bernstein summarized his physical examination findings as follows: "First, [the patient] demonstrated an inconsistent limp, where initially he had a marked avoidance, antalgic gait on the left side, bearing almost no weight whatsoever on the left leg, and then specifically when I went to observe him leaving the office, he was bearing weight almost equally with a mild limp on the left side and normal step-through, meaning swinging his leg through in a normal fashion. *** ¶ And then in terms of reflexes, he had normal reflexes. He had no atrophy. He had some complaints of pain with range of motion, but he did get his fingers to his mid shins, which is a competent range of motion in the low back. *** ¶ And then when I did the motor evaluation of his lower extremities, he had marked inconsistency on exam in that he demonstrated what I described as complete flaccid paralysis of the left leg from the knee down." Dr. Bernstein reviewed the MRI, noting postoperative changes at L3-L4, degenerative spondylolisthesis at L4-L5 and advanced degenerative changes at L5-S1. Dr. Bernstein continued: "I thought that [the patient's] examination was flagrantly manipulated, and I described that he demonstrated evidence of symptom magnification and exaggeration. The objective [*sic*] findings of paralysis of the left leg, inconsistent weakness of the left leg, cannot be explained by any objective findings, including the MRI scan. There's not adequate nerve root compression or stenosis to explain his presentation." Regarding the necessity of further medical care, Dr. Bernstein stated: "I didn't feel that he presented himself honestly, so I didn't believe that he was representing his symptoms honestly, and therefore I didn't think he merited any further treatment." Dr. Bernstein declared Petitioner at maximum medical improvement and stated he could return to work without restrictions.

Dr. Bernstein further testified that after reviewing medical records from Dr. Ghanayem he issued a supplemental report on July 25, 2013. Dr. Bernstein stated: "[The medical records] didn't alter my opinion regarding my physical examination and my position on the patient, but I understand that if a patient presents to a doctor with spondylolisthesis and leg pain that one of his options is to have either a decompression or decompression and fusion. *** ¶ [I]n terms of surgical options, it would not be unreasonable to consider an outpatient decompression since the patient's pain complex appears to be primarily radicular. *** ¶ And if that failed, I felt the patient would be a candidate for a decompression and fusion."

Dr. Bernstein further testified that after reviewing medical records from 2006 through 2009, including the FCE report from August of 2008, he issued a supplemental report on November 6, 2013. Dr. Bernstein opined that after the accident on February 6, 2013, "reasonable treatment included symptomatic care, physical therapy, and pain medication for a period of 6 to 12 weeks. *** ¶ [A]t the conclusion of that type of care, [the patient] would be at maximum medical improvement." Dr. Bernstein maintained Petitioner required no further treatment and "likely after 6 weeks he should have been able to do light-duty work, and after 12 weeks he should have been able to do full-duty work." Upon further questioning, Dr. Bernstein corrected himself that Petitioner "should be able to return to work within the confines of the [prior] functional capacity evaluation."

On cross-examination, the following colloquy occurred:

"Q. Clarify for me your July 25, 2013 report. I'm not sure I understand. You're saying that the surgery is recommended for this patient or it's not?

A. There were specific questions about this patient's condition, and they were kind of if-then questions. My opinion was that he's not a surgical candidate because of his presentation and the subjective complaints don't match. But if you ask me to look at the MRI scan and say if this patient is symptomatic from this condition, what is the ultimate treatment for it, surgery is the ultimate treatment for it.

Q. So you're saying if you're looking just at the objective findings, the MRI films and the other objective findings you were presented, then he is a surgical candidate?

A. No. What I'm saying is that the condition of spondylolisthesis frequently is treated with surgery when the symptoms are severe enough to justify surgery. Okay? That is the correct treatment for that condition. There are millions of people walking around with that condition who don't need surgery.

Q. Okay. So he came to you with complaints or symptoms, and he has objective findings, you just don't believe the symptoms he gave you, is that correct?

A. That's correct."

In sum, Dr. Bernstein explained his philosophy: "[I]f patients are straightforward and forthright, they're good candidates for surgery. And if they're not, they're poor candidates for surgery."

Petitioner testified that he continues to suffer from pain in the left side of the body and left leg, and wishes to proceed with the surgery. He had not been released to return to work.

The Arbitrator was persuaded by the opinions of Dr. Hennessy and Dr. Ghanayem, but not Dr. Bernstein. The Arbitrator found Petitioner's condition of ill-being was causally connected to the work accident on February 6, 2013, and Petitioner was entitled to the benefits he requested. The Commission agrees and affirms the Arbitrator's award.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 7, 2014, is hereby expanded, affirmed and adopted.

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

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

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

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

DATED: MAR 10 2015
SM/sk
o-2/26/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

MAGANA, ANDREW
Employee/Petitioner

Case# **13WC006231**

MEP AUTO SERVICES
Employer/Respondent

15IWCC0180

On 8/7/2014, 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 0.05% 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:

2988 CUDA LAW OFFICES
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6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW SHERIFF
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)

Andrew Magana
Employee/Petitioner
v.
MEP Auto Services
Employer/Respondent

Case # **13** WC **6231**

15IWCC0180

An *Application for Adjustment 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 **April 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **February 6, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$22,176.84**; the average weekly wage was **$434.84**.

On the date of accident, Petitioner was **44** 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 **$9,737.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,737.14**.

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 **$290.00**/week for **63 2/7^{ths}** weeks, commencing **February 7, 2013** through **April 25, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **February 7, 2013** through **April 25, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$9,737.14** for temporary total disability benefits that have been paid.

Respondent shall pay for the medical services incurred from February 6, 2013 through April 25, 2014, 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 due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall authorize and pay for low back surgery as prescribed by Dr. Ryon Hennessy

No benefits are awarded for penalties and attorneys fees, because Respondent was not unreasonable and its reliance upon its examining physician's opinions.

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

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

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

Signature of Arbitrator

August 7, 2014
Date

AUG – 7 2014

FACTS

Petitioner has been employed by Respondent as a mechanic. Petitioner testified that he had prior back surgery in 2007 while working for a different employer. The surgery, which consisted of an L3-L4 fusion, was performed by Dr. Hennessey, an orthopedic surgeon. Petitioner was released to work in 2008. Petitioner testified that from 2008 to February 6, 2013 he did not have any trouble with his back. Petitioner testified that on February 6, 2013 he was lifting tires on to a balancer machine and reinjured his back. Thereafter, Petitioner underwent unsuccessful conservative medical treatment. Dr. Hennessy has opined that Petitioner has aggravated a pre-existing condition and now requires surgery at the L5-S1 level. Dr. Hennessy testified at an evidence deposition. Another orthopedic surgeon, Dr. Ghanayem, agrees with the need for surgery. Respondent's examining orthopedic surgeon, Dr. Bernstein, disagrees because he does not believe Petitioner. Dr. Bernstein testified at an evidence deposition. Respondent has disputed all further benefits based upon Dr. Bernstein's opinions.

CAUSATION, PAST MEDICAL BENEFITS, PROSPECTIVE MEDICAL BENEFITS, AND TEMPORARY TOTAL DISABILITY BENEFITS

The Arbitrator has reviewed Petitioner's testimony, the medical records, and the medical testimony. The Arbitrator finds that the opinions of Dr. Hennessy and Dr. Ghanayem are persuasive. The Arbitrator further finds that the opinions of Dr. Bernstein are not persuasive.

Therefore, the Arbitrator finds that Petitioner's current condition of ill being is causally related to the accident of February 6, 2013.

Based upon the foregoing, the Arbitrator further finds that the requested benefits shall be awarded.

PENALTIES AND ATTORNEYS' FEES

Although the Arbitrator does not agree with Dr. Bernstein's opinions, it was reasonable for Respondent to rely upon those opinions.

Therefore, Petitioner's claims for penalties and attorneys fees are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Previs Del Olmo

Petitioner,

vs.

No. 07 WC 10029

Milton Industries, Inc.

Respondent.

15IWCC0181

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to an order of remand from the Circuit Court of Cook County. In accordance with the order of the Circuit Court entered on July 16, 2013 the Commission herein states the facts and conclusions of law setting forth the legal and evidentiary bases for its award of temporary total disability, partial permanent disability and medical expenses ordered by the Commission on December 10, 2012 and being advised of the facts and law, finds that Petitioner is entitled to benefits as stated below.

On March 7, 2007, Petitioner filed an application for adjustment of claim in case No. 07WC10029, alleging that on February 12, 2007 he re-injured his back at work. Arbitrator Fratianni held a hearing on January 30, 2012. Arbitrator Fratianni issued a decision on March 30, 2012 finding that Petitioner's current back condition is causally related to the February 12, 2007 work accident and awarded: TTD from April 4, 2007 through December 6, 2007; PPD for the loss of use of the person as a whole to the extent of 25%; medical expenses in the amount of $14,656.68; attorney's fees and finding Respondent eligible for a credit of $22,754.44 for paid TTD.

15IWCC0181

The Petitioner filed a Petition for Review and the matter was fully briefed. The issues on review before the Commission were causal connection, medical expenses, TTD and PPD. The Petitioner also contested findings concerning wages and whether the Petitioner had dependents.

The Commission modified certain findings of the Arbitrator in her March 30, 2012 decision and otherwise adopted and affirmed. The Commission ordered the Respondent to pay to Petitioner temporary total disability benefits of $184.00 per week for 99 2/7 weeks from April 4, 2007 through February 26, 2009 finding this to be the period for which compensation is payable.

The Commission found that causal connection existed between the re-injury asserted by Petitioner and the original work injury of February 12, 2007. The medical records reflect that the Petitioner continued to receive treatment for his low back from Dr. Malek until his last visit on February 26, 2009. At that time Dr. Malek noted that the Petitioner was being managed well with the spinal stimulator and that he had good control of lumbar spine symptoms. Petitioner was determined to be MMI as of that date.

During the ensuing period the Petitioner continued to seek treatment eventually receiving a spinal stimulator which offered him significant, although not complete, relief of his back symptoms. The Respondent failed to accommodate Petitioner's light duty work restrictions until February 26, 2007.

The Commission ordered the Respondent to pay the Petitioner the sum of $173.32 per week for a period of 175 weeks, as provided by Section 8(d) 2 of the Act, having found that the injuries sustained caused permanent partial disability equivalent to 35% loss of the use of the person as a whole. The Commission having reviewed the totality of the medical records, Section 12 report, and testimony of the Petitioner, viewed the evidence of disability differently from the arbitrator and increased the percentage loss to 35% accordingly.

The Respondent asserts that the Petitioner never underwent the surgery for a disc decompression on August 4, 2007. An operative note was prepared by Dr. Hassan reflecting the procedure having been performed. It was also billed by Dr. Hassan. The sole basis for the Respondent's position that the procedure was never performed and hence should not be paid as a medical expense arises from the Petitioner's testimony on cross examination at trial. The Respondent's counsel posed a compound question which was asked through an interpreter that produced an unclear response. At page 36 of the Petitioner's trial testimony counsel for the Respondent asks the following question on cross examination and receives the following response from the Petitioner:

Q. Dr. Hasan in August of 2007 talked about a follow up after a disc decompression which is a type of surgery. They never opened you up and actually did surgery, did they?

A. No, no.

Unfortunately, there was no further clarification of this issue on redirect. There were however exhibits introduced at trial i.e. Dr. Hasan's note and the billing that are persuasive that the surgery was performed and the billing is legitimate. More likely than not the Petitioner's ambiguous testimony is explained by the minimally invasive nature of the percutaneous disc decompression at L4-5 and L5-S1. For the foregoing reasons the Commission found the medical treatment to be reasonable and necessary and ordered the payment by the Respondent of medical bills totaling $196,450.80.

A review of the Petitioner's testimony at trial is replete with answers that indicate a lack of understanding of the question asked. On occasion the Petitioner expressed his difficulty in understanding what was being asked of him.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed on March 30, 2012 is modified as stated in the Commission's prior order of December 10, 2012 and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the order of the Commission entered on December 10, 2012 awarding Petitioner temporary total disability benefits in the amount of $184.00 per week for 99 2/7 weeks from April 4, 2007 through February 26, 2009 shall stand for the foregoing reasons stated in this decision as well as the bases stated by the COMMISSION in its prior order.

IT IS FURTHER ORDERED BY THE COMMISSION that the COMMISSION'S prior order of December 10, 2012 awarding the Petitioner the sum of $173.32 per week for a period of 175 weeks as provided under Section 8(d) 2 of the Act for injuries sustained that caused permanent partial disability equivalent to 35% of the loss of the person as a whole shall stand for the reasons stated in this decision as well as the bases stated by the COMMISSION in its prior order.

IT IS FURTHER ORDERED BY THE COMMISSION that the COMMISSION'S prior order of December 10, 2012 awarding the Petitioner the sum of $196,450.80 for medical expenses under Section 8 (a) of the Act subject to the medical fee schedule shall stand for the reasons stated in this decision as well as the bases stated by the COMMISSION in its prior order.

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

No bond is required for removal of this cause to the Circuit Court, the court having retained jurisdiction in its order of July 16, 2013.

DATED: MAR 1 2 2015
SM /msb
d- 11/5/14
44

Stephen J. Mathis

Charles DeVriendt

Ruth White

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Storage,

Petitioner,

vs.

NO: 07 WC 40871

15IWCC0182

Follett Corporation/Library Resources,

Respondent.

DECISION AND OPINION ON §8(a) PETITION AND PETITION UNDER §19 AND §16

This matter comes before the Commission for consideration of Petitioner's §8(a) Petition and Petition for Penalties and Attorneys' Fees. The issues on Review are whether Petitioner incurred additional medical expenses since approval of the lump sum settlement contract on October 28, 2010 and whether Petitioner is entitled to additional compensation as provided in §19 and attorneys' fees as provided in §16 of the Act. After due consideration, the Commission grants Petitioner's §8(a) Petition and awards additional medical expenses of $9,630.76, but denies Petitioner's Petition for Penalties and Attorneys' Fees for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Arbitration was held on April 4, 2008, May 8, 2008 and June 6, 2008. In a §19(b) Decision dated September 16, 2008, Arbitrator Andros found that Petitioner had sustained accidental injuries arising out of and in the course of his employment on July 20, 2007. On that date, Petitioner, a 44 year old quality service inspector, while pushing a tote on an assembly line his shirt became entangled and he was jerked and twisted. Petitioner continued working after this happened, but started experiencing lumbar radicular pain as the day continued. Petitioner subsequently underwent a number of facet injections and epidural steroid injections without improvement. After seeing Dr. Zelby for a §12 evaluation, Petitioner attempted returning to work on September 26, 2007, but was unable to continue. On February 27, 2008, Petitioner underwent a two-level fusion by Dr. Bernstein, an anterior lumbar interbody fusion at the L4-L5

and L5-S1 levels. At no time following the work accident did treating Drs. Lami, Prunskis or Bernstein release Petitioner to return to work. Regarding accident, the Arbitrator found that the preponderance of evidence was that Petitioner sustained accidental injuries on July 20, 2007. The Arbitrator gave no weight to the unproven allegation of an ATV incident. The Arbitrator found that the history given to the medical providers was consistent in referring to the July 20, 2007 accident. The Arbitrator found causal connection, an aggravation of a preexisting condition (a prior 2005 low back injury from a motor vehicle accident). The Arbitrator adopted the causal connection opinions of Dr. Bernstein and Dr. Bergin and found them more persuasive than §12 Dr. Zelby's no causal connection opinions. The Arbitrator found causal connection for Petitioner's need for surgery. The Arbitrator awarded $161,628.54 in medical expenses subject to the Fee Schedule. The Arbitrator gave credit to Respondent for medical expenses paid; no amount was noted.

On the face sheet of his Decision, the Arbitrator noted that Petitioner's average weekly wage was $326.09 and awarded TTD benefits from July 21, 2007 to July 25, 2007 and from September 27, 2008 through April 4, 2008, a period of 36-6/7 weeks at $326.09 per week. The Arbitrator gave Respondent credit of $3,120.94 for paid TTD benefits. However, in the body of the Decision, the Arbitrator awarded TTD benefits from July 21, 2007 through September 25, 2007 and from September 27, 2007 through April 4, 2008, a period of 36-6/7 weeks at $326.09 per week. The Arbitrator denied penalties and attorneys' fees, finding that Respondent reasonably relied on §12 Dr. Zelby's opinions.

Respondent filed a timely Petition for Review. In its May 21, 2009 Decision and Opinion on Review, the Commission affirmed and modified the Arbitrator's Decision. The Commission noted the TTD dates on the face sheet were incorrect and that the correct dates were in the body of the Decision and the correct TTD period was 36-5/7 weeks. The Commission also corrected the clerical error in average weekly wage to $489.18 and affirmed all else.

A §19(f) Motion was filed, noting that the Decision and Opinion on Review did not state that the Medical Expenses award was subject to the Fee Schedule under §8.2 of the Act. The §19(f) Motion was granted and the Decision and Opinion on Review was recalled.

In its Corrected Decision and Opinion on Review dated June 25, 2009, the Commission added that the Medical Expenses award was subject to the Fee Schedule under §8.2 of the Act and the rest remained the same.

2. The parties entered into a lump sum settlement contract. The Commission awards were noted. The amount of the settlement was $65,000.00, which represented approximately 44% loss of the man as a whole. This was a full and final settlement of all claims under the Workers' Compensation Act and Occupational Diseases Act. The parties agreed to the following: "This settlement includes liability for temporary total compensation, temporary partial compensation, and all medical, surgical, rehabilitation, and hospital expenses incurred, with the exception of the Petitioner's bill from Lutheran General Spine Center for treatment rendered by Dr. Bernstein on February 8, 2010. This bill will be paid by the Respondent pursuant to Section 8 of the Act and the Fee Schedule."

"In regards to any medical expenses incurred after October 6, 2010, the Respondent agrees to pay, pursuant to its obligations under the Workers' Compensation Act, the reasonable and necessary medical expenses incurred by the Petitioner that are causally connected to the accident of July 20, 2007, as long as the Petitioner is a Medicare recipient. If at any time after October 6, 2010, the Petitioner is not receiving Medicare benefits, the Petitioner's medical rights under Section 8 of the Act will cease immediately, effective the date and time that the Petitioner is no longer receiving or entitled to receive Medicare benefits. Furthermore, it is expressly agreed by the parties that the only rights that will remain open as stated above are the Petitioner's rights to medical care under Section 8 of the Act. The Petitioner waives all other rights under Section 8 of the Act upon approval of this contract by the Workers' Compensation Commission."

"Nothing stated above shall be deemed as a waiver by the Respondent of any of its rights under the Act concerning the Petitioner's medical expenses and both parties agree that the Respondent retains all its defenses under the Act to these charges. Review under Section 19(h) and all other rights under Sections 4, 8, 16 and 19 of the Workers' Compensation Act and the corresponding sections of the Occupational Disease Act, with the exception of Section 4(h), Section 19(g) and the Petitioner's medical rights under Section 8(a) as outlined above, are expressly waived by the parties hereto. This settlement represents: approximately 44% loss of use of a man as a whole."

"Finally, the parties agree that the Respondent shall retain all of its rights and remedies under Section 5 of the Workers' Compensation Act following the Illinois Workers' Compensation Commission's approval of this settlement contract." The lump sum settlement contract was approved by Arbitrator Lee on October 28, 2010.

3. On October 15, 2013, Petitioner's attorney filed this Petition for Penalties and Attorneys' Fees and Relief under §8(a). In this Petition, Petitioner's attorney noted the lump sum settlement contract and that future medical rights were kept open. Petitioner's attorney noted that Petitioner had continued with ongoing medical care with the Spine Center and his orthopedic surgeons and that the medical bills have been gone unpaid. Petitioner's attorney argued that the medical bills should be paid and that Respondent's conduct in not paying the medical bills was wrongful, vexatious and without cause. Petitioner's attorney requested that the medical bills be paid and Petitioner be awarded penalties and attorneys' fees. Attached to the Petition were medical bills for Petitioner's visits with Dr. Bernstein on February 25, 2011, August 20, 2011 and September 27, 2012 and the office notes from each of those visits. The charge for each visit was $250.00 and the total charges for the three visits were $750.00. Petitioner's attorney set the Petition to be heard on November 8, 2013 before Commissioner Lamborn. The matter was subsequently continued at various times.

4. Hearings were held before Commissioner Lamborn on May 15, 2014 and June 19, 2014. At the May 15, 2014 hearing, Petitioner testified that Dr. Bernstein had performed a two-level fusion surgery on February 27, 2008. Dr. Bernstein remained his treating surgeon subsequent to the surgery (Tr 11). Petitioner identified Px1 as the lump sum settlement contract he had agreed to (Tr 11). It is Petitioner's understanding that as part of that lump sum settlement contract, his medical rights with Workers' Compensation for his low back were to remain open and that is one

of the reasons he elected to settle his case (Tr 12). When Petitioner settled the case in October 2010, he believed he was going to need more care and treatment for his back (Tr 12). In October 2010, his low back was still very sore (Tr 13). At that time he was supposed to be going to physical therapy, but the workers' compensation people told him he was not allowed to go to therapy (Tr 13). Petitioner has not had formal physical therapy since October 2010 (Tr 14).

On September 23, 2010, Dr. Bernstein released Petitioner with restrictions (Tr 14). Since being released by Dr. Bernstein, Petitioner tried going golfing with his son, who is a golf professional. Petitioner ended up vomiting on the course and getting very sick (Tr 14). Petitioner tried doing some walking with his niece (Tr 14). Petitioner went to Tennessee with his younger brother and consulted for him and talked to a superintendent on a job site to tell him stones were broken and he ended up getting sick again (Tr 14). Petitioner tries to do as much as he physically can (Tr 15). His brother has two garbage cans on wheels and Petitioner tries to wheel those out. He tries to take care of his brother's daughter as much as he can (Tr 15). Doctors have said he should try to walk and Petitioner tries to walk a little bit each day (Tr 15).

Since October 2010, Petitioner's low back has been increasingly gotten very numb. His left leg began to burn and he has a loss of feeling in his left foot. Petitioner has tingling in his left hand and has dizzy spells. He has a lack of energy basically all around and with everything (Tr 15). His low back has gotten worse since October 2010 (Tr 15). He has lost more range of motion in his low back (Tr 16). Dr. Bernstein will not see him because he has not been paid up to date (Tr 16). The last time Petitioner saw Dr. Bernstein was on September 27, 2012 (Tr 16). On that date, Dr. Bernstein believed Petitioner needed a cutanal nerve injection, which he received (Tr 16). Petitioner was getting injections at Comprehensive Pain Care (Tr 16-17). Petitioner did not believe Dr. Bernstein referred him out for pain management on September 27, 2012, but he was not 100% sure (Tr 17). He would have no reason to disagree with Dr. Bernstein's records if they indicate he referred him for pain management on September 27, 2012 (Tr 17). Petitioner has been doing his pain management at Comprehensive Pain Management in Carol Stream, Illinois (Tr 17).

Petitioner testified that Respondent's workers' compensation insurer has not paid for any of his medical expenses since the date the settlement contract was entered (Tr 17). Respondent's workers' compensation insurer has not approved any physical therapy for him and he is desirous of attending physical therapy (Tr 18). Petitioner stated he needs physical therapy to strengthen his lower core and stomach where the surgery was and his lower back and he needs to lose weight (Tr 18). At the request of the workers' compensation carrier, Petitioner saw Dr. Butler (Tr 18). Petitioner testified that Dr. Butler believed he needed to have weight loss and dietary modification (Tr 18). Petitioner was not in physical therapy when he saw Dr. Butler (Tr 19). He has not had any physical therapy since October 2010 (Tr 19). Petitioner believed he had 20 or 25 injections at Comprehensive Pain Care (Tr 19). Petitioner takes Lortab, Hydrocodone, Tramadol and Norco daily (Tr 19). He also takes his high blood pressure and cholesterol medications and a daily dose of baby aspirin (Tr 19). Dr. Bernstein had been prescribing them to him as was the doctor at the pain clinic and then Dr. Wu (Tr 20).

Petitioner testified he was declared Social Security disabled (Tr 20). He got recertified in February 2014 (Tr 20). He believed he was originally Social Security disabled in 2010 or 2011, but was not 100% sure (Tr 20). Petitioner testified he is a Medicare recipient (Tr 20). He is allowed to work when he is on Social Security disability, if he can physically do something. He believes he can earn $1,000 a month and not lose his Social Security disability benefits (Tr 20-21). Since the date of the settlement contract, Petitioner has worked and earned money, but has not ever made over $1,000 a month (Tr 21). He worked for his brother Chris as a consultant with Perimeter Tuck Pointing and Masonry. This entailed talking with the job site supervisor, inspecting stones that come in on trucks and to let the fork lift driver know where to put the stones (Tr 21). Sometimes he did not get paid for this and he was doing it as a consultant just to help his brother and he never made more than $1,000 a month (Tr 21-22). Petitioner testified his Medicare has remained in effect since the date he got it to the present time (Tr 22). He still has the Medicare card today (Tr 22). Petitioner currently takes Norco as needed and some days he takes 4, some days 5 (Tr 24). He currently takes Tramadol as needed, anywhere from 2 to 6 a day (Tr 24-25). He takes these pain medications daily for the pains in his leg and to help take down some of the swelling (Tr 25). No doctor has ever informed him that it might not be a great idea to take 4 Norco's or 5 Tramadol's a day because it would be bad for his liver (Tr 25).

On cross-examination, Petitioner testified that to his recollection, he has had no accidents since July of 2007 (Tr 26). He did not have a slip and fall in a parking lot (Tr 26). He has not been in an automobile accident (Tr 26). In 2010, Petitioner's son was involved in a motor vehicle accident and submitted a claim to Geico Insurance for it; the vehicle was in Petitioner's name and his son got in the accident; Petitioner was not the driver and was not a passenger in the motor vehicle accident (Tr 27). Petitioner testified he has remained a Medicare recipient since the contract approval in October 2010 (Tr 28). In that time Petitioner has not gone off Social Security disability (Tr 28). As of the date of this hearing, Petitioner is still receiving Medicare benefits (Tr 28). If Dr. Bernstein's records indicate that Petitioner reported in August 2012 he had been working for a motel called Drury Motel as an overseer, that was his brother's company working for Drury Motel and Petitioner was working for his brother Chris (Tr 28-29). His brother Chris was the mason installing the stone at Drury Motel and his brother asked him to be a consultant to make sure the stones were not broken before they were unloaded from the semi (Tr 29). Petitioner only consulted on that one occasion (Tr 29). Around that time, Petitioner told Dr. Bernstein that the numbness and shooting pain in his left leg was continuing along with the low back pain (Tr 30).

If the records state such, the first time Petitioner saw Dr. Bernstein after the contract was approved was on February 25, 2011 (Tr 30). During that time, Petitioner was living in California, Chicago and Florida (Tr 30-31). He did indicate to Dr. Bernstein that his pain was pretty decent and in good control (Tr 31). His pain did some increasing with the weather change (Tr 31). Petitioner was asked that when he was in California, did he go on walks on the beach with his dog. Petitioner answered: "I don't have a dog, never went on the beach, never told him that." (Tr 31). Petitioner did not tell Dr. Bernstein he went biking at that time and did not tell him he was trying to exercise (Tr 31). Petitioner testified he tried to go to physical therapy, but could never get it approved (Tr 32). Petitioner did not go anywhere and exercise at all (Tr 32). Petitioner acknowledged he was walking with a cane at this hearing (Tr 32). He has been using a cane off and on for about a year now or so (Tr 32). Dr. Carobene and Dr. Wu have suggested he

use a cane as needed for stability (Tr 33). The pain he has been experiencing is the same ongoing pain he has had since the date of surgery (Tr 33). Petitioner did not believe that in February 2010 he started to undergo tests to determine if he needed another surgery (Tr 33-34). If Dr. Bernstein's records from March 4, 2010 indicate that Petitioner wanted to proceed with another surgery, then that is accurate (Tr 34). The reason he wanted to proceed with another surgery was that he was in a lot of pain (Tr 34). The reason Petitioner is seeking treatment at the present time and did so in 2013 again is because he is in a lot of pain (Tr 34).

Back in 2010 when he was in a lot of pain, Petitioner indicated he tried to play golf with his son, but ended up throwing up and getting sick (Tr 34). Before getting sick, Petitioner's son played 18 holes and he was riding with him, but Petitioner did not actually participate in all 18 holes of golf (Tr 35). On May 6, 2010, Petitioner was riding in a golf cart with his son; his son played the holes; Petitioner believed he played 4 or 5 holes and did not complete any holes (Tr 38). The same occurred on September 6, 2010 (Tr 38). Petitioner has tried to ride a bike since his 2008 surgery, but just cannot do it (Tr 39). He did a little bit of yard work here and there and then would get physically sick and throw up because of the amount of pain he was in (Tr 39). Petitioner saw Dr. Butler on January 31, 2014 at Respondent's request (Tr 40).

On re-direct examination, Petitioner testified that Dr. Bernstein never told him not to play golf, to not try to ride a bike or try to walk (Tr 41). Doctors have encouraged him to exercise or try to be active (Tr 41-42). Petitioner tries to do as much as he can. When he does that, sometimes he gets violently sick, throws up and gets a fever and he has to go down and sleep (Tr 42).

5. At the June 19, 2014 hearing, Joel Knoblock testified that he is currently employed with Third Shore Investigations as an investigator and has been so for 4 months (Tr 49). Prior to that, he was an investigator with Research Consultant Group for 10 years (Tr 50). He surveilled Petitioner on May 25, 2014. On that date, there was a party in the front yard of Petitioner's residence with two large tents in the driveway and a kid pool. There was a fair amount of people there. Mr. Knoblock video recorded what he observed (Tr 52). He documented 4 hours of Petitioner walking around and talking to people at the party, drinking beer and smoking cigars (Tr 53). A couple of times he saw Petitioner on his hands and knees attending to a meat smoker and occasionally sitting down in lawn chairs. Mr. Knoblock identified Rx11A through Rx11D as video footage he shot on DVD on May 25, 2014 (Tr 54).

On cross-examination, Mr. Knoblock testified that on May 25, 2014, he did not observe Petitioner lifting anything heavy (Tr 54). Petitioner appeared to walk in a normal fashion (Tr 54). Beer cans were the only thing he observed Petitioner lifting (Tr 54-55). Mr. Knoblock was on site from approximately 12:30 p.m. to 5:30 p.m. Petitioner may have lifted a pair of tongs when he handled the meat there (Tr 55). Petitioner did not participate in any of the games played at the party (Tr 55).

On re-direct examination, Mr. Knoblock testified he did not see Petitioner using any assistive device when he was walking that day (Tr 56). On re-cross examination, Mr. Knoblock testified he had not reviewed any video that was taken on January 31, 2014 (Tr 57).

6. Anthony Filipello testified that he is employed with Research Consultants Group (RCG) and has been so since April 1, 2004 as an investigator (Tr 60). Mr. Filipello was assigned to conduct surveillance of Petitioner in 2008, 2009 and 2010 (Tr 61). In May 2010, he observed Petitioner at his residence, at his brother's residence and doing some errands going in and out of stores and as a passenger in a vehicle. On May 5, 2010, he observed Petitioner and a female go to a storage facility and removed a metal and wood bench and place it in the back of a SUV (Tr 62). Petitioner also retrieved a golf bag and put it in the vehicle and drove back to his residence. There Petitioner removed the golf bag and left the bench in the SUV. Later that day, Petitioner was picked up by a younger man and the golf bag and a suitcase were placed in the man's vehicle. They traveled to Peru, Illinois and made a stop at a gas station and then a hotel. Petitioner retrieved the suitcase and left the golf bag in the vehicle. Petitioner returned to the vehicle without the suitcase and they drove to a private residence. Later they drove to a bar, where they remained for several hours. Mr. Filipello observed Petitioner in the bar drinking and playing darts for several hours, conversing with people, standing up and sitting down. Then Petitioner was taken back to the hotel (Tr 63). The next day, in the morning Petitioner was picked up by the younger man at the hotel and there was another young man in the car. They traveled to a Target and then went to a golf course. Mr. Filipello observed Petitioner play 18 holes of golf. Then they went to the Target again and then to a bar; he assumed for lunch, but he did not go into the bar (Tr 63). They were there less than an hour and then they traveled back to the same golf course and played another 18 holes of golf (Tr 64). Mr. Filipello watched Petitioner play golf. He observed Petitioner remove the golf bag from the vehicle and change his shoes. Petitioner carried the golf bag into the golf shop with his companions and then a few minutes later they emerged and got into 2 golf carts. Petitioner was a passenger and they went to the first hole and started playing (Tr 64). Mr. Filipello was on the course with Petitioner. In the beginning hours for the first 9 holes, he was conducting surveillance with Ben Jordan (Tr 65). They used video equipment and he recorded what he saw (Tr 66). He reviewed the recording. He did not record everything that he saw that day, but it did accurately depict some of what he saw (Tr 66). During the morning and afternoon of May 6, 2010, Mr. Filipello observed Petitioner play golf between 4 and 6 hours (Tr 66). There were times Petitioner was out of his sight (Tr 66).

On cross-examination, Mr. Filipello testified he had seen Petitioner since May 6, 2010 (Tr 67). He saw Petitioner on May 7, 8, 9, 10 and he thought 11, 2010. He also observed Petitioner a couple days in June 2010 and November 2010 (Tr 67). He believes he also saw Petitioner in 2011. He ran into Petitioner at a pet store in Naperville in 2012. He did not introduce himself. He observed Petitioner walking around the store with a female individual and a child. Petitioner was just walking around looking at the animals and products (Tr 68). He also saw Petitioner in May 2014 at the hearing site for a brief moment (Tr 68). He has not reviewed any video taken of Petitioner between January 8, 2014 and May 25, 2014 (Tr 68-69). It is safe to say that he did not know Petitioner's physical condition in 2014 (Tr 69). He did not know Petitioner's physical condition since 2012 (Tr 69). He did not observe Petitioner lift anything at the pet store (Tr 69).

7. Benjamin Jordan testified he is owner and president of Third Shore Investigations and has been so for 9 months (Tr 72). He oversees the business and conducts investigations as needed. Prior to this he worked for Research Consultants Group and his most recent position

there was Director of Sales and Marketing. Prior to that, he was Chicago regional manager and before that, in different positions over 9 to 10 years, including investigator (Tr 73). He was assigned to surveil Petitioner around 2009, 2010. In the summer of 2010, he observed Petitioner playing golf and he was with Anthony Filipello at that time (Tr 75). He operated a golf cart while Mr. Filipello shot video of Petitioner (Tr 75). Throughout the day, he observed Petitioner from 30 to 40 feet away and sometimes a hundred yards or so (Tr 75). He believed he stayed the whole day with Mr. Filipello (Tr 75). Mr. Jordan also observed Petitioner on January 31, 2014 and April 18, 2014 (Tr 76). He videoed Petitioner on January 31, 2014 (Tr 76). That day, he Jordan observed Petitioner leaving a medical building and walking to a pick-up truck. The medical office was located at 1300 Higgins Road in Park Ridge, Illinois (Tr 76). It appeared Petitioner was walking in a different manner that what he had seen before in 2010; Petitioner was walking slower and with a cane (Tr 77). On April 18, 2014, Mr. Jordan observed Petitioner walking on a driveway at 982 Viewpoint Drive in Lake in the Hills, Illinois. He believed there was a beer in Petitioner's hand and he waived at people as they passed by. Petitioner bent over and picked up a weed or something. He noticed nothing about the manner in which Petitioner moved on that date (Tr 78). Petitioner was not using any assistive device on that date (Tr 78). Mr. Jordan made a recording of what he observed on those two dates and he reviewed the recordings and they depict what he saw (Tr 78).

On cross-examination, Mr. Jordan testified he saw Petitioner playing golf in May 2010 and the next time he saw him was on January 31, 2014 and he was using a cane. On January 31, 2014, Petitioner was coming out of a doctor's office. Mr. Jordan did not know if any doctor had prescribed Petitioner use a cane when needed (Tr 79). He knew nothing about Petitioner's medical condition at all (Tr 79). It appeared Petitioner had gained weight when he saw him on January 31, 2014 compared to May 2010 and he was moving slower (Tr 79-80). Petitioner did not appear to be moving slower on April 18, 2014 and he appeared to be walking normally (Tr 80). He did not see Petitioner lifting anything on April 18, 2014 or on January 31, 2014 (Tr 80-81). He did not see Petitioner playing golf in 2014 (Tr 81). Mr. Jordan did not know any medical opinions that doctors were giving now concerning Petitioner (Tr 81).

8. According to Dr. Bernstein records, Px2, Petitioner was seen on January 8, 2009 to obtain x-rays because prior to Christmas he was involved in a slip and fall in a parking lot on December 21, 2008. Petitioner reported significant increasing pain, which he reported was subsiding but still slightly increased. Up to that point, Petitioner felt he was doing well. He was on weaning process from Vicodin. On examination, Dr. Bernstein noted Petitioner did not stand fully erect and had a slight right-sided antalgic gait. He was neurologically intact. X-rays showed the lumbar fusion in good position and appeared healed. Dr. Bernstein recommended symptomatic care and he was to follow-up with a CT scan in a few months.

Petitioner followed-up on April 20, 2009 and Dr. Bernstein noted that all of Petitioner's care was being denied by the workers' compensation insurer. Dr. Bernstein noted that Petitioner did not have an alternative insurance source, but he was hoping to get Social Security disability and Medicare insurance. Dr. Bernstein noted that he was somewhat stuck in terms of treating him. Dr. Bernstein noted that Petitioner required a CT scan to evaluate his lumbar fusion. Dr. Bernstein also noted that Petitioner had not been allowed to participate in physical therapy. At

this point, Dr. Bernstein considered Petitioner to be permanently disabled. Dr. Bernstein prescribed Ultram for pain and Elavil for anti-depression. He noted Petitioner complained of depression and weight gain.

On August 17, 2009, Petitioner reported he continued to have low back pain. Dr. Bernstein noted Petitioner had never been able to pursue the previously recommended treatment. Petitioner reported that the other day his left leg felt weak and got numb and was slightly improved this day. On examination, Dr. Bernstein noted that Petitioner was constantly shifting positions. He had limited, if any, bending and getting his fingers to his knees. He had intact strength, sensation and reflexes. Straight leg raises caused some back discomfort. Dr. Bernstein's assessment was Petitioner clearly had chronic residual low back pain, although substantially improved from his pre-operative circumstances. Dr. Bernstein continued to recommend Petitioner complete the work-up and the therapy that was recommended in the past. He wanted Petitioner to have a CT scan of his lumbar spine. Given Petitioner's recent radiating leg pain and numbness, Dr. Bernstein recommended an updated MRI scan. He prescribed Mobic and Valium. He had Petitioner remain off work until his clinical condition could be fully assessed.

Petitioner reported on October 19, 2009 that he had his physical therapy approved with a private trainer. Dr. Bernstein noted he had talked to the trainer and recommended core and general conditioning and strengthening. Dr. Bernstein opined this treatment was reasonable to rehabilitate Petitioner up to a point where he plateaus and he discussed this with the trainer. On examination, Dr. Bernstein noted Petitioner walked more fully erect and had a minimal antalgic gait. Dr. Bernstein noted Petitioner underwent a lumbar CT scan, that he reviewed same and noted that it demonstrated a healed fusion in his lumbar spine. Dr. Bernstein's assessment was Petitioner appeared much better and his fusion appears healed. Dr. Bernstein recommended Petitioner proceed with physical therapy and refilled Valium. Dr. Bernstein noted that he wanted to see Petitioner get off all medications and follow-up in 6 months.

9. At Respondent's request, Petitioner saw Dr. Butler on January 6, 2010. In his report, Rx1A, Dr. Butler noted he had reviewed Petitioner's medical records to that date. Dr. Butler noted Petitioner's current prescribed medications. Petitioner reported numbness in the thighs and feet and mostly low back pain, which he rated at 5-6/10. Flexion/extension x-rays were obtained which showed motion along the superior aspect of the interbody fusion at L5-S1. L4-5 appeared to be solid and there was no motion evident. The screws at S1 appeared to have some progressive backout. There was no obvious lysis. Dr. Butler's impression was pseudoarthrosis at L5-S1. Dr. Butler opined that Petitioner's pain was directly related to the pseudoarthrosis. Dr. Butler opined that Petitioner was in need of additional treatment in the form of a CT scan to assess the pseudoarthrosis. If this was confirmed, then posterior spinal fusion at L5-S1 would be the recommended treatment. Dr. Butler opined Petitioner was not at maximum medical improvement and he was not capable of returning to work at that time.

10. Petitioner reported to Dr. Bernstein on January 14, 2010 that he had seen Dr. Butler for an independent medical evaluation. Petitioner reported that Dr. Butler informed him that he believed he had a pseudoarthrosis of the lumbar spine that required a posterior spinal fusion. Petitioner reported increasing low back pain, despite the fact that he was doing quite well on his

recent visit. Petitioner further indicated that he was definitely substantially improved from his pre-operative condition. On examination, Dr. Bernstein noted Petitioner did not walk with an antalgic gait, but he did walk with a shuffling mechanical gait which did not appear smooth. Petitioner complained of discomfort to the left side of the low back at about the L5-S1 level. This was the area of his main pain complaint. Bending was very difficult for him and he would get to about 20-30 degrees and it caused increased low back pain. Straight leg raises were negative. Dr. Bernstein reviewed copies of the flexion/extension views performed by Dr. Butler that Petitioner brought with him and he did not identify any motion that suggested a pseudoarthrosis. Dr. Bernstein opined that flexion/extension views were unlikely to demonstrate any motion, even in the presence of a pseudoarthrosis, given Petitioner's type of fusion and instrumentation and he would not consider it a competent assessor of his lumbar fusion. Dr. Bernstein reviewed the lumbar CT scan that Petitioner had undergone and it appeared to demonstrate healing at the end plates of both grafts at both levels, strongly supporting a healed fusion. Dr. Bernstein noted he requested his associate Dr. Spencer review this independently. Dr. Spencer agreed with Dr. Bernstein's findings. Dr. Bernstein noted that Dr, Michael was asked to review the CT scan and answer if he thought the fusion was healed or not. Dr. Michael reported a healed fusion. Dr. Bernstein noted that the most accurate assessment of a lumbar fusion is an intra-operative evaluation. Dr. Bernstein noted Petitioner's options consisted of: 1) accepting his clinical situation and Dr. Bernstein's clinical judgment that he had a radiographically healed fusion or 2) consider a fusion exploration and a possible revision with a posterior spinal fusion, which would involve a midline incision in his lumbar spine and assess his fusion by trying to demonstrate motion from L4 to S1. If motion were identified consistent with a pseudoarthrosis, a revision instrumented posterior spinal fusion would immediately commence. Petitioner was to consider his options. Dr. Bernstein opined that in the absence of any surgical treatment, Petitioner was at maximum medical improvement.

On February 8, 2010, Petitioner saw Dr. Bernstein to review an updated CT scan that was done at 3T Imaging. Dr. Bernstein noted this failed to identify a failed fusion or pseudoarthrosis and the instrumentation was in good position and there appeared to be bridging bone in the interbody space. Dr. Bernstein went over the results with Petitioner. Petitioner insisted he had continued low back pain radiating into the left lateral thigh that he found unlivable. Dr. Bernstein noted that he did recommend a MRI scan, which had yet to be obtained and that after that was obtained, Petitioner's situation would be reviewed as well as his options.

Petitioner saw Dr. Bernstein on March 4, 2010 and had with him an updated MRI scan. Dr. Bernstein reviewed same and noted his proximal levels were really benign, he had good T2 signals in the proximal discs and he had some facet degenerative change at the L3-4 level, which Dr. Bernstein did not believe was responsible for his symptoms. Dr. Bernstein reviewed the CT scan which at L4-5 appeared to show a healed fusion and at L5-S1 it was likely that his fusion was healed. Petitioner requested proceeding with a fusion exploration and possible posterior revision fusion. Dr. Bernstein explained to Petitioner that if at the time of the surgery no motion could be identified at the lower levels, he would abort any further surgery. If motion was identified, Dr. Bernstein would proceed with posterior lumbar fusion with instrumentation. Dr. Bernstein noted he would try and obtain approval for the fusion exploration and possible posterior revision fusion. (Px2).

11. At Respondent's request, Petitioner saw Dr. Butler again on March 10, 2010. In his report, Rx1B, Dr. Butler noted he had reviewed updated films from February 4, 2010 and the lumbar MRI of February 19, 2010. Dr. Butler opined that there was a solid fusion at L5-S1 as well as L4-5. Dr. Butler noted the CT scan showed a nice anterior bridge of bone and he saw no evidence of a pseudoarthrosis that was previously noted. Dr. Butler opined that this obviated the necessity for a re-exploration and repeat fusion. Dr. Butler diagnosed a solid fusion from L4 to the sacrum. Dr. Butler opined Petitioner was at maximum medical improvement. Dr. Butler opined Petitioner could return to his prior work restrictions. He noted Petitioner may need a new functional capacity evaluation.

In his September 27, 2010 report, Rx1C, Dr. Butler noted that Petitioner had undergone a functional capacity evaluation on April 8, 2010, which assessed him at sedentary demand level. Dr. Butler noted the May 6, 2010 surveillance video of Petitioner golfing 36 holes with no observed limitation in activity or behavior. Dr. Butler opined that based on his examination, the functional capacity evaluation and surveillance video, Petitioner required no further treatment as a result of the July 20, 2007 back injury. Dr. Butler opined that the functional capacity evaluation restrictions were clearly below what Petitioner was capable of. Dr. Butler opined that based on the surveillance video, Petitioner was able to return to work at Respondent to his previous position.

12. Petitioner followed-up with Dr. Bernstein on February 25, 2011. Dr. Bernstein noted that Petitioner looked well. Petitioner reported he was living in California, Chicago and Florida. Petitioner ambulated full erect. Petitioner reported his pain was under reasonably good control and he used Tramadol. Petitioner reported that when he is in Chicago, he seemed to have more symptoms due to the weather and activity. Petitioner requested Lortab and Dr. Bernstein prescribed same. Dr. Bernstein noted: "He reports that in California, he walks on the beach with the dog and that he bikes and he is trying to exercise." Dr. Bernstein noted that Petitioner did appear to have gained weight and had a significant protuberant abdomen. Dr. Bernstein noted that Petitioner was to follow-up as needed.

Dr. Bernstein saw Petitioner on August 20, 2012 and noted he had not been there in some time. Dr. Bernstein noted Petitioner apparently was working for a motel called Jury Motel as an overseer. Petitioner reported he started to experience increasing numbness in his left leg and shooting pain. He did not have a new incident or event and he was unable to continue working because of the pain. Petitioner reported he has a sensation of bugs crawling on his legs bilaterally. On examination, Dr. Bernstein found good lower extremities power, he was neurologically intact, he had limited range of motion with getting his fingers to just below his knees and he remained overweight. Dr. Bernstein recommended a lumbar MRI scan and prescribed Lortab. Petitioner was to contact him once this was completed.

Petitioner saw Dr. Bernstein on September 27, 2012 and complained of left anterior thigh pain. Dr. Bernstein reviewed the recent lumbar MRI scan, which was benign and demonstrated relatively healthy discs above his fusion. Dr. Bernstein noted: "We know from prior evaluation that his fusion is stable." On examination, Dr. Bernstein found no tenderness over the iliac crest, but his symptoms were compatible with meralgia paresthetica. Dr. Bernstein referred Petitioner to the Pain Service for treatment of his condition. (Px2).

13. According to the records of Comprehensive Pain Care, Px3, Petitioner saw Dr. Carobene on July 22, 2013 on referral from Dr. Wu. Petitioner reported low back pain that radiated into the left buttock and into the anterior thigh. Petitioner reported feeling pins and needles on the bottom of his foot and occasionally left leg weakness and buckling while ambulating. Dr. Carobene noted the 2007 work injury and fusion surgery. Petitioner rated his pain from 3-10/10. Petitioner reported that sitting, walking too long, bending and lying down too long tended to aggravate his pain. Prescribed medications helped somewhat. Dr. Carobene's impression was lumbar radiculopathy with a probable component of lumbar facet pain. Dr. Carobene's plan was to administer a diagnostic lumbar facet block on August 12, 2013.

Petitioner underwent a lumbar CT scan on July 25, 2013 that had been requested by Dr. Carobene. The radiologist's conclusion was: 1) postsurgical changes from an L4-S1 fusion; hardware was intact and alignment was anatomic; 2) a hypertrophic left posterolateral osteophyte approaching the exiting left L4 nerve root laterally, but there was no significant central canal or neural foraminal stenosis at L5-S1 or at any of the levels of the lumbar spine.

On August 12, 2013, Petitioner underwent a lumbar facet block performed by Dr. Carobene. On August 21, 2013, Petitioner underwent radiofrequency thermo coagulation of lumbar dorsal medial facet branches performed by Dr. Carobene. On September 23, 2013, Petitioner underwent a lumbar selective nerve root block performed by Dr. Carobene. On October 2, 2013, Petitioner followed-up with Dr. Carobene and reported he was okay for 3-4 days with gradual recurring of central low back pain to his left thigh. Petitioner also complained of a pulling sensation in his low back and a numbness/burning sensation in his left anterior thigh. Dr. Carobene's impression was lumbar radiculopathy. Petitioner was to follow-up with Dr. Bernstein and ask if there was a reasonable surgical option.

On December 27, 2013, Petitioner saw Dr. Lami for a spinal consultation. Petitioner reported that the injections helped for a while. Dr. Lami reviewed the lumbar CT scan and examined Petitioner. Dr. Lami's impression was chronic low back pain. Dr. Lami opined: "My current impression is that he does not have a surgical indication."

14. At Respondent's request, Petitioner saw Dr. Butler on January 31, 2014. In his report, Rx1D, Dr. Butler noted Petitioner reported persistent low back pain. Petitioner reported he used a cane with his right hand and had difficulty lifting his children. He was off all pain medications. Petitioner reported he treats with Dr. Wu and receives Xanax and Flexeril as needed. Petitioner reported occasional pain to the leg and foot based on activity. He rated his pain at 7/10. Petitioner reported moderate to severe difficulties with ADLs. Dr. Butler noted Dr. Bernstein's office visit. Dr. Butler noted that the September 13, 2012 lumbar MRI was a normal post-operative study of a fusion L4-S1. Dr. Butler's assessment was lumbar degenerative disc disease. Dr. Butler opined that Petitioner's subjective complaints stem from progressive deconditioning as he has gained 63 pounds since he last saw him on January 6, 2010. Dr. Butler noted Petitioner's subjective complaints remained unchanged. Dr. Butler opined Petitioner's current condition is no longer related to the work injury and subsequent fusion. Dr. Butler opined Petitioner needed to pursue a home exercise program and seek out some form of dietary modification for weight loss. Dr. Butler noted that the meralgia paresthetica symptoms were

present to some degree 4 years ago and have likely worsened as his abdominal pannus has markedly enlarged. Dr. Butler saw no indication for formal pain management.

15. Petitioner's attorney submitted the lump sum settlement contract into evidence and it was admitted as Px1. Petitioner's attorney also submitted the following medical bills, which were admitted as Px4: Comprehensive Pain Care: $8,620.00 (bills from 7-22-13 through 10-2-13); The Spine Center, Dr. Bernstein: $750.00 (bills for 2-25-11, 8-20-12 and 9-27-12); Illinois Spine Institute, Dr. Lami: $260.76 (bill for 12-27-13). The total of the above medical bills is $9,630.76.

16. Respondent submitted the following DVD surveillance videos and they were admitted into evidence. The Commission has viewed the videos.
Rx2A: 1st DVD surveillance taken 11-5, 7, 10, 11 and 19 of 2009;
Rx2B: 2nd DVD surveillance taken 11-5, 7, 10, 11 and 19 of 2009;
Rx3: DVD surveillance taken 5-6-10;
Rx4: DVD surveillance taken 1-18-10;
Rx5A: 1st DVD surveillance taken 9-4, 5, 6 of 2010;
Rx5B: 2nd DVD surveillance taken 9-4, 5, 6 of 2010;
Rx6: DVD surveillance taken 1-8, 15 of 2014;
Rx7: DVD surveillance taken 1-31-14;
Rx8: DVD surveillance taken 2-2, 3, and 12 of 2014;
Rx9: DVD surveillance taken 4-9-14;
Rx10: DVD surveillance taken 4-18-14;
Rx11A through Rx11D: DVD surveillance taken 5-25-14.

Based on the record as a whole, the Commission grants the §8(a) Petition. The Commission finds that Petitioner's treatment with Dr. Bernstein and Dr. Carobene was causally related, reasonable and necessary to relieve the effects of Petitioner's low back injury of July 20, 2007. The Commission notes that Petitioner testified that he continues to be a Medicare recipient. The Commission denies Petitioner's Petition for Penalties and Attorneys' Fees finding that Respondent reasonably relied on the opinions of §12 Dr. Butler.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §8(a) Petitioner is hereby allowed and that Respondent shall pay to Petitioner the sum of $9,630.76 for medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Attorneys' Fees is hereby denied.

15IWCC0182

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,700.00. 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: MAR 16 2015
MB/maw
o01/15/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

Nagwa Kirollos,
Petitioner,

vs.

NO: 09 WC 16095
09 WC 48305

Exxon Mobile,
Respondent.

15IWCC0183

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, notice, medical expenses, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that Respondent raised the issue of dismissing Petitioner's appeal due to a failure to file an authenticated transcript on or before the May 9, 2014 return date on review. The Commission further notes that Respondent contends it is currently raising the issue for the purpose of preserving the issue on appeal. The Commission finds that it already addressed this issue in its October 8, 2014 interlocutory Order. Having reviewed the entire transcript and file, the Commission finds that there is no basis to alter its prior October 8, 2014 holding.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 15, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that ruling in the October 8, 2014 Order stands and there is no basis to alter the Commission's prior holding.

15IWCC0183

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

DATED: MAR 16 2015

MB/jm

O: 3/5/15

43

Mario Basurto

David L. Gore

Stephen Mathis

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

KIROLLOS, NAGWA
Employee/Petitioner

Case# **09WC016095**
09WC048305

EXXON MOBIL CORP
Employer/Respondent

15IWCC0183

On 10/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% 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:

4444 VINCENT WAGNER
4541 N MONTICELLO
CHICAGO, IL 60625

STRECKER JEPSON & ASSOCIATES
601 N HICKS RD
SUITE C
PALATINE, IL 60067

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

15IWCC0183

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)

NAGWA KIROLLOS
Employee/Petitioner

Case # 09 WC 16095

v.

Consolidated case: 09 WC 48305

EXXON MOBIL CORP.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the cities of **Chicago** and **Urbana**, on the dates of **September 17, 2012, October 10, 2012, January 22, 2013** and **August 20, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 18, 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 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 **$8,630.96**; the average weekly wage was **$165.98**.

On the date of the alleged accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

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

ORDER

The Arbitrator finds that Petitioner has failed to sustain her burden of establishing a work accident or that her condition of ill-being is related to her work with Respondent. Accordingly, benefits are hereby denied.

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

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

Signature of Arbitrator

10/07/2013
Date

ICArbDec19(b)

OCT 15 2013

15IWCC0183

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

NAGWA KIROLLOS
Employee/Petitioner

v.

Case # 09 WC 16095
Consolidate Case: 09 WC 48305

EXXON MOBIL CORP.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Nagwa Kirollos, testified that she was born in Egypt; her primary language is Arabic, but she speaks some English. (Arbitration Transcript (Tr.), Vol. I, p. 17).[1] Petitioner testified that she worked for Respondent, Exxon Mobil Corporation, since approximately 2001 in a gas station owned and operated by Respondent. (Tr., Vol. I, p. 18). Petitioner testified that she worked at Respondent's Hoffman Estates store location for six to nine months prior to January 28, 2009. (Tr., Vol. I, p. 25). The Arbitrator notes that at some instances during the trial testimony, Petitioner was advised to wait for the translator to translate prior to answering the pending questions.

January 28, 2009 Claimed Date of Accident (Case Number 09 WC 48305)

On January 28, 2009, Petitioner testified that she arrived at work between 2:00 and 2:10 p.m. She testified that she was working her regular job as a cashier. (Tr., Vol. I, pp. 19, 21). Petitioner testified that her job as cashier included mopping the floors, cleaning the pump, cleaning the glass, stocking coolers, and stocking Mobil Oil on the shelves of the store. (Tr., Vol. I, p. 19). Petitioner testified that she worked between 16 to 20 hours per week. (Tr., Vol. I, p. 20). She testified that when she arrived on January 28, 2009, Gary, the store manager, was present, but he left between 4:00 and 5:00 p.m. (Tr., Vol. I, p. 22). Petitioner testified that after Gary left she was at the store by herself. (Tr., Vol. I, p. 23).

Petitioner testified that on January 28, 2009, Gary gave her a notice that there was to be no gasoline available at around 7:00 to 8:00 p.m. Petitioner testified that she therefore went outside to close the gas pumps. She testified that it was "sort of slippery" outside, "like glass," and when she was walking toward customers outside, she slipped and hit her knee. (Tr., Vol. I, p. 24). Petitioner testified specifically that she

[1] This matter was heard on four separate dates (September 17, 2012 in Chicago, Illinois; October 10, 2012 in Chicago, Illinois; January 22, 2013 in Urbana, Illinois; and August 20, 2013 in Chicago, Illinois). There are thus four distinct transcripts for each day the matter was heard on the record, and those transcripts will be identified as Volume I (September 17, 2012), Volume II (October 10, 2012), Volume III (January 22, 2013), and Volume IV (August 20, 2013).

would place either a sticker or paper on the pump so the customers would know they could not use the pump. (Tr., Vol. I, p. 27). She testified that she was coming back from closing the pump when she fell. (Tr., Vol. I, p. 28). Petitioner testified that her right leg hit the ground when she fell. (Tr., Vol. I, p. 28). Petitioner further testified that she was wearing a sweater, pants and special shoes required by Respondent for the snow and ice, which were to protect her from slipping. (Tr., Vol. I, p. 29). Petitioner did not fill out an employee statement form for her alleged accident date of January 28, 2009. (Tr., Vol. II, p. 75).

Petitioner testified that at the time she fell she was carrying the papers that she needed to use to cover the pumps. (Tr., Vol. I, p. 30). Petitioner testified that when she fell she felt a lot of pain in her right leg. She further testified that after her shift she went home. Petitioner testified that she told her husband about her accident at work. (Tr., Vol. I, p. 31). Petitioner's husband, Ehmed Kirollos, testified that on January 28, 2009, Petitioner told him that she had fallen on her knees. He testified that he brought her ice and asked her to put it on her knees. (Tr., Vol. II, p. 62).

Albir Sadek testified via evidence deposition. (Petitioner's Exhibit (PX) 30). Mr. Sadek testified that he worked as a manager for Exxon Mobil from August 2001 until May 2010. (PX 30, p. 7). Mr. Sadek testified that he worked as a store manager, and he was responsible for supervising employees. (PX 30, pp. 8-9). Mr. Sadek specifically testified that he did not supervise Petitioner; he did not work at the Hoffman Estates store in question, but at another location. (PX 30, p. 54). Mr. Sadek testified that as a store manager for Exxon Mobil, he had been trained to take certain actions if an employee was to get injured. (PX 30, p. 9). He testified that the first step would be to call the triage nurse or 911 if the injury is life-threatening. The second step would be to call the "TM" (territory manager), and advise him as to the particulars of the incident. The third step would be to watch the store surveillance video to determine exactly what happened. (PX 30, p. 10). Mr. Sadek testified that as an Exxon Mobil manager, it was Respondent's policy for its employees to be instructed to report any injury, even a paper cut, to the manager or managers. (PX 30, p. 51).

Mr. Sadek testified that he saw Petitioner regularly at church. (PX 30, p. 16). He testified that his family and Petitioner's family were "good friends." He testified that the families spent time at each other's homes. (PX 30, p. 48).

Mr. Sadek testified that he did not witness Petitioner falling down in January 2009. (PX 30, p. 59). He testified that two or three days after it happened, Petitioner told him that she fell down at the store when she was doing something around the gas pumps. (PX 30, pp. 17-18). Mr. Sadek testified that he asked Petitioner if she was "ok" and that Petitioner replied that the incident hurt her. Mr. Sadek then asked Petitioner if she told the manager, Uhri, about the incident, because this was standard procedure. (PX 30, p. 18).[2] Mr. Sadek testified that Petitioner told Uhri (Gary) the day following the alleged incident, because Uhri had already left when the alleged incident occurred. (PX 30, p. 18). Mr. Sadek further testified that he insisted that Petitioner call Uhri (Gary) again to find out what he did because that is Exxon Mobil's procedure. He testified that once an incident is reported to a manager, the manager then reports the incident to his manager. (PX 30, p. 19). Mr. Sadek testified that every time he met Petitioner, at church or anywhere else, he continued asking her what Uhri (Gary) had done. Mr. Sadek reported that Petitioner informed him that Uhri (Gary) did not do anything. (PX 30, p. 19).

Mr. Sadek specifically testified that he did not tell Gary or Mark (the TM) about what Petitioner had told him about falling at work in January 2009. (PX 30, pp. 54, 61, 63-64). He further testified that following

[2] The deposition transcript of Albir Sadek incorrectly references Manager Gary Ciancio as "Uhri."

the March 18, 2009 incident (discussed *infra*), at a business meeting, Gary asked Mr. Sadek how Petitioner was feeling, and he testified that he responded that she did not feel well and was seeking treatment. (PX 30, pp. 61-62).

Mr. Sadek testified that the video surveillance used at Exxon Mobil stores stayed on a hard disc for thirty-one (31) days, and after that there would be no available record. (PX 30, p. 38).

Petitioner testified that she presented to her family doctor on January 30, 2009 (a Friday), and that she waited two days because she had to schedule an appointment. (Tr., Vol. I, p. 32).[3] She testified that she told her doctor what had happened at work, *i.e.*, that she had fallen. (Tr., Vol. I, p. 32). Petitioner further testified that she had a problem communicating with the doctor because the doctor did not speak Arabic. (Tr., Vol. I, pp. 33-34).

The medical records of Dr. Ahmar Shaikh dated January 30, 2009 note that Petitioner complained of pain in the right knee that started the day before, with "no trauma, etc." The record from that date also notes that Petitioner worked at a gas station and stood for twelve hours per day. A history was reported of left knee pain in the past, but that it was "not too bad" on that date. Petitioner also complained of pain in the left foot and back (mid and lower). The doctor's assessment and plan noted: 1) Right knee pain – DJD; 2) Chronic left knee pain, questionable –DJD; 3) Left foot pain; and 4) Back pain. (RX 6).

Petitioner testified that Dr. Shaikh provided her with a work restriction slip on January 30, 2009. (Tr., Vol. I, p. 35). She further testified that she gave the slip to Gary and that he told her, "I'm sorry," and brought her a chair and asked her to sit down. (Tr., Vol. I, pp. 35-36). Petitioner testified that she told Gary that she did not want to cause any trouble for him. (Tr., Vol. I, p. 38). Petitioner testified that Gary did not provide her with any paperwork to fill out. (Tr., Vol. I, p. 39).

Gary Ciancio testified at trial. He testified that he was a manager of the Hoffman Estates Exxon Mobil store. (Tr., Vol. II, p. 70). He testified that Mark Yeary was his supervisor and Territory Manager. (Tr., Vol. II, p. 70). Mr. Ciancio testified that he supervised Petitioner at the time of her alleged dates of accident. (Tr., Vol. II, p. 70). He testified that he spoke English when he supervised her. (Tr., Vol. II, p. 70). He testified that it was "not very often" that Petitioner had difficulty understanding what he was saying. (Tr., Vol. II, p. 70). He testified that Petitioner spoke with an accent. (Tr., Vol. II, p. 108). Mr. Ciancio testified that surveillance cameras recorded 24 hours a day at the Hoffman Estates store. (Tr., Vol. II, p. 71). Mr. Ciancio testified that he always reviewed videotape if something unusual happened. (Tr., Vol. II, p. 72). Mr. Ciancio testified that employees were instructed to always report an accident immediately. (Tr., Vol. II, pp. 72-73). He testified that there was a process followed, including calling the triage nurse and possibly 911 as well as contacting his territory manager. (Tr., Vol. II, pp. 73-74). He testified that he would never tell an employee not to report an accident. (Tr., Vol. II, p. 73). He testified that if an employee failed to report an accident that he or she would be subject to discipline for non-reporting. (Tr., Vol. II, p. 73). He testified that he would review the store videotape if an injury was reported. (Tr., Vol. II, p. 74). Mr. Ciancio testified that Petitioner never reported that she had injured herself on January 28, 2009. (Tr., Vol. II, p. 74). He testified that Petitioner never completed an injury report for January 28, 2009. (Tr., Vol. II, p. 75). He testified that if Petitioner had reported an accident that surveillance from the pump location would have been saved. (Tr., Vol. II, p. 75). He testified that he never reviewed any tape from January 28, 2009, because nothing had been reported to him. (Tr., Vol. II, p. 75). He testified that he did not complete any accident investigation because

[3] The transcript testimony incorrectly refers to Petitioner's primary care physician as Dr. Shaffer.

nothing had been reported to him. (Tr., Vol. II, p. 76). Mr. Ciancio specifically testified that he never advised Petitioner not to report an injury, and that if he did something like that, he would lose his job. (Tr., Vol. II, pp. 104-105). Mr. Ciancio testified that if a manager was not present at the store and if an accident occurred, employees were instructed to follow directions on the emergency flow chart form. (Tr., Vol. II, p. 77). Mr. Ciancio testified that Petitioner brought in a note that stated that she needed to sit while working. (Tr., Vol. II, p. 78). Mr. Ciancio testified that Petitioner did not tell him why she needed to be able to sit while working. (Tr., Vol. II, p. 78). He testified that the note did not indicate why Petitioner needed to be seated. (Tr., Vol. II, p. 78). Mr. Ciancio testified that he did not recall ever being asked to bring a chair for Petitioner. (Tr., Vol. II, p. 92). Mr. Ciancio testified that Petitioner generally worked the morning hours, but he had no specific recollection of when Petitioner punched in and out on January 28, 2009. (Tr., Vol. II, pp. 99-100). Mr. Ciancio testified that it was possible that he was not present after 4:00 p.m. on January 28, 2009. (Tr., Vol. II, p. 101).

A work restriction note dated February 1, 2009 from Alexian Brothers indicates that Petitioner could return to work on February 2, 2009, noting "sitting only for five days." The note does not indicate a reason for the restriction or a diagnosis. The triage assessment from that date also indicates that Petitioner denied any injury, and she had pain from her right calf to her thigh. An x-ray taken of Petitioner's right knee on that date was negative. (RX 9).

Mark Yeary testified at trial. He testified that he was a territory manager for Exxon Mobil from July 1998 through December 2010, but at the time of trial, he was employed by Buchanan Energy. (Tr., Vol. II, p. 131). He testified that he was responsible for store sales, safety and reports. (Tr., Vol. II, p. 131). He testified that Albir Sadek did not have any supervisory role over Petitioner. (Tr., Vol. II, p. 132). He testified that Mr. Sadek never reported that Petitioner had had an injury in January 2009. (Tr., Vol. II, p. 132). Mr. Yeary testified that on January 28, 2009, he was responsible for the Hoffman Estates store. (Tr., Vol. II, pp. 132-133). Mr. Yeary testified that it was Exxon Mobil's policy that any accidents were to be reported immediately, without exception. (Tr., Vol. II, p. 133). He testified that an employee could be disciplined for failure to report an accident. (Tr., Vol. II, pp. 133-134). Mr. Yeary testified that there was an emergency flow chart, indicating who to call and what the process was regarding reporting accidents. (Tr., Vol. II, p. 134). He testified that he did not receive any notice from the store manager as to any accident occurring on January 28, 2009. (Tr., Vol. II, p. 134). Mr. Yeary testified that if he had been notified of an accident, he would have conducted an investigation and reviewed the surveillance videotape. (Tr., Vol. II, p. 135). He testified that Exxon Mobil would not be able to use videotape to investigate an accident if it were not reported within 30 days. (Tr., Vol. II, p. 135). Mr. Yeary testified that he initially reviewed Petitioner's payroll records for January 28, 2009, approximately a month after March 18, 2009, which was the date upon which he was notified of the alleged incident of January 28, 2009. (Tr., Vol. II, p. 160). He testified that after reviewing the payroll records, he established that Petitioner worked the second shift on January 28, 2009. (Tr., Vol. II, p. 160).

Petitioner next presented to Dr. Shaikh on February 25, 2009. On that date, the records evidence that Petitioner presented with complaints of very severe pain in the right knee and difficulty walking. It was noted Petitioner stood at work for nine hours at a time. Difficulty sleeping secondary to knee pain was also noted. There was no mention of trauma in that note. The assessment and plan noted continued right knee pain. An MRI of right knee was recommended and an orthopedic referral was made. (RX 6).

Petitioner testified that she remembered having an MRI on her right knee. (Tr., Vol. I, p. 41). Medical records evidence Petitioner underwent an MRI of her right knee on March 1, 2009, with a history given of

right knee pain. The impression was noted as a complex tear involving the posterior horn of the medial meniscus with suspicion of a bucket handle component. (RX 6; RX 9).

On March 3, 2009, Dr. Shaikh noted that the MRI showed a tear in the posterior horn of medial meniscus of the right knee. Petitioner was noted to have increasing pain. The note indicated that Dr. Shaikh discussed possible treatment with Petitioner, and it was noted that copies of reports were given along with an instruction to follow up with orthopedics. (RX 6).

On March 9, 2009, Petitioner again presented to Dr. Shaikh, complaining of knee pain and difficulty walking and standing. On this date, Petitioner reported to the doctor that she had fallen at work in the last week of January 2009. It was also noted that the doctor had difficulty understanding Petitioner on this date, and that she was "not speaking good English." The assessment on March 9, 2009 was that Petitioner had a torn meniscus in the right knee. The note stated that Petitioner was unable to find an orthopedic surgeon, and Dr. Shaikh advised Petitioner to go to Loyola. It was also noted she was a Public Aid patient. (RX 6).

March 18, 2009 Claimed Date of Accident (Case Number 09 WC 16095)

Petitioner testified that on March 18, 2009, she was carrying a box of water and was going to pour it in the windshield wiper bin outside by the fuel pumps. Petitioner testified that she tripped over boxes while carrying the bucket, and that she fell. (Tr., Vol. I, pp. 42-43). Petitioner testified that Gary was on the store premises when she fell. (Tr., Vol. I, p. 45). Petitioner testified that she fell forward on both her knees and moved her head back. (Tr., Vol. I, p. 45). Petitioner testified that Gary called the nurse, who asked if she would like to go to the hospital. Petitioner testified that she said she wanted to go to the doctor because this was the second time this had happened to her. (Tr., Vol. I, p. 47). She testified that Gary told her not to talk about the first incident because it would cause him trouble. (Tr., Vol. I, p. 47). Petitioner testified that she did not know what he meant by that, whether he was covering up or something to that effect, but that he told her not to give him trouble. (Tr., Vol. I, p. 47). She testified that this was the first time that Gary had indicated to her that she should not give him any trouble. (Tr., Vol. I, pp. 47-48). Petitioner testified that the supervisor, Mark, came and called the clinic in Joliet. Mark then took her there. (Tr., Vol. I, p. 49).

Video surveillance of the store premises entered into evidence shows that Petitioner was in the storeroom at the Hoffman Estates store location on March 18, 2009. (RX 5). Petitioner identified herself as the individual in the DVD recording. (Tr., Vol. III, pp. 41-42). The recording shows Petitioner moving a box on the floor out of the way of the walkway. (RX 4; RX 5). The recording next shows Petitioner looking at the boxes and then moving them into the walkway. (RX 4; RX 5). The recording then shows Petitioner falling while carrying a bucket of water. (RX 4; RX 5). When called on rebuttal on January 22, 2013 after the recording was viewed during the October 10, 2012 trial, Petitioner testified that she was initially attempting to move the box out of the walkway. (Tr., Vol. III, pp. 22-23). Petitioner testified that she was trying to move a bug or a spider away from the chips that were on the floor. (Tr., Vol. III, pp. 24, 51-54). Petitioner testified that it was part of her regular job duties to fill window wash buckets. (Tr., Vol. II, p. 32).

Mr. Ciancio testified that he heard Petitioner fall and went to assist her and sat her down on a chair. (Tr., Vol. II, p. 84). Mr. Ciancio testified that he called triage and the territory manager. (Tr., Vol. II, p. 84). He testified that Mark Yeary, territory manager, came within ten minutes. (Tr., Vol. II, p. 84). He testified that it was not part of Petitioner's regular duties to fill the window wash buckets. (Tr., Vol. II, p. 85). He testified that in the middle of March, Exxon Mobil uses washer fluid in the wash buckets instead of water as water could freeze, and that Petitioner was using improper procedure if she was indeed using water to fill the

buckets. (Tr., Vol. II, pp. 85-86).

Mr. Ciancio testified that territory manager, Mr. Yeary, conducted an accident investigation after the March 18, 2009 date of accident. (Tr., Vol. II, p. 82). Mr. Ciancio testified that he prepared a statement as part of that investigation. (Tr., Vol. II, p. 82). He testified that he reviewed the recording and prepared a statement in which he noted the following: "[Petitioner], while walking past (2) boxes, seemed to move the boxes with her foot so as to cause them to stick out and be in the way of walking traffic. As she walked past these boxes with the water bucket, she moved directly towards the boxes and fell. In my opinion, there was not any reason to have moved the boxes in the first place. The boxes were out of the way in the first place, and moving them closer to the middle of the floor did not make any sence (sic.)." (RX 2; Tr., Vol. II, pp. 84-85).

Mr. Yeary testified that Mr. Ciancio called him on his cell phone to report an incident on March 18, 2009. (Tr., Vol. II, p. 136). He testified that he immediately went to the store location and reviewed the surveillance recording. As part of his investigation, Mr. Yeary testified that he prepared a summary of the videotape as a regular part of his investigation. (Tr., Vol. II, pp. 137-138). Mr. Yeary testified that he filled out an accident report. (Tr., Vol. II, p. 145). Mr. Yeary testified that he asked Petitioner if she had any prior injury to her knee before the current day, and he reported that Petitioner stated that she had not. (Tr., Vol. II, p. 145). Mr. Yeary testified that it was not part of Petitioner's regular job duties to fill window wash buckets. (Tr., Vol. II, p. 145). He further testified that generally the overnight shift person fills window wash buckets, but it is not impossible that Petitioner would have done so. (Tr., Vol. II, p. 146). Mr. Yeary further testified that Exxon Mobil used window wash solvent in the buckets, and not water, as water would freeze. (Tr., Vol. II, p. 146). Mr. Yeary testified that when first asked, Petitioner stated that a customer yelled at her while she was at the cash register because the buckets needed filled. She later told Mr. Yeary that the customer incident occurred outside. (Tr., Vol. II, pp. 146-147). Mr. Yeary testified that when he reviewed the video recording, he did not see Petitioner speaking to anyone. (Tr., Vol. II, p. 147). Mr. Yeary testified that he felt like Petitioner understood him when he spoke, but he may have had to repeat himself. (Tr., Vol. II, p. 147).

Petitioner testified that following the incident, the doctor at the clinic examined her and gave her medication. She testified that she initially complained about her knees, but when she returned on Friday, she complained of pain to her knees, her back and her neck. (Tr., Vol. I, pp. 51-52). Petitioner testified that the doctor at the clinic gave her medications and work restrictions. (Tr., Vol. I, pp. 56-57).

Medical records from Physicians Immediate Care evidence that Petitioner presented on four dates for treatment. On March 18, 2009, Petitioner presented to Physicians Immediate Care and provided a history of falling onto both knees when tripping while carrying a pan of water. X-rays were obtained and were negative for both knees. Dr. Jon Price diagnosed Petitioner with bilateral knee contusions. No additional history of knee complaints was provided in that record. Dr. Price noted that Petitioner could work at full duty with no restrictions. (RX 7).

On March 21, 2009, Petitioner again presented to Physicians Immediate Care. Petitioner complained of knee and back pain. She denied any activity that would have caused her to have this pain other than her fall. Dr. Price assessed: 1) Bilateral knees contusions; 2) Lumbar strain with radiation; and 3) Thoracic strain. On March 25, 2009, Petitioner again presented to Physicians Immediate Care. Petitioner provided a history of the March 18, 2009 fall at work. She denied any previous problems with her knees or back. (RX 7).

On March 31, 2009, Petitioner presented to Physicians Immediate Care. She reported that she was having discomfort in her knees and some discomfort in her back. Dr. John Koehler noted the history of Petitioner's alleged fall of March 18, 2009. No additional history was noted. Dr. Koehler assessed: 1) Bilateral knee contusions, slowly improving; 2) Cervical strain, slowly improving; 3) Lumbar strain, slowly improving; and 4) Thoracic strain, slowly improving. Dr. Koehler noted that he was not able to identify any clinically significant abnormality on exam or radiographically. It was noted specifically that Petitioner was requesting MRIs of both knees. (RX 7).

Petitioner testified that she indeed asked for an MRI. (Tr., Vol. I, p. 57). Petitioner testified on cross-examination that she already knew that she had a complex tear of the medial meniscus of her right knee at that time. (Tr., Vol. II, pp. 15-16). Petitioner testified that she went to the clinic between three and four times and that Mark drove her each time. (Tr., Vol. I, p. 58). Petitioner testified that she then began treating with Dr. Charles Brikha. (Tr., Vol. I, p. 59).[4]

Mr. Sadek testified that he was called to the Hoffman Estates store on March 18, 2009, because the store was unable to reach Petitioner's husband. (PX 30, pp. 26-27). He testified that Petitioner told him that it was not her first accident. (PX 30, p. 34). Mr. Sadek testified specifically that Petitioner was not telling Uhri (Gary), she was telling him. (PX 30, p. 34).

Petitioner presented to Dr. Brikha on April 4, 2009. According to the medical record of that date, Petitioner provided a history of falling at work on March 18, 2009. Past medical history is noted as "unremarkable." No additional history of injury was reported. (PX 4). Petitioner testified that Dr. Brikha spoke Arabic. (Tr., Vol. I, p. 66). Petitioner testified that Dr. Brikha ordered MRIs on both of her knees, her back and her neck. (Tr., Vol. I, p. 63). Petitioner testified that Dr. Brikha authorized Petitioner off of work. (Tr., Vol. I, p. 63). Petitioner underwent MRIs to her cervical spine, lumbar spine and her bilateral knees on April 6, 2009. (PX 4).

On April 13, 2009, Petitioner filed an Application for Adjustment of Claim for her March 18, 2009 date of accident. (Case Number 09 WC 16095).

Petitioner testified and medical records reflect that on April 21, 2009, she presented to Dr. David Schaffer. (Tr., Vol. I, p. 64; RX 8). Petitioner provided a history of the date of accident of March 18, 2009 in the Patient Registration and History form. The history noted in Dr. Schaffer's report notes specifically that Petitioner denied any history of injuries to her knees, back or neck prior to the accident of March 18, 2009. Dr. Schaffer opined that Petitioner's bilateral knee condition was directly related to the accident which occurred at work on March 18, 2009. He recommended bilateral knee arthroscopies and partial medial meniscectomies. (RX 8). Petitioner testified that she did not tell Dr. Schaffer about her knee symptoms before March 18, 2009, because of a fear of Gary. (Tr., Vol. II, p. 29). The following exchange took place between Respondent's counsel and Petitioner:

[Q]: Isn't it true, at that time [the April 21, 2009 evaluation with Dr. Schaffer], you denied any histories of injury to your knees, back or neck prior to this incident?

[A]: No. Before that, I didn't have any. Before the fall, I didn't have any pain in my knees and back.

[4] The transcript of proceedings incorrectly spells Dr. Brikha's name as "Brigga."

[Q]: We are talking about the March 18, 2009 date of accident; is that correct?

[A]: Yes.

(Tr., Vol. II, p. 29).

Petitioner saw Dr. Michel Malek on April 29, 2009. (Tr., Vol. I, p. 67; PX 7). The history provided in that record is of the March 18, 2009 fall. There is no history of any prior injury, including the alleged injury of January 28, 2009. (PX 7). Petitioner testified that she spoke to Dr. Malek in Arabic. (Tr., Vol. II, p. 52).

Petitioner testified that she was not truthful with her doctors. (Tr., Vol. II, p. 53).

On November 24, 2009, Petitioner filed an Application for Adjustment of Claim for her January 28, 2009 date of accident. (Case Number 09 WC 48305).

CONCLUSIONS OF LAW

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

January 28, 2009 Claimed Date of Accident (Case Number 09 WC 48305)

The Arbitrator finds that Petitioner did not prove she suffered an accident that arose out of and in the course of her employment by Respondent on January 28, 2009. Petitioner testified that she worked for Respondent for approximately nine years. Petitioner did not fill out an accident report for her alleged date of accident of January 28, 2009. Petitioner did not contact the store manager at the time of her accident per Exxon Mobil emergency flow chart procedures.

Multiple medical records immediately following the alleged accident do not support a compensable injury. Medical records of Dr. Shaikh specifically state that Petitioner denied trauma but was complaining of bilateral knee pain, and it was noted that she worked at a gas station standing twelve hours per day. Dr. Shaikh diagnosed bilateral DJD (degenerative joint disease), including chronic left knee pain. Medical records from Alexian Brothers dated February 1, 2009 indicate Petitioner had been complaining of right knee pain for two days. The triage assessment notes a specific denial of injury. The two medical notes closest in time to Petitioner's alleged injury do not support a compensable accident.

Respondent's two witnesses, Gary Ciancio and Mark Yeary, testified consistently that all Exxon Mobil employees are instructed to immediately report an injury or accident. They both credibly testified that Petitioner did not report an accident on January 28, 2009. Both Mr. Ciancio and Mr. Yeary testified that if Petitioner had reported an accident, the video surveillance recordings from the pump area would have been saved. Both also testified credibly that no accident investigation was completed because no accident was reported to have occurred on January 28, 2009.

Petitioner's testimony as to what occurred at the time of the alleged accident is inconsistent. She testified that she was walking toward the customers when she slipped and hit her knee, yet she also testified that she was returning from closing the pump when she slipped. She testified that she was returning from closing the pump when she slipped, but she also testified that she was carrying the paper that she would have put onto the pump to notify customers that they could not use the pump.

Petitioner testified that she fell onto her right knee; however, her husband, Ehmed Kirollos, testified that she had injured her bilateral knees and that he brought her ice for her knees. Mr. Kirollos' testimony is consistent with initial medical reports showing that Petitioner was making complaints to her bilateral knees.

The Arbitrator finds that Petitioner is not credible. The Arbitrator notes the inconsistent testimony provided by Petitioner on multiple occasions, her own admission in not being truthful to her medical providers, and her demeanor when testifying, *i.e.*, that she appeared to be endeavoring to provide untruthful and incredible testimony. Concerning any alleged language barrier, the Arbitrator notes that Petitioner was admonished at trial for attempting to answer questions before the translation was given. The Arbitrator further finds that Gary Ciancio and Mark Yeary were credible witnesses. Both endeavored to give forthcoming and truthful testimony.

Mr. Sadek testified he was friends with Petitioner and her family and that he had no supervisory role over her. He testified that when asked if she was "ok," Petitioner told him that she was hurting. Mr. Sadek instructed Petitioner to tell Gary, because that is how to handle the issue. He testified that he continued asking her what her manager had done and that Petitioner reported to him that Gary had not done anything.

The first medical report indicating that Petitioner was alleging that she fell at work is a note from Dr. Shaikh dated March 9, 2009. This is after Petitioner's initial MRI of her right knee on March 1, 2009, and after treatment plans were discussed with Dr. Shaikh on March 3, 2009, and at a time Petitioner was unable to find an orthopedic surgeon. Dr. Shaikh instructed her as a Public Aid patient to go to Loyola.

March 18, 2009 Claimed Date of Accident (Case Number 09 WC 16095)

The Arbitrator finds that Petitioner did not prove an accident that arose out of and in the course of her employment by Respondent on March 18, 2009. The Arbitrator again notes that Petitioner is not credible. At the time of her alleged injury of March 18, 2009, Petitioner was aware that she needed right knee surgery. Dr. Shaikh's note of March 9, 2009 indicated that Petitioner was not able to find an orthopedic surgeon and Dr. Shaikh referred her as a Public Aid patient to Loyola.

The video recording in evidence shows Petitioner moving a box into the walkway and then tripping over the box while performing a task that both Respondent's witnesses credibly testified was not part of her usual job duties. On rebuttal testimony over three months after the case had previously been heard, and after seeing the video surveillance and hearing the testimony of Mr. Ciancio and Mr. Yeary, Petitioner explained that she kicked the box out of the way and into the walkway to move a bug or spider. Petitioner's explanation as to why she moved the box a second time is not credible.

Petitioner then saw multiple physicians and failed to provide any history of her alleged January 28, 2009 injury. She testified that she was not truthful with her physicians. Medical records support that Petitioner was not truthful with the physicians at Physicians Immediate Care. Medical records evidence that Petitioner was not truthful with Dr. David Schaffer. Medical records evidence that Petitioner was not truthful with Dr. Michel Malek. Petitioner is not a credible witness, and great weight is placed on this factor when taking into account all of the evidence.

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

January 28, 2009 Claimed Date of Accident (Case Number 09 WC 48305)

The Arbitrator finds that Petitioner failed to provide proper notice for the claimed January 28, 2009 accident. Petitioner testified that she gave Gary a restriction slip on January 30, 2009. The restriction slip in evidence does not indicate that Petitioner had an injury, nor does it state the reason for the five day sitting restriction, nor does it indicate a diagnosis.

Gary Ciancio testified that Petitioner never informed him that she was injured on January 28, 2009. If Petitioner had properly provided notice, Mr. Ciancio testified that the video recording would have been saved and reviewed as part of an accident investigation. Mark Yeary testified consistently with Mr. Ciancio that video would have been saved if an accident had been properly reported. Mr. Yeary testified that Petitioner did not report an accident, and he was unable to complete an accident investigation. He confirmed that after 30 days, video evidence is gone. Mr. Yeary testified credibly that he was first provided notice that Petitioner was alleging an accident date of January 28, 2009 approximately 80 days after the alleged injury. Mr. Yeary further testified that at the time of Petitioner's March 18, 2009 incident, he asked her if she had ever injured her knee before and she stated, "no."

Petitioner failed to provide proper notice as required by Section 6(c) of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). The purpose of the notice requirement is to enable an employer to conduct an investigation into an alleged accident. Under the Act, notice must be provided to the employer as soon as practicable, but no later than 45 days after the accident. 820 ILCS 305/6(c). Mere notice to an employer of some type of injury is not sufficient to satisfy the notice requirement. *White v. Workers' Comp. Comm'n*, 374 Ill. App. 3d 907, 911, 873 N.E. 2d 388 (4th Dist. 2007). In the case at bar, Respondent was prejudiced by its inability to view video surveillance from January 28, 2009.

March 18, 2009 Claimed Date of Accident (Case Number 09 WC 16095)

The evidence establishes that store manager Gary Ciancio and territory manager Mark Yeary were present with Petitioner immediately after she fell on March 18, 2009. Mr. Ciancio heard the fall and immediately came to Petitioner. Mr. Yeary took Petitioner to the hospital following the incident. It is apparent that Respondent received notice of the alleged work accident on the day in question, and therefore, Petitioner has satisfied the notice requirement for the March 18, 2009 alleged accident.

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

Dr. David Schaffer provided an opinion that Petitioner's current complaints with regard to her knees was directly related to the accident which occurred on March 18, 2009. A doctor's opinion is only as reliable as the bases provided for the opinion. *Gross v. Workers' Comp. Comm'n*, 2011 IL App. (4th) 100615WC, 960 N.E.2d 587, 594 (4th Dist. 2011). Petitioner testified that she was not truthful with her doctors. Dr. Schaffer's record clearly has a faulty history. Petitioner failed to provide a history of her pre-existing right medial meniscal tear.

Dr. Michel Malek diagnosed Petitioner with low back and neck injury post-injury of March 18, 2009. Petitioner testified that she did not provide a truthful history to Dr. Malek. Dr. Malek's medical records confirm that Petitioner did not provide an accurate history.

The physicians providing causal relationship of Petitioner's condition of ill-being to her date of accident are relying on inaccurate histories provided by Petitioner and their opinions are not reliable. The Arbitrator also notes the conclusions concerning accident, discussed *supra*. Accordingly, the Arbitrator finds that Petitioner has failed to prove her current condition of ill-being is causally related to any work injury.

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

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

Based on the conclusions concerning accident and causal connection discussed above, the Arbitrator denies an award of medical bills or temporary total disability benefits in this matter.

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

KIROLLOS, NAGWA
Employee/Petitioner

Case# **09WC048305**
09WC016095

EXXON MOBIL CORPORATION
Employer/Respondent

15IWCC0183

On 10/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% 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:

STRECKER JEPSON & ASSOCIATES
601 N. HICKS RD
SUITE C
PALATINE, IL 60067

4444 VINCENT WAGNER
4541 N. MONTICELLO
CHICAGO, IL 60625

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

15IWCC0183

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)

NAGWA KIROLLOS
Employee/Petitioner

Case # 09 WC 48305

v.

Consolidated case: 09 WC 16095

EXXON MOBIL CORP.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the cities of **Chicago** and **Urbana**, on the dates of **September 17, 2012, October 10, 2012, January 22, 2013** and **August 20, 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

15IWCC0183

FINDINGS

On the date of accident, **January 28, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this alleged accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$9,433.84**; the average weekly wage was **$181.42**.

On the date of the alleged accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

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

ORDER

The Arbitrator finds that Petitioner has failed to sustain her burden of establishing a work accident or that her condition of ill-being is related to her work with Respondent. Accordingly, benefits are hereby denied.

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

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

Signature of Arbitrator

10/07/2013
Date

ICArbDec19(b)

OCT 15 2013

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

Dennis Gulley,

Petitioner,

15IWCC0184

vs.

NO: 10 WC 39383

The American Coal Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2014, is hereby affirmed and adopted.

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

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

15IWCC0184

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

DATED: MAR 17 2015
o3/4/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

15IWCC0184

GULLEY, DENNIS
Employee/Petitioner

Case# **10WC039383**

THE AMERICAN COAL COMPANY
Employer/Respondent

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

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

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

0755 CULLEY & WISSORE
HAROLD B CULLEY JR
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0143 CRAIG & CRAIG
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

15IWCC0184

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

DENNIS GULLEY
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 10WC 39383

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 **February 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **March 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 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 **$57,999.76**; the average weekly wage was **$1,115.38**.

On the date of accident, Petitioner was **56** 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

3/21/14
Date

APR 4- 2014

The Arbitrator makes the following finding on all disputed issues:

Petitioner was 60 years old at the time of arbitration. He did not have any formal education after graduating from high school. His work career included 19 years of coal mining, all of which was underground. During his coal mining career in addition to coal dust, he was regularly exposed to silica dust, rock dust, roof bolting glue and diesel fumes.

Petitioner last worked a shift in coal mine employment on March 28, 2010, for Respondent. His classification on that last day was mine examiner. He was exposed to coal mine dust on that day. Petitioner did not return to work because of cancer of the kidney and treatment for same.

Petitioner began his coal mining career at 18 years of age. During times of layoff, he did various factory work and other temporary work. He testified that he first noticed his breathing problems two years before he left the mine. At that time he was working as an examiner. He testified that during the first part of his shift he did escape ways so he was able to sit and rest a few times. It was more difficult on the pre-shift exam because he had to keep going. A lot of his time entailed jumping on golf carts and running to the next place. Petitioner testified that as examiner the miles he had to walk per day could vary from four to eight. Petitioner testified that half of the time was spent walking in the return air and the other half in active working sections. Petitioner testified that any coal or rock dust or diesel fumes come out in the return air.

Petitioner testified that he had an inhaler that he used when he needed it. Prior to being a mine examiner, Petitioner worked as a roof bolter. He testified that he took the mine examiner job hoping that it would be in less coal dust and also it was a little more money. Petitioner testified that the mine examiner job required more walking but less lifting and that type of thing than the roof bolter job. In the examining job, Petitioner found out that the rock dust was worse than the coal dust. Petitioner testified that he smoked for 15 or 16 years, quitting in 1991. He testified that he never smoked over a pack a day.

Petitioner testified that but for the diagnosis of cancer he would have tried to continue mining. He testified that he has not worked anywhere since March 28, 2010, and has not looked for any work. Petitioner testified had he had collected short term disability benefits and was currently receiving long term disability benefits as a result of his cancer. He also applied for and received Social Security Disability.

Petitioner saw Dr. Glennon Paul one time on January 10, 2011, at the request of his counsel. (Petitioner's Exhibit No. 1, p. 34, Deposition Exhibit No. 2). Dr. Paul is board certified in internal medicine and asthma, allergy and immunology (Petitioner's Exhibit

No. 1, Deposition Exhibit No. 1). Dr. Paul described Petitioner's chest x-ray as showing nodules in the right hilar area and a small nodular area throughout all the lung fields. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). He testified that he reads hundreds of chest x-rays per week and has been doing so for 35 years. (Petitioner's Exhibit No. 1, p. 33). Dr. Paul is not an A or B-reader (Petitioner's Exhibit No. 1, p. 39).

Petitioner related to Dr. Paul that he had exertional shortness of breath. Dr. Paul testified that there are many causes of same. (Petitioner's Exhibit No. 1, p. 35). Dr. Paul charted in his report that Petitioner would get coughing attacks in the morning with sputum. (Petitioner's Exhibit No. 1, p. 36). On physical examination of Petitioner's chest, Dr. Paul heard wheezes, rhonchi and rales. He attributed the wheezes and rhonchi to asthma and the rales to coal workers' pneumoconiosis. (Petitioner's Exhibit No. 1, p. 10). Dr. Paul testified that regarding the pulmonary function report, minimal obstruction would be read because of the decrease in the forced vital capacity and borderline decrease in the FEV1 and decrease in the FEF 25/75. Dr. Paul testified that this was reversible because Petitioner's FEF 25/75 went up to 103% of predicted with treatment with dilators. (Petitioner's Exhibit No. 1, p. 11). Dr. Paul testified that Petitioner had coal workers' pneumoconiosis caused by coal dust and asthma caused by coal dust and the coal mine environment including roof bolting glue fumes, diesel fumes and silica. (Petitioner's Exhibit No. 1, pp. 12-13).

Dr. Paul testified that by definition if one has coal workers' pneumoconiosis, he has some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (Petitioner's Exhibit No. 1, p. 18). Dr. Paul testified that in light of the diagnoses of coal workers' pneumoconiosis and asthma, Petitioner could have no further exposure to the environment of the coal mine without endangering his health. (Petitioner's Exhibit No. 1, p. 13). Petitioner did not tell Dr. Paul that he left work at the time he did on the advice of a physician or that he had any difficulty in performing the last job duties he had at the coal mine. (Petitioner's Exhibit No. 1, pp. 36-37). Dr. Paul testified that he did not discuss with Petitioner any triggers for his asthma. (Petitioner's Exhibit No. 1, p. 37).

Dr. Paul did not know the date of the chest x-ray that he reviewed. Dr. Paul testified that profusion is the amount of air that the lung will take in. Dr. Paul testified that profusion does not mean the concentration of the small opacities in the affected lung zones. (Petitioner's Exhibit No. 1, pp. 38-39). Dr. Paul testified that Petitioner's coughing in the morning and throughout the day with sputum fulfilled the criteria for chronic bronchitis. Dr. Paul testified that chronic bronchitis was caused by exposure to coal dust and Petitioner's 20-pack-year smoking history. (Petitioner's Exhibit No. 1, pp. 41-42).

Dr. Henry K. Smith, board certified radiologist and certified B-reader, interpreted chest x-rays at the request of Petitioner's counsel. He interpreted chest x-ray dated April 20, 2010, as positive for pneumoconiosis, category 1/0 with P/S opacities in all lung zones. He interpreted chest x-ray of September 17, 2010, as positive for pneumoconiosis, category 1/0 with P/P opacities in all lung zones. Dr. Smith also reviewed CT scans dated March 31, 2010, May 19, 2010, July 22, 2010, October 13, 2010, and December 27, 2010. He interpreted the CTs of the chest as showing simple coal workers' pneumoconiosis with small opacities throughout the bilateral upper, mid and lower zones, P/S, profusion 1/0. (Petitioner's Exhibit No. 2). Dr. Robert Cohen, board certified pulmonologist and certified B-reader, interpreted chest x-rays dated April 20, 2010, and September 17, 2010, as positive for pneumoconiosis, category 1/0 with S/T opacities in all lung zones. (Petitioner's Exhibit No. 3).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed PA and lateral chest x-rays dated April 20, 2010, and September 17, 2010. He also reviewed a chest CT scan dated March 31, 2010. Dr. Meyer found the chest x-rays to be quality 1. Dr. Meyer found the lungs to be clear and found no evidence of coal workers' pneumoconiosis on the films. He did note extensive hilar and mediastinal lymphadenopathy. (Respondent's Exhibit No. 1, p. 40).

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, p. 20). Dr. Wiot was on the original committee that designed the training program which is called the B-reader program. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. (Respondent's Exhibit No. 1, p. 32). Dr. Meyer testified that the radiologists have about a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation in normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making the distinction between 0/1 and 1/0. (Respondent's Exhibit No. 1, pp. 34-35).

Dr. Meyer testified that the B-reader looks at the lung x-ray 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. (Respondent's Exhibit No. 1, p. 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. (Respondent's Exhibit No. 1, pp. 28-29). The distribution of opacities

is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant disease process. (Respondent's Exhibit No. 1, pp. 22-23). The last component of the lung involvement piece for small opacities is the extent of the lung involvement, the so-called profusion. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer testified that profusion is basically trying to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 30).

Dr. Jeff Selby examined Petitioner on April 26, 2012, at the request of Respondent's counsel. (Respondent's Exhibit No. 2, p. 9). Dr. Selby is board certified in internal medicine and pulmonology. He has been a B-reader since 1985. (Respondent's Exhibit No. 2, p. 4). Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient and all manner of consultation work as far as the chest, lung or breathing disorders (Respondent's Exhibit No. 2, p. 5).

Petitioner complained to Dr. Selby of shortness of breath which he started noticing in 2000. Petitioner reported to Dr. Selby that Dr. Thompson gave him an Albuterol inhaler several years ago. Petitioner reported that he wheezed every day, especially at night. He had a productive cough every day of brown to black mucous. The triggers for wheezing and coughing were nail polish remover and cleaners. (Respondent's Exhibit No. 2, pp. 10-11). Petitioner reported to Dr. Selby that one to two nights per week he would wake up at night having trouble breathing. Dr. Selby testified that same is most commonly seen in asthma and congestive heart failure. (Respondent's Exhibit No. 2, pp. 11-12). Petitioner gave a history of smoking one pack of cigarettes a day from 1971 to 1991. (Respondent's Exhibit No. 2, p. 15).

Dr. Selby's examination of Petitioner's chest was normal with good air flow and clear breath sounds. (Respondent's Exhibit No. 2, p. 16). Pulmonary function testing was interpreted as showing normal spirometry without improvement post bronchodilator, normal lung volumes and normal diffusion capacity. (Respondent's Exhibit No. 2, p. 17). His spirometry did not reveal the presence of an obstruction. (Respondent's Exhibit No. 2, p. 18). Dr. Selby testified that Petitioner's normal total lung capacity ruled out the presence of a restrictive disease. (Respondent's Exhibit No. 2, p. 19). Dr. Selby concluded from the testing that he performed that Petitioner was capable of heavy manual labor from a pulmonary standpoint. (Respondent's Exhibit No. 2, p. 21).

Dr. Selby reviewed CTs of Petitioner's chest dated March 31, 2010, May 19, 2010, July 22, 2010, October 13, 2010, and December 27, 2010. Dr. Selby found no evidence of coal workers' pneumoconiosis on these films. He did note significant mediastinal adenopathy on each of the films. He also reviewed chest x-rays dated April 20, 2010, and

September 17, 2010. He found no evidence of coal workers' pneumoconiosis. He noted there was a four to five centimeter right infra-hilar density consistent with malignancy or adenopathy on the September 17, 2010, chest x-ray. (Respondent's Exhibit No. 2, pp. 21-22). Dr. Selby testified that when evaluating a film for the presence of coal workers' pneumoconiosis, it is important to note the profusion of the film. He testified that profusion is the concentration of small opacities in affected zones of the lungs. Dr. Selby testified that it is not possible to diagnose pulmonary impairment strictly from a chest x-ray. (Respondent's Exhibit No. 2, p. 23).

Dr. Selby concluded that Petitioner did not suffer any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment. Dr. Selby concluded that Petitioner had asthma based entirely on his history of wheezing especially at night and being treated by his primary physician using Albuterol inhaler. Dr. Selby testified that if Petitioner has asthma, it was not caused by or exacerbated by his coal mine employment but is garden variety and related to his genetic makeup and viral infections. (Respondent's Exhibit No. 2, pp. 23-24).

Dr. Selby reviewed medical records of Dr. Bob Thompson and Dr. Oza. He also reviewed the medical report of Dr. Paul. Dr. Selby testified that the results of the pulmonary function testing by Dr. Paul did not reveal an obstruction for Petitioner. (Respondent's Exhibit No. 2, pp. 25-26). Dr. Selby disagreed with Dr. Paul's diagnosis of chronic bronchitis. He did not see that diagnosis anywhere in Petitioner's treatment records. (Respondent's Exhibit No. 2, p. 27). Dr. Selby testified that Petitioner had clinical signs consistent with asthma, but there was no evidence of asthma on any testing. The diagnosis of asthma was never made in any of the treatment records that Dr. Selby reviewed. (Respondent's Exhibit No. 2, pp. 27-28).

According to his Disability Insurance Claim, Petitioner was unable to continue working in April 2010, due to his advanced renal cell carcinoma and treatment for same. (Respondent's Exhibit No. 8). In his Application for Social Security Disability benefits, Petitioner listed metastatic renal carcinoma as the physical condition which limited his ability to work (Respondent's Exhibit No. 7, p. 23).

Petitioner first saw Dr. Oza at Center for Comprehensive Cancer Care on March 31, 2010. On the Patient Questionnaire Petitioner denied cough, expectoration and shortness of breath. (Respondent's Exhibit No. 3, p. 599). Dr. Oza completed an Attending Physician's Statement of Disability for Respondent on April 9, 2010, indicating that Petitioner's primary diagnosis was renal cell carcinoma and that the condition was not work related. (Respondent's Exhibit No. 3, pp. 576-577). When Petitioner saw Dr. Oza on September 1, 2010, May 23, 2012, and December 27, 2012, review of systems

respiratory revealed no cough, expectoration or shortness of breath (Respondent's Exhibit No. 3, pp. 64-65, 84, 498). Physical examination of the chest on those same dates revealed the lungs to be clear to auscultation and percussion. (Respondent's Exhibit No. 3, pp. 65, 85, 499). Petitioner was seen at Dr. Oza's office on February 7, 2013. He related he was short of breath at that time. His hemoglobin was a little low and anemia workup was ordered. Review of systems respiratory revealed no cough or expectoration. Physical examination of the chest revealed the lungs clear to auscultation and percussion. (Respondent's Exhibit No. 3, p. 60). When seen by Dr. Oza on March 21, 2013, and July 23. 2013, review of systems respiratory was negative for cough, expectoration or shortness of breath. Physical examination of the chest revealed the lungs to be clear to auscultation and percussion. (Respondent's Exhibit No. 3, pp. 40-41, 55). On July 23, 2013, Petitioner was continued on his current dose of Sutent. The plan was to monitor the disease state and to look for recurrence, toxicity and/or end-organ dysfunction. (Respondent's Exhibit No. 2, pp. 42).

Petitioner underwent an upper EUS at Barnes Jewish Hospital on April 30, 2010 (Respondent's Exhibit No. 4, p. 32). In the pre-sedation assessment, Petitioner denied any respiratory problem including shortness of breath, asthma, bronchitis and emphysema. (Respondent's Exhibit No. 4, p. 13).

Petitioner was seen by Dr. David R. Knowles on April 7, 2010. On that date the social history included a 20-pack-year history of smoking, having quit said habit. In review of systems respiratory, Petitioner denied seasonal allergies and shortness of breath. Examination of the chest revealed even and unlabored respirations. (Respondent's Exhibit No. 5, p. 1). Petitioner was seen by Dr. Knowles on December 8, 2010. Review of systems respiratory revealed no shortness of breath and the physical examination of the chest revealed even and non-labored respirations. (Respondent's Exhibit No. 5, p. 13).

Petitioner's primary care physician was Dr. Bob Thompson. Petitioner saw Dr. Thompson on March 1, 2010, to discuss diabetes issues. On examination, chest was clear to auscultation and percussion. (Respondent's Exhibit No. 6, p. 13). Petitioner was seen by Dr. Thompson on September 21, 2010. On examination it was noted that Petitioner's chest was clear to auscultation and percussion. Dr. Thompson was going to author a letter for Petitioner stating that he had cancer of the kidney which was terminal so that he could apply for Social Security Disability. (Respondent's Exhibit No. 2, p. 10).

The Arbitrator concludes:

1. Petitioner has failed to prove by a preponderance of the evidence that he has sustained an occupational disease arising out of and in the course of his

employment. The Arbitrator finds the B-readings by Dr. Meyer and Dr. Selby to be more credible.

2. Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being is causally connected to his employment

3. Petitioner has failed to prove timely disablement as required by Sections 1(e) and 1(f) of the Occupational Diseases Act. The event which caused Petitioner to cease earning full wages in coal mine employment was his renal carcinoma, not the presence of coal workers' pneumoconiosis. See Forsythe v. Industrial Comm'n, 263 Ill. App. 3d 463 (5th Dist. 1994).

4. Petitioner's claim for benefits pursuant to Section 8 is 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

Stacy Phillips,

Petitioner,

15IWCC0185

vs.

NO: 11 WC 46939

Bugle Ridge Inc., d/b/a Red Oak Estates,

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, 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 June 16, 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.

15IWCC0185

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

DATED:
o3/4/15 MAR 17 2015
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

15IWCC0185

PHILLIPS, STACY
Employee/Petitioner

Case# **11WC046939**

BUGLE RIDGE INC D/B/A RED OAK ESTATES
Employer/Respondent

On 6/16/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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BRET TAYLOR
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

15IWCC0185

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

Stacy Phillips
Employee/Petitioner

v.

Bugle Ridge, Inc. d/b/a Red Oak Estates
Employer/Respondent

Case # **11WC 046939**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **April 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **02/25/2010**, 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 **N/A** given to Respondent.

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

In the five (5)-week pre-injury work history preceding the injury, Petitioner earned **$1,762.00**; the average weekly wage was **$352.40**.

On the date of accident, Petitioner was **34** 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 for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of $0

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

ORDER

Petitioner has failed to meet her burden of proof as to the issue of Accident. All other issues therefore are moot, and the 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.

D. Dyk McCarthy
Signature of Arbitrator

June 10, 2014
Date

JUN 16 2014

MEMORANDUM OF DECISION OF ARBITRATOR

Petitioner alleges she suffered a low back injury as a result of lifting a resident at Respondent's assisted living facility on February 25, 2010. Petitioner testified she began working for Respondent as an assisted living caregiver in its facility at the end of January 2010, or approximately five weeks prior to the alleged accident. Petitioner testified she was assisting a disabled resident out of her wheelchair to dress when she felt a pop in her lower back. She testified she had an immediate onset of low back pain that has continued throughout her course of treatment. She denied any prior low back injuries or low back pain. Petitioner testified on the date of accident she told the co-owner of Respondent, Kevin Williams, she suffered a low back injury while lifting a resident on the date of the accident, and he referred her to Klinedinst Chiropractic Clinic. Petitioner testified she initially treated with Chiropractor R.L. Klinedinst and her primary care provider, Debra Hayes, CFNP, at Graham Medical Group. Petitioner was then referred to Dr. Glen Feather at the Illinois Regional Pain Clinic who prescribed physical therapy and epidural steroid injections. She was subsequently referred to Dr. Richard Kube who performed two low back surgeries, the first on August 3, 2012, and the second on March 18, 2013. Petitioner testified Dr. Kube has placed her on light duty restrictions and has indicated she may be a candidate for a dorsal column stimulator in the future.

The medical evidence shows Petitioner sought treatment with Chiropractor Klinedinst on the date of injury, February 25, 2010. (RX-3). The chiropractic registration and history form reflects the reason for the visit was back pain, and the symptoms began on February 25, 2010, around 5:00 a.m. (RX-3). The office note for this visit reflects the chief complaint was mid back pain on the right side. (RX-3). Petitioner reported the symptoms began "this a.m. – woke up with it." (RX-3). Where Petitioner could have identified whether the complaints were work-related and how the injury occurred, Petitioner provided no information. (RX-3). However, under the category of other causes, it was underlined "unknown." (RX-3). Petitioner provided a complaint history of no cervical pain but could feel the pain in her shoulder blades with cervical range of motion. (RX-3). She noted it hurt to move her right arm. (RX-3). Petitioner marked an "X" on her right scapula for the location of pain in the pain diagram, and treatment was given to the cervical and thoracic spine but not to the lumbosacral spine. (RX-3). There was no reference to a work-related low back injury. (RX-3). The next visit with Chiropractor Klinedinst was on June 17, 2010, four months later. (RX-3). She again reported continuing right scapular complaints. (RX-3). Treatment was provided to the cervical and thoracic spine; however, no treatment was provided to the lumbosacral spine. (RX-3). There was no reference to a work-related low back injury. (RX-3). Petitioner's next visit was on November 4, 2010, approximately nine months after the date of injury. Again, Petitioner noted her chief complaint was in the right scapula area, and Petitioner placed an "X" in the right scapular region of the pain diagram. (RX-3). There was no reference to low back complaints or a work-related injury. (RX-3).

Petitioner completed an employee health questionnaire which she signed and dated on January 6, 2011. (RX-5). The purpose of the questionnaire was a physical for her employer. (RX-5). When asked whether she currently or previously had complaints in the back (spine) or backaches, Petitioner checked off "no." (RX-5).

Petitioner's primary care physician was Graham Medical Group. Petitioner regularly treated with this group, and Nurse Practitioner Debra Hayes for numerous conditions and complaints. (PX-4). The first

reference to back pain was provided to Nurse Practitioner Hayes on May 24, 2011, 15 months after the date of injury. (PX-4; RX-6). At that time, she reported having back pain which was on the right, beneath the scapula. (RX-6). She noted the pain was transient in nature. She felt it was aggravated by heavy lifting at work. (RX-6). She reported no back trauma and a history of scoliosis. (RX-6). There was no reference to a work-related low back injury. (RX-6). Petitioner was seen again on October 17, 2011, when she again reported a history of chronic back pain and treatment with a chiropractor. (PX-4; RX-7). She again reported no trauma. (RX-7). She noted the pain was in the low back. (RX-7). She also reported she had no insurance and limited care options. (RX-7). There was no reference to a work-related injury history in the medical note. (RX-7).

Petitioner was prescribed physical therapy at that time. (RX-7). On the initial physical therapy evaluation and treatment note of November 14, 2011, Petitioner provided a history of low back pain since December 2009. (RX-8; PX-3). She reported a history of having back pain for 18 months and then the past summer developing burning on the medial aspect of the right foot. (RX-8). Though she provided details on her work activities as well as her home activities, she did not provide a work-related injury history. (RX-8).

Petitioner began treating with Dr. Feather at the Illinois Regional Pain Institute in December 2011. (PX-5). On her first medical visit of December 21, 2011, Petitioner reported right low back pain radiating into the right leg as a result of an on-the-job injury of February 10, 2010. (PX-5). This medical visit was 22 months after the alleged date of injury. Petitioner reported working as a caregiver in a facility for disabled and confined patients which required lifting on a frequent basis. (PX-5). Petitioner continued to treat with Dr. Feather through April 10, 2013. (PX-7). Following an MRI in November 2011 and a course of epidural steroid injections, Dr. Feather referred Petitioner to Dr. Kube. (PX-7).

Petitioner began treating with Dr. Kube on April 10, 2012. (PX-14). During the course of his care, he performed an L3-4 right hemilaminectomy with microdiscectomy on August 3, 2012. (PX-15). Petitioner had continuing reports of right-sided low back and right lower extremity radicular complaints post-operatively. (PX-14). Dr. Kube ordered two additional EMG/NCV studies on July 2, 2012, and January 10, 2013. (PX-11; PX-12). He ultimately performed a second surgery on March 18, 2013, to remove a lateral disc herniation at L3-4 on the right. (PX-16). Petitioner continued to have post-operative complaints, and a Functional Capacity Evaluation was performed on September 12, 2013. (PX-18). Following the FCE, Dr. Kube placed Petitioner on permanent light duty work restrictions. (PX-14).

In addition to the foregoing, Petitioner began seeking medical treatment with plastic surgeon K.G. Shah on March 15, 2010, 18 days after the alleged date of injury. (RX-9). The purpose of this treatment was to begin the process for cosmetic breast enhancement procedures. (RX-9). Petitioner ultimately underwent a bilateral breast augmentation mammoplasty on March 31, 2010. (RX-9). She was released from Dr. Shah's care on April 28, 2010. (RX-9). During the course of her treatment with Dr. Shah, Petitioner made no reference to low back complaints or a low back injury at work. (RX-9).

Petitioner testified at arbitration she was initially referred for treatment with Chiropractor Klinedinst by Mr. Williams on the date of injury. However, the chiropractic records reflect Petitioner previously treated with Chiropractor Klinedinst and reflect Petitioner was referred to him by Sam Ruey, her child's

father. On cross examination, Petitioner testified she would not dispute she had been referred by Mr. Ruey to Chiropractor Klinedinst.

Petitioner testified she only reported low back complaints to her medical care providers, only sought treatment for low back complaints from her medical care providers and reported a work-related injury history to all of her medical care providers. However, upon cross examination, Petitioner ultimately acknowledged she did not report low back pain related to an on-the-job injury in February 2010 until she saw Dr. Feather for the first time in December 2011. When asked why she waited 22 months to report an on-the-job injury to her medical care providers, Petitioner testified all of her medical care providers refused to document a work-related injury history or low back pain because they did not have "the paperwork."

Petitioner testified she stopped working for Respondent in December 2011 but was subsequently able to locate employment which did not require her to do any lifting. Petitioner testified she fixed meals for an elderly couple in their 90's and was their general companion. However, on cross examination Petitioner acknowledged she did more than cook meals for the elderly couple. Petitioner testified she began working for the elderly couple, the Sthleighs, in 2008. She testified she provided services for the Sthleighs on a regular basis beginning in 2010 through August 2012. She further acknowledged her services included assisting Mr. Sthleigh in activities such as getting dressed, bathing and assisting him if he were to stumble and fall while using a walker. She acknowledged the services she provided to Mr. Sthleigh required her to lift.

Robin Walters testified on behalf of Petitioner. Ms. Walters testified she previously worked with Petitioner for Respondent. Ms. Walters testified she has been friends with Petitioner for six or seven years, and they regularly communicate with each other three or four times per week. Ms. Walters testified she socializes with Petitioner and that she would like to see Petitioner successful in her workers' compensation claim. Ms. Walters testified she saw Petitioner working on the day in question and observed her talking to Mr. Williams on the day in question. Ms. Walters testified she observed Petitioner in pain on the day in question.

Petitioner also called Alexis Simkins to testify. Ms. Simkins testified she is a former employee of Respondent who worked in an LPN capacity. Ms. Simkins also testified she has been a friend of Petitioner since at least 2004-05. Ms. Simkins previously worked for Respondent as an LPN. Ms. Simkins testified she was terminated from her employment with Respondent. She acknowledged she, Ms. Walters and Petitioner drove to court together on the date of arbitration. As to the accident in question, Ms. Simkins acknowledged when she was working she would frequently be in a supervisory capacity over Petitioner, but she was not working on the date of the alleged accident. Ms. Simkins testified Petitioner called her on the date of the alleged accident and told her that she had injured her herself that day while lifting a resident. She said the Petitioner reported that it felt like something had shot down her body. She then drove to Petitioner's house to put ice packs on her back. She did not testify as to whether she notified the employer about the Petitioner's reported injury.

Kevin Williams testified on behalf of Respondent. Mr. Williams testified he is a part owner of Respondent and was working on the date of the alleged accident. Mr. Williams testified he recalled Petitioner telling him she was having back complaints, but he did not recall whether her back complaints

were located in her upper, mid or lower back. Mr. Williams testified Petitioner did not tell him she had suffered any type of lifting or work-related injury resulting in the back complaints. Mr. Williams further testified he did not tell Petitioner to see Chiropractor Klinedinst at any time. Mr. Williams acknowledged Petitioner left work to see a doctor on the date of the alleged injury, but thereafter she continued to work without restriction through December 16, 2011. He testified she continued to perform her regular job activities without limitation and did not appear to be disabled or limited in any way during the ensuing 22 months following the alleged accident of February 25, 2010. Mr. Williams testified he was not made aware of a work-related injury in February 2010 until he received a letter from Petitioner's attorney on December 16, 2011. Mr. Williams then completed the Form 45 on the date he received notice of the alleged work-related injury. (RX-2).

Petitioner was seen by Dr. Avi Bernstein, a Board-certified orthopedic surgeon, for a Section 12 examination on November 18, 2013. (RX-1). In addition to obtaining a history from Petitioner, Dr. Bernstein also conducted a clinical examination and reviewed all of her medical records up to the date of the examination. (RX-1). Based upon the medical records, Dr. Bernstein opined Petitioner's lumbar disc herniations and resulting lumbar treatment and lumbar spine surgeries were not related to the accident of February 25, 2010. (RX-1). Dr. Bernstein noted the chronology of complaints in the medical records. (RX-1). Dr. Bernstein noted Petitioner's first report of low back pain in the medical records was on October 17, 2011, and that her subsequent complaints of low back pain and radiculopathy were too far removed from the date of incident "to even remotely suggest" her low back problems were causally related to the alleged incident. (RX-1).

Petitioner's treating orthopedic surgeon, Dr. Richard Kube, provided deposition testimony in this matter. (PX-20). Dr. Kube testified Petitioner began treating with him on April 10, 2012. (PX-20, p. 10). His diagnosis at this time was a disc herniation at L3-4 on the right side. (PX-20, pp. 21-22). Dr. Kube ordered an EMG and prescribed conservative treatment but ultimately performed a minimally invasive microdiscectomy at L3-4 on the right side on August 3, 2012. (PX-20, pp. 25-26). Post-operatively Petitioner had continuing low back and radicular complaints, and an EMG/NCV was performed on January 10, 2013. (PX-20, p. 35). A new MRI was performed on January 28, 2013, and Dr. Kube proceeded with a second microdiscectomy on March 18, 2013. (PX-20, p. 44). Dr. Kube causally related the abnormal condition he diagnosed and treated at the L3-4 level to the work accident of February 25, 2010. (PX-20, pp. 58-59). The basis for this opinion was the history provided by Petitioner of a contemporaneous onset of low back symptoms at the time of the injury, consistent complaints throughout her treatment and ongoing treatment through the date he first treated her. (PX-20, p. 59).

Dr. Kube acknowledged the basis for his causal connection opinion was the history Petitioner provided him on her first visit, April 10, 2012. (PX-20, pp. 66-67). On cross examination, Dr. Kube initially stated if the medical records from the date of accident through December 2011 reflected Petitioner provided a different history of onset of complaints and did not reflect consistent treatment or complaints, his medical opinion could change regarding causal connection. (PX-20, pp. 71-72). Dr. Kube was provided copies of Chiropractor Klinedinst's records, the Graham Medical Group records and the Graham Hospital physical therapy records. When it was noted these records reflected no history of a work-related low back injury and only complaints of pain between the shoulder blades on the date of injury, as well as reporting no low back complaints for 20 months after the date of injury and no work injury history for 22 months, Dr. Kube became evasive and ultimately stated he would defer to the

Arbitrator regarding a causal relationship. (PX-20, pp. 72-91). Dr. Kube also testified that the actual history he received from the Petitioner was that there was no specific trauma but instead that her work aggravated her lower back. (PX 20 at 93) Dr. Kube also testified it would be unusual for a patient who has a low back injury severe enough to require two spinal surgeries, permanent restrictions and the possibility of a spinal cord stimulator to begin the process of proceeding with bilateral breast enhancement procedures three weeks after the alleged injury. (PX-20, pp. 102-103).

BASED UPON THE FOREGOING, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT IN REFERENCE TO ALL DISPUTED ISSUES:

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner testified she had immediate onset of low back pain which has not resolved to date. She initially testified she sought treatment for her low back complaints on the date of the alleged injury and provided a work-related low back injury history to each and every one of her physicians throughout the course of her treatment. Petitioner also testified she provided a low back work injury history to her employer on the date of injury. The Arbitrator does not find Petitioner's testimony credible. After lengthy questioning, Petitioner ultimately acknowledged she did not provide a work-related low back injury history to a medical provider until 22 months after her date of injury. The reason she stated for not providing this history until that time was the doctors would not document such a history without the proper "paperwork." The contemporaneous chiropractic records of Chiropractor Klinedinst on February 25, 2010, do not reflect complaints of low back pain. Rather, the treatment records on the date of the alleged injury reflect pain in the shoulder blades and upper back on the right side. She denied knowing what caused the onset of her symptoms and she simply woke up with them that morning. She was provided the opportunity to document her complaints were work-related and did not do so. The medical evidence substantiates she did not report low back pain to any of her medical providers until October 17, 2011, 20 months after the date of injury. She did not report a work-related injury history as the cause of her low back complaints until December 21, 2011, 22 months after the date of injury. Mr. Williams testified he recalled Petitioner telling him she was having back complaints on the date of the alleged injury but could not recall whether they were upper or lower back. He testified Petitioner did not advise her complaints were in any way related to a work-related injury. Mr. Williams did not become aware of a work-related injury history until he received documentation regarding the present workers' compensation claim from Petitioner's attorney in December 2011, which correlates chronologically with the first medical notation evidencing a work-related injury history to a medical provider. The testimony of Ms. Walters and Ms. Simkins, friends of Petitioner and former employees of Respondent, establishes neither witness was present at the time of the alleged accident nor witnessed the alleged accident. Based upon the foregoing, the Arbitrator finds Petitioner failed to prove she suffered an accident arising out of and in the course of her employment on February 25, 2010.

In light of the above finding, all other issues become moot. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rocio Perez,

Petitioner,

vs.

No. 07 WC 40315

15IWCC0186

Wendy's,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the appellate court. The appellate court vacated the Commission's decision and opinion on review and remanded the matter to the Commission "for a determination of [the claimant's] benefits under the Act as a result of the workplace accident." The appellate court found that Petitioner proved the lateral meniscal tear in her left knee is causally connected to the work accident on June 19, 2007, noting the parties agreed Petitioner's preexisting ACL tear in the same knee is not a compensable injury under the Act. Perez v. Workers' Compensation Comm'n, 2014 IL App (2nd) 130220WC-U. The issues on remand are temporary total disability, medical expenses and permanent disability related to the lateral meniscal tear in the left knee.

Petitioner, an assistant manager, injured her left knee at work on June 19, 2007. Eventually, she came under the care of Dr. David Schafer. On July 26, 2007, Dr. Schafer performed an ACL reconstruction (unrelated to the work accident) and lateral meniscal repair (related to the work accident), noting in pertinent part, a complex tear or the posterior horn of the lateral meniscus. Postoperatively, Petitioner underwent physical therapy. On December 11, 2007, Petitioner reported to Dr. Schafer occasional lateral sided pain with activity and denied instability. On physical examination, she complained of mild lateral sided pain with deep flexion. She had mild quadriceps atrophy with 5-/5 strength. Dr. Schafer stated: "I explained to the patient that her current lateral symptoms that occur with activity may never completely resolve. She had a significant portion of her meniscus removed in the region. She will likely have

a slow progression of arthritis in the lateral compartment of the knee secondary to her lateral meniscal injury. She is doing very well from the ACL reconstruction overall. I will discharge her from my care today. *** I would not recommend further meniscal surgical treatment such as a meniscal allograft unless her symptoms worsen." Dr. Schafer did not impose any restrictions.

On August 5, 2009, Dr. Jay Levin examined Petitioner at Respondent's request, noting in his report that Petitioner complained of pain below the patella along the medial/lateral aspects of the patellar tendon, rating the pain a 7/10 on average. She also complained of infrapatellar knee pain, increased discomfort in the knee when she crossed her legs, and the knee giving way and cracking. She related she could sit or walk for 30 minutes before the pain increased and that standing was painful. Physical examination of the knee was benign. In his evidence deposition, Dr. Levin testified that Dr. Schafer's prognosis on December 11, 2007, mainly related to the lateral meniscal tear, and not the ACL tear.

Petitioner testified that on August 26, 2007, she went to work for another employer. She has not treated for her left knee condition since Dr. Schafer discharged her from care on December 11, 2007. At the time of the arbitration hearing, Petitioner worked full-time as a warehouse associate, which she described as a desk job. Regarding her current left knee condition, Petitioner testified the knee hurts during cold weather and with weather changes. It also hurts with bending, running, wearing high heels and prolonged sitting. Petitioner stated she no longer plays soccer or performs much physical activity.

In the request for hearing form, Respondent disputed liability for temporary total disability benefits, but agreed Petitioner was off work from July 26, 2007, through August 25, 2007. The Commission awards temporary total disability benefits for this time period. Further, the Commission finds Respondent is liable for the medical bills in evidence for the diagnosis and treatment of the lateral meniscal tear. The Commission notes that Petitioner testified her medical bills were paid by her former husband's medical insurance, although she did pay some amounts out of pocket. The Commission orders Respondent to discharge its liability to Petitioner in accordance with sections 8(a) and 8.2 of the Act. See Springfield Urban League v. Workers' Compensation Comm'n, 2013 IL App (4th) 120219WC ¶¶ 33-39 (The Commission is not required to determine the dollar amount of the award of medical expenses). Turning to the nature and extent of Petitioner's disability, the Commission finds the lateral meniscal tear caused loss of use of the left leg to the extent of 20 percent thereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.00 per week for a period of 4 3/7 weeks, from July 26, 2007, through August 25, 2007, 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 is liable for the medical bills in evidence for the diagnosis and treatment of the lateral meniscal tear. Respondent shall pay to Petitioner the award of medical expenses in accordance with sections 8(a) and 8.2 of the Act.

15IWCC0186

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $288.00 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of the left leg to the extent of 20 percent thereof.

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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,800.00. 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: MAR 17 2015
SM/sk
o-03/05/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

CHRIS ADEN,
Petitioner,

vs.

SO1-CHOATE MENTAL HEALTH CENTER,
Respondent,

NO: 10WC036814

15IWCC0187

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: MAR 17 2015
MJB/bm
o-3/10/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

ADEN, CHRIS
Employee/Petitioner

Case# **10WC036814**

15IWCC0187

SOI-CHOATE MENTAL HEALTH CENTER
Employer/Respondent

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2500 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

1745 DEPT OF HUMAN SERVICES
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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

JUN - 9 2014

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

15IWCC0187

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRIS ADEN
Employee/Petitioner
v.
STATE OF ILLINOIS – CHOATE MENTAL HEALTH CENTER
Employer/Respondent

Case # 10 WC 36814

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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, **May 28, 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 **$38,341.50**; the average weekly wage was **$737.34**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** children under 18.

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 **$94,031.50** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$94,031.50**.

Respondent is entitled to a credit for all medical bills paid by it or its group carrier pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services set forth in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have credit for all bills paid by it or its group insurance carrier pursuant to Section 8(j) of the Act.

Respondent shall pay for and approve the further medical treatment as recommended by Dr. K. Brandon Strenge, pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability (TTD) benefits of $491.56/week for the period commencing August 2, 2010 through April 2, 2014, as provided in Section 8(b) of the Act. Respondent shall have credit for TTD benefits paid in the amount of $94,031.50 (see above).

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

05/28/2014
Date

ICArbDec 19(b) p. 2

JUN 9 - 2014

15IWCC0187

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHRIS ADEN
Employee/Petitioner

v.

Case # 10 WC 36814

STATE OF ILLINOIS –
CHOATE MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Chris (Christine) Aden, underwent a cervical fusion at C5-6 and C6-7 on March 25, 2011.This procedure was accepted by Respondent, and performed by Dr. Jon Taveau. After surgery, Petitioner had relief from her previous symptoms for a period of about six weeks. After six weeks, her symptoms returned as they had been before, with neck pain, left shoulder pain and arm pain down to her hand. Even with Petitioner's ongoing complaints, Dr. Taveau returned her to work and ended his care with her. (Petitioner's Exhibit (PX) 3). Because she was still in pain, Petitioner sought a second opinion from Dr. K. Brandon Strenge, a neurosurgeon. Dr. Strenge ordered an MRI of the cervical spine and an EMG of Petitioner's upper extremities and neck. After a review of the results of the testing, Dr. Strenge recommended a revision surgery of Petitioner's previous levels and to include the C4-5 level. (PX 6).

The care and treatment completed through Dr. Strenge's testing was approved and paid for by Respondent. Temporary total disability (TTD) benefits were also paid by Respondent up through the date of trial. Petitioner still complains of neck pain, left arm pain and tingling from her neck down her arm. She takes Norco four times per day currently.

On September 13, 2011, Respondent had Petitioner evaluated by Dr. Robert Bernardi pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). (RX 5). Dr. Bernardi completed an addendum to his previous report on October 7, 2013 to address the recommendation for a revision surgery including level C4-5. Dr. Bernardi did not disagree with Dr. Strenge's surgical recommendation, but he did not believe that Petitioner's C5-6 and C6-7 fusions are responsible for the degenerative disease she has subsequently developed at C4-5. (RX 6).

CONCLUSIONS OF LAW

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

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

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

Petitioner has an accepted injury to her cervical spine that led to a cervical fusion at C5-6 and C6-7. Dr. Strenge has recommended that Petitioner would benefit from a revision surgery, this time including the C4-5 level. Dr. Strenge opined that Petitioner suffers from adjacent level degenerative disc disease. Dr. Strenge's opinion is that C4-5 has problems because it was adjacent to the levels that were fused from the previous surgery.

Dr. Bernardi, Respondent's examining physician, believes that Petitioner's problems at C4-5 are more genetic in nature and not related to her previous surgery. Dr. Bernardi goes on to establish in his testimony that he agrees that the medical community within neurosurgery is still "up in the air" on the issue of adjacent level stress. (See RX 7, p. 20).

The Arbitrator finds that the opinion of the treating physician prevails over that of the opinion of Respondent's examining doctor, and hereby adopts the opinions of Dr. Strenge. As such, the need for a revision surgery that includes level C4-5 arises out of Petitioner's employment and is causally connected to her work-related injury. Respondent shall accordingly authorize and pay for said surgical treatment, subject to the medical fee schedule, Section 8.2 of the Act. The Arbitrator also makes special note that Petitioner was a very credible witness at trial, and testified in an open and forthcoming manner. She appeared to be endeavoring to give the full truth during her testimony.

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

The Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary and are the financial responsibility of Respondent. Respondent shall therefore pay for the related medical charges contained in Petitioner's Exhibit 10, subject to the medical fee schedule, Section 8.2 of the Act. Respondent shall have credit for all medical bills paid by it or through its group insurance pursuant to Section 8(j) of the Act.

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

TTD benefits have been paid to Petitioner from August 2, 2010 until the date of trial, April 2, 2014. Dr. Strenge has a current recommendation for surgery with Petitioner still being unable to work. Accordingly, Petitioner is entitled to TTD benefits for the period claimed, and Respondent shall have the appropriate credit for TTD benefits paid. (See Arbitrator's Exhibit 1).

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy Hockaday,
Petitioner,

vs.

NO: 10 WC 21899

Edwardsville School District,
Respondent,

15IWCC0188

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 and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator.

The Commission finds that Petitioner is entitled to temporary total disability from May 6, 2010 through June 24, 2010. Respondent shall pay all medical related to the injury up to and including June 24, 2010. The Arbitrator's award of permanency is modified to 2% loss of use of the person as a whole.

Dr. Adams, in a prescription note prepared on June 25, 2010, returned the Petitioner to work without restrictions and found her at MMI. (Petitioner Exhibit 2)

Respondent is not responsible for any medical bills incurred after June 24, 2010 because Dr. Adams found her at MMI and none of the physicians who have seen her since have causally connected her alleged lower back pain to the May 5, 2010 injury.

The Commission modifies the Arbitrator's permanent disability award to 2% loss of use of the person as a whole. X-rays at Anderson Hospital (Petitioner Exhibit 3) and a CT scan and Gateway Regional Medical Center (Petitioner Exhibit 2) were both negative for any lumbar disease.

The Commission also finds that Respondent paid temporary total disability from May 6, 2010 through June 30, 2010. They are entitled to a credit for all temporary total disability paid to the Petitioner after June 24, 2010.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $314.68 per week for a period of 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 $283.20 per week for a period of 10 weeks, as provided in §8 (d) (2) of the Act, for the reason that the injuries sustained caused the loss of use of the person as a whole to the extent of 2%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses as they pertain to her lower back from May 5, 2010 through June 24, 2010 under §8(a) and §8-2 of the Act.

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

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

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

DATED: MAR 17 2015

Charles J. DeVriendt

Ruth W. White

o012815
CJD/hf
049

15IWCC0188

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 28, 2015, before a three-member panel of the Commission including members Charles J. DeVriendt, Daniel R. Donohoo and Ruth W. White, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Daniel R. Donohoo on February 23, 2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Donohoo's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Donohoo voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

NOTICE OF ARBITRATOR DECISION

HOCKADAY, TAMMY
Employee/Petitioner

Case# **10WC021899**

15IWCC0188

EDWARDSVILLE SCHOOL DISTRICT
Employer/Respondent

On 5/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2396 KNAPP OHL & GREEN
DAVID GREEN
P O BOX 446
EDWARDSVILLE, IL 62025

15IWCC0188

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

TAMMY HOCKADAY
Employee/Petitioner

v.

EDWARDSVILLE SCHOOL DISTRICT
Employer/Respondent

Case # 10 WC 21899

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Edward Lee**, Arbitrator of the Commission, in the city of **Belleville, IL** on **March 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: Nature and extent of the injury

15IWCC0188

FINDINGS

On the date of accident, **May 5, 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 **52 weeks** preceding the injury, Petitioner earned **$24,544.00;** the average weekly wage was **$472.00**

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

Respondent ***has*** paid all temporary total disability benefits to which Petitioner is entitled.

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

ORDER

Respondent is to pay the medical bills identified in Petitioner's Exhibit 5 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule: **$995.50 to Anderson Hospital, $760.00 to Dr. Michael Adams at Heartland Healthcare, $5,231.06 to Gateway Regional Medical Center, $238.00 to Uptown Emergency Physicians, LLP, and $308.00 to Dr. Craig Beyer.** Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$283.20 per week** for a period of 25 **weeks**, as provided in **Section §8(e)** of the Act, because the injury sustained caused **5% loss of use MAW.**

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

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

Grant Lee
Signature of Arbitrator

5/12/14
Date

ICArbDec19(b)

MAY 15 2014

STATE OF ILLINOIS)

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

15IWCC0188

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATOR DECISION

TAMMY HOCKADAY
Employee/Petitioner

v. Case # 10 WC 21899

EDWARDSVILLE SCHOOL DISTRICT
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This claim involves an injury to Petitioner's low back. The parties agree the issues are accident, causal connection, liability for medical bills, liability for temporary total disability, and nature and extent of the injury. The parties agree notice is not an issue.

On May 5, 2010 Petitioner was 44 years old, single, with one dependent child. She worked as a custodian for the Respondent. She passed a pre-employment physical before starting the job in 2006. Petitioner testified that besides a temporary injury to her low back in August 2005 and low back pain related to a urinary tract infection in May 2007, during the days, weeks, and months before May 5, 2010 she didn't experience any significant low back pain or pain, tingling or numbness going into either leg. She had no difficulties performing her job dutics during the days, weeks, and months before May 5, 2010.

On May 5, 2010, around 9:30pm, Petitioner carried a full trashcan weighing 100 lbs. to a large green dumpster outside the school. As she lifted the trashcan above her shoulders to dump it, she heard her low back "pop". She instantly felt severe low back pain. She didn't have any leg pain at that time. She thought she'd only "pulled a muscle". Petitioner finished her shift and went home.

The next morning, Petitioner's low back remained painful. She began to experience numbness and tingling going into both legs. That day she provided notice of her injury to the Respondent's principal. The same day, she sought treatment at Anderson Hospital Urgent Care Center in Glen Carbon, Illinois. Pain medication was prescribed. (PX. 1) On May 11, 2010 Petitioner saw Dr. Adams, who kept Petitioner off work and prescribed physical therapy. (PX. 2) Petitioner attended therapy at Gateway Regional Medical Center from May 12, 2010 to May 31, 2010. (PX. 3) The therapy didn't provide complete relief of her low back pain but did provide total relief from her leg complaints. Dr. Adams allowed Petitioner to return to work full duty on June 26, 2010. Respondent paid temporary total disability benefits from May 6, 2010 to June 30, 2010. (RX. 12) She didn't return to work for the Respondent. Petitioner worked as a housekeeper at MICDS in Ladue, Missouri in August 2010.

On November 22, 2010 Petitioner returned to Dr. Adams. Petitioner described having "breakthrough pain" that came and went depending on her activities. (PX. 2) The pain radiated into her left buttocks and upper leg. Petitioner testified the pain was similar to the pain she experienced after her May 2010 injury. Dr. Adams recommended another session of physical therapy, which Petitioner attended at Gateway Regional Medical

Center from February 15, 2011 to February 28, 2011. (PX. 3) Petitioner continued to work while undergoing therapy. The therapy helped Petitioner marginally. She did not suffer any new injuries at home or while working at MICDS.

Over the remainder of 2011 and 2012, Petitioner returned to Dr. Adams for other ailments and he would note, for time to time, her continued low back pain. For example, on March 8, 2012 and November 29, 2012 Petitioner saw Dr. Adams for other medical issues but he noted low back pain. (PX. 2)

On January 29, 2013 Dr. Adams noted left-sided low back pain, radiating down her leg that prompted Petitioner to go to the emergency room where she had a CT scan that showed osteosclerotic lesions. He believed Petitioner should see an orthopedist. On February 11, 2013 Petitioner saw Dr. Craig Beyer, who noted Petitioner's low back and left buttock pain. He was aware Petitioner had attended physical therapy twice and still had persistent symptoms. He believed Petitioner had mechanical low back pain and some early radicular pain. He recommended a program of weight reduction, activity modification, and a Medrol tapered Dosepak. On April 8, 2013 Dr. Adams saw Petitioner for other unrelated ailments and he did note continued low back pain.

Petitioner testified currently she has low back pain that comes and goes. She experiences weather sensitivity. She has more good days than bad depending on the number of hours she works. The pain is 5 out of 10 on the average. She is presently employed by Anderson Hospital as a "housekeeper/sanitize tech". This job is less physically demanding than her job duties for the Respondent. She doesn't have any difficulty performing her present job duties. She takes over-the-counter pain medication for her low back pain.

Testimony of Keith Rabey (RX. 6)

The deposition of Respondent's witness Keith Rabey was offered into evidence. In May 2010 he was the head custodian for Respondent. (RX. 6, p. 5) He testified about the Respondent's procedure for reporting work accidents. This involved reporting the work accident to the head custodian or an administrator and potentially calling a nurse if the injury is serious enough. (RX. 6, p. 6-8) He testified Petitioner did not tell him she suffered a work accident in May 2010. (RX. 6, p. 11) He wasn't aware Petitioner suffered an injury until principal Dennis Cramsey informed him Petitioner claimed she suffered an injury on May 3, 2010. (RX. 6, p. 11-12) He testified Petitioner's responsibilities as a custodian did involve taking a full trashcan out to the outside dumpster and dumping it into the dumpster. (RX. 6, 17-18) He testified on May 5, 2010, during the shift Petitioner claimed she was injured, he was performing various activities around various parts of the school. (RX. 6, p.19) On May 5, 2010 he didn't accompany or watch Petitioner while she performed her job duties and he isn't aware of any witnesses to Petitioner's claimed injury. (RX. 6, p. 19-20).

Testimony of Dennis Cramsey (RX. 7)

The deposition of Respondent's witness Dennis Cramsey was offered into evidence. Mr. Cramsey is currently the principal of Edwardsville High School. (RX. 7, p. 5) In 2010 he was the principal for the Respondent. (RX. 7, p. 5) He said the procedure for employees to report an injury is to report it immediately to their immediate supervisor or an administrator. (RX. 7, p. 6) He testified about a meeting had on May 6, 2010 attended by Petitioner, Steve Morrison (Director of Building and Grounds), Chris Spenser (union representative), and himself to discuss concerns about Petitioner's job performance. (RX. 7, p. 8) Petitioner reported her injury to him after that meeting. (RX. 7, p. 10) He testified on May 6, 2010 Petitioner reported her injury and completed an incident report. (RX. 7, p. 14)

CONCLUSION 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 an accident did occur that arose out of and in the course of Petitioner's employment with the Respondent. In support of this conclusion the Arbitrator notes the following: Petitioner testified creditably that she suffered an acute injury to her low back while performing her job duties, lifting and dumping a 100 lbs. trashcan into a dumpster, for the Respondent. There is no evidence that directly contradicts her testimony.

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the May 5, 2010 injury. In support of this conclusion the Arbitrator notes the following: Again, Petitioner's testimony is creditable. Petitioner testified in the days, weeks, and months before May 5, 2010 she had did not have any low back pain or difficulty performing her job duties as a custodian. There is nothing in evidence that directly contradicts this. Furthermore, after the May 4, 2010 injury, her complaints are consistent with the medical records from Anderson Hospital Urgent Care, Dr. Adams, Gateway Regional Medical Center, and Dr. Beyer.

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

The Arbitrator concludes Respondent owes Petitioner TTD benefits from 05/06/10 through 06/30/10 (8 weeks). Respondent paid TTD for this period of time. Therefore, Respondent's owes no TTD benefits to Petitioner. In support of this conclusion the Arbitrator notes the medical records of Dr. Adams (PX. 2), keeping Petitioner off work from 05/06/10 through 06/30/10, and evidence of Respondent's payment of TTD benefits from 05/06/10 to 06/30/10. (RX. 12)

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 all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is responsible for the medical bills incurred as a result thereof. Respondent is to pay the medical bills identified in Petitioner's Exhibit 5 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule: $995.50 to Anderson Hospital, $760.00 to Dr. Michael Adams at Heartland Healthcare, $5,231.06 to Gateway Regional Medical Center, $238.00 to Uptown Emergency Physicians, LLP, and $308.00 to Dr. Craig Beyer. Respondent shall be given a credit for amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Issue (O): Nature and extent of Petitioner's injury.

The Arbitrator concludes as a result of the acute low back injury of May 5, 2010 Petitioner sustained permanent partial disability to the extent of 5% loss of use of MAW. In support of this conclusion the Arbitrator notes the following: Petitioner's current complaints include periodic low back pain and weather sensitivity.

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 Causal connection Cervical Spine	☐ Second Injury Fund (§8(e)18)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Faye Lee,

Petitioner,

vs. NO: 11 WC 30449

State of Illinois/Dept. of Juvenile Justice,

15IWCC0189

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, and temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator regarding his findings as to Petitioner's lumbar spine but reverses the Arbitrator's findings that the Petitioner's cervical spine condition is causally connected to the accident. 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 the Petitioner's condition, as it relates to her cervical spine, is not causally connected to the accident on May 31, 2011, and denies prospective surgery and incurred medical for that condition.

On May 31, 2011, she was breaking up a fight between two youths. As she was breaking up the fight she felt something pull in her back. She finished her shift and the next morning she had discomfort in her lower back. (Transcript Pgs. 9-11) In her Employee's Notice of Injury, which she signed on June 1, 2011, she stated that as a result of the altercation her "lower back hurts, pain down right leg can't stand due to pain in back and leg." (Petitioner Exhibit 1 Pg. 3)

Respondent is not disputing any of incurred treatment and recommended treatment as it pertains to Petitioner's lower back. They do take issue with the prospective treatment and medical incurred in regard to her cervical spine.

Petitioner sought out the treatment of Dr. Berfer. She first saw him on June 2, 2011 and advised him that she had felt a muscle pull in her low back. There was nothing mentioned regarding the cervical spine. Berfer saw her again on June 14, 2011 and again on June 29, 2011. She complained of low back pain both times and Berfer recommended that she see a neurosurgeon. Petitioner saw Dr. Berfer again with no improvement on July 27, 2011. On August 8, 2011, Petitioner called the doctor and advised him that her attorney was setting her up with Dr. Gornet. Nothing was mentioned to Dr. Berfer regarding Petitioner's cervical spine until August 29, 2011, when she advised him that she was "Also now having neck pain going to right arm it is acting up again from last year." (Petitioner Exhibit 3)

Petitioner first saw Dr. Gornet on August 22, 2011. Petitioner gave him a history of the fight and that her chief complaint was low back pain to both sides, both buttocks, both legs right greater than left. She also has neck pain, headaches, pain in her right shoulder and intermittent numbness down her right arm. Her current problem began on May 31, 2011. She further told the Doctor that she had neck pain in the past but no trauma. Dr. Gornet was of the opinion that Petitioner's cervical condition was causally connected to her work injury on May 31, 2011. On October 11, 2011, Gornet opined "I do believe she has a component aggravation of her pre-existing condition as well as a new injury as the MRI would also indicate a disc herniation. We believe her symptoms (Cervical Spine) are causally connected to her work injury..." (Petitioner Exhibit 5)

The Commission notes that the first mention of any neck and cervical spine pain made to a physician after the May 31, 2011 accident was on August 22, 2011. This was approximately 63 days after the accident.

Petitioner testified that she had an MRI to her cervical spine on June 21, 2010, but the pain went away after that. (Transcript Pgs. 19-20)

Dr. Robson saw the Petitioner on February 15, 2012. He is a Board Certified Orthopedic Surgeon who specializes in the spine. He agreed that Petitioner was in need of surgery to the cervical spine but that her cervical spine was not aggravated or made worse by the May 31, 2011 accident. He reviewed the MRI before and after the accident and found that the C5-6 disc was worse in the June 2010 MRI and the C3-4 level was better in the subsequent MRI taken after the accident. Petitioner did not complain about neck pain in a temporal fashion to when the injury occurred on May 31, 2011. He could understand a week or so that the lower back pain dominated. However, if something happened to her neck at the time of the injury he would expect to have heard something regarding her cervical spine before three months later. It was his opinion that the altercation did not result in an aggravation of Petitioner's cervical condition. (Respondent Exhibit 3 Pgs. 13-15, 22-23)

The Commission finds the testimony of Dr. Robson more persuasive than that of Dr. Gornet. Therefore, the Commission finds that the Petitioner's cervical condition is not causally connected to the accident on May 31, 2011 and Respondent is not liable for the prospective surgery to the cervical spine and for the medical bills incurred regarding the cervical spine.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 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.

DATED: MAR 17 2015
o12715
CJD/hf
049

Charles J. DeVriendt

Ruth W. White

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 27, 2015, before a three-member panel of the Commission including members Charles J. DeVriendt, Daniel R. Donohoo and Ruth W. White, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Daniel R. Donohoo on February 23, 2015, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Donohoo's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Donohoo voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

Joshua D. Luskin

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

LEE, FAYE
Employee/Petitioner

Case# **11WC030449**

15IWCC0189

SOI/DEPT OF JUVENILE JUSTICE
Employer/Respondent

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

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

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

4548 FISHER KERKHOVER & COFFEY
JASON E COFFEY
P O BOX 191
CHESTER, IL 62233

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

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

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

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

APR 4 2014

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

15IWCC0189

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Faye Lee
Employee/Petitioner

v.

SOI/Deparment of Juvenile Justice
Employer/Respondent

Case # 11 WC 30449

Consolidated cases: None

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **February 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? **CERVICAL CONDITION ONLY**
K. ☒ Is Petitioner entitled to any prospective medical care? CERVICAL CONDITION ONLY
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, **May 31, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,820.00**; the average weekly wage was **$1,247.00**.

On the date of accident, Petitioner was **57** 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 **$72,301.88** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$72,301.88**.

Respondent is entitled to a credit under Section 8(j) of the Act if any of the Petitioner's medical bills have been paid to the date of Arbitration.

ORDER

Respondent shall pay reasonable and necessary medical services relating to Petitioner's cervical condition as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for all reasonable and necessary prospective medical treatment relating to Petitioner's cervical condition including the currently recommended surgical procedure.

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

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

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

Signature of Arbitrator

3/21/14
Date

APR 4- 2014

The parties presented at arbitration pursuant to Section 19(b) of the Act with Petitioner alleging a work injury to her cervical spine occurring on May 31, 2011. The Respondent disputed accident, causation, and prospective medical treatment with respect to Petitioner's cervical condition. It is undisputed the Petitioner suffered a back injury as part of the same work injury. The Respondent has fully accepted liability for the Petitioner's back injury on May 31, 2011. The parties agreed prior to proceeding this decision would only address the disputed issues with respect to Petitioner's cervical condition.

The Petitioner testified she was a juvenile justice specialist at the Illinois Youth Center in Murphysboro on May 31, 2011. The Petitioner explained the facility was like an open dorm room with approximately 24 youths aging from 13 to 19. The Petitioner was responsible for getting the youths up in the morning, making sure they showered, making sure they brushed their teeth, having them dress for school, and getting them to school on time. Then, the she would be assigned to stand in the hallway to monitor the classrooms and line them up against the wall in the hallway when they changed classes. The facility houses strictly male youths.

The Petitioner further testified that, a little after 10:00 a.m., the youths were making a class change and lining up against the wall. About this time, two male youths began fighting in the hallway. The Petitioner described the youths as swinging and fighting with blood going everywhere. The Petitioner went to grab one of the youths who she estimated was approximately 6'2" in height, weighed about 180 pounds, and was approximately 17 years old.

The Petitioner grabbed this male youth, jerked him to the left, and pinned him against the wall. The Petitioner stated she was clutching the youth with both of her arms as he was struggling to get away. The Petitioner held him there for a period until she was assisted by one of her supervisors.

The Petitioner finished her shift on May 31, 2011, but alerted her employer the next day she was having discomfort in her low back. She was told to fill out a report and seek medical attention. The Petitioner testified she sought medical attention with her primary-care physician, Dr. Belfer. Dr. Belfer ordered physical therapy for Petitioner's back and MRI examination. Following the MRI, Petitioner was referred to an orthopedist, Dr. Matthew Gornet. The Petitioner testified she first saw Dr. Gornet in August 2011, and he diagnosed the Petitioner with both a lumbar and cervical spine condition and recommended MRI examination on the cervical spine (Petitioner's Exhibit #4, pg. 81). Dr. Gornet noted he believed "her current symptoms in her low back, neck, and shoulder are causally connected to her work related injury of May 31, 2011, in her neck either as aggravation of a pre-existing condition" (Petitioner's Exhibit #4, pg. 81).

The Petitioner testified she underwent MRI examination and injections on her cervical spine. The Petitioner further testified these conservative treatments have not permanently alleviated her cervical condition. The Petitioner stated it had, in fact, gotten worse as she no longer has full mobility in her neck. Dr. Gornet is recommending surgical intervention at this time, and Petitioner would like to undergo the surgery as currently recommended. The Petitioner noted she was evaluated by Dr. Robson pursuant to

Section 12 of the Act at the request of Petitioner's employer and he agreed surgical intervention on Petitioner's neck was reasonable and necessary treatment at this time.

The Petitioner testified she has had previous medical treatment on her neck, and that she told both Dr. Gornet and Dr. Robson of her prior neck treatment. The medical records indicate Petitioner underwent MRI examination for her cervical spine on June 21, 2010 (Petitioner's Exhibit #3, pg. 18). The Petitioner testified she had the MRI in 2010 but no further treatment because her neck pain went away. She stated it lasted maybe only a week. The Petitioner stated she has never had neck surgery, never underwent physical therapy or injections on her neck prior to May 31, 2011, and never missed any extended period of work due to neck pain prior to May 31, 2011. The Petitioner did acknowledge there was no mention of neck pain in the medical records prior to August 2011. The Petitioner stated she was concentrating more on her lower back, and she honestly thought the pain in her neck was going to go away. The Petitioner testified she did have neck pain, but did not mention it. She also thought the physical therapy she was undergoing for her lower back kind of aggravated the neck some more.

On cross-examination, the Petitioner was asked why she underwent MRI in 2010. The Petitioner responded she honestly thought she was having a stroke. She had a little bit of neck problems that went down her right arm into her fingers, and it lasted for two days, so she was getting paranoid about maybe having a stroke. She did not recall Dr. Belfer discussing the MRI of 2010 with her because the pain went away so quickly. The Petitioner admitted she did not recall telling Dr. Belfer about any neck pain right after the work injury of May 31, 2011. However, she did report the pain to Dr. Gornet at her first visit with him.

Dr. Gornet testified, via deposition, that he was treating the Petitioner for both cervical and lumbar spine conditions. Dr. Gornet further testified that, "while she did have a pre-existing MRI, it was clear and I interpreted that on her first visit. She was also truthful in telling me she had a pre-existing condition. There was no indication that that was giving her ongoing problems or any other issue until her work related event of May 31, 2011. If the work related altercation that she was involved with was enough to injure her lumbar spine, certainly it could aggravate an underlying condition that was determined to be present as of June 21, 2010, but that was asymptomatic or minimally symptomatic at the time of her work related accident of May 31, 2011, and but not for that altercation, I do not believe that she would have the requirement for surgical intervention" (Petitioner's Exhibit #4, pg. 12). Dr. Gornet further stated "I do believe her symptoms in their current magnitude and severity are causally connected to her work-related injury as described" (Petitioner's Exhibit #4, pg. 14). Dr. Gornet felt there were a lot of changes between the MRI images of June 2010 and the MRI of 2011 following the work accident. However, Dr. Gornet did note the MRI of 2011 was of superior quality (Petitioner's Exhibit #4, pg. 18).

The Section 12 examiner, Dr. Robson, also testified via deposition. Dr. Robson testified he evaluated Petitioner and reviewed the medical records, and he believed the accident was not the cause of her cervical injury based upon the fact that she had admittedly had problems preexistent to the accident. On cross-examination, Dr. Robson testified he reviewed both MRI films from June 2010 and the MRI of 2011 following the work accident. Dr. Robson noted pathology at C5/6 on the MRI of 2011, but did not

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note any pathology at this level in the MRI of June 2010 prior to the work accident and admitted there were changes between the two MRI's (Respondent's Exhibit #3, pg. 23).

Based upon the foregoing findings of fact, the Arbitrator hereby makes the following conclusions of law with respect to the disputed issues:

Accident: The Petitioner sustained her burden of proof that she suffered an accident in the course of and arising out of her employment with the respondent. The Petitioner's testimony is credible. The Petitioner gave a consistent account of how the injury occurred and her medical treatment both preceding and following her work accident. The Petitioner credibly testified she was having neck pain shortly following the accident, but that her focus was her lower back and she honestly felt her neck pain would subside as it had done in the past. There is clear evidence the Petitioner had MRI examination of her neck before the accident, but the pain leading to the MRI subsided shortly thereafter. If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Construction Co. v. Industrial Commission*, 37 Ill.2d 123. The accident may be a blow, a fall, or certain acts or phases of regular job duties that result in the breaking down of body structures. See *Gilster Mary Lee Corp. v. Industrial Commission*, 326 Ill.App.3d 177. The Petitioner suffered an injury to her cervical spine when she was attempting to pin a 17 year old struggling male against a wall to restrain him. The employer accepted liability for Petitioner's back injury herein. If defies all logic that an accident which is significant enough to cause a lumbar injury would not be significant enough to aggravate a previously asymptomatic neck condition based upon the Petitioner's credible description of how the accident occurred.

Causal Relationship: The Petitioner sustained her burden of proof regarding the causal relationship between the work accident of May 31, 2011 and her current cervical condition. The Arbitrator hereby finds the testimony of Dr. Gornet more persuasive than that of the Section 12 examiner, Dr. Robson in light of the fact that both doctors opined there were differences between the MRI's of June 2010 (prior to the work accident) and August 2011 (after the work accident), and the Petitioner's credible testimony of the accident suffered herein.

Prospective Medical: The Respondent shall authorize and pay for all reasonable and necessary medical treatment with respect to Petitioner's cervical condition. The Respondent disputed liability for prospective medical based upon accident and causal relationship. Based upon the conclusions referenced above, the Respondent shall be liable for the surgery currently recommended herein. It is noted that both Dr. Gornet and the Section 12 examiner, Dr. Robson, agree the Petitioner is in need of the neck surgery currently recommended.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ 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

James McDaniel,

Petitioner,

vs.

NO: 12 WC 9373

15IWCC0190

City of Columbia,

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, extent of temporary total disability, medical expenses and prospective medical care 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 where, in addition to accidents of March 2, 2012, he noted an accident occurring on December 27, 2011. The accident of December 27, 2011 is the subject of claim 12 WC 15842 for which a separate Decision is being issued. The Commission affirms the Arbitrator's finding that Petitioner failed to prove a causal relationship exists between the accidental injuries sustained on March 2, 2012 and his current condition of ill-being. The Commission affirms the Arbitrator's findings that §12 Dr. Lange's no causal connection opinions more credible as he had reviewed all of Petitioner's medical records. Treating Dr. Kennedy opined causal connection, but he had not reviewed Petitioner's prior medical records, which showed extensive preexisting conditions. Dr. Kennedy admitted that his causal connection opinions could be changed depending on what information may have been contained in those prior medical records. The Commission affirms the award of

15IWCC0190

$1,940.00 in medical expenses for Petitioner's visits to the emergency room on March 2, 2012 and to Dr. Daigle on March 5, 2012. The Commission affirms the Arbitrator's denial of Petitioner's claim for temporary total disability benefits, prospective medical care and penalties. The Commission further notes that Dr. Lange opined that there was no permanent impact on either Petitioner's lumbar or cervical conditions. Therefore, since Petitioner failed to prove a causal relationship exists between the accidental injuries sustained on March 2, 2012 and his current condition of ill-being, there is no need to remand this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2013 is hereby affirmed and adopted, except for correction of the clerical error noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,940.00 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 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 19 2015
MB/maw
o01/29/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McDANIEL, JAMES
Employee/Petitioner

Case# **12WC009373**
12WC015842

CITY OF COLUMBIA
Employer/Respondent

15IWCC0190

On 2/20/2013, 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 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
BRADLEY D GILLESPIE
PO BOX 488
GRANITE CITY, IL 62040

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

15IWCC0190

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

James McDaniel
Employee/Petitioner

v.

City of Columbia
Employer/Respondent

Case # 12 WC 09373

Consolidated cases: 12 WC 15842

An *Application for Adjustment 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 Herrin, on December 17, 2012. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 2, 2012, and December 27, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injuries, Petitioner earned $47,840.00; the average weekly wage was $920.00.

On the date of accident, Petitioner was 52 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. The parties stipulated to credits of $4,584.80 for a PPD advancement and $8,527.46 for benefits from the IMRF for a total credit of $13,112.26.

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 of $1,940.00 for medical services provided to Petitioner on March 2 and March 5, 2012, as identified in Petitioner's Exhibit 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Arbitrator's Conclusions of Law attached hereto, all other benefits are denied.

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

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

William R. Gallagher, Arbitrator

ICArbDec p. 2

February 15, 2013

Date

FEB 20 2013

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 12 WC 15842, Petitioner alleged that he sustained an injury to his low back on December 27, 2011, when he was pulling up the roll top of a dumpster and it broke loose which caused him to land hard on his heels. In case number 12 WC 09373, Petitioner alleged he sustained an injury to his low back on March 2, 2012, when he was standing on a concrete block while dumping a five gallon bucket of oil and the block rolled out from under him. Respondent stipulated that Petitioner did sustain accidental injuries on both December 27, 2011, and March 2, 2012; however, Respondent disputed its liability on the basis of causal relationship. At trial, an oral motion was made by Petitioner's counsel to consolidate the cases and this motion was granted by the Arbitrator.

Petitioner testified that he worked for Respondent in the Street Department for approximately 27 years. Petitioner's job duties varied and included street repairs, black topping, trash collection, grass cutting, etc. On December 27, 2011, Petitioner was in the process of attempting to open a frozen trash container with a roll top. The top suddenly became loose and, as a result thereof, Petitioner sustained a jolt to his low back. Petitioner sought no medical treatment following this accident and he continued to work.

Petitioner testified that on March 2, 2012, he was in the process of dumping a five gallon bucket of used motor oil while standing on a cinder block. The cinder block rolled out from under him and this caused him to sustain a jolting sensation to his low back. Later on that same day, Petitioner stated that he was lifting a trash container that weighed approximately 30 pounds and he twisted his feet and sustained low back pain that radiated down his right leg. Accordingly, Petitioner actually described two work accidents occurring on March 2, 2012.

Following the accidents of March 2, 2012, Petitioner went to the ER of St. Antony's Medical Center. The ER records contained a history of the Petitioner having back pain for the past several months with shooting pain into the right leg and groin. The Petitioner did advise the ER personnel of his having sustained a work injury that day when he was standing on a brick and slipped twisting his back and that he had back pain and shooting pain which were much worse thereafter. Petitioner also advised that, prior to this accident he had an appointment with a neurologist and was going to have an MRI performed. Petitioner was given some pain medication and directed to see his own physician.

Prior to all of these accidents, Petitioner had sought medical treatment for low back pain at St. Antony's Medical Center. On September 11, 2000, Petitioner was seen there with complaints of low back pain which he attributed to moving furniture approximately three days prior. X-rays were obtained which revealed some mild degenerative changes. On October 15, 2004, Petitioner was referred by Dr. Gary Vickers to the Physical Therapy Department of St. Antony's Medical Center for constant low back pain with shooting pains into his right scrotum, leg and ankle. It was noted in that record that Petitioner began experiencing lumbar symptoms in 1983 after an 18 foot fall which resulted in three compression fractures and that his symptoms had been getting

progressively worse within the past few years. The records also made note of the fact that Petitioner had undergone an MRI scan which revealed a bulging disc.

On February 1, 2012, Petitioner sought treatment from Dr. Carrie Daigle, for complaints of pain in the right testicle and back which he had been experiencing for the past four years but which had gotten progressively worse in the preceding four months. Dr. Daigle referred Petitioner to Dr. Christopher Vulin, a urologist, who initially saw Petitioner on February 23, 2012. When seen by Dr. Vulin, Petitioner complained of a stabbing pain radiating to the inguinal canal and abdomen which wrapped around to the back and right leg. Dr. Vulin referred Petitioner to Dr. Goldring, a neurologist. At trial, Petitioner testified he was unable to keep the appointment with Dr. Goldring. At Dr. Daigle's direction, Petitioner had an MRI scan performed on March 16, 2012, which revealed a right disc protrusion at L5–S1 compressing the origin of the S1 nerve root and a small annular tear at L4–L5.

Dr. Daigle saw Petitioner on March 28, 2012, and Petitioner complained of pain in his left hip and low back as well as numbness in his right foot. Petitioner stated that because of the lack of feeling in his right foot, he almost had a car accident on March 9, 2012. At that time, Dr. Daigle restricted Petitioner from lifting and driving and referred him to Dr. David Kennedy, a neurosurgeon.

On March 13, 2012, Petitioner was charged with driving under the influence (DUI) and he has not had a valid driver's license since that time. At trial, Petitioner agreed that possession of a valid driver's license was a requirement of his job for Respondent.

On May 9, 2012, Petitioner was examined by Dr. David Kennedy. At that time, Petitioner informed Dr. Kennedy's about the accident of March 2, 2012, and that he had complaints of severe low back pain with radiation into the right leg as well as pain in the right arm and the third and fourth fingers of the right hand. Dr. Kennedy reviewed the MRI scan of March 16, 2012, and opined that Petitioner had sciatica on the right side with a documented disc herniation at L5–S1 and radicular symptoms in the right arm consistent with cervical radiculopathy. Dr. Kennedy opined that Petitioner should have a trial of epidural steroid injections for the low back and an MRI scan of the cervical spine. Dr. Kennedy further opined that Petitioner's symptoms were causally related to the accident of March 2, 2012.

Dr. Kennedy was deposed on December 12, 2012, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Kennedy's testimony was consistent with the information contained in his medical records. On cross-examination, Dr. Kennedy agreed that he had not reviewed any medical records prior to his evaluation of May 9, 2012. Dr. Kennedy admitted that prior treatment records indicated that Petitioner had complaints that pre-existed the accident and that this could change his opinion as to causal relationship.

At the direction of the Respondent, Petitioner was examined by Dr. David Lange on June 14, 2012. In connection with his examination, Dr. Lange had a complete set of Petitioner's medical records which he noted in both his initial report of June 14, 2012, and a supplemental report of July 20, 2012. After obtaining a history of the accident from the Petitioner and reviewing treatment records both prior and post accident of March 2, 2012, Dr. Lange opined that

Petitioner's cervical and lumbar symptoms were not related to his work activities of March 2, 2012, because Petitioner had the same neurological symptoms prior to this accident. Dr. Lange admitted that the events at work may have cost a temporary aggravation of an underlying condition; however, he further stated that there was no permanent impact on either his lumbar or cervical condition whatever they might be. He further stated that no additional treatment was indicated for any work-related problems and that Petitioner did not require any work restrictions. Dr. Lange was deposed on September 27, 2012, and his deposition testimony was received into evidence at trial.

Conclusions of Law

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

The Arbitrator finds Petitioner's current conditions of ill-being are not related to the accidents of December 27, 2011 or March 2, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner's medical records clearly indicated that Petitioner had long-standing, pre-existing conditions and that, at best, the accidents of December 27, 2011, and March 2, 2012, caused only a temporary increase in his symptoms.

The Arbitrator finds the opinion of Dr. Lange to be more credible than that of Dr. Kennedy. While both of physicians only saw Petitioner on one occasion, Dr. Lange had the benefit of reviewing all of the Petitioner's medical records in reaching his opinions as to causal relationship. Dr. Kennedy did not have the opportunity to review the Petitioner's medical records and admitted that his opinion in respect to causal relationship could be changed depending upon what information may have been contained in those records.

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

The Arbitrator finds Respondent is liable for the medical bills incurred immediately following the accident of March 2, 2012. This includes the charges of St. Antony's Medical Center; Anthony's ER Physicians and South County radiology for charges incurred on March 2, 2012; and Dr. Daigle's charges for services rendered on March 5, 2012. Respondent is not liable for any other past or prospective medical charges.

Respondent shall pay reasonable and necessary medical services of $1,940.00 for medical services provided to Petitioner on March 2 and March 5, 2012, as identified in Petitioner's Exhibit 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

Because of the Arbitrator's conclusion in disputed issue (F), the Arbitrator finds Petitioner is not entitled to payment of any temporary total disability benefits.

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

Because of the Arbitrator's conclusion in disputed issue (F), the Arbitrator finds Petitioner is not entitled to any permanent partial disability benefits.

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

Because of the Arbitrator's conclusions in disputed issues (F), (K) and (L), the Arbitrator concludes that Petitioner is not entitled to penalties or attorneys' fees.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ 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

James McDaniel,

Petitioner,

vs. NO: 12 WC 15842

City of Columbia,

15IWCC0191

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, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, vacates the award of medical expenses, 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 where, in addition to an accident of December 27, 2011, he noted accidents occurring on March 2, 2012. The accidents of March 2, 2012 are the subject of claim 12 WC 9373 for which a separate Decision is being issued. The Commission affirms the Arbitrator's finding that Petitioner failed to prove a causal relationship exists between the accidental injuries sustained on December 27, 2011 and his current condition of ill-being. The Commission affirms the Arbitrator's findings that §12 Dr. Lange's no causal connection opinions more credible as he had reviewed all of Petitioner's medical records. Treating Dr. Kennedy opined causal connection, but he had not reviewed Petitioner's prior medical records, which showed extensive preexisting conditions. Dr. Kennedy admitted that his causal connection opinions could be changed depending on what information

15IWCC0191

may have been contained in those prior medical records. The Commission vacates the award of $1,940.00 in medical expenses, finding that the services provided pertain to the 12 WC 9373 claim. The Commission affirms the Arbitrator's denial of Petitioner's claim for temporary total disability benefits, prospective medical care and penalties. The Commission further notes that Dr. Lange opined that there was no permanent impact on either Petitioner's lumbar or cervical conditions. Therefore, since Petitioner failed to prove a causal relationship exists between the accidental injuries sustained on December 27, 2011 and his current condition of ill-being, there is no need to remand this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2013 is hereby affirmed and adopted, except for correction of the clerical error noted above and vacating of the medical expenses award.

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

DATED: MAR 19 2015
MB/maw
o01/29/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McDANIEL, JAMES
Employee/Petitioner

Case# **12WC015842**

12WC009373

CITY OF COLUMBIA
Employer/Respondent

15IWCC0191

On 2/20/2013, 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 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
BRADLEY D GILLESPIE
PO BOX 488
GRANITE CITY, IL 62040

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

15IWCC0191

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

James McDaniel
Employee/Petitioner

v.

City of Columbia
Employer/Respondent

Case # 12 WC 15842

Consolidated cases: 12 WC 09373

An *Application for Adjustment 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 Herrin, on December 17, 2012. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0191

FINDINGS

On December 27, 2011, and March 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 not causally related to the accident.

In the year preceding the injuries, Petitioner earned $47,840.00; the average weekly wage was $920.00.

On the date of accident, Petitioner was 52 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. The parties stipulated to credits of $4,584.80 for a PPD advancement and $8,527.46 for benefits from the IMRF for a total credit of $13,112.26.

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 of $1,940.00 for medical services provided to Petitioner on March 2 and March 5, 2012, as identified in Petitioner's Exhibit 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Arbitrator's Conclusions of Law attached hereto, all other benefits are denied.

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

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

William R. Gallagher, Arbitrator

February 15, 2013
Date

FEB 20 2013

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 12 WC 15842, Petitioner alleged that he sustained an injury to his low back on December 27, 2011, when he was pulling up the roll top of a dumpster and it broke loose which caused him to land hard on his heels. In case number 12 WC 09373, Petitioner alleged he sustained an injury to his low back on March 2, 2012, when he was standing on a concrete block while dumping a five gallon bucket of oil and the block rolled out from under him. Respondent stipulated that Petitioner did sustain accidental injuries on both December 27, 2011, and March 2, 2012; however, Respondent disputed its liability on the basis of causal relationship. At trial, an oral motion was made by Petitioner's counsel to consolidate the cases and this motion was granted by the Arbitrator.

Petitioner testified that he worked for Respondent in the Street Department for approximately 27 years. Petitioner's job duties varied and included street repairs, black topping, trash collection, grass cutting, etc. On December 27, 2011, Petitioner was in the process of attempting to open a frozen trash container with a roll top. The top suddenly became loose and, as a result thereof, Petitioner sustained a jolt to his low back. Petitioner sought no medical treatment following this accident and he continued to work.

Petitioner testified that on March 2, 2012, he was in the process of dumping a five gallon bucket of used motor oil while standing on a cinder block. The cinder block rolled out from under him and this caused him to sustain a jolting sensation to his low back. Later on that same day, Petitioner stated that he was lifting a trash container that weighed approximately 30 pounds and he twisted his feet and sustained low back pain that radiated down his right leg. Accordingly, Petitioner actually described two work accidents occurring on March 2, 2012.

Following the accidents of March 2, 2012, Petitioner went to the ER of St. Antony's Medical Center. The ER records contained a history of the Petitioner having back pain for the past several months with shooting pain into the right leg and groin. The Petitioner did advise the ER personnel of his having sustained a work injury that day when he was standing on a brick and slipped twisting his back and that he had back pain and shooting pain which were much worse thereafter. Petitioner also advised that, prior to this accident he had an appointment with a neurologist and was going to have an MRI performed. Petitioner was given some pain medication and directed to see his own physician.

Prior to all of these accidents, Petitioner had sought medical treatment for low back pain at St. Antony's Medical Center. On September 11, 2000, Petitioner was seen there with complaints of low back pain which he attributed to moving furniture approximately three days prior. X-rays were obtained which revealed some mild degenerative changes. On October 15, 2004, Petitioner was referred by Dr. Gary Vickers to the Physical Therapy Department of St. Antony's Medical Center for constant low back pain with shooting pains into his right scrotum, leg and ankle. It was noted in that record that Petitioner began experiencing lumbar symptoms in 1983 after an 18 foot fall which resulted in three compression fractures and that his symptoms had been getting

progressively worse within the past few years. The records also made note of the fact that Petitioner had undergone an MRI scan which revealed a bulging disc.

On February 1, 2012, Petitioner sought treatment from Dr. Carrie Daigle, for complaints of pain in the right testicle and back which he had been experiencing for the past four years but which had gotten progressively worse in the preceding four months. Dr. Daigle referred Petitioner to Dr. Christopher Vulin, a urologist, who initially saw Petitioner on February 23, 2012. When seen by Dr. Vulin, Petitioner complained of a stabbing pain radiating to the inguinal canal and abdomen which wrapped around to the back and right leg. Dr. Vulin referred Petitioner to Dr. Goldring, a neurologist. At trial, Petitioner testified he was unable to keep the appointment with Dr. Goldring. At Dr. Daigle's direction, Petitioner had an MRI scan performed on March 16, 2012, which revealed a right disc protrusion at L5–S1 compressing the origin of the S1 nerve root and a small annular tear at L4–L5.

Dr. Daigle saw Petitioner on March 28, 2012, and Petitioner complained of pain in his left hip and low back as well as numbness in his right foot. Petitioner stated that because of the lack of feeling in his right foot, he almost had a car accident on March 9, 2012. At that time, Dr. Daigle restricted Petitioner from lifting and driving and referred him to Dr. David Kennedy, a neurosurgeon.

On March 13, 2012, Petitioner was charged with driving under the influence (DUI) and he has not had a valid driver's license since that time. At trial, Petitioner agreed that possession of a valid driver's license was a requirement of his job for Respondent.

On May 9, 2012, Petitioner was examined by Dr. David Kennedy. At that time, Petitioner informed Dr. Kennedy's about the accident of March 2, 2012, and that he had complaints of severe low back pain with radiation into the right leg as well as pain in the right arm and the third and fourth fingers of the right hand. Dr. Kennedy reviewed the MRI scan of March 16, 2012, and opined that Petitioner had sciatica on the right side with a documented disc herniation at L5–S1 and radicular symptoms in the right arm consistent with cervical radiculopathy. Dr. Kennedy opined that Petitioner should have a trial of epidural steroid injections for the low back and an MRI scan of the cervical spine. Dr. Kennedy further opined that Petitioner's symptoms were causally related to the accident of March 2, 2012.

Dr. Kennedy was deposed on December 12, 2012, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Kennedy's testimony was consistent with the information contained in his medical records. On cross-examination, Dr. Kennedy agreed that he had not reviewed any medical records prior to his evaluation of May 9, 2012. Dr. Kennedy admitted that prior treatment records indicated that Petitioner had complaints that pre-existed the accident and that this could change his opinion as to causal relationship.

At the direction of the Respondent, Petitioner was examined by Dr. David Lange on June 14, 2012. In connection with his examination, Dr. Lange had a complete set of Petitioner's medical records which he noted in both his initial report of June 14, 2012, and a supplemental report of July 20, 2012. After obtaining a history of the accident from the Petitioner and reviewing treatment records both prior and post accident of March 2, 2012, Dr. Lange opined that

Petitioner's cervical and lumbar symptoms were not related to his work activities of March 2, 2012, because Petitioner had the same neurological symptoms prior to this accident. Dr. Lange admitted that the events at work may have cost a temporary aggravation of an underlying condition; however, he further stated that there was no permanent impact on either his lumbar or cervical condition whatever they might be. He further stated that no additional treatment was indicated for any work-related problems and that Petitioner did not require any work restrictions. Dr. Lange was deposed on September 27, 2012, and his deposition testimony was received into evidence at trial.

Conclusions of Law

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

The Arbitrator finds Petitioner's current conditions of ill-being are not related to the accidents of December 27, 2011 or March 2, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner's medical records clearly indicated that Petitioner had long-standing, pre-existing conditions and that, at best, the accidents of December 27, 2011, and March 2, 2012, caused only a temporary increase in his symptoms.

The Arbitrator finds the opinion of Dr. Lange to be more credible than that of Dr. Kennedy. While both of physicians only saw Petitioner on one occasion, Dr. Lange had the benefit of reviewing all of the Petitioner's medical records in reaching his opinions as to causal relationship. Dr. Kennedy did not have the opportunity to review the Petitioner's medical records and admitted that his opinion in respect to causal relationship could be changed depending upon what information may have been contained in those records.

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

The Arbitrator finds Respondent is liable for the medical bills incurred immediately following the accident of March 2, 2012. This includes the charges of St. Antony's Medical Center; Anthony's ER Physicians and South County radiology for charges incurred on March 2, 2012; and Dr. Daigle's charges for services rendered on March 5, 2012. Respondent is not liable for any other past or prospective medical charges.

Respondent shall pay reasonable and necessary medical services of $1,940.00 for medical services provided to Petitioner on March 2 and March 5, 2012, as identified in Petitioner's Exhibit 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

Because of the Arbitrator's conclusion in disputed issue (F), the Arbitrator finds Petitioner is not entitled to payment of any temporary total disability benefits.

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

Because of the Arbitrator's conclusion in disputed issue (F), the Arbitrator finds Petitioner is not entitled to any permanent partial disability benefits.

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

Because of the Arbitrator's conclusions in disputed issues (F), (K) and (L), the Arbitrator concludes that Petitioner is not entitled to penalties or attorneys' fees.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheny Segura,

Petitioner,

vs.

NO. 10WC 20970
15IWCC0192

Ecolab, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 7, 2014 is hereby affirmed and adopted.

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

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

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

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

DATED: MAR 2 0 2015
SJM/sj
o-2/5/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SEGURA, SHENY
Employee/Petitioner

Case# **10WC020970**

ECOLAB INC
Employer/Respondent

15IWCC0192

On 8/7/2014, 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 0.05% 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:

4678 PARENTE & NOREM PC
PARAG P BHOSALE
221 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
JOHN CAMPBELL
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0192

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

SHENY SEGURA
Employee/Petitioner

v.

ECOLAB, INC.
Employer/Respondent

Case # 10 WC 20970

Consolidated cases:

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 Choice of physicians

FINDINGS

On **December 1, 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 **$28,912.00**; the average weekly wage was **$$556.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

Petitioner has not exceeded her choice of physicians.

Respondent shall be given a credit of any amounts paid for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of **$$53,411.25** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner Temporary Total Disability benefits of **$370.67/week** for **204 & 4/7ths weeks**, commencing **6/06/10** through **5/08/14**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner Permanent Partial Disability benefits of **$333.60/week** for **125 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused permanent partial disability to the Petitioner to the extent of **25% of a person as a whole.**

Respondent shall pay for reasonable and necessary medical services billed currently billed at **$549,918.93**, (Bill specifics contained in the addendum of this opinion) at a rate pursuant to the medical fee schedule provided in Sections 8(a) and 8.2 of the Act. Respondent shall provide to the Petitioner an itemization with regard to said fee schedule reduction calculations along with the payment.

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

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

Kathi Steffen
Signature of Arbitrator

8/5/16
Date

PROCEDURAL HISTORY

This matter was presented for a hearing on the merits before Arbitrator Ketki Steffen on May 8, 2014. Both parties were represented by counsel and have entered into several stipulations that are contained as Arbitrator's Exhibit No. 1 ("AX1") for the trial record. The case relates to an accident date of December 1, 2009; a date which predates the September, 2011 AMA guidelines amendment to the Act.

FACTUAL HISTORY

Petitioner was fifty-seven years and had worked for Respondent, Ecolab, since 2004. She was born and raised in Guatemala. On December 1, 2009 Petitioner worked in the plumbing department. Her work duties involved the breakdown, cleaning and reassembly of small to moderate sized plumbing parts.

On December 1, 2009 Petitioner was working on the Apex machine. She testified that she was using a wrench to tighten a pipe when she felt a snap in her neck. She explained that her injury occurred while tightening the pieces together. She testified that she had a prior right shoulder surgery twenty years prior but had healed. The work incident caused her pain in the neck and left shoulder area.

Petitioner testified that she reported her injury to her supervisor, Hector Delgado and that a written report was completed. Mr. Delgado was working near her at the time of the incident. Petitioner completed the work day as the incident happened at 2:30 p.m. and her shift ended at 3 p.m. She did not seek medical care on the date of the incident as she was hoping her symptoms would go away and she did not wish to jeopardize her job.

Petitioner continued to work full duty without medical care until her appointment with her primary care physician Dr. Pla on December 17, 2009. Petitioner testified that Dr. Pla told her he did not wish to get involved in a work injury case. The records from Dr. Pla reflects primary complaints of

fever and body ache as well as right arm pain for the past two weeks. This record is silent of any complaints of neck pain or allegations of a work injury (Respondent's Exhibit #8, Page 17). There are prior medical notes from Dr. Pla regarding prior complaints of right arm, and mid and upper back pain from August 13, 2009. Records dating back as far as April 4, 2005 reflect complaints of neck pain as well as left arm pain (Respondent's Exhibit #8, Page 32). Lower back as well as upper back pain was also mentioned in the March of 2006 record (Page 33).

Following her appointment with Dr. Pla, Petitioner was sent by corporate services to the occupational health clinic on December 18, 2009. Petitioner undertook a course of therapy and was on light duty for a brief duration. The records from occupational clinic at Alexian Brothers (Petitioner's Exhibit #4) reflect initial complains of right shoulder and neck pain with a resolution of Petitioner's right shoulder pain complaints as of February 11, 2010 visit.

Petitioner continued treatment with her primary care physician, Dr. Pla, and handwritten notes make mention of a Dr. Prinz in the January 21, 2010 record. The record contain no clear referral to Dr. Prinz and the handwritten and well as many of the older records from Dr. Pla are illegible.

The records of Dr. Prinz reflect a referral to Dr. Lawrence Frank. Dr. Frank treated Petitioner with injections which Petitioner claims provided no relief (Petitioner's Exhibit #7). The records of Dr. Frank do not reflect any referral to another treating physician.

Petitioner underwent a cervical MRI examination on February 20, 2010 which revealed a mild central disc bulging at C3-4 with similar bulging and degeneration at C-4, C4-5, and C5-6 (Petitioner's Exhibit #7).

On June 7, 2010 Petitioner presented to Dr. Jose Castellanos. The record reflects a referral to "our Neuro" which appears to be a referral to Dr. Michael Malek.

Dr. Malek records (Petitioner's Exhibit #12, "PX12") indicate a patient visit on June 16, 2010 for a surgical consultation. Petitioner described her alleged work injury and Dr. Malek conducted an

exam which found cervical radiculopathy neurological deficit on exam. The annular bulging and narrowing in the cervical spine pursuant to the MRI was noted. The doctor requested the prior MRI scans and ordered additional ones along with physical therapy. On subsequent visits, Dr. Malek continued to recommend another MRI and commented on the IME of Dr. Levin.

The medical record of Dr. Malek of August 26, 2010 reflects a return visit with examination. A diagnosis of cervical radiculopathy was restated and in the doctor's recommendations, which involve eleven points, there is no indication for a referral or any other second opinion from another medical provider including any neuro or orthopedic surgeon. Dr. Malek simply indicated he was in need of MRI films as well as records from Dr. Franks.

On August 31, 2010 Petitioner treated with Dr. Anthony Rinella. The treatment records do not reflect a referral. Petitioner testifies that there was a referral from Dr. Malek to Dr. Rinella.

On August 1, 2011 Dr. Anthony Rinella performed a cervical discectomy and fusion at C4-5 and C5-6 and performed an extension of the fusion to C6-7 at a surgical procedure on December 4, 2012. Thereafter, Petitioner continued to complain of pain rated eight out of ten. Petitioner testified that she was slightly better after surgery. Dr. Rinella's placed the Petitioner on a 5 lbs lifting restriction with no repetitive bending or twisting.

Petitioner testified that she could only understand a little English, and had sought to see a doctor who spoke Spanish. She stated that her human resources representative, Claudia Chavez told her that they would not accommodate her work restrictions. She explained that on 7/7/10 she stopped physical therapy treatments so she could fly to Gautemala to see her dying mother. She had never injured her neck and her shoulder surgery was from 20 year ago when she lived in Gautemala.

Petitioner testified that she continues to have difficulty with activities of daily living and is unable to perform household tasks. Petitioner asserted that she did attempt to secure work on a

sedentary basis but has been unable to secure employment. Petitioner expresses that her complaints of pain remain with regard to her neck and right side of her upper back and shoulder. Petitioner remains on Norco and Valium and rates her pain as seven out of ten.

Job Survey reports of Daniel R. Minnich (RX7)

Respondent Exhibit #7 includes a vocational assessment from Aegis Rehabilitation Consulting Services. This vocational report dated January 14, 2014 identifies approximately forty alternative jobs within a light 5 lbs work restriction pursuant a stated restriction by Dr. Rinella. The number of current job openings were listed within the Aegis report. The certified vocational counselor, Daniel Minnich, concluded that Petitioner would be capable of returning to the general labor market in a light duty capacity. Mr. Minnich believed Petitioner could return in similar occupations consistent with the assembly job she had previously performed. It is noted that the job identified was the testing cleaning job and not the plumbing job performed by Petitioner. Mr. Minnich found the job pay in this capacity to be in the range of $9.56 to $15.00 per hour and that job openings are readily available in Illinois (Respondent's Exhibit #7).

Mr. Minnich interviewed the Petitioner and prepared a labor market survey having a entry wage ranging from $8.72/hour to $10.36/hour.

Medical Reports and Testimony from IME Physician Dr. Mark Levin

Dr. Levin was secured as an independent medical examiner by Respondent and prepared a total of six reports. Dr. Levin testified at deposition (Respondent's Exhibit #1) and explained the results of his first examination of April 27, 2010. The doctor explained his review of the MRI showed no frank herniation in the cervical spine. The doctor noted that Petitioner's initial complaints were of right shoulder pain which had resolved. Petitioner was felt to be at maximum medical improvement for her right shoulder with no objective pathology. Dr. Levin found the more recent complaints of neck

discomfort to be different from the initial complaints as referenced by Dr. Pla in the initial treatment records (Respondent's Exhibit #1, Page 14).

Dr. Levin's next examination was on July 27, 2010 whereupon he had the opportunity to review additional medical records for treatment early on in the case. Dr. Levin concluded that Petitioner was at maximum medical improvement for the right shoulder which appeared to be related to the work injury in December 2009. Dr. Levin released Petitioner to full duty at this time.

Petitioner was next examined on January 4, 2011 by Dr. Levin. Dr. Levin again restated that he believed the work injury was related only to the right shoulder complaints and not any cervical involvement. The doctor also expressed subjective complaints that were out of proportion and involved symptom magnification and suggested further diagnostic testing before any surgery was performed on the cervical spine (Petitioner's Exhibit #1, Page 22-Page 27). Dr. Levin testified to an additional review of records and commented that the suggestion for a cervical fusion was not indicated based on additional EMG studies that failed to show myelopathy (Respondent's Exhibit #1, Page 28). Dr. Levin stated that any cervical surgery would not be related to the alleged injury in December 2009 (Petitioner's Exhibit #1, Page 29). Dr. Levin saw Petitioner again on September 11, 2012 post surgery. The doctor again reiterated that he found Petitioner's surgery to be unnecessary based on subjective complaints.

Dr. Levin also reviewed a job video for the "testing cleaning" job at Ecolab. Dr. Levin commented that his prior findings were unchanged after review of the job video and he did not find any cause or relation to Petitioner's cervical complaints to her job (Petitioner's Exhibit #1, Page 38-39). The job video did not include the job duties in the plumbing department which is the job performed when Petitioner alleges she was hurt. Dr. Levin opined that the cervical condition was not part of any work related injury in December 2009.

Testimony of Dr. Anthony Rinella

Dr. Anthony Rinella was the treating surgeon and testified upon two depositions in this case. Dr. Rinella first testified on March 21, 2012 and explained the basis for his initial surgery of August 1, 2011 to the cervical spine. Dr. Rinella indicated he felt the treatment he provided all stemmed from the alleged work injury of December 1, 2009 and that his surgeries were appropriate in an effort to attempt to alleviate Petitioner's complaints (Respondent's Exhibit #2, Page 23-24). He opined that the diagnosis of cervical myelopathy (spinal cord compression) is progressive, takes a long time to develop and that the petitioner's condition of myelopathy became symptomatic in December, 2009 following her work accident and that this was an aggravation of a preexisting condition. (PX2 p. 10)

When asked how Petitioner came to be a patient, the doctor indicated she was obtaining a second opinion but the doctor did not recall any details or specifically how Petitioner came to his office (RX2, P. 7).

Dr. Rinella was deposed a second time after the second surgery and offered testimony on August 14, 2013. The doctor was again asked regarding how Petitioner presented to him and Dr. Rinella indicated he has seen patients that had treated with Dr. Malek. However, there is no indication that Dr. Rinella confirmed a referral of Petitioner from Dr. Malek in this case (RX3, P. 47). Dr. Rinella placed a 10 lbs weight restriction on Petitioner (PX3, P. 55).

Testimony of Naqui Haider

Mr. Haider testified on behalf of Respondent. He is employed as a production supervisor for Ecolab and was so employed on December 1, 2009. Mr. Haider testified that he himself has performed both the testing cleaning job previously performed by Petitioner as well the work in the plumbing department as described by Petitioner in her direct testimony.

Mr. Haider testified that Respondent's Exhibit #6 A is the job video of the "test and clean" position. Mr. Haider testified Petitioner did perform this work at various times during her tenure. He

also testified regarding Respondent's Exhibit # B, a video entitled "Plumbing Refurb Process. He explained that this was the type of work Petitioner was performing on her alleged date of injury.

The job video was introduced in court to the Arbitrator with all parties, including Petitioner and Counsels present. Mr. Haider explained the various elements to the job while the video was played in court. He explained that the pieces were typically six to eight inches in length and the removal and placement of plumbing pieces did involve the use of a wrench. He clarified that hand tightening and loosening of some parts was required to a maximum, approximate a half a turn with a wrench. Mr. Haider testified that the tightening required caution as workers were instructed not to tighten the pieces too tightly as it could damage the internal rubber ring.

During cross examination, Petitioner agreed that this was the instruction and process for this job. She acknowledged that the job video did reflect a large portion of the job duties she performed on the alleged date of loss and the only difference was an additional attachment of pipe that was not specifically shown on the video. Mr. Haider explained that the same level of force to perform this additional task as alleged by Petitioner was consistent with the other job processes on the video.

Ultimately, Mr. Haider explained that the level of force used to disassemble and assemble these pieces is approximately the same as opening a jar of jelly or peanut butter.

Findings/Analysis

As to the issue of whether the accident occurred in the course of and arose out of the Petitioner's employment with Respondent, the Arbitrator finds as follows:

The Petitioner testified clearly regarding her job duties and was convincing in her explanation that she was performing a twisting motion when she felt a snap in her neck. There is a immediate outcry to her supervisor, Hector Delgado. Petitioner testifies that some paperwork was filled out and she explains why she finished the last half hour of her shift and why she waited for two weeks to go see her physician. The Arbitrator finds her testimony and the mechanism of her accident to be

believable, especially in light of the job description video introduced into evidence. Therefore, the Arbitrator finds that the accident arose during the course of employment.

As to the issue of whether the Petitioner's current condition of ill-being is causally related to the work injury, the Arbitrator finds as follows:

Petitioner testified that she suffered a cervical injury during work that necessitated two neck surgeries. Petitioner's prior medical history indicates a prior history of right shoulder surgery approximately twenty years ago and more recent right arm and mid and upper back pain (2009) as well as neck and left arm pain (April 2005). There is also documentation of therapy at Alexian Brothers occupational clinic (2010) The prior medical history is devoid of any findings of cervical myelopathy, radiculopathy, or stenosis prior to her accident on 12/01/09. An EMG taken on 5/06/05 documents this history. The Alexain Borthers Hospital intake records of December 21, 2009 document a 'R Shoulder/Neck' area as the location of pain. (RX4)

Petitioner reports an injury and is seen by her primary care physician two weeks later. Respondent continues under the care of various physician and untimately undergoes two cervical surgeries. The medical records of Dr. Pla, Petitioner's primary care physician, Dr. Prinz, Dr. Frank, Dr. Castellanos, Dr. Malek, and the desposition testimony from Dr. Rinella all provide a causal connection between the 12/01/09 accident and her neck injury.

Specifically, Dr. Rinella, the treating surgeon, opines that the diagnosis of cervical myelopathy (spinal cord compression) is progressive, that it takes a long time to develop and that the petitioner's condition of myelopathy became symptomatic in December, 2009 following her work accident and that this was an aggravation of a preexisting condition. (PX2 p.10) Dr. Rinella testified to a reasonable degree of medical and surgical certainty that the 12/01/09 accident caused an aggravation of pre-existing stenosis that resulted in myelopathy, thus necessitating the two major neck surgeries. During his depositions, Dr. Rinella testified as to the basis for his initial surgery of August 1, 2011 to the cervical spine. Dr. Rinella indicated he felt the treatment he provided all

stemmed from the alleged work injury of December 1, 2009 and that his surgeries were appropriate in an effort to attempt to alleviate Petitioner's complaints (Respondent's Exhibit #2, Page 23-24).

Dr. Levin, the IME has also provided a medical opinion that is contrary to Dr. Rinella. Dr. Levina has opined that there is no causal connection between the Petitioner's injury and her subsequent treatment. The basis for his opinion is that his review of the MRI showed no frank herniation in the cervical spine. The doctor noted that Petitioner's initial complaints were of right shoulder pain which had resolved, that Petitioner was at MMI for her right shoulder injury, which was work related. He opined that Petitioner's work accident did not have any cervical involvement and that her subjective complaints were out of proportion and involved symptom magnification. (PX1, P. 22-27). Dr. Levin also testified a cervical fusion was not indicated based on additional EMG studies that failed to show myelopathy (Respondent's Exhibit #1, Page 28). Dr. Levin opined that any cervical surgery would not be related to the alleged injury in December 2009 (Petitioner's Exhibit #1, Page 29). He was clear in his testimony and opinion that the Petitioner's subjective complains were not supported by objective pathology. Additionally, Post-surgery, he reiterated that he found Petitioner's surgery to be unnecessary based on subjective complaints. (RX1, p. 31) He also felt that Petitioner's below shoulder level work was not the type of activity that could have put stress on the cervical spine. (RX1, p. 38). Dr. Levin also reviewed a job video for the "testing cleaning" job at Ecolab and opined that this could not have cause Petitioner's cervical injury. (Petitioner's Exhibit #1, Page 38-39). Although, Dr. Dr. Levin's was not provided the the plumbing department job video which the Petitioner was working at during her work accident, his opinion regarding the below shoulder work is an crucial detail. Lastly, Dr. Levin indicated that during his exams Petitioner continued to complain to pain and physical limitation when asked directly to bend or turn but when observed during other aspects of examination, Petitioner was clearly capable of a lot more then she subjectively complained of. (RX1 p. 66-70).

The Arbitrator has carefully considered the testimony of witnesses and the medical records in evaluation the opinions and testimony of Dr. Rinealla and Dr. Levin. The Arbitrator the finds the opinion of Dr. Rinella to be more persuasive that the opinion of Dr. Levin on the issue of whether Petitioner suffered a work injury to her shoulder and neck. Dr. Rinella is the treating surgeon with first-hand knowledge of Petitioner condition. Both surgeons have excellent credentials but Dr. Rinella specialized in cervical/spine surgeries. Dr. Rinella's opinion is backed by the causal connection opinion of several other doctors, is supported by the Petitioner's subjective complains and description of the work accident. Dr. Levin agrees that there is a work accident but opines that it is only a shoulder injury that reached MMI and that the cervical condition just arose contemporaneously. The Arbitrator finds this argument non-persuasive and relies on the opinion of the treating surgeon to find that the Petitioner's condition of ill-being is causally connected to her work accident.

As to the issue of whether the medical services provided the Petitioner were reasonable and necessary, the Arbitrator finds as follows:

The Arbitrator finds all of the treatment provided to the Petitioner after 12/01/09 was reasonable and necessary and caused as a result of her work accident. This includes the two cervical surgeries that were performed by Dr. Rinella.

The Arbitrator finds that the Petitioner suffered cervical myelopathy as a result of that trauma that occurred on 12/01/09. Dr. Rinella's opinion is persuasive on this point as is the medical consensus that this is a progressive condition. The Arbitrator notes that Dr. Pha's records do not document the work accident. However, the Petitioner has given a reasonable explanation of the same and the Alexian Brother's Hospital records two weeks later document petitioner's complains of neck pain and work accident.

The Arbitrator finds that the Respondent shall pay for the following medical bills subject to the medical fee schedule under Sections 8(a) and 8.2:

Illinois Spine & Scoliosis Center (Dr. Rinella)	$ 192,434.38
Center for Minimally Spine Surgery (8/01/11 surgical facility)	306,960.00
Homer Glen Open MRI	2,600.00
Morton Grove Medical Imaging	2,020.00
Dr.Michel Malek	1,100.00
Silver Cross Hospital (12/04/12 surgical facility)	44,804.55

TTD Payments

The Arbitrator finds that the Petitioner is entitled to Temporary Total Disability payments from 6/06/10 to the date of the arbitration hearing, 5/08/14. The Petitioner was proven that she was kept off work or was provided with restrictions during this time period by Dr. Malek and Dr. Rinella.

The Petitioner testified that Gloria Chavez informed her that her restrictions would not be accommodated. Ms. Chavez's name appears as the Respondent's contact person in several records, including those from the Alexian Brother Work clinic. The Petitioner's testimony regarding the failure to accommodate is not rebutted. Ms. Chavez is the employee of the Respondent and presumable available to either sides as a witness regarding availability of job accommodations.

As to the issue of Choice of physicians, the Arbitrator finds as follows:

In relation to choice-of-referrals, Section 8(a) provides:

Notwithstanding the foregoing, the employer's liability to pay for such medical services selected by the employee shall be limited to:

(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 or by any other physician,

consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus

(3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense. This paragraph shall not affect the duty to pay for rehabilitation referred to above. 820 ILCS 305/8(a).

No provision in the Act states that a physician referral must be in writing to remain within a choice-of-referral.

The Arbitrator finds that the Petitioner did not exceed her two choice-of-referrals. The following summarizes the referral chains:

1st chain: Dr. Pla referred the Petitioner to Dr. Prinz, which is documented in writing in her records. Dr. Prinz referred the Petitioner to Dr. Frank, which is evidenced by Dr. Frank's first treating record specifically thanking Dr. Prinz for the referral.

2nd chain: Dr. Castellanos referred the Petitioner to Dr. Malek, which was documented in writing to a "neurosurgeon" for the same date as the first visit with Dr. Malek. Dr. Malek referred the Petitioner to Dr. Rinella, which is evidenced by the Petitioner's testimony and Dr. Rinella's testimony that Dr. Malek has referred him patients in the past.

Evidence can be in the form of an exhibit or testimony. Although there may not be a written referral from Dr. Malek to Dr. Rinella, there is testimony from the Petitioner that creates a prima facie presumption on the issue. There was no evidence to rebut the Petitioner's testimony and the resulting presumption. The Arbitrator finds that there was a valid referral keeping with the choice-of-referrals allowed in Section 8(a).

Therefore, Petitioner has not exceeded her choice of physicians.

As to the issue of what is the nature and extent of the injuries, the Arbitrator finds as follows:

Petitioner has suffered an injury to her shoulder and cervical spine that required two surgeries. Petitioner has been released by her physicians with lifting restrictions and no repetitive bending and twisting. Respondent Exhibit #7, a vocational assessment from Aegis Rehabilitation Consulting Services dated January 14, 2014 identifies approximately forty alternative jobs within a light 5 lbs work restriction pursuant a stated restriction by Dr. Rinella. The number of current job openings were listed within the Aegis report. The certified vocational counselor, Daniel Minnich, concluded that Petitioner would be capable of returning to the general labor market in a light duty capacity. Mr. Minnich believed Petitioner could return in similar occupations consistent with the assembly job she had previously performed. It is noted that the job identified was the testing cleaning job and not the plumbing job performed by Petitioner. Mr. Minnich found the job pay in this capacity to be in the range of $9.56 to $15.00 per hour and that job openings are readily available in Illinois (Respondent's Exhibit #7).

Mr. Minnich interviewed the Petitioner and prepared a labor market survey having a entry wage ranging from $8.72/hour to $10.36/hour. No doctor or professional has rendered a opinion that petitioner is permanently and totally disabled. Petitioner testified in court that she is able to do nothing, including housework. Petitioner is not credible on this issue based on the physical abilities as witnessed in court and as clearing noted by Dr. Levin. The Arbitrator has found Dr. Levin's deposition testimony to be very persuasive in regards to the Petitioner amplifying her condition and limitations. Dr. Levin's medical documentation of Petitioner symptom magnification is also on point. Petitioner claims diligent but unsuccessful attempts to find work. She presents no proof by way of logs or specifics. Petitioner claims that her medical condition, age, training, education, and experience render her unfit to perform any but the most menial tasks for which no stable labor market

exists. The labor market report prepared by the certified vocational counselor, Daniel Minnich, concludes the contrary.

The Arbitrator finds that the Petitioner is more than capable of returning to the general labor market in a light duty capacity. She has failed to prove any efforts to return to the job market.

In spite of this finding, Petitioner did suffer a work injury that has placed her with physical limitations on her abilities. The Arbitrator has considered many factors including but not limited to Petitioner's age, education, vocation and medical condition. The Arbitrator finds that Petitioner has suffered permanent partial disability in the amount of 25% of a person as a whole. Respondent shall pay the Petitioner PPD benefits of $333.60/week for 150 weeks as provided in Section 8(d)2 of the Act.

Kelli Stetten
Signature of Arbitrator

8/5/14
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

Lauren Mlade,
Petitioner,

vs.

NO: 11WC 2848

PAEC Elementary School,
Respondent,

15IWCC0193

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2014, is hereby affirmed and adopted.

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

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

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

DATED: MAR 2 3 2015
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MLADE, LAUREN
Employee/Petitioner

Case# **11WC002848**

PAEC ELEMENTARY SCHOOL
Employer/Respondent

15IWCC0193

On 1/8/2014, 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 0.08% 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:

0544 LOSS & PAVONE PC
JOSEPH J LOSS
1920 S HIGHLAND AVE SUITE 203
LOMBARD, IL 60148-6149

0863 ANCEL GLINK
ERIN BAKER
140 S DEARBORN 6TH FL
CHICAGO, IL 60603

15IWCC0193

2STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LAUREN MLADE
Employee/Petitioner

v.

PAEC Elementary School
Employer/Respondent

Case # 11 WC 02848

Consolidated cases: D/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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **December 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. xxxx Causation as to the right shoulder is stipulated. Did Petitioner establish causation as to her claimed left shoulder and cervical spine conditions of ill-being?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. xxx Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent provided all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. xxx 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 29, 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.

Respondent stipulated to causation only with respect to Petitioner's right shoulder condition of ill-being. Arb Exh 1. T. 4-6. The Arbitrator finds that Petitioner established causation as to her current left shoulder and cervical spine conditions of ill-being.

In the year preceding the injury, Petitioner earned **$94,349.76**; the average weekly wage was **$1,965.62**.

On the date of accident, Petitioner was **60** 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 **$18,467.39** for TTD for a total credit of **$18,467.39**.

Respondent is entitled to Section 8(j) credit per the Arbitrator's causation and medical findings and the parties' stipulation. See pages 16-17 of the attached conclusions of law.

ORDER

MEDICAL BENEFITS/SECTION 8(J) CREDIT

SEE PAGES 16-17 OF THE ATTACHED CONCLUSIONS OF LAW FOR THE ARBITRATOR'S FINDINGS AS TO MEDICAL AND SECTION 8(J) CREDIT.

PERMANENCY

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $669.64 PER WEEK FOR 137.5 WEEKS BECAUSE THE INJURY SUSTAINED CAUSED 27.5% LOSS OF THE PERSON AS A WHOLE AS PROVIDED IN SECTION 8(D)(2) OF THE ACT.

THE ATTACHED STATEMENT OF FACTS AND CONCLUSIONS OF LAW ARE INCORPORATED 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.

Molly C Mason
Signature of Arbitrator

1/3/14
Date

JAN 8 - 2014

Lauren Mlade v. PAEC Elementary School
11 WC 2848

15IWCC0193

Arbitrator's Findings of Fact

The parties agree that Petitioner injured her right shoulder on October 29, 2010 while working as a principal at Respondent elementary school. Respondent disputes causation with respect to Petitioner's claimed cervical and left shoulder conditions, with Petitioner attributing the latter to overuse. Arb Exh 1. T. 4-6.

Petitioner testified she was the principal at Respondent school for 18 or 19 years before her work accident. She described the school's students as severely emotionally disturbed and sometimes violent. T. 11-13. If a student acted out, putting himself or others at risk, the administration followed a set protocol that progressed, as necessary, from "physically managing" the student to escorting the student to an isolation area. The isolation area included a room that was equipped with padded walls, a camera, a heavy metal door and an observation window. Petitioner testified there was a pad on the floor outside this room. As long as someone stood on this pad, the metal door would stay locked, so as to prevent the student from exiting the room or being left unattended. T. 14-15.

Petitioner denied having any problems with her neck or either shoulder before her accident of October 29, 2010. T. 56. On that date, she was walking down the school hallway when she observed a staff member bring a student into the isolation area. Because the staff member seemed somewhat upset, Petitioner went into the isolation area to make sure everything was all right. At that point, both the student and the staff member were inside the isolation room. Petitioner stepped onto the pad, with the intention of locking the door, and leaned over to look through the window. As she leaned over, she raised her right hand. Just at that moment, the staff member decided to exit the room. Although Petitioner was on the pad, the pad did not function properly. The staff member was able to forcefully push the door open. Petitioner testified the door caught the tips of the fingers of her right hand, twisting her right arm backward. She let out a gasp. T. 16-17.

Petitioner testified she went to the school nurse immediately after the accident. The nurse recommended that Petitioner go to a hospital. Petitioner testified she went home instead, since it was a Friday and she hoped to improve. T. 17. Her shoulder did not get better. On Sunday, October 31, 2010, she went to the Emergency Room at Good Samaritan Hospital. T. 18. The history set forth in the Emergency Room records is fully consistent with Petitioner's testimony. PX 2, p. 13 of 20. Petitioner complained of pain in her right shoulder as well as occasional tingling in the second, third and fourth fingers of her right hand. The examining physician noted reproducible pain in the supraspinatus and proximal humeral area with rotation, range of motion, forced flexion and supraspinatus testing. He ordered right shoulder and right humerus X-rays, which showed some degenerative changes in the humeral head but no fractures or dislocations. Based on Petitioner's account of the accident, the examining physician theorized that forceful movement of Petitioner's right arm caused an acute right

shoulder strain and possible rotator cuff injury. He placed Petitioner's right arm in a sling. He prescribed Naprosyn and Vicodin and recommended that Petitioner see an orthopedic specialist. PX 2.

Petitioner testified she saw Dr. Ryon Hennessy, a board certified orthopedic surgeon (Hennessy Dep Exh 1), in follow-up on November 3, 2010. She provided the doctor with her Emergency Room records. T. 19.

Dr. Hennessy's handwritten note of November 3, 2010 reflects that Petitioner sustained a "hyperextension injury" on October 29, 2010 when a heavy metal door struck her extended right hand. Dr. Hennessy noted that Petitioner denied having any right shoulder or neck problems before the injury.

Dr. Hennessy's lengthy typed note of the same date reflects that, on October 29, 2010, Petitioner felt "electrical shooting in the right arm and shoulder" after a heavy door "came open forcibly into her right hand." He interpreted the X-rays taken at the Emergency Room as showing moderate degenerative changes in both the humeral head and the acromioclavicular joint. He noted that Petitioner complained of pain running down her right shoulder "with tingling into the right C7 dermatome in the 2nd, 3rd and 4th fingers." He indicated that Petitioner "denies any left-sided complaints or cervical headaches at this time."

Dr. Hennessy diagnosed right shoulder rotator cuff tendinopathy and cervical radiculopathy. He indicated he planned to observe the radiculopathy. He recommended physical therapy for the right shoulder and released Petitioner to light duty with no student contact, no lifting above chest leval and no lifting over 10 pounds. He indicated he would give consideration to MRI scanning and/or a shoulder injection if Petitioner failed to improve. PX 3, pp. 44-46.

On November 9, 2010, Petitioner underwent an initial therapy evaluation at Midwest Physical Therapy. The evaluating therapist recorded the following history:

> "The patient is a 61-year-old principal who reports to physical therapy today reporting injury to her shoulder and cervical spine on 10/29/10. The patient reports while at work, a metal door caught her hand and twisted her arm and neck region, causing some increased force."

The therapist noted that Petitioner complained of limitations with respect to reaching, gripping, pulling and overhead activity as well as difficulty lying on her right side. PX 3, p. 119. Petitioner began attending therapy following this evaluation. T. 20.

Petitioner returned to Dr. Hennessy on November 17, 2010, with the doctor noting possible slight improvement but complaints of tingling in the right second, third and fourth fingers, occasional right thumb numbness, difficulty sleeping on the right side and "intrinsic

right shoulder pain." The doctor noted that Petitioner had stopped taking the Naprosyn. On re-examination, he noted a little weakness to resisted external rotation to the right shoulder and a complaint of very sharp right shoulder pain with impingement testing. He prescribed MRIs of the right shoulder and cervical spine. He continued the previous work restrictions and told Petitioner to re-start the Naprosyn. PX 3, p. 40-42.

Petitioner testified that, as of her November 17, 2010 visit to Dr. Hennessy, she was experiencing neck pain, tightness behind her head and shock-like pain radiating down her right arm. She did not have left-sided symptoms at that time. T. 21.

On December 15, 2010, Petitioner underwent the recommended right shoulder MRI. The interpreting radiologist noted a "large full-thickness rotator cuff tear involving the majority of the supraspinatus tendon." He described the tendon as "avulsed at its greater tuberosity insertion and retracted centrally to the level of the 12 o'clock position on the humeral head." He also noted rotator cuff tendinopathy. PX 3, p. 59.

Petitioner returned to Dr. Hennessy on December 17, 2010. In his note of that date, the doctor indicated that "unfortunately, work comp did not approve the cervical MRI" and that Petitioner continued to have radiculopathy predominantly in the right C7 dermatome going into the second, third and fourth fingers.

With respect to the right shoulder MRI (mistakenly referred to as the cervical spine MRI), Dr. Hennessy interpreted the scan as showing a "full-thickness rotator cuff tear of decent size." He described the labrum as intact. He recommended an open rotator cuff repair with acromioplasty, based on the size of the tear.

Dr. Hennessy indicated he did not believe it was safe to place Petitioner under anesthesia to perform the rotator cuff repair until the cervical spine MRI had been performed. He again recommended this MRI. He refilled the Naprosyn prescription and continued the work restrictions. PX 3, p. 38-40.

Petitioner underwent the cervical spine MRI on January 6, 2011. Petitioner testified she called "workmen's comp" at least ten times, "crying on the phone," before this MRI was approved. T. 22-23.

The radiologist who interpreted the cervical spine MRI noted moderate degenerative disc disease at C5-C6 with right neural foraminal stenosis due to asymmetric disc protrusion and superimposed bony spondylotic changes, milder disc bulging at C3-C4, C4-C5 and C6-C7 and no occult bony or spinal cord lesions. PX 3, p. 128.

Dr. Hennessy met with Petitioner on January 10, 2011 in order to discuss the cervical spine MRI results. In his note of that date, he indicated he had spent "a lot of time trying to discern between the radiculopathy symptoms and the rotator cuff symptoms." He indicated that, "in the end, [Petitioner's] symptoms go from the neck down the right arm and she also

has periscapular pain, [going] mostly to the right second finger." He described the osteophyte pathology at C5-C6 as "right worse than left" and thus "consistent with [Petitioner's] symptoms."

Dr. Hennessy addressed causation as follows:

> "My diagnosis is right rotator cuff tear directly caused by the accident at work. She had an exacerbation of a pre-existing spinal stenosis and disc bone osteophyte complex in the right C5-6 from the accident."

Dr. Hennessy went on to state that Petitioner might ultimately require an anterior cervical discectomy and fusion at C5-C6 but that he planned to "start with the rotator cuff." He warned Petitioner that she might have persistent pain following a rotator cuff repair. He allowed Petitioner to continue to work "as long as she does not have any contact with the students." PX 3, p. 36.

At Petitioner's request, Dr. Hennessy clarified the "no student contact" portion of his restrictions on January 10, 2011, indicating Petitioner was unable to physically manage children or be in the same area with children. He continued the previous lifting-related restrictions. PX 3, pp. 34-35.

Petitioner testified that workers' compensation did not approve the recommended right shoulder surgery until mid-April 2011. T. 26.

At Respondent's request, Petitioner saw Dr. Bach, a board certified orthopedic surgeon specializing in shoulder problems (Bach Dep Exh 1), for a Section 12 examination on February 3, 2011. T. 27. Petitioner testified this examination had previously been set for sometime in January 2011 and again on February 2, 2011, with both of those appointments being cancelled.

Petitioner testified that Dr. Bach asked her about how her injury occurred, moved her arm in several directions while taking measurements and ultimately told her he believed the injury was "caused by the door." T. 27-28.

No February 3, 2011 report of Dr. Bach is in evidence. At his deposition, taken on July 2013, Dr. Bach acknowledged examining Petitioner on February 3, 2011, dictating his report at that time and sending the dictation off for transcription. Two weeks thereafter, however, he learned that the dictation was unrecoverable, either because his Dictaphone had malfunctioned or the dictation had been lost. He asked Petitioner to "come back in for a repeat independent medical evaluation at no charge." RX 6 at 8. The repeat examination took place on April 11, 2011. RX 6 at 8.

In his report of April 11, 2011, Dr. Bach described Petitioner as a right-handed principal who injured her right shoulder and neck on October 29, 2010 when a door struck her right arm.

He noted that Petitioner was performing light duty as of February 3, 2011 and April 11, 2011. He indicated Petitioner complained of significant pain and difficulty sleeping on her right side.

On bilateral shoulder examination, Dr. Bach noted 165 degrees of forward elevation and abduction on the right versus 175 on the left, internal rotation of 40 degrees on the right versus 50 on the left and external rotation of 55 degrees on the right versus 60 on the left. He noted a positive impingement sign without indicating which shoulder(s) he was referring to.

Dr. Bach interpreted the right shoulder MRI as showing a full-thickness rotator cuff tear, some biceps signal changes and a type 2 acromion.

Dr. Bach indicated he re-reviewed a shoulder survey form that Petitioner completed on February 3, 2011. This form is not in evidence.

Dr. Bach also indicated he reviewed the cervical spine MRI report and Dr. Hennessy's records.

Dr. Bach found a causal relationship between the accident and Petitioner's right shoulder condition, noting that Petitioner's right arm was struck and jerked while the arm was extended in mid-abduction. He indicated this type of injury could cause a rotator cuff injury. In his opinion, the absence of atrophy suggested the tear was recent rather than chronic. He found Petitioner to be at maximum medical improvement with respect to non-surgical measures. Bach Dep Exh 2.

At his deposition, held on July 18, 2013, Dr. Bach testified that, as of April 11, 2011, he felt that Petitioner needed a right rotator cuff repair and that she might also require a concurrent biceps surgery. RX 6 at 13-14. He again opined there was a causal relationship between the work accident and Petitioner's right shoulder condition. RX 6 at 14.

Dr. Bach testified that, as of April 11, 2011, Petitioner was capable of light duty. RX 6 at 14.

Dr. Bach indicated that Petitioner did not complain of her left shoulder during the "initial IME." [He did not clarify whether he was referring to the February 3 or April 11, 2011 examination.] He indicated Petitioner did not mention the left shoulder on the shoulder survey form she completed. RX 6 at 14-15.

On April 19, 2011, Dr. Bach issued an addendum recommending surgery consisting of an "arthroscopic versus mini-open rotator cuff repair, an acromioplasty, as needed, and biceps surgery, as needed." He indicated Petitioner "will need extensive physical therapy if she undergoes surgical treatment" and "would be at maximum medical improvement somewhere between six and eight months postoperatively." PX 3, p. 65. RX 2. He reiterated these opinions at his deposition. RX 6 at 15-16.

Dr. Hennessy operated on Petitioner's right shoulder at Elmhurst Memorial Hospital on May 17, 2011. He performed a right shoulder arthroscopy and partial synovectomy, debridement of the biceps and labrum, a chondroplasty of the glenohumeral joint and an open rotator cuff repair with open acromioplasty. In his operative report, he noted the surgery was delayed "secondary to workers' compensation approval." At the end of the surgery, he placed Petitioner's right arm in an "abduction orthosis" and placed a "polar care" icing device on the right shoulder. PX 3, pp. 68-70.

Petitioner testified that, from the work accident through the May 17, 2011 surgery, she relied primarily on her left hand and arm to perform most work and non-work activities. She found this awkward and tedious since she is right-handed. T. 36. It took her longer than usual to vacuum and iron because she was not accustomed to performing such tasks with her left hand. When she went to work, she carried her purse, lunch bag and laptop case on her left shoulder or in her left hand. T. 36-37. Her reliance on her left hand and arm continued after the surgery. She described the "abduction orthosis" as a cylindrical device that was placed under her right arm so as to hold the arm forward and away from her body. She wore this device 24 hours a day for seven weeks after the surgery. T. 34. During this same period, she could not lie down to sleep. She initially slept in a chair. Later, she "graduated" to a recliner. She lay on her left shoulder once she began using the recliner. When she resumed driving, she propped her right arm on a pillow and primarily used her left hand to steer. T. 38-39.

Petitioner testified she "casually mentioned" left shoulder discomfort to her medical providers in the spring of 2011. By August 2011, she was really complaining of this discomfort.

On May 20, 2011, three days after the right shoulder surgery, Dr. Hennessy noted that Petitioner was "doing surprisingly well given the nature of her surgery" and taking Norco twice daily. He noted that Petitioner was still complaining of some cervical radiculopathy going to her hand. He instructed Petitioner to remain off work and begin some Codman exercises. PX 3 at 31-32. A week later, he replaced Petitioner's steri-strips. He instructed Petitioner to stay off work, continue the Codman exercises and abduction orthosis and return to him in three weeks. PX 3, pp. 29-30.

Petitioner underwent an initial physical therapy evaluation on June 21, 2011. The evaluating therapist noted "guarding of the upper extremity" and "altered posture with soft tissue and mobility limitations which are consistent with [the] post-operative status." He measured Petitioner's grip strength at 20 pounds on the right (at level 2) and 40 on the left. PX 3, p. 77.

On July 25, 2011, Petitioner underwent an initial therapy evaluation for her cervical spine. The evaluating therapist noted complaints relative to the right trapezius and right hand. The therapist also indicated that Petitioner reported "some pulling on the right side greater than the left side of her neck." PX 4, p. 23.

On August 22, 2011, Petitioner's physical therapist noted that Petitioner complained of right shoulder pain, primarily at night. He also noted that Petitioner described her left shoulder as "tired as well." PX 4, p. 19.

Petitioner returned to Dr. Hennessy on August 26, 2011. Petitioner complained of neck pain radiating to her right arm but reported some improvement secondary to therapy. Petitioner also complained of "significant" left shoulder pain that had "worsened since the right shoulder surgery."

On bilateral shoulder examination, Dr. Hennessy noted 5/5 strength in both upper extremities, internal rotation to the thoracolumbar area on the right versus the mid-thoracic area on the left, flexion of 150 degrees on the right versus 170 degrees on the left and positive impingement testing on the left.

Dr. Hennessy injected Petitioner's left shoulder joint with cortisone. He instructed Petitioner to call him the following week. He released Petitioner to light duty with no lifting over ten pounds, no overhead lifting and no physical management of students. PX 3, p. 23.

Petitioner testified the left shoulder injection provided some relief but she continued to experience pain when she used her left arm.

When Petitioner next saw Dr. Hennessy, on October 7, 2011, she reported having returned to light duty. She also reported a flare of her right shoulder and cervical symptoms secondary to pulling a wheeled suitcase.

On examination, Dr. Hennessy noted that Petitioner could abduct to about 150 degrees on the right and to 160 degrees on the left. He described Petitioner's strength as good. He characterized the flare as a minor strain. He did not see the need for a repeat MRI. He recommended Petitioner continue therapy versus work conditioning and gradually increase her lifting. He instructed Petitioner to return to him in five weeks. PX 3, p. 22.

Petitioner returned to Dr. Hennessy on December 12, 2011. The doctor noted Petitioner "seems to be recovering from the setback." He described her as having "great abduction and flexion" but somewhat limited internal rotation. He indicated she had stopped taking the Naprosyn again. He also indicated she was still experiencing "the right C7 radiculopathy" but expressed no interest in having a cervical injection or surgery. He continued the restriction of "no student contact" and recommended that Petitioner return to him in six weeks. PX 3, p. 20.

At Respondent's request, Dr. Bach re-examined Petitioner on January 23, 2012. In his report of the same date, Dr. Bach noted Petitioner had undergone right shoulder surgery and a post-operative injection since the last time he had seen her. He also noted that Petitioner was performing light duty and reported deriving benefit from the surgery and injection.

On examination, Dr. Bach noted very minimal tenderness on palpation of the right acromioclavicular joint and no tenderness over the biceps groove. He measured active forward elevation to 175 degrees on the right (versus 180 degrees with respect to the "unaffected" left shoulder) and abduction to 175 degrees on the right (same on the left).

Dr. Bach indicated he reviewed Dr. Hennessy's right shoulder operative report. He noted that Dr. Hennessy described Petitioner's rotator cuff tear as 4 centimeters in size and the repair as "well fixed with a slight gap between the distal rotator cuff edge and the repair secondary to the nature of the tear."

Dr. Bach noted that Petitioner complained of "some slight discomfort around the shoulder region." Dr. Bach described this discomfort as "diffuse" and "not localized."

Dr. Bach found Petitioner to be at maximum medical improvement but recommended "continued maintenance and strengthening." He further found that Petitioner "can return to work in accordance [with] her functional capacity evaluation." The Arbitrator notes that no functional capacity evaluation is in evidence. RX 3.

At his deposition, Dr. Bach testified he tested range of motion in both of Petitioner's shoulders on January 23, 2012. He described the left shoulder range of motion as normal and noted no complaints relative to the left shoulder. RX 6 at 18-19.

Petitioner also saw Dr. Hennessy on January 23, 2012, with the doctor recording the following:

> "Ms. Mlade is here for the right shoulder. Her motion is the same. She still has right C7 radiculopathy. Her symptoms are about the same. **Most notably she also has some left shoulder pain but has full abduction and flexion. She said sometimes it could hurt quite a bit. I have even given her a cortisone injection in the past. She feels this is from overcompensation from not being able to use the right shoulder."**

(emphasis added). The doctor also noted that Petitioner was continuing to work subject to his restriction and reported taking narcotic pain medication once daily. He found Petitioner to be at maximum medical improvement and discharged her from care, again noting she did not want to pursue care for her cervical condition. He indicated the left shoulder could be evaluated at a later date "if it worsens." PX 3, p. 17. On a separate work status note, he indicated that Petitioner's "permanent restrictions are no physical management of students." PX 3, p. 18.

Petitioner returned to Dr. Hennessy on March 5, 2012, with the doctor recording the following:

> "[Petitioner's] right shoulder, neck and right cervical radiculopathy are stable. She has increased left shoulder pain. She first noticed it sometime in August 2011 during the rehabilitation for the right shoulder. It was bad enough we gave her a cortisone injection in August and it helped quite a bit for a while. In my October 2011 visit we didn't make any mention of it as it was improved. In January, however, the pain started to recur but it wasn't bad enough and she wished to return to work. She has permanent restrictions of no physical management of students and she has been working for some time."

On left shoulder examination, Dr. Hennessy noted abduction to 160 degrees and internal rotation to the upper lumbar spine. He also noted positive impingement signs. He recommended a left shoulder MRI. PX 3, p. 16.

Petitioner underwent the recommended left shoulder MRI on April 20, 2012. The interpreting radiologist noted a full-thickness tear of the supraspinatus tendon, rotator cuff tendinopathy, mild to moderate degenerative changes and a small joint effusion. He also noted that the biceps tendon could not be completely visualized, which prompted him to suspect a tear. PX 5.

Dr. Hennessy performed a left shoulder rotator cuff repair and acromioplasty on July 10, 2012. He described the rotator cuff tear as 3 centimeters in size. He described the biceps tendon as "split but otherwise intact in its normal anatomic position." He repaired the split but did not perform a biceps tenodesis or tenolysis. PX 5.

Dr. Bach issued another addendum on July 17, 2012, after reviewing the left shoulder MRI report and scan. He interpreted the MRI as showing a full-thickness rotator cuff tear with 2 centimeters of retraction. He also noted a "fair amount of atrophy in the muscle," which prompted him to conclude that the tear was likely pre-existing. RX 6 at 21-22. He found no causal relationship between Petitioner's left shoulder problem and the work accident, noting that his previous notes and reports contained no mention of left shoulder complaints. He did not believe there was any compensatory component. RX 4. He again found causation as to the right shoulder. RX 6 at 23.

In another addendum dated September 13, 2012, Dr. Bach explained why he did not view Petitioner's left shoulder condition as causally related to the work accident:

> "It should be noted that rotator cuff tears can either occur from a traumatic or atraumatic basis. Many patients over the age of 50 will have a natural degeneration of the rotator cuff tendon and may

have a rotator cuff tear without knowledge of this."

Dr. Bach attributed Petitioner's left shoulder rotator cuff tear to "natural progression of tendon degeneration." RX 5. Bach Dep Exh 4. At his deposition, Dr. Bach testified that if you performed MRIs on 100 patients over the age of 50 or 55, a significant percentage of those patients would exhibit rotator cuff abnormalities despite having minimal or no symptoms. RX 6 at 24. Petitioner was 62 years old when he first saw her. Her left shoulder MRI findings were abnormal but frequently seen in her age group. RX 6 at 25. Unlike Dr. Hennessy, he noted atrophy within the supraspinatus muscle belly of the left shoulder. RX 6 at 25.

Petitioner returned to Dr. Hennessy on November 16, 2012. In his note of that date, Dr. Hennessy described Petitioner's left shoulder as "much improved." He noted Petitioner could abduct to about 150 degrees. He continued the previous work restrictions and directed Petitioner to continue therapy. PX 3, p. 3A.

Dr. Hennessy gave a deposition on behalf of Petitioner on January 9, 2013. The doctor's CV (Hennessy Dep Exh 1) reflects that he is a fellowship-trained, board certified orthopedic surgeon. He is also a certified independent medical examiner.

Dr. Hennessy testified there is a causal relationship between Petitioner's work accident and her right shoulder and cervical spine conditions. He found the cervical spine MRI consistent with Petitioner's right-sided complaints in that the MRI showed a right-sided protrusion complex at C5-C6. PX 1, pp. 7-8.

Dr. Hennessy opined that the six-month delay in obtaining authorization for Petitioner's right shoulder surgery adversely affected the outcome of that surgery. Due to the delay, the right rotator cuff "did not come fully out to length." PX 1, pp. 12-13.

Dr. Hennessy testified he first noted complaints relative to Petitioner's left shoulder on August 26, 2011. PX 1, pp. 12-13. The left shoulder MRI did not reveal significant atrophy within the supraspinatus muscle belly, which indicated the rotator cuff tear was recent rather than chronic. PX 1, p. 17. The biceps, which remained supple despite being split, was another indication that the tear was recent. PX 1, p. 22. Petitioner encountered difficulty in getting her right shoulder rehabilitation performed in a timely fashion. Petitioner's right shoulder was "out of commission for quite some time," meaning she had to perform her activities of daily life with her left arm. PX 1, pp. 17-18. In Petitioner's case, and in the absence of any history of trauma to the left shoulder, Petitioner's left shoulder condition more likely than not stems from overuse. PX 1, pp. 18, 22. The left shoulder surgical findings, specifically the suppleness of the biceps and the relative ease of repairing the rotator cuff tear, also support the conclusion that the left shoulder condition resulted from overuse. PX 1, p. 22-23.

Under cross-examination, Dr. Hennessy acknowledged meeting with Petitioner's counsel prior to his deposition. Petitioner's counsel did not provide him with any new information. PX 1, p. 24. All of his publications and presentations relate to knee and cervical spine conditions.

PX 1, p. 24. He sees a fair number of shoulder problems in his office, since his patient population is "pretty old," but he treats the majority of these problems non-operatively. PX 1, p. 25. His January 23, 2012 note reflects that it was Petitioner who attributed her left shoulder complaints to overuse but he agrees with Petitioner's assessment. The objective MRI and surgical findings, along with the temporal history of no prior left shoulder injury, support Petitioner's subjective statements. PX 1, p. 26. His understanding is that Petitioner's non-work activities include housework and light workouts. Petitioner did not participate in anything dramatic such as tennis. It is possible that Petitioner's household and exercise activities could have contributed to her left shoulder condition. PX 1, p. 27. He agrees with Dr. Bach's opinions and surgical recommendations concerning the right shoulder. PX 1, p. 29. He also agrees with Dr. Bach's statement that many individuals over the age of 50 have natural degeneration of their rotator cuff tendons. It is possible that a woman in her 60s would exhibit such degeneration. PX 1, pp. 30-31. He also agrees with Dr. Bach's statement that up to 25% of 100 patients over the age of 50 with no shoulder pain might have partial or full-thickness rotator cuff tears. PX 1, p. 31. He disagrees, however, with Dr. Bach's opinion that Petitioner's left shoulder condition was due to natural tendon degeneration rather than overuse. PX 1, p. 31. He knows Dr. Bach and has a lot of respect for him but Dr. Bach is "using generic data" rather than considering the specifics of Petitioner's situation. PX 1, p. 31. He had an advantage over Dr. Bach in that he actually visualized Petitioner's left rotator cuff during surgery, "not just on MRI scan." PX 1, pp. 31-32. Dr. Bach relied on what he assessed as 2 centimeters of retraction but "there's always some retraction." What's more, Petitioner's left rotator cuff and biceps demonstrated acute changes. There was a split in the left biceps but the tendon was not significantly frayed or scarred. This indicates the problem was "more acute" in nature. PX 1, p. 32. Dr. Bach's opinions would have been better supported had Petitioner's left rotator cuff been atrophic. PX 1, p. 33. While 25% of patients over 50 may have asymptomatic rotator cuff tears, 75%, or the vast majority, don't. Petitioner's history, coupled with that statistic, supports the claim that the left shoulder condition was a "more acute finding from the overcompensation." PX 1, pp. 33-34. He waited a number of months before ordering a left shoulder MRI because the cortisone injection he administered left Petitioner relatively asymptomatic for a while. PX 1, p. 34.

On redirect, Dr. Hennessy reiterated that Dr. Bach relied on data rather than any specific information concerning the manner in which Petitioner relied on her left arm after the right shoulder surgery. PX 1, p. 35. Dr. Bach commented that it was solely Petitioner's opinion that her left shoulder problem stemmed from overuse but he (Dr. Hennessy) disagreed with this comment. Petitioner's subjective opinion on the subject was supported by the objective radiographic and surgical findings. PX 1, pp. 35-36.

Following the deposition, Petitioner returned to Dr. Hennessy on January 18, 2013. The doctor noted Petitioner was still experiencing shoulder pain, left worse than right, and was sleeping in a recliner two to three times per week. He also noted Petitioner was taking Advil at night two to three times per week. On examination, he noted abduction to 170 degrees on the right (versus 150 on the left), symmetric internal rotation to the thoracolumbar junction, good strength and slightly positive impingement signs of the left shoulder.

Dr. Hennessy noted that Petitioner was now working part-time at the school where she had previously served as principal. He continued the work restrictions and encouraged Petitioner to perform home exercises. PX 3, p. 4A.

Petitioner testified she continues working at Respondent school but is no longer the principal. She currently works about 7 ½ hours per week in the after school program. She continues to experience bilateral shoulder pain, even when she is resting. Her left shoulder hurts more than her right. Driving for an extended period causes increased pain in her shoulders. She cannot lie on either shoulder for more than a few minutes without experiencing pain. She sometimes resorts to sleeping on the couch. She has difficulty using her left arm to reach, curl her hair or lift a pot. She invested in a new set of lightweight dishes. She is able to vacuum but it is painful. Her son helps her retrieve items from overhead shelves. She continues to experience tightness in her neck, arm numbness and mild headaches. On a couple of occasions, Dr. Hennessy recommended she undergo cervical spine surgery but she declined because she was worried about the result. T. 49-54.

Under cross-examination, Petitioner testified she will turn 65 in January 2014. T. 56. Before the accident, she practiced yoga occasionally and belonged to a health club but her work schedule prevented her from exercising on a regular basis. She used to enjoy dancing but she no longer does this. T. 57. She experiences numbness in her arms almost every night. T. 59. In her current job, she does not perform any lifting and is not required to place her hands on the students. She assumes that the work restrictions Dr. Hennessy imposed are permanent. T. 59-60.

On redirect, Petitioner testified she recalled seeing Dr. Bach on only two occasions: February 3, 2011 and April 11, 2011.

Respondent did not call any witnesses. Respondent offered into evidence various reports authored by Dr. Bach, along with the doctor's deposition transcript. The doctor's reports and direct examination are summarized above. Under cross-examination, the doctor testified that an acute finding is one that is noted within six weeks of an injury whereas a chronic finding develops over time. RX 6 at 27. An acute rotator cuff tear can be traumatic or atraumatic. A traumatic rotator cuff tear is frequently accompanied by significant neck pain. RX 6 at 27-28. Atraumatic rotator cuff tears are generally bigger and accompanied by atrophy of the muscle. When a doctor sees atrophy in the muscle, "that's a poor prognostic finding for the ability to surgically repair" the rotator cuff tear. RX 6 at 28. The ability to visualize a tear during surgery does not allow a physician to more accurately determine whether a tear is acute or chronic. "You will not be able to assess the muscle volume under direct vision." RX 6 at 29. The absence of atrophy within the supraspinatus muscle belly indicates that the tear is acute. RX 6 at 31. A split in the biceps tendon would cause him to conclude that the injury was "more chronic." He would not give much weight to whether the tendon remained supple. He is "not concerned about the mobility" of the tendon. RX 6 at 32. A chronic biceps tear does not necessarily result in stiffness of the biceps muscle. RX 6 at 32. He was not provided with a

formal description of Petitioner's job. Nor did Petitioner describe her non-work activities. RX 6 at 33. When he first examined Petitioner, she exhibited a good range of right shoulder motion. RX 6 at 33. He is not aware that Dr. Hennessy noted left shoulder complaints on August 26, 2011. RX 6 at 35. Nor is he aware that Dr. Hennessy found no atrophy of the rotator cuff and no significant biceps tendon degeneration when he operated on Petitioner's left shoulder. RX 6 at 36. He personally finds it difficult to assess muscle atrophy, either arthroscopically or when performing an open procedure. RX 6 at 36. Direct observation can be very helpful under certain circumstances but there are also things you can see on MRI that you cannot see during surgery. RX 6 at 38. He stands by his previous statement that the lack of significant atrophy within the right supraspinatus muscle belly prompted him to conclude the right rotator cuff tear was acute rather than chronic. RX 6 at 38. If he had interpreted Petitioner's left shoulder MRI as showing no muscle atrophy, he would have said it is possible the left shoulder condition stemmed from physical therapy or compensatory types of activities. RX 6 at 41. In his report concerning his left shoulder MRI review, he noted "some corresponding atrophy." He did not use the terms "significant" or "severe" when describing the atrophy. RX 6 at 42. He examined Petitioner but did not undertake to treat her. RX 6 at 43.

On redirect, Dr. Bach testified Petitioner did not specifically complain of left shoulder pain when he examined her in January and April. On the form that Petitioner completed, Petitioner specifically indicated that it was her right shoulder that was causing problems. RX 6 at 44. Petitioner "might have irritated" her pre-existing left rotator cuff tear during therapy but he does not believe she extended the size of the tear. Petitioner "probably just had some inflammation." RX 6 at 44.

Under re-cross, Dr. Bach testified that, if Petitioner had a pre-existing left rotator cuff tear, she might have irritated her left shoulder "using her shoulder in therapy" but that irritation would have caused only bursitis or an inflammatory response and not the tear itself. Petitioner's left shoulder MRI suggests that her left rotator cuff tear was in fact pre-existing. RX 6 at 44-46. Dr. Hennessy is "entitled to his opinion" that the left rotator cuff tear was acute but he is a spine specialist, not a shoulder-trained surgeon. RX 6 at 46. He (Dr. Bach) would not alter an opinion simply because he is retained by an insurance carrier. RX 6 at 46-47.

[CONT'D]

Lauren Mlade v. PAEC Elementary School
11 WC 2848

Arbitrator's Credibility Assessment

Petitioner was an articulate witness. She was the principal of Respondent school for two decades. She provided detailed testimony concerning her accident, treatment and current condition. The Arbitrator found her highly credible.

Arbitrator's Conclusions of Law

Did Petitioner establish causation as to her various conditions of ill-being?

There is no dispute that Petitioner injured her right shoulder at work on October 29, 2010. Nor is there is any dispute that this injury led to the need for surgery, with Dr. Hennessy performing a right rotator cuff repair on May 10, 2011, more than three months after Dr. Bach, Respondent's Section 12 examiner, first examined Petitioner. At his deposition, Dr. Bach characterized the repair as difficult. He took no issue with Petitioner's post-operative care, which progressed from immobilization to passive range of motion to active therapy and rehabilitation.

Petitioner, who is right-handed, testified she primarily relied on her non-dominant left arm to perform work and non-work activities prior to her right shoulder surgery, due to right shoulder pain and in conformance with Dr. Hennessy's restrictions. She even used her left hand and arm to position and prop up her affected right arm. Petitioner further testified she was essentially unable to use her right arm for about seven weeks following the May 10, 2011 surgery. During this period, her right arm was in a sling, resting atop a bolster that held her arm in front of and away from her body. T. 33-34. Before and after the surgery, she could not lie on her right side while resting or trying to sleep. She used her left hand and arm to wash her body and hair, operate a blow dryer, vacuum, iron, retrieve items from cupboards and steer her car. She was not accustomed to doing this. Her movements were awkward and it took her longer than usual to accomplish the tasks.

Petitioner testified she first mentioned left arm complaints to Dr. Hennessy in the spring of 2011. By August of that year, her left arm pain had become intolerable. T. 39. At that point, Dr. Hennessy administered a left shoulder cortisone injection, which provided relief for several months. Ultimately, he operated on Petitioner's left shoulder.

The Arbitrator finds credible Petitioner's testimony concerning her reliance on her left hand and arm before and after the right rotator cuff repair. The Arbitrator also finds credible Petitioner's testimony that she had no problems with either shoulder before the work accident. None of the records in evidence call this testimony into question. The Arbitrator relies on the testimony in finding that Petitioner established causation as to her current left shoulder

condition via an overuse or compensatory theory. The Arbitrator also relies on the causation opinions of Dr. Hennessy, Petitioner's surgeon. The Arbitrator relies on Dr. Hennessy rather than Dr. Bach for the following reasons: 1) Dr. Hennessy treated Petitioner over an extended period and was familiar with the timeline of the left shoulder complaints; 2) unlike Dr. Bach, Dr. Hennessy had the opportunity to visualize Petitioner's torn left supraspinatus tendon during surgery; 3) Dr. Hennessy, while clearly respectful of Dr. Bach's experience, cogently explained that Dr. Bach's opinions rested on generalized data rather than the specifics of Petitioner's case.

Dr. Bach testified he noted no left shoulder complaints when he last examined Petitioner on January 23, 2012. The Arbitrator notes, however, that Dr. Hennessy injected Petitioner's left shoulder prior to this examination. Petitioner credibly testified she experienced a period of pain relief following this injection. Dr. Hennessy also testified to this.

The Arbitrator views Dr. Bach as equivocating when it came to the question of the significance of muscle atrophy. With respect to the right shoulder, Dr. Bach acknowledged that the absence of muscle belly atrophy was indicative of an acute rather than chronic tear. RX 1. With respect to the left shoulder, however, he claimed essentially the opposite, while simultaneously conceding that he never saw Dr. Hennessy's operative report.

The Arbitrator also notes that Dr. Bach made a significant concession during redirect and re-cross when he testified that Petitioner "irritated" her left rotator cuff via therapy and/or compensatory use following the right rotator cuff repair. Dr. Bach did not rule out that irritation as a factor leading to the need for a left shoulder injection and subsequent surgery.

The Arbitrator further finds that Petitioner established causation as to her current cervical spine condition, noting that Dr. Hennessy recommended surgery for that condition. In so finding, the Arbitrator relies in part on Petitioner's credible testimony that she had no neck problems before the work accident. The Arbitrator also relies on the treatment records, which reflect that Petitioner complained of radicular symptoms to the Emergency Room physician as well as to Dr. Hennessy. PX 2. PX 3, pp. 44-45. Dr. Hennessy diagnosed cervical radiculopathy as well as right rotator cuff tendinopathy on November 3, 2010. PX 3, pp. 44-45. When Petitioner began a course of therapy on November 9, 2010, she complained of neck as well as right shoulder pain and indicated she twisted both her neck and right shoulder during the accident. PX 3, pp. 46, 57-58. Dr. Hennessy prescribed MRIs of both the right shoulder and the cervical spine at Petitioner's second visit, on November 17, 2010. PX 3, pp. 203-204. On December 17, 2010, Dr. Hennessy noted that Petitioner was still reporting radicular symptoms. He emphasized he could not proceed with treatment of the right rotator cuff tear until the cervical spine MRI had taken place. PX 3, pp. 219-220. In January of 2011, shortly after the positive cervical spine MRI, Dr. Hennessy opined that the work accident resulted in an aggravation of an underlying condition at the C5-C6 level. Respondent's examiner, Dr. Bach, did not specifically address causation with respect to the neck but noted that Petitioner injured her cervical spine as well as her right shoulder during the accident. Dr. Bach also conceded that

the torquing Petitioner described was of sufficient force to cause a rotator cuff tear. RX 1. The Arbitrator relies on this testimony in concluding that the force was also sufficient to injure or aggravate the cervical spine.

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

As indicated above, Respondent does not dispute Petitioner's right shoulder injury or treatment. At the hearing, the parties stipulated that, if the Arbitrator found causation as to the disputed body parts, and awarded expenses relating to treatment of those body parts, Respondent would receive Section 8(j) credit as appropriate so long as it held Petitioner harmless against any payments made by the group carrier. T. 5-6.

For the reasons stated in the preceding section, the Arbitrator has found that Petitioner established causation as to her left shoulder and cervical spine conditions of ill-being. The Arbitrator further finds that the treatment Petitioner underwent for her left shoulder and cervical spine was reasonable and necessary. Dr. Bach, Respondent's examiner, did not render any opinions concerning the cervical spine condition. He acknowledged that the left shoulder MRI showed a significant rotator cuff tear. RX 6, p. 21. At no point did he question the need for the left shoulder injection, surgery and therapy Dr. Hennessy performed or recommended.

At the hearing, Petitioner offered into evidence various bills and receipts (PX 6-12) relating to the treatment she underwent for her left shoulder and cervical spine. Respondent did not object to any of these documents. T. 68-74.

PX 6 is an itemized bill from ATI Therapy. The last three pages of PX 6 reflect that Petitioner paid $810.00 to ATI toward left shoulder therapy provided from September 6, 2012 through December 6, 2012. PX 6, pp. 14-16. The Arbitrator, having found that Petitioner established causation as to her left shoulder and that the left shoulder treatment was reasonable and necessary, awards Petitioner $810.00 in reimbursement of the expenses she paid.

PX 7 consists of a group of itemized bills relating to Petitioner's August 26, 2011 left shoulder injection and subsequent left shoulder surgery. Petitioner paid $265.53 in connection with this treatment. The Arbitrator, having found that Petitioner established causation as to her left shoulder and that the left shoulder treatment was reasonable and necessary, awards Petitioner $265.53 in reimbursement of the expenses she paid.

PX 8 consists of various receipts totaling $74.58 from Osco Drug in connection with prescription medication Petitioner paid for on October 31, 2010 [Naproxen and Hydrocodone prescribed by Dr. Spiller, the Emergency Room physician], January 31, 2011 [Naproxen prescribed by Dr. Hennessy] and May 17, 2011 [Naproxen and Hydrocodone prescribed by Dr. Hennessy]. This medication relates to the undisputed right shoulder condition. The Arbitrator

awards Petitioner $74.58 in reimbursement of the expenses she paid. PX 8 also contains a receipt from Target Pharmacy in the amount of $4.00. This receipt is dated November 29, 2010, within the relevant period, but it is not accompanied by an actual prescription. The Arbitrator declines to award Petitioner reimbursement of this paid expense since it is not clear the expense relates to treatment stemming from the work accident.

PX 9 is an itemized bill from ATI Physical Therapy relating to left shoulder therapy Petitioner underwent from September 6, 2012 through December 6, 2012. The bill reflects total charges of $19,880.85, total payments of $5,810.00, total discounts of $14,070.85 and a zero balance. Of the $5,810.00 in payments, Petitioner paid $810.00 (see PX 6 above) and CIGNA paid $5,000.00. The Arbitrator, having found that Petitioner established causation as to her left shoulder and that the left shoulder treatment was reasonable and necessary, and based on the parties' stipulation, finds that Respondent is liable for the expenses enumerated in PX 9, subject to the fee schedule, and is entitled to Section 8(j) credit in the amount of $5,000.00, with Respondent holding Petitioner harmless against said amount.

PX 10 is an itemized bill from Midwest Physical Therapy Center relating to right shoulder therapy and cervical spine therapy Petitioner underwent from November 9, 2010 through October 17, 2011. The bill reflects multiple payments by Sedgwick, the workers' compensation carrier, and a $3.00 balance. [Sedgwick denied payment of $3.00 in services for reasons that are not clear.] The Arbitrator makes no award with respect to PX 10.

PX 11 consists of two itemized bills from Orthopedic Specialists, S.C. relating to treatment rendered by Dr. Hennessy from November 3, 2010 through August 12, 2013. The bill includes charges relating to treatment of the left shoulder and left knee. The bill reflects that Dr. Hennessy performed left knee surgery, i.e., a left medial meniscectomy, on June 4, 2013 and continued seeing Petitioner postoperatively. Petitioner makes no claim relative to the left knee. The bill reflects payments by Blue Shield of Illinois and Petitioner. The Arbitrator, having found that Petitioner established causation as to her left shoulder and that the left shoulder treatment was reasonable and necessary, awards Petitioner only those expenses relating to the left shoulder, subject to the fee schedule. In accordance with the parties' stipulation, Respondent is to receive credit for any payments made by a Section 8(j) group carrier. Respondent shall hold Petitioner harmless against said payments.

PX 12 is an itemized bill in the amount of $38,541.33 from Elmhurst Memorial Hospital relating to pre-operative testing Petitioner underwent on May 9, 2011 and surgery Petitioner underwent on May 17, 2011. In her proposed decision, Petitioner asserts that the charges in PX 12 relate to the disputed left shoulder. In fact, they relate to the undisputed right shoulder surgery of May 17, 2011. The bill also reflects payments and adjustments in the amount of $38,551.33. The Arbitrator makes no award with respect to PX 12.

What is the nature and extent of Petitioner's injury?

Respondent concedes it is liable for Petitioner's right shoulder injury. The Arbitrator has found that Respondent is also liable for Petitioner's left shoulder and cervical spine conditions. Because the accident resulted in injuries to both shoulders, as well as the spine, the Arbitrator awards permanency pursuant to Section 8(d)2. Will County Forest Preserve District v. IWCC.

The Arbitrator finds that Petitioner established permanency equivalent to 27.5% loss of use of the person as a whole, or 137.5 weeks of compensation. In so finding, the Arbitrator relies on Petitioner's credible testimony concerning her current bilateral shoulder and neck complaints, the MRI and operative reports, Dr. Hennessy's permanent restriction (PX 3, p. 18) and cervical spine treatment recommendations and Dr. Hennessy's note of January 18, 2013, which reflects that Petitioner remained symptomatic, was still taking Advil and continued to sleep on a recliner several times per week. PX 3, p. 4A.

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

THEODORE POLASHEK,

Petitioner,

vs.

NO: 13 WC 11186

15IWCC0204

TOWN OF CICERO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical, temporary total disability (TTD), and permanent partial disability (PPD) and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Theodore Polashek established that he sustained an accident arising out of and in the course of his employment on March 22, 2013.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. Based on the evidence, the Commission finds that Petitioner sustained a work-related injury on March 22, 2013. As the result of the accident, the Petitioner is entitled to TTD benefits from March 22, 2013 through May 24, 2013. The Petitioner is also entitled to medical expenses totaling $26,943.84. The Commission finds Petitioner sustained 10% loss of use of the right arm pursuant to Section 8(e)(10) of the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Mr. Polashek has been employed by the Town of Cicero as a firefighter for over 10 years. T.8. He was in good health prior to March 22, 2013. T.10.

2. On March 19, 2013, Petitioner took part in a training exercise that required him to maneuver through a trailer on his hands and knees. T.13. He was wearing his full gear including his air pack, face mask, helmet and gloves. *Id.* Petitioner testified that he developed a small bruise and breaks in his skin as a result of the exercise. T.14. He stated that his elbow was sore and tender following the exercise.

3. According to the training sheet, the March 19, 2013 training exercise was completed without incident and no injuries were reported. Assistant Fire Chief Rick Moravecek indicated Petitioner never mentioned an injury on March 19, 2013. RX.4.

4. Petitioner testified that he was lifting weights at the firehouse on March 22, 2013 and noticed pain in his right arm along with some swelling that was getting worse. T.17. He informed Lieutenant Peszynski that he was having a hard time turning the wheel of the fire truck. T.19. The Fire Chief was called to the firehouse. Petitioner testified that he advised the Chief of his pain and an ambulance was called. T.22.

5. According to the report, Mr. Moravecek indicated they were at the scene of a fire and Petitioner never exited the truck and did not complain of an injury. RX.4. Petitioner testified that he told Chief Moravecek that the injury was work-related. T.43.

6. Petitioner was transported to the emergency room via ambulance on March 22, 2013. According to the ambulance report, the Petitioner indicated that he had right elbow pain since 11 a.m. this morning. His elbow was fine until he tried to work out. He had mild swelling and pain with range of motion of the elbow. The assessment revealed swelling, redness and the tissue was hot to the touch. Petitioner denied any recent trauma to the joint. PX.1.

7. While in the hospital, Petitioner was diagnosed with cellulitis and an abscess of the upper arm. According to the history provided on March 22, 2013, Petitioner's pain began 6 to 12 hours earlier and had gradually worsened. He had right elbow pain and breaks in his skin along with chapping and mild swelling. Petitioner also had celiac disease. PX.2.

8. An incident report was completed on March 22, 2013 by Assistant Chief Rick Moravecek, which indicated Petitioner had some arm pain and his arm was swollen. Petitioner indicated he wanted medical treatment.

9. According to the March 24, 2013 medical record, Petitioner had pain and tenderness of the right elbow. He presented with redness, swelling and tenderness of the right elbow

that happened after working with the sewer while having scratches on his elbow. The diagnoses were celiac disease, cellulitis and leukocytosis. In a progress note, Petitioner's right elbow was noted to be warm to the touch and reddened as evidenced by the circular initial markings done on Friday night. The elbow was noted to have possible insect bites. PX.2.

10. On March 26, 2013, Dr. John Hardek of Rush Oak Park Hospital authored a letter to "Whom it May Concern." He stated that Petitioner had cellulitis of his right elbow and his symptoms began at work on Friday, March 22, 2013. His return to work was unknown. PX.2.

11. According to the employee's report of injury dated April 3, 2013, Petitioner alleged injury on March 22, 2013 when he noticed severe pain in the right elbow while performing training and conditioning exercises. His condition was aggravated by his work duties. RX.1.

12. On April 10, 2013, Petitioner provided an addendum stating he was crawling through an obstacle on his knees and elbows on March 19, 2013 and then on March 22, 2013 he was working out when he felt a sharp pain in his right elbow. His pain progressed and an ambulance was called. He was told he cracked his right elbow and his skin was broken near the right elbow and he had cellulitis. RX.1.

13. According to the witness report dated April 6, 2013, Brian Mlader noted Petitioner went to work out and later complained of pain in the elbow. His pain and swelling continued. According to Gary Budzik, Petitioner complained of elbow pain. According to Josh Novinger, Petitioner was working out in the fitness room and complained of elbow pain. According to Michael Stahl, Petitioner was resting at the firehouse and also responded to a call. He began to feel pain and had swelling in the elbow. According to Petitioner everything was unknown. RX.1.

14. According to the incident report completed by Assistant Chief Rick Moravecek, he had no knowledge of the sewer being cleaned and they were not cleaned between March 19, 2013 and March 22, 2013. He never saw anyone cleaning the sewer during his daily visits. RX.2.

15. Mr. Moravecek testified that the reporting officer had no knowledge of the sewers being cleaned between March 19, 2013 and March 22, 2013. He would not have known if they were cleaned on March 16, 2013 as he was not assigned to work that day. T.57. He stated that during his career he never stuck his hand in the drain hole. T.59. Mr. Moravecek testified that Petitioner indicated that the injury was not work-related. T.72. He noted that Petitioner's arm was swollen on March 22, 2013. *Id.*

16. Mr. Peszynski completed an incident report indicating that the floors were usually cleaned on a Saturday or when water would not drain. The drains were cleaned in March but he was not sure of the day. He had no report of injury. He also completed an incident report on March 22, 2013. He indicated the mechanism of injury was not discussed between the Petitioner and himself. There was swelling of the elbow. RX.7.

17. Mr. Peszynski stated that the Petitioner reported to him that his elbow had been bothering him and getting worse. T.82. He did not question Petitioner as to where the injury occurred. T.83. He did not recall when the drains were cleaned. T.86. There was training on March 19, 2013 and they were required to crawl on their hands and knees through tight spaces. T.91. He did not perform an investigation of the accident.

18. Petitioner was returned to regular duties on May 24, 2013. PX.2. He currently performs his job duties without restriction. T.35. He still has some right elbow pain when lifting over 40 pounds. T.36. He was not paid for his lost time between March 22, 2013 and May 24, 2013 and had to use sick time. T.38.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991).

In order for accidental injuries to be compensable under the Act, a Petitioner must show such injuries arose out of and in the course of his employment. *Eagle Discount Supermarket,* 82 Ill. 2d at 337-38, 412 N.E.2d at 496; *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill. App. 3d 1103, 1106, 641 N.E.2d 578, 581, 204 Ill. Dec. 354 (1994)."Arising out of" refers to the requisite causal connection between the employment and the injury. In other words, the injury must have had its origins in some risk incidental to the employment. See *Eagle Discount Supermarket,* 82 Ill. 2d at 338, 412 N.E.2d at 496; *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. "In the course of" refers to the time, place, and circumstances under which the accident occurred. See *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. Whether the claimant suffered from a compensable accident is a question of fact to be determined by the Commission. *National Freight Industries v. Illinois Workers' Compensation Comm'n,* 2013 IL App (5th) 120043WC, ¶ 26, 993 N.E.2d 473.

The evidence establishes that the Petitioner was required to take part in a training exercise on March 19, 2013 and had some bumps and bruises including a break in his skin as a result of the exercise. Subsequently, Petitioner cleaned the sewer drain and lifted weights at work. He noted that his condition progressed to the point he needed to seek medical treatment.

The Commission notes that Petitioner's version of the accident is supported by the medical records and the witness statements. The witness statements reveal that Mr. Polashek was lifting weights when he experienced pain. The ambulance report and initial medical record

indicates that Petitioner's arm was swollen and red, and that his condition had been present since earlier in the day.

Further, the Petitioner's history that he was cleaning the sewer drain with a scratch on his elbow was not contradicted by the Respondent. The Commission finds the testimony of Mr. Moravecek and Mr. Peszynski's not persuasive. Mr. Moravecek testified that he was not present and would not know if the sewer was cleaned. The Commission also affords no weight to Mr. Moravecek's testimony that Petitioner indicated his condition was not work-related. Mr. Moravecek noted Petitioner's arm was swollen at the time the ambulance was called and the ambulance report indicated that the arm was fine until he tried to work out earlier in the day. His arm was red, swollen and hot to the touch. The credible evidence establishes his condition was work-related. Furthermore, Mr. Peszynski's testimony is not persuasive as he noted Petitioner told him his elbow was bothering him and getting worse. However, Mr. Peszynski admitted to never questioning the Petitioner as to where the injury occurred. The Commission finds Petitioner established that he sustained an accident arising out of and in the course of his employment on March 22, 2013.

As a result of the incident, Petitioner was diagnosed with cellulitis of the right elbow. The Commission awards Petitioner TTD from March 22, 2013 through May 24, 2013. Petitioner is also entitled to medical expenses of $26,943.84. The Commission finds Petitioner sustained 10% loss of use of the right arm pursuant to Section 8(e)(10) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 11, 2014, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,000.00 per week for a period of 9 weeks, March 22, 2013 through May 24, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 25.3 weeks, as provided in §8(e)(10) of the Act, for the reason that the injuries sustained caused the loss of use of 10% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $26,943.84 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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: MAR 2 3 2015

MJB/tdm
2-2-15
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

POLASHEK, THEODORE
Employee/Petitioner

Case# **13WC011186**

TOWN OF CICERO
Employer/Respondent

15IWCC0204

On 7/11/2014, 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:

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ANTHONY CUDA
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5303 SANCHEZ DANIELS & HOFFMAN LLP
ELIZABETH J DALTON
333 W WACKER DR SUITE 500
CHICAGO, IL 60606

15IWCC0204

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

Theodore Polashek
Employee/Petitioner

v.

Town of Cicero
Employer/Respondent

Case # **13** WC **11186**

Consolidated cases: _____

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

DISPUTED ISSUES

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

on-duty Shift Chief on March 22, 2013, and that after the Petitioner complained of right elbow pain, he asked the Petitioner, in the presence of Lieutenant Peszynski, if his injury was work-related, or if the injury occurred on the job. Asst. Chief Moravecek testified the Petitioner answered, "No". (Id. at 71-2.) This conversation was memorialized by Asst. Chief Chief Moravesek in an incident report he wrote on March 22, 2013. (RX 6)

On the afternoon of March 22, 2013, the Petitioner was transported to Rush Oak Park Hospital by ambulance. Cicero Fire Department records reflect the following narrative:

> *Patient stated complaint of right elbow pain since "about 11 am this morning." Patient stated that his "elbow was fine until" he "tried to work out." At that point patient noted mild swelling and pain with range of motion movement of the elbow. Assessment of the injured area revealed swelling redness and tissue that was hot to the touch. Patient denied any itchiness or recent trauma to the joint.* (PX2, p. 6)

Petitioner was treated for cellulitis in his right arm and released the same day. (*Id.* at 58.)

On March 23, 2013, Petitioner returned to Rush Oak Park Hospital with complaints of increased symptoms to his right elbow. Rush Oak Park Hospital records reflect that Petitioner stated the problem "initially started" because his elbows were "dry and cracked". (Id. at 58). Petitioner was treated for six days for cellulitis and oleocranon bursitis in his right elbow.

On March 29, 2013, Petitioner's discharge summary states that Petitioner's right elbow symptoms "happened after scratches working with sewer." (Id. at 72).

On April 3, 2013, the Petitioner authored a Report of Injury in which he stated that he injured his right elbow on March 22, 2013, "while performing training and condition exercises, noticed severe pain in right elbow, aggravated by work duties." (RX 1; TX 33-34.)

On April 10, 2013, the Petitioner prepared an "Addendum to Work Injury Report for 3/22/13" in which he stated that on March 19, 2013, he was crawling through an obstacle on his knees and elbows while wearing SCBA with full protection gear and then on March 22, 2013, he began working out and suddenly felt a sharp pain his right elbow. (RX 1; TX 35)

Petitioner was treated for his injuries through May 20, 2013. Petitioner was released to full duty on May 24, 2013. (TX 29).

Asst. Chief Moracevek and Lieutenant Peszynski testified about the sewer cleaning process, and both indicated that it was not the practice for firemen to stick their arms down the sewers in such a manner that their elbows might be scratched. (*Id.* at 59-60, 78.) Chief Moravecek and Lieutenant Peszynski also testified that firemen would clean the sewers with high-pressure fire-hoses and rarely involve their hands. Chief Moravecek testified that he had never seen someone involve their elbows when cleaning one of the sewers. (*Id.* at 60, 78.)

15IWCC0204

OPINION AND ORDER
Accident Arising Out of Employment

The Petitioner has the burden of proving by a preponderance of credible evidence that the accidental injury both arose out of and in the course of his employment. *Horath v. Industrial Commission*, 96 Ill 2d 349, 449 N.E.2d 1345 (1983). The Workers' Compensation Commission, based on the factual situation presented to it, has the obligation and the duty to draw all reasonable inferences from the facts, including determining the credibility of the witnesses, and making judgment thereon. *City of Chicago v. Industrial Commission,* 60 Ill.2d 283, 326 N.E.2d 769 (1975); *Allen v. Industrial Commission,* 61 Ill.2d 177, 334 N.E.2d 142 (1975). The Supreme Court has held that an "injury is accidental within the meaning of the Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee." *Matthiessen & Hegeler Zinc Co. v. Industrial Board,* 284 Ill. 378, 120 N.E.2d 249, 251 (1918).

In this matter, the Petitioner has failed to provide credible evidence with respect to the time, place, and cause of his accident and that the injury occurred during the course of his employment. The Petitioner's testimony with respect to his mechanism of injury was at odds with his later testimony during the hearing and the testimony of his supervisors. The Petitioner stated that his right elbow pain and symptoms began to manifest after he completed a training exercise on March 19th, 2013, but he did not communicate this information to his supervisors prior to April 3, 2013. At one time during the hearing the Petitioner stated that he only had "typical" aches and pains following the training exercise and did not experience arm pain until March 22nd, 2013, and during another time in the hearing the Petitioner said his pain began on March 19th, 2013, and was continual and worsening until March 22nd, 2013. In the April 3 and April 10 2013, written reports of injury created by Petitioner, he maintains that he injured his right elbow on March 22, 2013, while performing training and condition exercises.

Furthermore, the Petitioner's medical records indicate different mechanisms of injury reported by Petitioner to different medical providers: Some state that the Petitioner's initial injury came from a scratch that became infected, another records indicates the injury was the result of dry skin chapping, while others state it was from working with sewers, and others state it came from a training exercise.

The Petitioner also testified that he did not consider the source of his injury before seeking medical treatment, which is at odds with his testimony that his symptoms began during a training exercise and were constant and worsening, and his Injury Report where he stated that his pain was severe after the training exercise, and later aggravated. If Petitioner indeed suffered severe pain or increasing or continual pain following the training exercise, it would not make sense for the Petitioner to answer "no" when he was asked by Chief Moravecek if his injury was work-related.

The Incident Reports kept by the Respondent show that the Petitioner did not report a work-related injury until after he was released from the hospital on April 3, 2013.

When the Petitioner was asked on March 22, 2013, if his injury was work-related, the Petitioner stated, "No" each time. Asst. Chief Moravecek testified regarding this conversation and authored an incident report on the same day. (RX 6)

Both Asst. Chief Moravecek and Lieutenant Peszynski credibly testified regarding the procedure used to clean sewers, and both offered undisputed testimony that there would be no reason for the Petitioner's elbow to be injured through that work, as a high-pressure fire hose was used to clean out the drain and no one stuck their arms down the drain in order to clean it.

Given the conflicting testimony from the Petitioner, his supervisors, and his medical records, the Arbitrator finds that he has not met his burden of proof and shown by a preponderance of credible evidence that his injury arose out of and in the course of his employment.

All other 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANGEL BLANCO,

Petitioner,

vs.

NO: 09 WC 24303

15IWCC0205

LAKE COUNTY FOREST PRESERVE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability (TTD), and permanent partial disability (PPD) and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

Based on the totality of the evidence, the Commission finds that the Petitioner established that his current condition of ill-being is causally related to his undisputed work-related injury of March 13, 2007. The Commission awards Petitioner TTD benefits from September 9, 2010 through June 3, 2011, and medical expenses of $52,830.56. The Commission finds Petitioner is entitled to 15% man-as-a-whole. All else is affirmed and adopted.

Mr. Blanco sustained an undisputed work-related injury on March 13, 2007. The Respondent offered no evidence to rebut Mr. Blanco's testimony that he had no back issues prior

to March 2007. Following the accident, Petitioner underwent treatment to his low back and returned to work on two occasions. The Commission notes that there is a gap in medical treatment from June 16, 2008 to March 2009. However, Petitioner testified that despite his return to work, he still experienced back pain and had to have assistance performing some of his job duties. His testimony was not contradicted.

The Respondent argues that Petitioner failed to prove causal connection after June 18, 2008. In support of its contention, they argue that Ms. Lurel Diver testified that Petitioner did not have any job modifications after June 2008 as such information was not in his personnel file. The Commission is not persuaded by Respondent's argument. The Commission notes that Ms. Diver stated on cross-examination that the performance evaluation would not mention if Petitioner needed help performing his job duties; rather, it would only show if Petitioner did not meet his job expectations. Further, Ms. Diver testified that since she did not bring Petitioner's personnel file to the hearing, she did not know if Petitioner made a request for treatment after May 2007.

Petitioner testified that he informed his supervisor of his continued back issues after June 2008. Ms. Diver testified that she did not know if Petitioner made any complaints to his supervisor. The Respondent did not offer any evidence or testimony to rebut Petitioner's assertion of continued back issues.

The Respondent asserts that Petitioner worked overtime on 16 separate occasions, which established that he did not have continued low back complaint. It implies that Ms. Diver's unrebutted testimony was that these overtime hours were likely voluntary for snow removal. The Commission is again not persuaded by this argument. The fact that Petitioner worked overtime between June 16, 2008 and March 20, 2009 is not indicative whether Petitioner's condition has healed or not. There is no testimony that establishes whether the overtime was voluntary, like Respondent contends, or mandatory. Ms. Diver testified that overtime could be mandatory and there was no way of knowing by looking at the payroll sheet. No testimony was proffered to contradict Petitioner's testimony that he had to do more work during the winter months as he had no seasonal help during the winter season.

Lake County Forest Preserve suggests that Petitioner did not mention any low back issues to Dr. Nemickas during February 2009. The Commission notes that Petitioner was seen by Dr. Nemickas for shoulder issues that were unrelated to his back. The medical records do not indicate that Dr. Nemickas ever examined Petitioner's back. Rather, Dr. Nemickas' medical records indicate that the Petitioner did not sustain any new trauma. This supports Mr. Blanco's testimony that he did not sustain a new injury after June 2008.

While there is a gap in Blanco's medical treatment between June 16, 2008 and March 2009, the objective medical evidence establishes no significant change in his medical condition.

The Commission notes that the MRI film taken between April 2007 and June 2008 does not show any significant change. The April 2007 MRI revealed a diffuse disc bulge with a small left central disc protrusion/early herniation at L4-L5, and a diffuse disc herniation at L5-S1. The July 2008 MRI revealed a posterior annular tear and a diffuse disc bulge at L4-L5, and a mild diffuse disc bulge and facet arthrosis without stenosis at L5-S1. The August 20, 2009 MRI

revealed a lateral protrusion at L5-S1 and a small posterior annular tear at L4-L5. All the MRIs revealed a disc bulge and do not reveal any significant change. The Respondent's argument that the April 2007 MRI showed no pathology for a herniated disk is without merit. The 2007 MRI noted a disc protrusion/early herniation at L4-L5 and a herniation at L5-S1. There was pathology as early as April 2007.

The Commission takes note that as of April 6, 2007, Mr. Blanco was found to have a mild positive straight leg raise test on the left. He also had pain radiating into the left buttock. While the June 16, 2008 medical record indicated that Petitioner was at maximum medical improvement (MMI), and noted that Petitioner was at MMI barring further changes. During the June 16, 2008 appointment, Petitioner had continued back pain with intermittent left lower radicular symptoms. His symptoms were still present as of June 16, 2008 and never fully went away.

The Commission finds Dr. Citow's opinions to be persuasive. Each of the treating doctors has recommended surgery. Dr. Bernstein, Respondent's Section 12 examiner has not. Dr. Citow's opinions are supported by the objective medical evidence. Also, the Respondent's argument that Dr. Hebel, Dr. Chhabria and Dr. Adamson never provided causal connection opinions is not accurate. Petitioner stated on the record that the medical records were being offered into evidence with the specific understanding that each doctor would testify to a causal connection between the accident, his current condition and the need for surgery. The Respondent never objected.

Due to the work injury, Petitioner underwent a left sided L5 and S1 hemilaminectomy with medial facetectomy and L5 and S1 foraminotomies with partial diskectomy with microdissection. Petitioner testified that he is still not 100 percent. He struggles every day and awakens most nights because of left leg numbness. He moves more slowly because of his back.

Based on the evidence, the Commission finds Petitioner established that his current low back condition is causally related to his undisputed work-related injury of March 13, 2007. The Petitioner further established that he is entitled to medical expenses totaling $52,830.56. The Petitioner is entitled to TTD from September 9, 2010 through June 3, 2011, in addition to the TTD previously awarded for the period of March 14, 2007 through May 14, 2007. The Commission finds Petitioner sustained 15% loss of use pursuant to Section 8(d)(2) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 11, 2014, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $666.66 per week for a period of 46-5/7 weeks, March 14, 2007 through May 14, 2007 and September 9, 2010 through June 3, 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 $600.00 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the

15IWCC0205

reason that the injuries sustained caused the loss of use of 15% man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $52,830.56 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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: MAR 2 3 2015

MJB/tdm
O: 2-2-15
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BLANCO, ANGEL
Employee/Petitioner

Case# **09WC024303**

LAKE COUNTY FOREST PRESERVE DISTRICT
Employer/Respondent

15IWCC0205

On 2/11/2014, 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 0.11% 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:

0412 RIDGE & DOWNES
JAMES M RIDGE
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angel Blanco
Employee/Petitioner

v.
Lake County Forest Preserve District
Employer/Respondent

Case # 09 WC 24303

Consolidated cases:

15IWCC0205

An *Application for Adjustment 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 Robert Falcioni, Arbitrator of the Commission, in the city of Waukegan, on 1/24/14. 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 _____

15IWCC0205

FINDINGS

On 3-13-07, 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.

In the year preceding the injury, Petitioner earned $52,000.00; the average weekly wage was $1,000.00.

On the date of accident, Petitioner was 48 years of age, married, 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $20,813.79 for other benefits, for a total credit of $20,813.79.

Respondent is entitled to a credit of $40,276.10 under Section 8(j) of the Act.

ORDER

The claim for compensation is partiallydenied for the reasons set forth in the findings of fact and conclusions of law attached hereto. The arbitrator finds petitioner failed to prove a causal relationship between the accident alleged and his current condition of ill-being as it relates to his herniated disc and subsequent surgery. The arbitrator awards petitioner 3% loss of use of man as a whole for permanent partial disability as further set forth herein. All medical bills, treatment and claim for TTD benefits after June 16, 2008 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.

Signature of arbitrator

February 5, 2014
Date

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FEB 11 2014

Findings of Fact

Petitioner resides in Waukegan, Illinois and has been employed with the Lake County Forest Preserve for the past 24 years. His job title was Crew Chief I. He is responsible for supervising employees. He denied any prior Worker's Compensation or low back injuries.

Petitioner testified that on March 13, 2007, he was clearing and picking up garbage when he slipped and fell on black ice. He immediately called his supervisor, Ed Shanahan, and filled out an accident report.

Following the work injury, petitioner treated at Condell Medical Center on March 13, 2007 where he was diagnosed with a lumbar contusion with strain.

Petitioner continued treatment at Condell Medical Center from March 17, 2007 through March 31, 2007. Through the course of his treatment, his diagnosis remained lumbar strain. He was continued with work limitations and prescribed medication. PX1

Petitioner testified that he eventually saw Dr. Stanford Tack at Illinois Bone & Joint. Petitioner first saw Dr. Tack on April 6, 2007. Petitioner reported back pain with radiating pain into his left buttock as a result of a slip and fall on ice March 15, 2007. A physical examination showed petitioner walked with a normal gait. He had a mildly positive straight leg raising sign on the left side at 45 degrees. This was negative on the right side. Petitioner's reflexes were normal and his motor function was normal. He was diagnosed with posttraumatic back pain. There was a suggestion of left lumbar radiculopathy. An MRI of the lumbar spine was recommended. PX2

Petitioner underwent the MRI on April 10, 2007. According to the radiologist, the MRI proved abnormal. There was evidence of disc desiccation with a small left-sided paracentral disc bulge/protrusion at L4-L5. There was evidence of disc desiccation changes at L5-S1. PX2

Petitioner saw Dr. Tack on April 13, 2007. Dr. Tack reviewed petitioner's MRI. He found significant disc degeneration at L4-L5 and L5-S1 without associated spinal stenosis. He diagnosed discogenic back pain. He recommended an epidural steroid injection. PX2.

Petitioner underwent an epidural steroid injection on the left side of L4-L5 level on April 20, 2007. PX2

Petitioner saw Dr. Tack again on April 27, 2007. Dr. Tack noted that petitioner has complaints of axial back pain with some radiation to the left PSIS regions. Dr. Tack did not believe that petitioner described characteristic radicular pain. He recommended a second injection. PX2.

Petitioner underwent a second epidural steroid injection at the L5-S1 level.PX2.

Petitioner saw Dr. Tack again on May 11, 2007. Dr. Tack notes that petitioner was no longer describing radicular symptoms after the second epidural injection. Petitioner had occasional PSIS discomfort but that was much improved. Dr. Tack released petitioner to work with a 30 lb restriction. PX2.

Dr. Tack saw petitioner in follow up on June 4, 2007. Dr. Tack noted that petitioner was doing reasonably well and no longer taking medication actively. He was functioning well at work and that his normal job activities required little lifting as he was a supervisor. He gave petitioner a release for regular work. He was to return in one month for follow up. PX2

Petitioner did not return to see Dr. Tack until April 2, 2008. He reported he had been working for the past nine months doing reasonably well. He reported recently developing recurring symptoms with radiating pain into his left leg. Dr. Tack recommended petitioner have another epidural steroid injection. He prescribed pain medication. It was noted that petitioner was a tobacco smoker and it was recommended that he stop smoking. PX2.

Dr. Amann performed another epidural steroid injection on May 15, 2008 at the L5-S1 level. PX2.

Dr. Tack reexamined petitioner on May 30, 2008. Petitioner continued to complain of left radicular symptoms. Dr. Tack recommended an updated MRI to determine if petitioner was a surgical candidate.

A second MRI was done on June 10, 2008. That MRI showed evidence of a posterior annular tear and diffuse disc bulging at L4-L5. There was evidence of a mild diffuse disc bulge at L5-S1. The radiologist diagnosed multilevel degenerative disc disease without spinal stenosis. PX2

Dr. Tack saw petitioner in follow up on June 16, 2008. Petitioner complained of chronic back pain with intermittent left lower extremity radicular symptoms. Dr. Tack reviewed petitioner's MRI. He found no evidence of a focal disc herniation or spinal stenosis. He noted that the MRI was most remarkable for disk degeneration at L4-5 and L5-S1. He recommended petitioner pursue therapy. He did not believe petitioner was good candidate for surgical treatment. Dr. Tack returned petitioner to work without restrictions. He believed petitioner was at MMI. PX2.

Petitioner testified that he believed Dr. Tack had recommended surgery to him during their discussions.

Petitioner testified that during the nine month gap in treatment, he told his supervisor many times that he had continued problems with his back. He requested that the Risk Manager, Larry Bakaneck, authorize more treatment. He testified that he spoke with Ann Traczek at PDRMA with respect to the problems in his back. He admitted that he had his own group health coverage from June 16, 2008 to March 20, 2009. He testified that he could have seen his primary care provider for treatment.

The records reflect that petitioner did see his primary care provider during this time period. Petitioner saw his primary care provider Dr. Nho from June 26, 2008 through January 29, 2009 on five separate occasions for unrelated treatment. During this time period, he complained of orthopedic left shoulder issues to Dr. Nho for which he ultimately underwent surgery for in August 2009. The records do not reflect any complaints of ongoing low back pain. RX6

Petitioner's hours from June 16, 2008 to March 20, 2009 reflect that he was working full time. RX1. The hours also reflected that petitioner was working overtime hours on fifteen separate occasions. Petitioner did not disagree with the hours reflected in the job log.

Petitioner also testified that during the gap in treatment, he had assistance many times in helping do his job during the winter months due to his back condition. He testified that in the summer, he had a group of laborers that would assist him. However, during the winter months it was only petitioner on duty. He testified that he would ask Mr. Shanahan to send someone to help him.

Petitioner's performance appraisals during this time period reflect that petitioner was able to do a satisfactory job while working full duty. Further, the performance appraisals show no indication that petitioner was receiving modifications of his job duties or extra assistance. RX2.

Petitioner testified that at some point, PDRMA authorized one visit to see Dr. Jonathan Citow. He saw Dr. Citow on March 20, 2009. Petitioner had apparently been referred by Dr. Jai Jung Nho. Dr. Citow took a history of back and leg pain as a result of petitioner's slip and fall at work. He noted a negative bilateral straight left raise test. He reviewed petitioner's MRI and found small L4 -S1 disc protrusions with degenerative changes. He did not find any significant neurologic abnormalities. He recommended petitioner undergo a left SI injection. PX3.

Petitioner testified that he was examined by Dr. Avi Bernstein on May 4, 2009. Dr. Bernstein's report indicates that petitioner provided a history of sustaining a back injury March 13, 2007 when he slipped and caught himself feeling a pop in his low back. Petitioner claimed he was off work for two months. He claimed that he had medication and returned to work. He complained of low back pain with a burning sensation over the left buttock area. A physical examination was negative. Petitioner's MRI from June 10, 2008 did not show any distinct disc herniation or nerve root compression. Dr. Bernstein diagnosed a lumbar discogenic injury or strain. He did not recommend surgery. Instead, he felt petitioner was at MMI. RX3.

Petitioner underwent an additional MRI on August 20, 2009. The radiologist noted a lateral disk disk protrusion at L5-S1 and annular tear at L4-5. PX3

Dr. Citow issued a report October 7, 2009. He reviewed the MRI. He claimed that it showed L4-S1 dehydration with a left-sided disc protrusion at L5-S1 narrowing the neuroforamen. PX3

Dr. Citow re-examined petitioner October 23, 2009. Petitioner reported that he was off work as a result of shoulder surgery. A physical examination showed some tenderness in the lumbar paraspinal musculature with limited motion but no neurologic abnormalities. Straight leg raise test remained negative bilaterally. Dr. Citow felt petitioner was symptomatic from his L5-S1 foraminal disc protrusion and L4-S1 bulging. PX3

Petitioner underwent an EMG on February 22, 2010. The EMG showed L5-S1 denervation. PX4

Petitioner saw Dr. James Adanson for a second opinion on June 8, 2010. Dr. Adamson recommended petitioner have a left-sided L5-S1 lumbar discectomy. He did not make any causal connection opinions. PX5.

Dr. Citow saw petitioner on June 26, 2010. Dr. Citow states that he reviewed an MRI done in April 2010. HE found that the MRI reportedly an L5-S1 disc herniation similar to the 2009 pathology. He recommended an L5-S1 left-sided microdiscectomy. PX3

Dr. Citow reexamined petitioner July 16, 2010. Petitioner complained of back pain with radiating pain into his left leg and foot. Dr. Citow's physical examination revealed positive straight leg raising on the left at 45 degrees. He noted petitioner had an EMG/NCV in February 2010 which showed left L5 and S1 radiculopathies. He noted the MRI of April 2010 showed a left side foraminal L5-S1 disc herniation. Dr. Citow recommended petitioner proceed with a microdiscectomy at L5-S1 on the left side.

Petitioner testified that he continued to work full duty for the Lake County Forest Preserve until his surgery.

On September 9, 2010, Petitioner underwent a left-sided L5 and S1 hemilaminectomy with medial facetectomy and L5 and S1 partial diskectomy with microdissection. PX3

Petitioner testified that he was off work from September 10, 2010 through June 3, 2011. He testified that during the time he did receive IMRF benefits.

After surgery, Dr. Citow saw petitioner October 6, 2010. Petitioner complained of continued back and left leg pain with some intermittent coldness in his left leg. Petitioner was prescribed therapy. PX3

Petitioner saw Dr. Citow on January 7, 2011. Petitioner continued to complain of low back achiness and some pain extending toward the left leg. Petitioner had undergone six weeks of physical therapy and remained off work at that time due to pain. Physical examination revealed tenderness in the lumbar paraspinal musculature. A straight leg raise was positive on the left at 45 degrees and negative on the right. Dr. Citow recommended an MRI of the lumbar spine which, if normal, he would then advise petitioner to begin work hardening. PX3.

On January 27, 2011, petitioner underwent an MRI which was positive for L5-S1 disk bulge. PX3

On February 4, 2011, Dr. Citow noted that he had reviewed the MRI of petitioner's lumbar spine. He noted that the disk herniation was much smaller than it was prior to the surgery and recommended petitioner proceed with work hardening at that time. PX3.

On February 23, 2011, Dr. Citow wrote a letter to petitioner's attorney outlining that be believed petitioner had a work-related injury secondary to his fall, causing him to have pain and likely exacerbation of a pre-existing degenerative L4-S1 condition. Dr. Citow recommended that petitioner undergo four weeks of work hardening and then undergo a functional capacity evaluation to determine whether he has any permanent limitations. He believed petitioner would be at MMI at that point. PX3.

Petitioner was next seen by Dr. Citow on June 3, 2011. Petitioner continued to complain of some mild low back achiness rated as a 3 out of 10 without distal pain, numbness, weakness, or paresthesias. Petitioner had completed work hardening and been released to work full duty. Physical examination revealed mild tenderness in the lumbar paraspinal musculature. The straight leg raise was negative bilaterally. Petitioner was concerned about immediately jumping into full duty due to some achiness in his back. However, he was willing to return with a 30 pound lifting restriction for two weeks followed by a full duty release. At that point, petitioner would be at MMI. PX3.

Petitioner was examined by Dr. Bernstein again on August 8, 2011. He reported that he continued to have some achiness in his low back and into his right gluteal region. Petitioner had some pain radiating down into his left leg. Petitioner reported that he was not treating with any physicians at the time and that he had no work restrictions. Upon physical examination, Dr. Bernstein noted that petitioner was able to stand without difficulty and had a normal gait. Petitioner demonstrated full range of motion of the lumbar spine and demonstrated good flexibility. There was no pain guarding. Petitioner's straight leg raising tests were negative. Petitioner did demonstrate less flexibility in his right hip. On examination, sharp external rotation of the right hip caused some pain in the right gluteal area. Dr. Bernstein reviewed a post-operative MRI scan dated January 27, 2011. This MRI revealed some degenerative changes from L4 to S1 but no evidence of recurrent disk herniation. Dr. Bernstein opined that he was unable to conclude that petitioner suffered a disk herniation as a result of the work-related incident. Dr. Bernstein continued to opine that petitioner sustained a lumbosacral strain as a result of his March 13, 2007 work injury and was at maximum medical improvement at about 3 months from the time of the incident. Dr. Bernstein did not feel that the microdiscectomy performed on September 9, 2010 was causally related to petitioner's work accident.

Petitioner testified that at the time of trial he was working full duty. He denied undergoing any treatment since he was released back to work. He denied any subsequent accidents since his work injury.

Petitioner testified that his low back was not the same since his work injury on March 13, 2007. He was struggling everyday. Petitioner testified his right leg was still numb and that he would have to get up at night. He testified that he still had radiating pain. He testified that he still called Mr. Shanahan to send people to assist him in the winter months. He said he especially needed help for "set ups." He testified that there was a stage that he needed 2-3 guys to help him lift. He did admitted that the Lake County Forest Preserve did not have the stage prior to his work injury. The stage weighed 100 pounds so he would have needed assistance with the stage even prior to his work injury.

Testimony of Laurel Diver

called out to perform voluntary snow removal during December 2008 while he was working full duty.

Ms. Diver testified that the one additional visit authorization to Dr. Citow was not for ongoing treatment. It was one additional visit with a reservation to get an independent medical examination after Dr. Citow examined petitioner.

Ms. Diver testified that she had no interest in the outcome of litigation. She would not be receiving any type of bonus or extra compensation should she testify favorably. She testified that there was no reason to withhold any documents and that to her knowledge there were no documents indicating a request by petitioner for additional medical treatment in his file. She testified that there was no threat to be fired if she provided adverse testimony on behalf of the Lake County Forest Preserve District. Ms. Diver testified that she was not told to bring her personnel file for the petitioner with her to the hearing site. Ms. Diver testified that she had not withheld any requests in the personnel file.

Laurel Diver testified on behalf of the Lake County Forest Preserve District. Ms. Diver testified that she was the Assistant Human Resources Manager for the past year and a half. She was previously an HR Generalist since 2002 through 2009. She was aware of petitioner's March 13, 2007 injury. She testified that the Human Resource Manager at the time, Larry Bakaneck would draft the incident report and it was her duty to type the reports and have them properly filed.

Ms. Diver testified that she was aware that petitioner returned to work full duty on June 16, 2008 She testified that she was unaware of any complaints made by the petitioner after June 16, 2008 with respect to his lumbar spine. She testified that if petitioner was receiving modified job duties and assistance that it had to be approved in advance. To her knowledge, no such modifications were approved during that time period. Ms. Diver testified that she was unaware of any complaints or requests for treatment made by the petitioner from June 16, 2008 to March 20, 2009. She testified that petitioner was able to work full duty for the Lake County Forest Preserve from June 16, 2008 until March 20, 2009.

Ms. Diver testified that petitioner's job description during the winter months included light maintenance. He was to oversee snow plow removal using a truck, blower or shovel. Petitioner was responsible for removing snow in the green belt, sidewalks and parking lot. She testified she did not know the exact size of the area petitioner was responsible for cleaning. She testified it was smaller than the other districts. She testified that Mr. Shanahan could send over additional help when needed. She testified that she had no knowledge of Mr. Shanahan sending over additional assistance to the petitioner on a frequent basis. She testified that Mr. Shanahan would have a duty to report if petitioner needed accommodations and was not performing all the goals and expectations of his position.

She testified that petitioner had access to his personal group health care from June 16, 2008 to March 20, 2009. Ms. Diver testified that the IMRF pension program was available to all employees after they completed 1,000 plus hours. Workers had to at least contribute 4.5% of their earnings into the pension. IMRF then matched a contribution to the fund. Once a contribution is made into the pension program, the employees also had access to a short term disability plan. The 4.5% earnings that the employee contributed to the pension program did not cover the short term disability. Should an employee elect to use to the short term disability, their own pension earnings were not affected.

Ms. Diver testified that petitioner did use the short term disability benefit from September 9, 2010 through June 3, 2011. She testified that the disability was 50% of wages. The wages were also taxed by Federal Income Tax. She reviewed PX10 which showed the IMRF lien and tax withholdings. She indicated that would mean petitioner was having Federal Income Tax withheld prior to receiving the IMRF check.

Ms. Diver testified that overtime hours were mandatory depending on the situation. She testified that overtime due to snowplowing was voluntary. The snow removal volunteers would callout at the beginning of the month if they were willing to work overtime during that month in order to assist in snow removal. Ms. Diver review petitioner's hours while he was working full duty from June 16, 2008 to March 20, 2009. RX1. She testified that it was likely that petitioner had

Conclusions of Law

F. Is Petitioner's Condition of Ill-being causally related to the injury?

After considering all of the evidence, the Arbitrator concludes that petitioner has failed to prove that his condition of ill-being after June 16, 2008 was causally related to the injury as alleged.

It is undisputed that petitioner sustained an accident on March 13, 2007 while working for the Respondent. Respondent paid for petitioner's medical care with Advocate Condell Medical Center and Dr. Stanford Tack. Respondent provided Petitioner with a full duty job when he was initially released on June 4, 2007. Petitioner resumed treatment in April of 2008 that again Respondent paid for and was released again on June 16, 2008.

After a nine month gap in treatment, petitioner sought treatment with Dr. Jonathan Citow. At issue, is petitioner's treatment and condition after March 20, 2009.

The Commission has previously denied benefits based upon a lack of causal connection when there is a significant gap in receiving treatment. See *Mercado v. Trak Auto, 99 WC 61550*, 02 ICC 0412 (causal connection denied in part based upon more than a year of gap in treatment): *Day v. Danville Housing Authority, 10 WC 22490, 11 ICC 0412* (causal connection denied when petitioner sought treatment 9-1/2 months following a full duty release).

There was not a single document of complaints of low back pain prior to March 2009 in the Lake County Forest Preserve records.

Petitioner testified that during the gap in treatment he had significant help in performing his job. He testified that his supervisor would send assistance when needed. Respondent presented evidence that petitioner had positive performance appraisals during the gap in treatment. RX2. The appraisals do not document any modifications to his job duties. Ms. Diver

also testified that should petitioner need modifications, they had to be approved by Human Resources prior to being made. No requests for modifications were ever received for the petitioner. Respondent also presented evidence that petitioner was not only working full duty work hours from June 2008 to March 2009 but on fifteen occasions worked overtime hours. Ms. Diver testified that petitioner most likely had volunteered for the overtime hours in December 2008 to assist in snow plowing. Petitioner did not present any testimony to contradict her allegations Petitioner testified that he had access to his group health coverage during this time period and could have seen his own doctor if his condition was that bad and the respondent would not authorize treatment. Petitioner's primary care doctor records with Dr. Nho document five visits from June 2008 to March 2009 for unrelated medical treatment. The treatment in the early part of 2009 was for an unrelated orthopedic left shoulder condition. However, the Arbitrator notes that the records are void of any low back pain complaints.

The Arbitrator also notes that medical records support that petitioner condition had resolved as of June 2008. During his initial course of treatment, petitioner denied radicular symptoms by May 11, 2007 and by June 2007 he reported he was functioning well and no longer taking medication actively. The return to Dr. Tack nearly 10 months later in April 2008 was prompted by recurrent radicular pain. By June 2008, the medical records document only intermittent radiculopathy and a return to work full duty. During petitioner's full course of treatment with Dr. Tack he always had a negative straight leg raise test. The records document that the first time petitioner had a positive straight leg raise test was July 2010, nearly 3 and a half years after petitioner's initial work injury. The Arbitrator further notes that there were significant changes in the MRI results over the two year period in question herein. No explanation by any treating or examining physician was offered by either party to explain how

Petitioner's objective MRI test results went from relatively innocuous in 2007 to significant enough to warrant surgery in 2009-2010. The pattern of Petitioner's medical treatment seems to indicate that there was some other cause for the change in MRI results than the sequalea of the accident sustained herein. Large gaps in treatment followed by increased complaints when Petitioner did see a doctor accompanied by significant changes in MRI results each time Petitioner returned to treat indicate that Petitioner's initial injury was not the herniated disc he ultimately underwent surgery for, nor is there any logical disease process set forth by any competent medical authority to explain how Petitioner's condition would have so progressed as a result of the L/S strain he was diagnosed with, treated for, and was released from in March thru June 2007.

In light of the record as a whole, the Arbitrator finds petitioner failed to prove causal connection between the accident and his resulting surgery with Dr. Citow. Dr. Citow performed left-sided L5 and S1 hemilaminectomy with medial facetectomy and L5 and S1 partial diskectomy with microdissection. The medical records in total do not support Dr. Citow's treatment nor a conclusion that petitioner's condition of ill-being was causally related to his accident of March 13, 2007.

In support of the Arbitrator's Decision relating to **J.**, ***Where the medical services that were provided to Petitioner reasonable and necessary?***, the Arbitrator makes the following findings:

Based upon the Arbitrator's finding in Section F above, Petitioner's claim for medical benefits after June 16, 2008 is denied. Respondent has made payments for all medical benefits and is not liable for any other payments. RX5.

The Arbitrator notes that petitioner made payments for medical services after June 16, 2008. RX5. The Arbitrator awards Respondent a credit for this treatment in the amount of $656.35.

In support of the Arbitrator's Decision relating to ***K., What temporary benefits are in dispute?***, the Arbitrator makes the following findings:

Based upon the Arbitrator's finding in Section F above, Petitioner's claim for temporary total disability benefits after June 16, 2008 is denied.

In support of the Arbitrator's Decision relation to **L.,** ***What is the nature and extent of the injury?***, the Arbitrator makes the following findings:

Based upon the Arbitrator's finding in Section F above, the Arbitrator finds that petitioner suffered a lumbar strain as a result of his work injury on March 13, 2007. The MRI's performed on April 10, 2007 and June 10, 2008 do not indicate any distinct herniation at L5-S1. As such, the Arbitrator awards petitioner permanent partial disability in the amount of 3% loss of use of man as a whole.

In support of the Arbitrator's Decision relation to ***N., Is Respondent due any credit?***, the Arbitrator makes the following findings:

For the reasons outlined above, the Arbitrator awards Respondent a credit for overpayment of related medical treatment in the amount of $656.35.

Petitioner stipulated that his medical bills after June 16, 2008 were paid by a group insurance policy that was paid, in whole or in part, by her employer. Therefore, pursuant to §8(j), Respondent is entitled to a credit of $40,276.10, which represents the amount paid by Blue Cross Blue Shield. PX8 to be applied solely to any claim for TTD that may be awarded herein.

Petitioner testified that he received short term disability from September 10, 2010 to June 3, 2011 totalling $20,157.44. The disability payment logs show that petitioner received the benefits from November 17, 2010 through June 6, 2011 with a monthly net amount of $2,509.34 equivalent to $627.34 per week. PX10. The Arbitrator awards the Respondent a credit of $20,157.44. PX10 again to be applied solely against any award of TTD that may be made herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chad Robinson,
Petitioner,

vs.

NO. 13 WC 14408
13 WC 14409

Owens Nursery,
Respondent.

15IWCC0206

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses and prospective medical expenses and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 2, 2014 is hereby affirmed and adopted.

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

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

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.

15IWCC0206

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2015

Joshua D. Luskin

Charles J. DeVriendt

o-03/03/15
jdl/wj
68

DISSENT

I respectfully dissent from the majority opinion. I would have found that Petitioner did not sustain his burden of proving a condition of ill being of his cervical spine was caused by work-related repetitive activity. Therefore, I would have reversed the Decision of the Arbitrator and denied compensation.

Petitioner alleged bilateral carpal tunnel syndrome and cervical injury due to repetitive trauma with a manifestation date for both conditions of October 30, 2012. The Arbitrator found that the Petitioner failed to prove his alleged carpal tunnel syndrome was related to his work activities. Petitioner did not seek review of that finding. The Arbitrator also found that his cervical condition was work-related and ordered Respondent to authorize cervical surgery recommended by Dr. Atwater, namely C6-7 spinal decompression and fusion. Respondent sought review of that finding.

Petitioner first sought medical treatment on November 2, 2012. At that time he complained only of left arm pain. Dr. Chow at OSF Occupational Health diagnosed left forearm strain/sprain. Petitioner continued to treat at OSF Occupational Health for his left arm through December 10, 2012. Petitioner resigned from Respondent's employ on December 19, 2012, to take another and better job as a plumber. Petitioner testified that his new job was more physically demanding than his previous job with Respondent. On December 20, 2012, Petitioner sought treatment from Dr. Carmichael who considered the possibility of a herniated cervical disc due to paresthesias and ordered an EMG and MRI.

On January 24, 2013, Petitioner returned to Dr. Carmichael. He was currently working as a plumber. This was the first time Petitioner reported any neck pain which he associated with the use of a chainsaw while working for Respondent. Dr. Carmichael noted that the MRI taken on January 15, 2013 showed only a biforaminal bulge at C6-7, which he characterized as surprisingly mild in light of Petitioner's subjective complaints. Petitioner continued to complain of symptoms that Dr. Carmichael interpreted as classical C6-7 cervical disc pathology. A repeat MRI was taken on February 27, 2013. It was interpreted as showing very minimal cervical spondylosis which was unchanged since the previous MRI, minimal disc bulge at C3-4, and no significant disc herniation or neural impingement.

After two epidural steroid injections failed to resolve Petitioner's subjective symptoms, he was referred to Dr. Atwater, a partner of Dr. Carmichael. On May 5, 2012, Dr. Atwater indicated that the EMG showed mild C6-7 radiculopathy and the MRIs showed possible disc herniation at C6-7. He opined that non-surgical treatment had failed and ordered a repeat EMG to see if the radiculopathy had progressed. Dr. Atwater testified at deposition that he expected the repeat EMG would show a worsening condition, but it did not and the second EMG was actually negative. However, Dr. Atwater testified that EMGs are not 100% sensitive and a patient's subjective complaints are the controlling factor in his recommendation for surgery.

Dr. Zelby performed an examination of Petitioner pursuant to section 12 of the Act. He found three out of five positive Waddell signs for inorganic pain behavior and symptoms magnification. Dr. Zelby opined Petitioner's constellation of symptoms did not correspond to any medical condition. He noted that all the objective tests, the EMGs and the MRIs were all essentially normal. Dr. Zelby was adamant that in his opinion surgery was not indicated and he found it inexplicable that surgery would be recommended in the absence of any objective evidence of neural impingement. Dr. Zelby diagnosed that Petitioner sustained only a forearm strain which had long since resolved.

In finding Petitioner sustained his burden of proving a causal connection between his work activities with Respondent and a condition of ill-being of his cervical spine, the Arbitrator found the testimony of Petitioner and Dr. Atwater were credible. He did not find the opinion testimony of Dr. Zelby persuasive.

In this instance, I find the opinion of Dr. Zelby more persuasive than the opinion of Dr. Atwater. It really appears that all the objective evidence supports the opinion of Dr. Zelby over that of Dr. Atwater. Even Dr. Atwater admitted at his deposition that the objective tests were essentially normal and that the pathology he identified in the studies was "subtle." He testified that he based his recommendation for surgery on Petitioner's subjective complaints which he opined were more compelling than the objective testing.

In addition, Petitioner's initial complaints were all limited to his left arm. He never complained of any neck pain until three months after the alleged manifestation of the cervical condition of ill being and more than a month after he resigned from Respondent's employment and over a month after Dr. Carmichael first broached the idea of a possible cervical condition. In my opinion Petitioner failed even to sustain his burden of proving he had a current condition of ill being of the cervical spine let alone that it was caused by repetitive trauma related to his work with Respondent.

For the reasons specified above, I respectfully dissent.

Ruth W. White

Ruth W. White

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

ROBINSON, CHAD
Employee/Petitioner

Case# **13WC014408**

13WC014409

OWENS NURSERY
Employer/Respondent

15IWCC0206

On 7/10/2014, 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 0.06% 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:

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHAD ROBINSON
Employee/Petitioner

v.

OWENS NURSERY
Employer/Respondent

Case # **13** WC **14408**

Consolidated cases: **13 WC 14409**

15IWCC0206

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS McCARTHY**, Arbitrator of the Commission, in the city of **BLOOMINGTON, ILLINOIS**, on **06/24/2014**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **10/30/2012**, 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 it involves a cervical disc injury with left arm radiation. The Petitioner's condition of bilateral carpal tunnel syndrome, the subject of 13 WC 14409, is not causally related to his work activities on the date alleged.

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 **41** 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, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$-0-**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $96.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall also authorize the treatment involving the cervical spine at the level of C 6-7recommended by Dr. Atwater.

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

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

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

D. Dylan McCarthy
Signature of Arbitrator

July 9, 2014
Date

ICArbDec19(b)

JUL 10 2014

ATTACHMENT TO ARBITRATOR'S DECISION

Chad Robinson vs. Owens Nursery

IWCC No.: 13 WC 14408 & 13 WC 14409

In Support of the Arbitrator's award as to **(F) Is Petitioner's current condition of ill-being causally related to the injury?**, the Arbitrator notes as follows:

Petitioner testified at Arbitration that he was employed by the Respondent, Owens Nursery, as a general laborer on October 30, 2012. On that date, the Petitioner testified that his job duties required him to run a chainsaw for several hours trimming branches off of Christmas trees. The Petitioner's testimony was corroborated by his work log found in Petitioner's Exhibit 5. The Petitioner testified that he immediately began to notice pain and discomfort in his left forearm. The Petitioner also testified that he experienced pain, discomfort and numbness down into the fingers of his left hand, which caused him difficulty with gripping.

The Petitioner first sought medical attention from the OSF Occupational Health facility on November 2, 2012 at the request of his employer. At that time, he gave a history consistent with his testimony at Arbitration, including complaints of pain and swelling in his left forearm and numbness/tingling in all the fingers of the left hand, as well as an inability to hold a cup of coffee with his left hand and increased pain with movement of his left hand when uncurling his fist. (Petitioner Exhibit 1) The Petitioner then began a course of physical therapy which did not alleviate his symptoms. At that point the Petitioner was referred to Dr. Joseph Newcomer. Dr. Newcomer was able to reproduce the Petitioner's symptomatology by turning his neck. He felt that the Petitioner's numbness and tingling were in the C6 distribution and therefore

recommended an EMG. (Petitioner Exhibit 2) The results of this EMG, performed on January 2, 2013, were "subtle findings suggestive of an acute (very early), mild, left C6 and C7 radiculopathy". (Petitioner Exhibit 3, p.26) At this point, the Petitioner was referred to McLean County Orthopedics where he came under the care of Dr. Craig Carmichael and Dr. John Atwater. Based upon the EMG findings, Dr. Carmichael performed two epidural steroid injections in an attempt to relieve the Petitioner's neck and arm pain. When said injections failed to alleviate the Petitioner's symptoms, Dr. John Atwater became the primary physician in charge of the Petitioner's care. The Petitioner first saw Dr. Atwater on May 2, 2013. After performing a physical examination and reviewing the EMG and MRI testing that had been done to date, it was Dr. Atwater's opinion that the Petitioner was suffering from "a C7 radiculopathy secondary to potential herniation". (Petitioner Exhibit 4, pp.6-8) At that point, Dr. Atwater recommended an additional EMG test. This test was performed on May 20, 2013. The results of this test indicated that the earlier findings of mild left C6 and C7 radiculopathy were no longer appreciated. Dr. Carmichael went on to state:

> This is a very frustrating case. His symptoms are pretty convincing for a cervical disk, but his test findings are equivocal with his MRI showing subtle changes at C6-7. His presentation is very straight forward. He continues to work and does not take pain medication and complains that his pain is quite substantial. It seems unlikely that this would be coming from some other cause.
>
> (Respondent Exhibit 4, p.1)

Based upon this review of the testing done and the results of his physical examination of the Petitioner, it was Dr. Atwater's opinion that the Petitioner needed an anterior cervical decompression and fusion at the C6-C7 level. (Petitioner Exhibit 4, p.9)

At the request of the Respondent, the Petitioner was then examined by Dr. Andrew Zelby on August 9, 2013. It was Dr. Zelby's opinion that the Petitioner was not suffering from any cervical condition which required surgery and, at most, had sustained a left forearm muscular strain as a result of the October 30, 2012 accident. (Respondent Exhibit 3)

During his evidence deposition, Dr. Atwater was asked to address the opinions given by Dr. Zelby. Dr. Atwater testified that based upon his reading of the MRI films, he believes the Petitioner is suffering from an interforaminal herniation. (Petitioner Exhibit 4, p.13) Dr. Atwater next addressed the equivocal findings in the Petitioner's EMG exam. Dr. Atwater explained:

> The number 1 thing is the patient's complaint and the finding on physical exam. ...this gentleman definitely had weakness in those muscle groups, and they're not 100% sensitive, the EMG studies, we already know that, and they're very much not specific. So I think I wouldn't – I'm not basing my treatment plan on the EMG nerve condition study. (Petitioner Exhibit 4, pp.14-15)

Dr. Atwater was then asked whether he felt that the Petitioner's work duties of October 30, 2012 were more probably than not the cause of his radicular symptoms and the need for the treatment being recommended. Dr. Atwater responded, "Yes". (Petitioner Exhibit 4, pp.16-18) Dr. Atwater also testified that in order for the Petitioner's job duties on October 30, 2012 to be causally related to his neck and radiating arm symptoms, they would have appeared within a day or two. (Id at 31)

The Petitioner testified that he had never had these problems prior to October 30, 2012. The Petitioner further testified that he had not suffered any additional accidents since October 30, 2012.

Based upon the foregoing, the Arbitrator finds the testimony of the Petitioner to have been credible and consistent throughout the treatment records. He testified that he began having neck pain and radiating numbness into his left hand following his work trimming trees on October 30. His history to OSF when he first sought treatment included a complaint of numbness and tingling in the fingers of the right hand. (PX 1) The symptom onset in the hand is consistent with Dr. Atwater's opinions on causation. Medical records from OSF after November 2 continue to show the petitioner with numbness and tingling to the fingers of the left hand. (See PX 1; 11-19-12; 12-10-12) After his initial exam on December 20, 2012, Dr. Newcomer wrote that the Petitioner's numbness and tingling was in the C6 distribution. (PX 2) Based upon the above facts, the Arbitrator finds that the Petitioner's current condition of ill-being with regards to his cervical condition to be causally related to the accident of October 30, 2012. The Arbitrator further finds that the Petitioner's condition of bilateral carpal tunnel syndrome is not causally related to the incident in question pursuant to the testimony of Dr. Atwater.

In Support of the Arbitrator's award as 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 notes as follows:

Having found that the Petitioner's cervical condition of ill-being is casually related to the October 30, 2012 accident, the Arbitrator further finds that the medical care given to the Petitioner has been both reasonable and necessary and therefore orders the

Respondent to pay the medical bill listed in Petitioner's Exhibit 6 pursuant to Section 8(a) and 8.2 of the Illinois Workers' Compensation Act.

In Support of the Arbitrator's award as to **(K) Is Petitioner entitled to any prospective medical care?**, the Arbitrator notes as follows:

Having found that the Petitioner's cervical problems are related to the accident of October 30, 2012 and having further found that the Petitioner's testimony was credible and that the opinions rendered by Dr. Atwater were also credible, the Arbitrator orders the Respondent to authorize the treatment recommended by Dr. Atwater with regard to the Petitioner's cervical condition. While the doctor acknowledged that the most recent EMG does not contains findings of radiculopathy, the Arbitrator finds persuasive his reasoning that surgery is indicated due to the Petitioner's findings of muscle weakness and numbness in the "dermatomal distribution." (PX 4 at 14-15)

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martina Komoromi,
Petitioner,

vs. NO: 07 WC 11082

Drury Hotels Co., LLC.

15IWCC0207

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 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: MAR 2 3 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-03/18/15
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOMOROMI, MARTINA
Employee/Petitioner

Case# **07WC011082**
07WC012034

DRURY HOTELS CO LLC
Employer/Respondent

15IWCC0207

On 3/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2453 CALLIS LAW FIRM PC
RAND S HALE
1326 NIEDRINGHAUS AVE
GRANITE CITY, IL 62040

LAW OFFICES OF MARK M ANSON
906 OLIVE ST
SUITE 720
ST LOUIS, MO 63101

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

Martina Komoromi
Employee/Petitioner

v.

Drury Hotels Co., LLC
Employer/Respondent

Case # 07 WC 11082

Consolidated cases: 07 WC 12034

15IWCC0207

An *Application for Adjustment 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 **Mt. Vernon**, on **February 9, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0207

FINDINGS

On **August 21, 2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

ORDER

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

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

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

Richard K. Simpson
Signature of Arbitrator

March 12, 2014
Date

MAR 13 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martina Komoromi,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 07 WC 11082**
	)	**consolidated with:**
Drury Inn, a/k/a Drury Hotels Co., LLC,	)	**07 WC 12034**
	)	
Respondent.	)	
	)	**15IWCC0207**

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 21, 2006, and February 18, 2007, 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.

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 by the Respondent; (2) What is the date of the accident; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Were the medical services that were provided to the Petitioner reasonable and necessary; Has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (5) Is the Petitioner entitled to TTD; (6) What is the nature and extent of the injury; and (7) Is the Petitioner entitled to payment for mileage.

STATEMENT OF FACTS

The petitioner testified that originally she was employed by the Pear Tree Inn. The Pear Tree Inn was bought by the Drury Company and so she became employed by the Drury Inn. At the According to the petitioner she recalls one single specific incident that occurred at the Drury Inn on August 21, 2006. She was employed in housekeeping and cleaned rooms.

Petitioner testified that on August 21, 2006, she was a supervisor for the day. She was cleaning rooms and had to turn a mattress over in one of the rooms. She had no one to help her at the time and she recalled when she turned the mattress over that she felt a shock in her neck. She did not stop working at the time, she did not seek medical treatment at the time and she did not report the incident at the time. A few days later the pain was going down her shoulder and into her hand.

The petitioner testified that on May 16, 2006, she had been involved in an automobile accident. She was injured in that accident and had been receiving treatment from a doctor Eavenson, a chiropractor. Petitioner described her injury from the accident as having been to her neck. According to the medical records of Anderson Hospital Emergency room the petitioner was the restrained driver of an automobile in which the airbag deployed as result of the collision. Petitioner stated to medical personnel that she had the worst headache of her life right before the accident but that in the ER the headache was a little better. X-rays were taken of her cervical spine they showed that there was no fracture or dislocation, no prevertebral soft tissue swelling or locked facet evident. The x-ray did show degenerative spurring at C6 – 7. She also had an x-ray of the lumbar spine which showed mild scoliosis and mild degenerative changes.

The respondent called a witness on their behalf named Melissa Holloway. She testified that she has worked for Drury Hotels for 9 years. She is the region 3 sales manager, it does not include Illinois. Ms. Holloway testified that she has also served in the capacity of assistant general manager and later general manager. She was the general manager of the Collinsville Drury Inn at the time that the petitioner was employed there. Ms. Holloway reviewed employment records with respect to the petitioner and verified that the petitioner was indeed an employee of the Drury Inn on August 21 of 2006. She testified further that according to the petitioner's work records the petitioner had taken significant time off of work prior to the date of August 21, 2006. She stated that according to the work records the petitioner had not worked for at least four days before August 21, 2006, did not work on August 21, and did not work the next three days after August 21, 2006, either. She described R. Ex. 3, as a report from the hotel system for the payroll. The document shows that the petitioner did not work from August 10 through August 20, she called in sick, she was not scheduled for August 21, 2006, and called in sick from August 21 through August 24, 2006, returning to work on August 25, 2006. (R. Ex. 3)

Respondent's exhibit number 6 consists of a Drury Hotels, personnel action notice, which serves as the record of petitioner's termination from the respondent on August 21, 2009, giving as the cause: failure to contact employer after release to return to work. Attached to the notice is a form identified as a "Verbal Discussion Record" which is signed and dated by the petitioner as July 18, 2006. According to the record, the petitioner was being spoken to regarding excessive absences and specifically warned that disciplinary action would result if she called off on or before August 7, 2006. (R. Ex. 6)

Ms. Holloway testified that the Drury Inn has a policy that requires two people to flip mattresses because of their size. She testified further that Drury Inn has a return to work policy wherein if an employee is injured at work, they try to get them back to work ASAP, in light duty capacity or full duty capacity, if the injury is not work related then the employee must come back full duty.

The petitioner was recalled in rebuttal. At that time she acknowledged that the respondent did have a policy that mattresses were supposed to be flipped by two people, but stated that sometimes there was not a second person available so she did it by herself. She also testified that the rooms had reclining chairs in them which had to be moved to vacuum under them and chests with the refrigerator and microwave that also had to be moved to vacuum behind because of the dust. She testified further that they were remodeling while she worked there and

there were days she had to move the new mattresses and furniture into the hotel so they did not sit out in the parking lot overnight. No time frame is given for when the remodeling occurred.

According to the petitioner's medical records, the petitioner saw Dr. Mark Eavenson, a chiropractor on August 9, 2006, complaining of neck pain that extended into the right shoulder. She described tingling and numbness in both hands that would wake her up at night. Dr. Eavenson reported that the petitioner "tells me about two weeks ago she flipped a heavy mattress at work and this may have precipitated the problem." (R. Ex. 1, ex. 2, p. 3) Dr. Eavenson had treated the petitioner from May 22, 2006, through June 15, 2006, for injuries to her neck, low back, right forearm and right shoulder due to a car accident that she had been in. He noted that she had settled the accident claim regarding that accident. (R. Ex. 1, ex. 2, p. 3)

On that same day, petitioner was also seen by Cory Voss, a physical therapist in Dr. Bell's and Dr. Eavenson's office. Cory Voss noted that petitioner had woken up with the symptoms the day before (August 8, 2006). It was also noted that the petitioner's work as a housekeeper involved repetitive activities. (R. Ex. 1, ex. 2, p. 3)

The petitioner filed an Application for Adjustment of Claim on March 14, 2007, (Arb. Ex. 4), listing the part of the body affected as the "neck"; the nature of the injury as "herniated disc"; and how the accident occurred as "repetitive trauma." (Arb. Ex. 4)

According to the medical records of Dr. Eavenson, the petitioner first saw him for treatment after her motor vehicle accident on May 22, 2006. At that time she reported that she was in a motor vehicle accident on May 16, 2006, in which she totaled her 2005 Durango when she hit a car. She told the doctor that she did not strike her head and she did not lose consciousness. At this time petitioner mentioned for the first time that she also suffered an injury to her right shoulder. The petitioner had been referred to Dr. Eavenson, for physical therapy and treatment by Dr. Bell. Petitioner attended physical therapy regularly with Dr. Eavenson.

At the time petitioner appeared at Dr. Eavenson's office for her regular physical therapy appointment on August 9, 2006, the petitioner reported to Dr. Eavenson that she had had no new accidents, however that morning she woke up with pain in her neck, her right upper extremities and her fingers. The notes from Dr. Eavenson indicate that the petitioner was last seen in June, that currently she is complaining of neck pain radiating to the right shoulder. He noted that it had an insidious onset, that the pain wakes her at night, and that she believed that two weeks ago when she flipped a mattress at work it may have caused the problem. She also mentioned that the numbness and tingling in her arm comes and goes. At that time Dr. Eavenson ordered an EMG/NCV bilateral for the upper extremities and an MRI of the petitioner's cervical spine.

The Petitioner testified that she was taken off of work by Dr. Kennedy as a result of this injury from August 26, 2006 through February 14, 2007. That during that time period multiple methods of treatment were used, including physical therapy, traction, being placed on a table and "realigining me, cracking and snapping my back." Eventually she underwent cervical spine "surgery by Dr. Kennedy and Dr. Raskus in the form of a metal plate, screws and fusing bones." Petitioner testified that she was off of work the whole time, was not paid TTD and no medical

bills were paid. She also testified that she had to drive 45 miles each way from her home to Dr. Kennedy's office.

Dr. David G. Kennedy testified at a deposition on June 24, 2008, regarding his treatment of the petitioner. (P. Ex. 11) At his deposition Dr. Kennedy testified that after his first consultation with the petitioner he determined that she had a disc prolapsed at C6-7 on the right side with encroachment of the right foramen. (P. Ex. 11, p. 8) At that time he believed that she would benefit from physical therapy and gave her a prescription for PT and then scheduled her for a follow-up appointment a few weeks later. He also placed restrictions on her ability to work, in that he limited the weight she could lift to ten pounds, and ordered that she not do any bending, twisting, stooping, pushing, pulling or overhead lifting. (P. Ex. 11. pp. 8-9)

According to Dr. Kennedy when the petitioner returned to see him on September 11, 2006, upon examination she had an "essentially normal examination" however she reported no improvement and complained of an increase in pain. She also described pain in her lower lumbar area and Dr. Kennedy referred her to Dr. John Graham. (P. Ex. 11, pp. 9-11) It was during this visit that Dr. Kennedy recommended surgery and took the petitioner off of work. According to Dr. Kennedy it was at this point that the petitioner mentioned she was a housekeeper and described her job duties, inquiring if the aggravation of her spine condition could be due to her employment. (P. Ex. 11, pp. 10-11)

Dr. Kennedy testified that on October 11, 2006, petitioner underwent cervical spine surgery. He removed the disc at C6-7, placed a bone graft and placed a titanium plate to lock the bone graft into place. He stated that he was assisted by Dr. Raskas during the surgery, and that during the surgery he found a "free fragment" of the disk. (P. Ex. 11, p. 11) The Petitioner returned to see Dr. Kennedy for follow-up visits on December 21, 2006, and December 29, 2006, and again on February 6, 2007. Although she complained of stiffness in the right trapezius muscle, Dr. Kennedy released the petitioner to return to work, full duty with no restrictions as of February 12, 2007. (P. Ex. 11, pp. 14-15)

The petitioner testified that she did return to work in February of 2007, with restrictions in place. The petitioner testified that she remembered working for three days being off for one and returning for one more day, that final day being the day she hurt her shoulder. (February 18, 2007) If petitioner's memory is correct, she returned to work on February 14, 2007, worked the 14th, 15th and 16th, was off on the 17th and then injured on the 18th when she returned to work. With respect to the second injury petitioner testified that while lifting a trash can she felt another shock in her neck and shoulder. She testified further that she believed that she had re- injured her neck and she returned to Dr. Kennedy on February 20, 2007.

The petitioner testified that on the day of her second injury, she had cleaned 6 rooms and was responsible for the lobby as well. In the lobby you mop the entire floor with a wet mop, and then take a second mop which is dry and mop the lobby floor a second time. She testified that she was worried about that activity. She stated that she had to pick up a heavy plastic lid off of a trash can and that is when she felt the shock to her neck and shoulder. She stated that she reported the injury to her supervisor and was sent by the supervisor to clean her assigned rooms. She went to the rooms and scrubbed tubs, and had pain while doing so. It was while she was

cleaning her assigned rooms that her supervisor came to her, stated that she had talked to the manager and they decided to send her home for the day, due to her injury. Petitioner testified that at the time she injured herself, she thought that she re-injured her neck. After seeing Dr. Kennedy and undergoing physical examination and the MRI it turned out that she tore her rotator cuff.

Dr. Kennedy testified that throughout the treatment petitioner received from him, she continuously had complaints of pain in her neck, at the base of her cervical spine and right trapezius. (P. Ex. 11, pp. 15-25) When she returned on February 20, 2007, she reported to him that the week before she was moving a heavy trash bag and experienced worsening pain at the base of her cervical spine with pain radiating to her right arm and hand, more in her thumb and index finger as opposed to her index and middle fingers. (P. Ex. 11, p. 15) Although he suspected a herniated disc at a different level, the MRI he ordered showed the post operative changes at C6-7 but no new disc abnormalities. (P. Ex. 11, pp. 15-16) Dr. Kennedy continued to treat the petitioner until, in his opinion, she reached MMI with respect to her neck and cervical spine on May 19, 2008. At that time she was still complaining of pain and increased soreness. (P. Ex. 11, pp. 23-25) Dr. Kennedy testified that he suggested to the petitioner that she not return to her work as a housekeeper and restricted her lifting to twenty pounds with no overhead lifting. (P. Ex. 11, p. 24)

The petitioner was seen and treated by Dr. George Paletta, Orthopedic Center of St. Louis, beginning April 16, 2007. According to Dr. Paletta, the petitioner's chief complaint at the time was right shoulder pain which began in February of 2007, when she was taking the lid off of some large trash bins. (P. Ex. 9, p. 7) The petitioner was treating simultaneously with Dr. Kennedy and Dr. Paletta from April of 2007 through her discharge by Dr. Kennedy in May of 2008.

According to Dr. Paletta, the petitioner reported to him that she had had spine surgery with Dr. Kennedy in October of 2006, and when she reported the onset of the shoulder pain, after the trash can incident, she was asked to see Dr. Kennedy, who determined the pain was not related to her spine and sent her for physical therapy. (P. Ex. 9, p. 7). After examining the petitioner, reviewing her x-rays and MRI scan, Dr. Paletta determined that the petitioner had subacromial impingement and symptomatic AC joint arthritis with distal clavicle edema. (P. Ex. 9, pp. 8-10) At the time of the examination, Dr. Paletta recommended that the Petitioner try a Medrol dose pack, followed by a non-steroidal anti inflammatory and if that did not work they would consider either an injection of the AC joint or surgery. Two weeks later, the petitioner advised Dr. Paletta that she had decided to proceed with surgery. (P. Ex. 9, p. 10-11) The next time Dr. Paletta saw the petitioner after the April 16, 2007, appointment was the date of the surgery, June 21, 2007.

Dr. Paletta testified at his deposition that the surgery he performed was a diagnostic arthroscopy of the shoulder, wherein petitioner was noted to have a little bit of wear and tear of the rotator cuff, but no big time full thickness or high grade tear, so he did a debridement and then the definitive procedures were a subacromial decompression, the acromioplasty to remove bone spurs and then he contoured the acromion so that it was flat and removed the distal end of the clavicle or the collar bone. The surgical procedures were all to the right shoulder. He

pointed out a typographical error in one of the reports wherein it states the left shoulder and stated he was unsure whether it was a typo or he misspoke in dictating the report. (P. Ex. 9, pp. 11-12)

Dr. Paletta admitted on cross examination that he did not have any prior medical records to review and that he based his opinions regarding causation on the history given him by the Petitioner and the x-rays and MRI that he reviewed. (P. Ex. 9, p. 22) The doctor testified that petitioner did not tell him that she had been in a motor vehicle accident in May of 2006, reporting injury to her neck, lower back and right arm. (P. Ex. 9, p. 22) Dr. Paletta also testified that the petitioner did not tell him that she had a five year history of neck, arm and shoulder pain prior to her surgery with Dr. Kennedy in October 2006. (P. Ex. 9, p. 23-24) It appears that Dr. Paletta was not aware that petitioner had been back to work less than one week, still experiencing pain in her neck, right shoulder and arm at the time of the February 18, 2007, injury. Dr. Paletta stated that he based his causation opinion on the report of the petitioner to him that she had not had any symptoms preceding the accident at work with the trash bins. He also admitted that he did not inquire how long petitioner had been symptom free at the time of the injury. (P. Ex. 9, p. 25)

On cross examination, Dr. Paletta admitted that the information regarding the five year history of previous neck, shoulder and arm pain would be something he would have considered in making his determination, and the information regarding the motor vehicle accident in May of 2006, would also potentially be relevant information that he would have considered in forming his opinion. (P. Ex. 9, pp. 22-24) He testified that it was his opinion that her osteoarthritis of the AC joint had been long standing, and is a condition that can wax and wane. The petitioner reported no symptoms before the trash can incident and he accepted that report. She did not offer information as to the length of time she had been symptom free and he did not inquire as to the length of time. (P. Ex. 9, p. 25)

Petitioner testified that she drove 50 miles from her home to Dr. Paletta's office and then 50 miles back home.

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.

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).

Did an Accident Occur to Petitioner that Arose out of and in the Course of Employment and Is Petitioner's Current Condition of Ill-being Causally Related to the Injury?

The Arbitrator finds, with respect to case number 07 WC 11082, that the Petitioner failed to prove that an accident occurred that arose out of and in the course of her employment and that her condition at the time of trial with respect to her neck is causally related to the alleged accident of August 21, 2006. This finding is based upon the payroll records that show that the petitioner was off of work for the time period from August 10, 2006 through August 24, 2006, which includes the date of the alleged accident. Moreover, the petitioner was in a motor vehicle accident in May of 2006, describing the same type of injury and pain for which she was being treated by Dr. Bell and then Dr. Eavenson. There were notes in the medical records during this treatment wherein petitioner made mention to the doctors that in addition to the car accident injury she may also have hurt her neck flipping a mattress at work, this appears to be after the car accident and well before the mattress flipping incident she remembers having occurred on August 21, 2006. Additionally petitioner is not reported to having described the "shock" that went through her neck and shoulder which turned into pain a few days later, in her shoulder, down her arm and into her hand, that she clearly described at the time of trial. She testified that this pain was what sent her to the chiropractor. Also petitioner indicated to her treating doctor that on August 10, 2006, she was having trouble at work, they were having a fit because she wanted to take her vacation and they wanted her to return to work.

The medical records do not support the petitioner's allegations with respect to the work injury. Dr. Kennedy's records indicate that on September 11, 2006, the petitioner added complaints of low back pain with occasional radiation into the left leg. It was at that time she told Dr. Kennedy that she did quite a bit of heavy lifting at work and wondered if there was a work component to her problem. The employment records, especially the payroll records contradict her testimony. The Application for Adjustment of Claim, lists August 21, 2006, as the date of injury. The accident is alleged to have occurred as "repetitive trauma," the part of the body affected was the "neck" and the nature of the injury is "herniated disc." (Arb. Ex. # 4) In Dr. Eavenson's records he refers to a comment made by the petitioner on August 9, 2006, after denying any new injury and describing a sudden onset of pain the day before. She goes on to speculate that she may have hurt her neck flipping a mattress about two weeks before, but does not describe the feeling of the shock she testified to at the hearing or the fact that the pain started several days later.

Petitioner testified that when Dr. Kennedy released her to return to work as of February 12, 2007, it was with restrictions. Dr. Kennedy's notes indicate that it was without restrictions. The notes indicate that she was still complaining of right sided pain and stiffness on the right side.

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; Is the Petitioner entitled to TTD; What is the nature and extent of the injury; and Is the Petitioner entitled to payment for mileage.

Because petitioner failed to prove a compensable accident as to the alleged injury of August 21, 2006, in case number 07 WC 11082, these issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson
Signature of Arbitrator

March 12, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martina Komoromi,
Petitioner,

vs.

NO: 07 WC 12034

15IWCC0208

Drury Hotels Co., LLC.

DECISION AND OPINION ON REVIEW

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

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

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

DATED: MAR 2 3 2015

Joshua D. Luskin

o-03/18/15
jdl/wj
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOMOROMI, MARTINA
Employee/Petitioner

Case# **07WC012034**
07WC011082

DRURY HOTELS CO LLC
Employer/Respondent

15IWCC0208

On 3/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2453 CALLIS LAW FIRM PC
RAND S HALE
1326 NIEDRINGHAUS AVE
GRANITE CITY, IL 62040

LAW OFFICES OF MARK M ANSON
906 OLIVE ST
SUITE 720
ST. LOUIS, MO 63101

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

Martina Komoromi
Employee/Petitioner

v.

Drury Hotels Co., LLC
Employer/Respondent

Case # 07 WC 12034

Consolidated cases: 07 WC 11082

15IWCC0208

An *Application for Adjustment 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 **Mt. Vernon**, on **February 9, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0208

FINDINGS

On **February 18, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Respondent shall be given a credit of **$8,497.80** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$8,497.80**.

ORDER

The Respondent shall pay the Petitioner **$212.45** / week for **10** weeks as the Petitioner sustained a **2%** loss of the man as a whole, pursuant to the Act.

The Petitioner has failed to prove a causal connection between the accident and the condition of ill-being that led to the need for the medical treatment that she received. Having failed to prove a causal connection the other benefits petitioner seeks, including TTD beyond May 20, 2007, medical bills and mileage are denied.

Respondent shall be given credit for TTD which has been paid in the amount of $8,497.80.

All other benefits are denied.

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

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

Richard K. Simpson
Signature of Arbitrator

March 12, 2014
Date

MAR 13 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martina Komoromi,	)	**15IWCC0208**
	)	
Petitioner,	)	
	)	
vs.	)	**No. 07 WC 12034**
	)	**consolidated with:**
Drury Inn, a/k/a Drury Hotels Co., LLC,	)	**07 WC 11082**
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 21, 2006, and February 18, 2007, 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.

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 by the Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services that were provided to the Petitioner reasonable and necessary; Has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is the Petitioner entitled to TTD; (5) What is the nature and extent of the injury; and (6) Is the Petitioner entitled to payment for mileage.

STATEMENT OF FACTS

The petitioner testified that originally she was employed by the Pear Tree Inn. The Pear Tree Inn was bought by the Drury Company and so she became employed by the Drury Inn. At the According to the petitioner she recalls one single specific incident that occurred at the Drury Inn on August 21, 2006. She was employed in housekeeping and cleaned rooms.

Petitioner testified that on August 21, 2006, she was a supervisor for the day. She was cleaning rooms and had to turn a mattress over in one of the rooms. She had no one to help her at the time and she recalled when she turned the mattress over that she felt a shock in her neck. She did not stop working at the time, she did not seek medical treatment at the time and she did not report the incident at the time. A few days later the pain was going down her shoulder and into her hand.

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Eavenson, a chiropractor. Petitioner described her injury from the accident as having been to her neck. According to the medical records of Anderson Hospital Emergency room the petitioner was the restrained driver of an automobile in which the airbag deployed as result of the collision. Petitioner stated to medical personnel that she had the worst headache of her life right before the accident but that in the ER the headache was a little better. X-rays were taken of her cervical spine they showed that there was no fracture or dislocation, no prevertebral soft tissue swelling or locked facet evident. The x-ray did show degenerative spurring at C6 – 7. She also had an x-ray of the lumbar spine which showed mild scoliosis and mild degenerative changes.

The respondent called a witness on their behalf named Melissa Holloway. She testified that she has worked for Drury Hotels for 9 years. She is the region 3 sales manager, it does not include Illinois. Ms. Holloway testified that she has also served in the capacity of assistant general manager and later general manager. She was the general manager of the Collinsville Drury Inn at the time that the petitioner was employed there. Ms. Holloway reviewed employment records with respect to the petitioner and verified that the petitioner was indeed an employee of the Drury Inn on August 21 of 2006. She testified further that according to the petitioner's work records the petitioner had taken significant time off of work prior to the date of August 21, 2006. She stated that according to the work records the petitioner had not worked for at least four days before August 21, 2006, did not work on August 21, and did not work the next three days after August 21, 2006, either. She described R. Ex. 3, as a report from the hotel system for the payroll. The document shows that the petitioner did not work from August 10 through August 20, she called in sick, she was not scheduled for August 21, 2006, and called in sick from August 21 through August 24, 2006, returning to work on August 25, 2006. (R. Ex. 3)

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Ms. Holloway testified that the Drury Inn has a policy that requires two people to flip mattresses because of their size. She testified further that Drury Inn has a return to work policy wherein if an employee is injured at work, they try to get them back to work ASAP, in light duty capacity or full duty capacity, if the injury is not work related then the employee must come back full duty.

The petitioner was recalled in rebuttal. At that time she acknowledged that the respondent did have a policy that mattresses were supposed to be flipped by two people, but stated that sometimes there was not a second person available so she did it by herself. She also testified that the rooms had reclining chairs in them which had to be moved to vacuum under them and chests with the refrigerator and microwave that also had to be moved to vacuum behind because of the dust. She testified further that they were remodeling while she worked there and there were days she had to move the new mattresses and furniture into the hotel so they did not sit out in the parking lot overnight. No time frame was provided for the remodeling.

According to the petitioner's medical records, the petitioner saw Dr. Mark Eavenson, a chiropractor on August 9, 2006, complaining of neck pain that extended into the right shoulder. She described tingling and numbness in both hands that would wake her up at night. Dr. Eavenson reported that the petitioner "tells me about two weeks ago she flipped a heavy mattress at work and this may have precipitated the problem." (R. Ex. 1, ex. 2, p. 3) Dr. Eavenson had treated the petitioner from May 22, 2006, through June 15, 2006, for injuries to her neck, low back, right forearm and right shoulder due to a car accident that she had been in. He noted that she had settled the accident claim regarding that accident. (R. Ex. 1, ex. 2, p. 3)

On that same day, petitioner was also seen by Cory Voss, a physical therapist in Dr. Bell's and Dr. Eavenson's office. Cory Voss noted that petitioner had woken up with the symptoms the day before (August 8, 2006). It was also noted that the petitioner's work as a housekeeper involved repetitive activities. (R. Ex. 1, ex. 2, p. 3)

The petitioner filed an Application for Adjustment of Claim on March 14, 2007, (Arb. Ex. 4), listing the part of the body affected as the "neck"; the nature of the injury as "herniated disc" and how the accident occurred as "repetitive trauma." (Arb. Ex. 4)

According to the medical records of Dr. Eavenson, the petitioner first saw him for treatment after her motor vehicle accident on May 22, 2006. At that time she reported that she was in a motor vehicle accident on May 16, 2006, in which she totaled her 2005 Durango when she hit a car. She told the doctor that she did not strike her head and she did not lose consciousness. At this time petitioner mentioned for the first time that she also suffered an injury to her right shoulder. The petitioner had been referred to Dr. Eavenson, for physical therapy and treatment by Dr. Bell. Petitioner attended physical therapy regularly with Dr. Eavenson.

At the time petitioner appeared at Dr. Eavenson's office for her regular physical therapy appointment on August 9, 2006, the petitioner reported to Dr. Eavenson that she had had no new accidents, however that morning she woke up with pain in her neck, her right upper extremities and her fingers. The notes from Dr. Eavenson indicate that the petitioner was last seen in June, that currently she is complaining of neck pain radiating to the right shoulder. He noted that it had an insidious onset, that the pain wakes her at night, and that she believed that two weeks ago when she flipped a mattress at work it may have caused the problem. She also mentioned that the numbness and tingling in her arm comes and goes. At that time Dr. Eavenson ordered an EMG/NCV bilateral for the upper extremities and an MRI of the petitioner's cervical spine.

The Petitioner testified that she was taken off of work by Dr. Kennedy as a result of this injury from August 26, 2006 through February 14, 2007. That during that time period multiple methods of treatment were used, including physical therapy, traction, being placed on a table and "realigning me, cracking and snapping my back." Eventually she underwent cervical spine "surgery by Dr. Kennedy and Dr. Raskus in the form of a metal plate, screws and fusing bones." Petitioner testified that she was off of work the whole time, was not paid TTD and no medical bills were paid. She also testified that she had to drive 45 miles each way from her home to Dr. Kennedy's office.

Dr. David G. Kennedy testified at a deposition on June 24, 2008, regarding his treatment of the petitioner. (P. Ex. 11) At his deposition Dr. Kennedy testified that after his first consultation with the petitioner he determined that she had a disc prolapsed at C6-7 on the right side with encroachment of the right foramen. (P. Ex. 11, p. 8) At that time he believed that she would benefit from physical therapy and gave her a prescription for PT and then scheduled her for a follow-up appointment a few weeks later. He also placed restrictions on her ability to work, in that he limited the weight she could lift to ten pounds, and ordered that she not do any bending, twisting, stooping, pushing, pulling or overhead lifting. (P. Ex. 11. pp. 8-9)

According to Dr. Kennedy when the petitioner returned to see him on September 11, 2006, upon examination she had an "essentially normal examination" however she reported no improvement and complained of an increase in pain. She also described pain in her lower lumbar area and Dr. Kennedy referred her to Dr. John Graham. (P. Ex. 11, pp. 9-11) It was during this visit that Dr. Kennedy recommended surgery and took the petitioner off of work. According to Dr. Kennedy it was at this point that the petitioner mentioned she was a housekeeper and described her job duties, inquiring if the aggravation of her spine condition could be due to her employment. (P. Ex. 11, pp. 10-11)

Dr. Kennedy testified that on October 11, 2006, petitioner underwent cervical spine surgery. He removed the disc at C6-7, placed a bone graft and placed a titanium plate to lock the bone graft into place. He stated that he was assisted by Dr. Raskas during the surgery, and that during the surgery he found a "free fragment" of the disk. (P. Ex. 11, p. 11) The Petitioner returned to see Dr. Kennedy for follow-up visits on December 21, 2006, and December 29, 2006, and again on February 6, 2007. Although she complained of stiffness in the right trapezius muscle, Dr. Kennedy released the petitioner to return to work, full duty with no restrictions as of February 12, 2007. (P. Ex. 11, pp. 14-15)

The petitioner testified that she did return to work in February of 2007, with restrictions in place. The petitioner testified that she remembered working for three days being off for one and returning for one more day, that final day being the day she hurt her shoulder. (February 18, 2007) If petitioner's memory is correct, she returned to work on February 14, 2007, worked the 14th, 15th and 16th, was off on the 17th and then injured on the 18th when she returned to work. With respect to the second injury petitioner testified that while lifting a trash can she felt another shock in her neck and shoulder. She testified further that she believed that she had re- injured her neck and she returned to Dr. Kennedy on February 20, 2007.

The petitioner testified that on the day of her second injury, she had cleaned 6 rooms and was responsible for the lobby as well. In the lobby you mop the entire floor with a wet mop, and then take a second mop which is dry and mop the lobby floor a second time. She testified that she was worried about that activity. She stated that she had to pick up a heavy plastic lid off of a trash can and that is when she felt the shock to her neck and shoulder. She stated that she reported the injury to her supervisor and was sent by the supervisor to clean her assigned rooms. She went to the rooms and scrubbed tubs, and had pain while doing so. It was while she was cleaning her assigned rooms that her supervisor came to her, stated that she had talked to the manager and they decided to send her home for the day, due to her injury. Petitioner testified

that at the time she injured herself, she thought that she re-injured her neck. After seeing Dr. Kennedy and undergoing physical examination and the MRI it turned out that she tore her rotator cuff.

Dr. Kennedy testified that throughout the treatment petitioner received from him, she continuously had complaints of pain in her neck, at the base of her cervical spine and right trapezius. (P. Ex. 11, pp. 15-25) When she returned on February 20, 2007, she reported to him that the week before she was moving a heavy trash bag and experienced worsening pain at the base of her cervical spine with pain radiating to her right arm and hand, more in her thumb and index finger as opposed to her index and middle fingers. (P. Ex. 11, p. 15) Although he suspected a herniated disc at a different level, the MRI he ordered showed the post operative changes at C6-7 but no new disc abnormalities. (P. Ex. 11, pp. 15-16) Dr. Kennedy continued to treat the petitioner until, in his opinion, she reached MMI with respect to her neck and cervical spine on May 19, 2008. At that time she was still complaining of pain and increased soreness. (P. Ex. 11, pp. 23-25) Dr. Kennedy testified that he suggested to the petitioner that she not return to her work as a housekeeper and restricted her lifting to twenty pounds with no overhead lifting. (P. Ex. 11, p. 24)

The petitioner was seen and treated by Dr. George Paletta, Orthopedic Center of St. Louis, beginning April 16, 2007. According to Dr. Paletta, the petitioner's chief complaint at the time was right shoulder pain which began in February of 2007, when she was taking the lid off of some large trash bins. (P. Ex. 9, p. 7) The petitioner was treating simultaneously with Dr. Kennedy and Dr. Paletta from April of 2007 through her discharge by Dr. Kennedy in May of 2008.

According to Dr. Paletta, the petitioner reported to him that she had had spine surgery with Dr. Kennedy in October of 2006, and when she reported the onset of the shoulder pain, after the trash can incident, she was asked to see Dr. Kennedy, who determined the pain was not related to her spine and sent her for physical therapy. (P. Ex. 9, p. 7). After examining the petitioner, reviewing her x-rays and MRI scan, Dr. Paletta determined that the petitioner had subacromial impingement and symptomatic AC joint arthritis with distal clavicle edema. (P. Ex. 9, pp. 8-10) At the time of the examination, Dr. Paletta recommended that the Petitioner try a Medrol dose pack, followed by a non-steroidal anti inflammatory and if that did not work they would consider either an injection of the AC joint or surgery. Two weeks later, the petitioner advised Dr. Paletta that she had decided to proceed with surgery. (P. Ex. 9, p. 10-11) The next time Dr. Paletta saw the petitioner after the April 16, 2007, appointment was the date of the surgery, June 21, 2007.

Dr. Paletta testified at his deposition that the surgery he performed was a diagnostic arthroscopy of the shoulder, wherein petitioner was noted to have a little bit of wear and tear of the rotator cuff, but no big time full thickness or high grade tear, so he did a debridement and then the definitive procedures were a subacromial decompression, the acromioplasty to remove bone spurs and then he contoured the acromion so that it was flat and removed the distal end of the clavicle or the collar bone. The surgical procedures were all to the right shoulder. He pointed out a typographical error in one of the reports wherein it states the left shoulder and

stated he was unsure whether it was a typo or he misspoke in dictating the report. (P. Ex. 9, pp. 11-12)

Dr. Paletta admitted on cross examination that he did not have any prior medical records to review and that he based his opinions regarding causation on the history given him by the Petitioner and the x-rays and MRI that he reviewed. (P. Ex. 9, p. 22) The doctor testified that petitioner did not tell him that she had been in a motor vehicle accident in May of 2006, reporting injury to her neck, lower back and right arm. (P. Ex. 9, p. 22) Dr. Paletta also testified that the petitioner did not tell him that she had a five year history of neck, arm and shoulder pain prior to her surgery with Dr. Kennedy in October 2006. (P. Ex. 9, p. 23-24) It appears that Dr. Paletta was not aware that petitioner had been back to work less than one week, still experiencing pain in her neck, right shoulder and arm at the time of the February 18, 2007, injury. Dr. Paletta stated that he based his causation opinion on the report of the petitioner to him that she had not had any symptoms preceding the accident at work with the trash bins. He also admitted that he did not inquire how long petitioner had been symptom free at the time of the injury. (P. Ex. 9, p. 25)

On cross examination, Dr. Paletta admitted that the information regarding the five year history of previous neck, shoulder and arm pain would be something he would have considered in making his determination, and the information regarding the motor vehicle accident in May of 2006, would also potentially be relevant information that he would have considered in forming his opinion. (P. Ex. 9, pp. 22-24) He testified that it was his opinion that her osteoarthritis of the AC joint had been long standing, and is a condition that can wax and wane. The petitioner reported no symptoms before the trash can incident and he accepted that report. She did not offer information as to the length of time she had been symptom free and he did not inquire as to the length of time. (P. Ex. 9, p. 25)

Petitioner testified that she drove 50 miles from her home to Dr. Paletta's office and then 50 miles back home.

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.

Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro supra.* "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000).

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).

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

Although the petitioner's testimony had very little credibility the petitioner proved that she did sustain an accidental injury on February 18, 2007. The nature and extent of the injury is debatable. She testified that she felt a shock in her neck and shoulder upon lifting the lid off of the trash can and that she immediately reported the injury to her supervisor after it happened. She stated that the manager sent her back to continue working and after a period of time sought her out and sent her home due to the injury. She testified that the pain was the same as the pain she was experiencing prior to her neck fusion that she had just returned back to work from so she sought treatment from Dr. Kennedy who had performed the neck surgery. She stated that it was not a re-injury to her neck but that she tore her rotator cuff instead. Work records and medical records support the petitioner's testimony that she suffered some type of injury on that day.

Dr. Kennedy determined that the petitioner did not sustain any new injury as far as her neck was concerned, the post operative changes were noted and there was no evidence of any change or injury other than the surgical ones. He sent her for physical therapy and eventually concluded and apparently recommended to the petitioner that she should find a different line of employment.

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure?

The petitioner has not proven that her current condition of ill-being is causally connected to the injury that she sustained on February 18, 2007. The petitioner's complaints of pain were the same before the neck surgery, remained after the surgery and were the same complaints after the work incident on February 18, 2007.

The petitioner's evidence that the injury she sustained to her shoulder resulted in the need for surgery is dependent upon the medical opinion of Dr. George Paletta. Dr. Paletta based his opinion upon the information provided to him by the petitioner when he saw her on April 16, 2007. At that time she did not provide copies of her previous medical records or treatment. She told him that she was not symptomatic prior to lifting the garbage out of the trash cans on February 18, 2007. She did tell him she thought she had reinjured her neck because the pain was the same and she saw Dr. Kennedy but he ruled out re-injury to her neck. Petitioner failed to disclose similar pain before the surgery, which remained after the surgery to Dr. Paletta. She did not provide a time frame for her statement that she was "system free" before the incident of February 18, 2007.

Dr. Paletta admitted that petitioner did not tell him she had a five year history of neck, shoulder and arm pain, nor did she tell him about the motor vehicle accident in May of 2006, with similar pain complaints. She did not even provide him with a time line for how long she had been without pain in her neck, shoulder or arm, and he did not inquire as to the length of time. He admitted he was not aware of or considering an "exact time frame" as to the question of how long petitioner had been symptom free. Dr. Paletta did not or would not consider the additional evidence and explain why it would or would not change his opinion. Instead he deflected the questions, stated that she said she was not symptomatic and he was sticking to his conclusions. Because Dr. Paletta's opinion is based upon incomplete information it is not credible and does not prove by a preponderance of the evidence that she had a new injury or an aggravation of a pre existing condition.

Dr. Paletta admitted that he had concluded that her osteoarthritis of the AC joint has been long standing. He noted that during the surgery she was found to have a little bit of wear and tear of the rotator cuff, so he did a debridement, but there was no full thickness tear. The definitive procedures were the subacromial decompression, the acromioplasty to remove the bone spurs and contouring the acromion so that it was flat then the removal of the distal end of the clavicle.

Based upon the testimony of the Petitioner, and the medical records, the petitioner did not really obtain any relief from the neck fusion performed by Dr. Kennedy. When she was returned to work after the fusion surgery she was still experiencing the pain in her neck and shoulder that she had prior to the surgery. She neglected to report this situation to Dr. Paletta however.

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?

Petitioner has failed to prove by a preponderance of the evidence that the medical treatment she underwent was reasonable and necessary and the need for it causally connected to the injury she sustained on February 18, 2007.

Since petitioner chose not to give a complete disclosure to Dr. Paletta regarding her medical condition Dr. Paletta's opinion on causation and necessity and appropriateness of the treatment is insufficient to support her claim. A rotator cuff tear, such as that described by Dr. Paletta would traditionally be treated conservatively before surgery would be recommended or attempted. Petitioner testified that she tore her rotator cuff on February 18, 2007, but there is no medical evidence to support that allegation, nor is there a medical opinion to support that diagnosis. The subacromial decompression, the acromioplasty to remove the bone spurs and contouring the acromion so that it was flat then the removal of the distal end of the clavicle have not been sufficiently established to have been the reasonable and necessary result of the injury petitioner sustained when lifting the trash can lid or lifting the trash however the injury actually occurred.

Dr. Kennedy does not provide a causal connection for Dr. Paletta's treatment either. Petitioner was actually treating with Dr. Paletta and Dr. Kennedy simultaneously. Petitioner has the burden of establishing by a preponderance of the evidence that the treatment she received was causally connected to the injury in some form and that the treatment was reasonable and necessary.

Is the Petitioner entitled to TTD?

The Respondent paid Petitioner TTD from February 19, 2007 through May 20, 2007, while petitioner was undergoing therapy with Dr. Eavenson. Having failed to prove that the surgical treatment that the petitioner underwent was reasonable or necessary, or that there was a time period that petitioner was symptom free between the time she returned to work after the fusion surgery for her neck, right shoulder and arm, and the accident she suffered on February 18, 2007, petitioner has failed to prove that she is entitled to TTD after May 20, 2007. It is not possible from the evidence presented to determine if the how long the petitioner would have required to be off of work because of the accident. Realizing that the petitioner need not prove that the accident was the sole cause of the injury or the primary cause of the injury and the necessity for the treatment, the petitioner still bears the burden of proving that it was a cause and that the treatment was reasonable and necessary. Petitioner has failed to prove that she was entitled to TTD beyond the date of May 20, 2007, based upon the evidence presented.

What is the nature and extent of the injury?

Petitioner is found to have suffered a permanent injury of **2%** loss the use of man as a whole pursuant to Section 8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **$212.45/week for 10 weeks**, because the injuries sustained caused the 2% loss of use of man as a whole, as provided in the Act.

Is the Petitioner entitled to payment for mileage.

Mileage expenses can be awarded under section 8(a) of the Act pursuant to a reasonableness standard, as discussed at length in *General Tire & Rubber Co. v. Industrial Commission*, 221 Ill.App.3d 641 (1991). There, the Appellate court held the respondent liable for long distance round trip mileage of approximately 100 miles to and from the petitioner's treating physician. However, the Commission has repeatedly held that "the holding in General Tire & Rubber Co. is the exception to the rule and that local mileage is not normally deemed to be reasonable and necessary. . ." *Kosinski v Mobile Chemical Co.*, 99 IIC 794. Applying the *General Tire & Rubber Co.* standard to this matter,

It is first notable that the treatment in this case cannot be found to be reasonable or necessary based upon the nature of the injury proven by the petitioner in this case. Secondly, the overall mileage in this case is not excessive in its scope and range. As Mileage is to be awarded only in unusual or excessive circumstances, the mileage expenses would not be

appropriate in this instance even if the petitioner had proven that her condition was result of the accident and the treatment was reasonable and necessary within the meaning of the Act.

ORDER OF THE ARBITRATOR

The Respondent shall pay the Petitioner **$212.45** / week for **10** weeks as the Petitioner sustained a **2%** loss of the man as a whole, pursuant to the Act.

The Petitioner has failed to prove a causal connection between the accident and the condition of ill-being that led to the need for the medical treatment that she received. Having failed to prove a causal connection the other benefits petitioner seeks, including TTD beyond May 20, 2007, medical bills and mileage are denied.

Respondent shall be given credit for TTD which has been paid in the amount of $8,497.80.

Richard L. Simpson
Signature of Arbitrator

March 12, 2014
Date

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

Laurie Chapman,

Petitioner,

vs.

No. 08 WC 00182

15IWCC0209

Marion High School,

Respondent.

DECISION AND OPINION/ORDER UNDER SECTION 19(h)

This matter comes before the Commission on a Petition for Review Under Section 19(h) filed by Respondent. The matter came for hearing before Commissioner Daniel Donohoo, and a record was made. The Commission, having been advised of the facts and law, enters and continues Respondent's 19(h) petition pending final disposition in companion case No. 09WC29095.

On January 3, 2008, Petitioner filed an application for adjustment of claim in case No. 08WC00182 alleging that on December 14, 2005, she sustained accidental injuries to her person as a whole while moving a table at work. On February 17, 2010, the Commission filed a decision and opinion on review finding the injuries sustained caused permanent disability to the extent of 40 percent of the person as a whole. Neither party appealed the Commission's decision.

On July 27, 2012, Respondent timely filed a petition for review under section 19(h), "mov[ing] this Honorable Commission to exercise jurisdiction *** on the grounds that Petitioner's disability has *increased*." (Emphasis added.) Respondent explains its unusual request to increase the permanency award by referencing case No. 09WC29095, which Petitioner filed against Respondent in connection with a work accident on October 8, 2008. In its brief, Respondent states the parties closed proofs in case No. 09WC29095 on December 16, 2014. Petitioner agrees the parties closed proofs in December of 2014 and are awaiting the Arbitrator's decision. Respondent further explains: "[T]he prior arbitration decision and the Commission award [in case No. 08WC00182] did not address the October 8, 2008 work accident or the

change in Petitioner's pain complaints arising from that 2008 work accident. Respondent could not consolidate the 2005 and 2008 accident dates because Petitioner did not file [a claim] on the 2008 accident date until after trial in the 2005 case."[1] The Commission's mainframe database shows that on February 25, 2015, the Arbitrator filed a decision in case No. 09WC29095 awarding temporary total disability benefits, medical expenses, vocational rehabilitation and maintenance benefits.

In case No. 08WC00182, the Commission found that after undergoing fusion surgery at L4-L5 and L5-S1 in December of 2006 and completing postoperative physical therapy, Petitioner returned to work in May of 2007. The Commission affirmed the Arbitrator's finding that Petitioner reached maximum medical improvement on June 21, 2007. Regarding permanency, the Commission noted that Petitioner testified her radicular leg pain stopped after the surgery. However, she felt limited as to what activities she could perform as a physical education teacher and gave up coaching duties. Likewise, she self-limited in her workouts and activities of daily living.

With respect to case No. 09WC29095, the parties agree that on October 8, 2008, Petitioner sustained accidental injuries when she fell backwards onto her buttocks while working as a physical education teacher for Respondent. The evidence submitted by the parties during a 19(h) hearing before Commissioner Donohoo on September 16, 2014, shows that on December 1, 2006, Dr. Kee Park performed a fusion surgery at L4-L5 and L5-S1. A CT scan performed April 11, 2007, was interpreted by Dr. Park as showing "excellent" solid fusion. On May 9, 2007, Petitioner followed up with Dr. Park reporting doing well with physical therapy. Dr. Park released Petitioner to return to work and opined she would reach maximum medical improvement upon completing physical therapy. Petitioner followed up with Dr. Park on November 1, 2007, complaining of recent onset of back pain. X-rays showed no evidence of hardware failure. Dr. Park recommended chiropractic treatment. Petitioner received minimal chiropractic treatment in late 2007 and early 2008.

Following the accident on October 8, 2008, Petitioner consulted Dr. Sonjay Fonn, a neurosurgeon, on January 22, 2009. Imaging studies showed minor epidural fibrotic changes at L5-S1 and degenerative disc disease and facet arthropathy at L3-L4, above the fusion. Dr. Fonn recommended physical therapy. Petitioner underwent physical therapy in February and March of 2009. Petitioner testified that ultimately Dr. Fonn recommended surgery, and she sought a second opinion from Dr. Matthew Gornet. On May 4, 2009, Dr. Gornet diagnosed failed fusion at L5-S1. In his clinical note, Dr. Gornet opined: "While this may be a preexisting condition, what is clear, at least by the patient's history, is that there is a chronological escalation of treatment at the time of her injury, including lost work time, imaging studies, and interventions by physicians. This is clearly defined as an aggravation of this preexisting asymptomatic condition, and now I believe she is symptomatic. *** I do believe her current symptoms are causally connected to her work related injury and fall most recently in October of 2008." Regarding the L3-L4 level, Dr. Gornet opined the disc looked fairly good.

On June 30, 2010, Dr. Robert Bernardi, a neurosurgeon, examined Petitioner at

[1] Case No. 09WC29095 was filed on July 14, 2009, whereas the arbitration hearing in case No. 08WC00182 took place on May 12, 2009.

Respondent's request. Dr. Bernardi diagnosed pseudoarthrosis/failed fusion at L5-S1, which he opined could be the source of the symptoms. Regarding causal connection, Dr. Bernardi stated: "It is my opinion, and apparently Dr. Gornet's opinion as well, that [the patient's] failed fusion was present prior to her 10/08/2008 slip and fall at work. That is to say, it is most likely that [the patient's] L5-S1 fusion never healed following her 12/19/2006 operation. The other possibility is that [the patient] did have a solid L5-S1 fusion and fractured through it at the time of her 10/08/2008 accident. This seems highly improbable. I do not think the type of injury described by [the patient] would have been sufficient to cause a solid interbody fusion to fracture. Furthermore, her CT scan has a rather typical appearance of a chronic pseudoarthrosis. At least to my eye, the findings do not look post-traumatic." (Emphasis in original.)

On July 7, 2010, Dr. Gornet performed a revision fusion surgery at L5-S1. On July 14, 2011, Dr. Gornet noted that a CT scan showed a solid fusion at L4-L5 and L5-S1. An MRI scan did not show any adjacent level failure. Petitioner complained of "some pulling and achiness down both sides of the back," which Dr. Gornet thought was "probably related to her original muscle dissection." Dr. Gornet declared Petitioner at maximum medical improvement and released her to return to work full duty. On July 12, 2012, Petitioner followed up with Dr. Gornet reporting worsening symptoms. Dr. Gornet stated Petitioner appeared to have a solid fusion from L4 to S1. However, X-rays showed instability developing at L3-L4. Dr. Gornet recommended CT and MRI studies. On September 17, 2012, Dr. Gornet noted the MRI showed adjacent level failure at L3-L4, which he opined was causally connected to the accidents in 2005 and 2008. He reiterated his recommendation for a CT scan.

Dr. Bernardi testified via evidence deposition on June 29, 2012. His causal connection opinion at the time was as follows: "[The patient's] 10/8 of 2008 fall did not cause her pseudoarthrosis. Pseudoarthrosis by definition means an almost fusion, a failed fusion. So in my opinion, her interbody fusion at L5-S1 had never healed following the initial operation by Dr. Park in 2006." Dr. Bernardi referenced Dr. Gornet's operative report stating that bone had grown into, but not completely across, the prosthetic cages. Dr. Bernardi therefore opined the abnormality Dr. Gornet identified "was almost certainly present prior to 10/8 of 2008." Dr. Bernardi also reviewed a CT scan from May 4, 2009, opining it showed a failed fusion or pseudoarthrosis, rather than a posttraumatic fracture. On cross-examination, Dr. Bernardi was asked whether the accident on October 8, 2008, aggravated preexisting pseudoarthrosis. Dr. Bernardi responded: "That's what the records would suggest and [the patient's] reporting of the worsening of her symptoms afterwards would suggest."

Dr. Gornet testified via evidence deposition on June 9, 2014. Dr. Gornet reiterated his opinion that the work accident on October 8, 2008, aggravated a preexisting delayed or failed fusion at L5-S1. Dr. Gornet confirmed that intraoperatively he visualized a failed fusion at L5-S1. At the time of the deposition, Dr. Gornet was concerned about structural problems at L3-L4, which he stated were connected to Petitioner's previous fusion surgery. Dr. Gornet was unable to opine whether the work accident on October 8, 2008, affected the condition at L3-L4. Dr. Gornet did not feel the condition at L3-L4 had reached the point to warrant extending the fusion upwards.

A functional capacity evaluation (FCE) performed July 22, 2014, showed Petitioner was

unable to work as a physical education teacher. On July 29, 2014, Dr. Bernardi reexamined Petitioner and agreed she required restrictions. Regarding causal connection, Dr. Bernardi stated:

> "I cannot determine whether [the patient's] 2008 accident may have contributed to her need for permanent restrictions or whether they are solely due to her accident in 2005. Quite frankly, the matter is too complicated to sort out with any degree of certainty. The fact that she returned to full duty after her December 19, 2006 surgery and continued working in this capacity until her slip and fall on 10/08/2008, might suggest that the latter event is principally responsible for why she is now physically limited. On the other hand, she was released without restriction by Dr. Gornet in January 2011 following her revision surgery in July 2010. She continued to work in that capacity for nearly a year before being taken off by Dr. Parks in December. Furthermore, it is not as if Dr. Gornet's surgery was addressing a new injury. Instead, he was repairing a failed fusion at L5-S1 that had never healed after her original operation by Dr. Park. This would argue that her need for restrictions traces back to the original accident. ¶ To complicate matters further, the precise etiology of [the patient's] ongoing symptoms is undefined. While they may be related to juxtafusional degenerative disease at L3-4, they may not. This cannot be known with any certainty. Even if it could be known that her symptoms are due to juxtafusional L3-4 disease, it cannot be known whether that disease was caused by her previous fusions. In short, I do not believe I can accurately sort out whether [the patient's] 2005 accident was solely, partly, or not responsible for her need for work restrictions. ¶ If it is assumed that [the patient's] 2008 accident aggravated a pre-existing and previously asymptomatic pseudoarthrosis; if it is assumed that her ongoing pain is related to juxtafusional L3-4 disc disease; and if it is assumed that her fusions are a causative factor in producing that juxtafusional disease, then [the patient's] ongoing complaints would most logically relate back to her accident in 2005."

Further, "[a]ssuming [the patient's] L3-4 degenerative disease was caused by her L4 to sacral fusion, it is my opinion that these findings are attributable solely to her 2005 accident. That process would have been initiated with her lower two motion segments were immobilized with interbody prosthetic cages and pedicle screws by Dr. Park in 2006." Dr. Bernardi also thought it was entirely possible the degenerative changes at L3-L4 had nothing to do with the fusions and "represent[ed] [the patient's] genetic predilection manifesting itself." Dr. Bernardi doubted the L3-L4 level was responsible for Petitioner's pain. Lastly, Dr. Bernardi opined Petitioner had reached maximum medical improvement. Petitioner testified she recently met with Respondent's superintendent, but Respondent did not offer her an accommodated position.

Petitioner further testified that she returned to work for Respondent during the 2010-2011 school year and had considerable difficulty performing her job duties. Her low back pain did not resolve after the revision fusion surgery. On December 16, 2011, Petitioner's primary care physician, Dr. Jeffrey Parks, took her off work because of the pain. Petitioner has not worked since. She feels she is unable to return to work, describing in detail how her condition is significantly worse than it was during the 2007-2008 school year.

The parties dispute whether the work accident on October 8, 2008, aggravated Petitioner's low back condition and accelerated the need for the revision fusion surgery, or whether the work accident on December 14, 2005, was solely responsible for the revision fusion surgery. In its 19(h) petition, Respondent asserts that it expects "Petitioner will seek to obtain a permanency award in case No. 09WC29095, without Respondent receiving any credit for the prior 40% MAW award." Respondent filed its 19(h) petition to "preserve[] Section 19(h) jurisdiction of the Commission in the event the Commission agrees that the pseudoarthrosis at L5-S1 is not attributable to the October 8, 2008 work accident in Case No. 09WC29095, but attributable to the December 14, 2005 work accident in Case No. 08WC00182." Respondent asks the Commission to "determine causal relationship of the L5-S1 pseudoarthrosis discussed herein; and render in its discretion an increased award of permanency and such other benefits resulting from the pseudoarthrosis; and to provide Respondent proper credit for the prior award of 40% MAW." In its brief, Respondent asserts "[t]he Commission can take judicial notice of [the] proceedings [in case No. 09WC29095]." Respondent requests "that the Commission consider consolidation of the two cases before the same panel once the Commission obtains jurisdiction over both claims."

Substantively, Respondent discusses the appellate court decisions in Vogel v. Industrial Comm'n, 354 Ill. App. 3d 780 (2005) and Teska v. Industrial Comm'n, 266 Ill. App. 3d 740 (1994), and contends "the original 2005 work accident is a causative factor of the failed fusion at L5-S1," and "the October 8, 2008 accident cannot be labeled as a superseding event that cuts off medical causation given that incomplete bone growth at L5-S1 pre-existed October 8, 2008." Respondent admits Vogel and Teska are distinguishable because the claimants in those cases had not reached maximum medical improvement when the subsequent accidents occurred. Nevertheless, Respondent argues that Vogel and Teska are applicable because "Petitioner herein never completely fused at L5-S1." Respondent continues: "While the October 8, 2008 [accident] may have amounted to an aggravation of a pre-existing condition, Petitioner had a pre-existing condition nonetheless. The issue this 19(h) proceeding raises is whether [the] fall accident amounts to an intervening accident cutting off medical causation as of October 8, 2008." Respondent submits that "medical causation exists when an original work injury causes a weakened state which, when coupled with a later injury, produces a more serious condition."

Petitioner opposes the 19(h) petition. Petitioner counters that "Respondent has introduced no evidence supporting its position that the October 2008 fall which resulted in additional back surgery was not an 'accident' for which Petitioner can seek benefits under the Act." Petitioner points to numerous cases reiterating a well established rule that a work-related aggravation of a preexisting condition is considered to be a separate work accident. With regard to consecutive work injuries, Petitioner argues that Respondent's position is contrary to Consolidated Freightways v. Industrial Comm'n, 237 Ill. App. 3d 549 (1992) (affirming an award for a successive work injury to the back) and Freeman United Coal Mining Co. v. Industrial Comm'n, 99 Ill. 2d 487, 498 (1984) ("Although the second injury was to the same part of the body as the first, the test is not whether [the claimant] sustained a new or independent type of injury, as [the employer] suggests, but whether he suffered a second accident which caused further disability of a type which the law would recognize as compensable").

The applicable (pre-amendatory) section 19(h) of the Act provides, in pertinent part:

> "[A]s to accidents occurring subsequent to July 1, 1955, which are covered by any *** award under this Act providing for compensation in installments made as a result of such accident, such *** award may at any time within 30 months after such *** award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.
>
> On such review, compensation payments may be re-established, increased, diminished or ended." 820 ILCS 305/19(h).

"The purpose of a section 19(h) proceeding is to determine whether a claimant's disability has changed since the time of the original decision by the Commission." City of Alton v. Industrial Comm'n. 231 Ill. App. 3d 334, 338 (1992).

It appears Respondent recognizes there are procedural and substantive obstacles to the relief it seeks. The Commission does not believe it is appropriate to consider the substance of Respondent's 19(h) petition at this juncture. The two claims are clearly intertwined. The Commission's mainframe database shows the Arbitrator has recently filed a decision in case No. 09WC29095. Given how contentious the matter is, a petition or cross-petitions for review is/are sure to follow. As part of its review in case No. 09WC29095, the Commission will consider the issue of causation of the need for revision fusion surgery at L5-S1—the very same issue that is subject of the section 19(h) petition in case No. 08WC00182. It would be inappropriate to circumvent the normal review process in case No. 09WC29095 under the guise of a section 19(h) petition filed in case No. 08WC00182.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's 19(h) petition is entered and continued pending final disposition in case No. 09WC29095.

This order is interlocutory and not immediately appealable.

DATED: MAR 2 4 2015
SM/sk
d-03/05/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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 reduce med exp award	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Jefchak,

Petitioner,

15IWCC0210

vs.

NO: 12 WC 43741

Mondelez International,

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, §8(j) medical credit, and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 60 year old employee of Respondent, who described his job as a merchandiser. Petitioner had been a truck driver for most of his career; he retired around 2006. Petitioner began working for Respondent in about 2007 on a part time basis; 32 hours per week, 8 hours per day, four days per week (Wednesday through Saturday). Respondent was previously known as Kraft or Nabisco. Petitioner explained that after a load had been delivered and received at a store, a merchandiser would go in and break the load down, put it onto a cart, take it to the grocery aisle and put the product up on the shelves. Petitioner stated that if there were displays, he had to build displays, cardboard hutches or easels that were in a box. Petitioner testified you had to open them up and construct them and put the product on them. Petitioner stated that some displays were end caps with metal shelves which he had to adjust based on the product height (cookies or

crackers). Petitioner testified that it was a put up, take down, and then clean up after yourself (your plastic and cardboard had to be broken down). Petitioner stated that he had to take the clean up back to the baler and whatever product that did not go up basically had to be restacked in the back stock area designated by the grocery store. Petitioner indicated that the store may have an area that was Nabisco and he put the products there. The product was delivered to the store by someone other than Petitioner so it was already there shrink wrapped on big pallets in the back. Petitioner stated that he used a box cutter to remove the shrink wrap. Petitioner testified that he had to break down the load from the pallet and put it onto the carts and then wheel it to the grocery store aisle area. It was his responsibility to make sure the product got onto the shelves or displays (he had to build the displays). Petitioner stated that some displays are made of metal shelves-end caps, that are changed weekly and some are done on hutches which are cardboard shelves, like a mini shelving unit that comes in a box and has flip flaps to make the displays. Petitioner testified that there was a quota as to pace; he stated Respondent wanted them to throw between 35 and 40 cases an hour. Petitioner stated that the cases are either crackers with 6-12 boxes in plastic, or cookies in cardboard boxes that are glued and/or taped. Petitioner testified that the boxes of cookies could be a cube, 12X12 up to 2 feet and most had about 12 packages per case. Petitioner stated there were procedures (ROTC) adopted about a year or so after he started for Respondent. Petitioner testified that the protocol was how to stack the cartons in the aisle to work on them, how to open the boxes (whether they were cardboard or plastic), and whether to use a cutter, which Respondent preferred you not to do. Petitioner stated that he had been instructed not to use the cutter on the cardboard boxes which were taped. Petitioner stated that he was instructed to press down to break the tape and then with his other hand rip the tape off the box to open it up. He again indicated the longest box was about 2 feet long. To press down he used his hand with his thumb; the cardboard had a little give and by doing that you give a little room to get your other hand in there to rip the tape off the box because Respondent did not want you to cut it. Petitioner is right hand dominant. He would press down with his left hand/thumb and he would have to do that 30 times per hour, 8 hours per day, 4 days per week. Petitioner testified that prior to working for Respondent he had no problems with his left hand/thumb and he had not seen any doctors for his left thumb.

- Petitioner testified that over time working at Respondent his left thumb started to hurt and he usually would go home and ice it. Petitioner testified that after several weeks of icing it he went to his family doctor who then referred him to a specialist. Petitioner agreed that he first saw the specialist, Dr. Jose Perez-Sanz at Midwest Orthopedic Consultants, on December 5, 2011. Petitioner stated that he had initially been prescribed a brace to wear. Petitioner stated that he returned to the doctor about three weeks later, on December 29, 2011. Petitioner testified that at that point the doctor injected his left thumb. Petitioner agreed that the injection helped for a couple of months before it began hurting again and then it was like back to the severity as prior to the shot. Petitioner, at that time, had still been doing his same job for Respondent; opening the cartons as previously noted. Petitioner testified that when the symptoms recurred he again sought medical treatment at the same orthopedic office as before. Petitioner returned for treatment on October 24, 2012 (date of manifestation). Petitioner testified that at that time the doctor recommended

that he have surgery to his left thumb. Petitioner underwent surgery on December 31, 2012, performed by Dr. Weisburger, Dr. Perez-Sanz's partner. Petitioner had post operative therapy and returned to work on April 10, 2013. Petitioner lost time from work basically from the time of surgery until April 10, 2013. Petitioner last saw Dr. Weisburger July 1, 2013 when he was found at MMI and discharged from care.

- Petitioner testified that the only doctor he saw after that time was Dr. Vender on July 25, 2013 at Respondent's request (IME). Petitioner agreed he had incurred medical bills that were disputed by Respondent's workers' compensation people. Petitioner had access then to his wife's group health insurance. As a part time employee, Petitioner did not have his own group health insurance. Petitioner submitted the medical bills through his wife's group carrier. Petitioner's wife at that time was employed by Respondent and that group health carrier via his wife, paid the bills.

- Petitioner testified that currently with his left thumb area there is a marked reduction in his strength in his hand in terms of opening a bottle or pulling anything. Petitioner stated that he had very diminished hand strength. Petitioner stated that the surgery he had was to his left forearm and thumb. Petitioner indicated the scar area from the incision where they took tendon. Petitioner indicated that the forearm surgery was about halfway between his palm and the crook of his elbow on the palm side of his forearm. Petitioner testified he also had a loss of feeling in the area of the incision on his left hand at the base of the thumb; about the size of a quarter; about an inch. Petitioner testified the area tingled and hurt, if he bumped it, but he did not have sensation in that area. Petitioner stated that he is still employed by Respondent as a merchandiser. Petitioner does still perform his whole job but stated that he used a cutter almost all of the time; he does not rip open the boxes like he used to. Petitioner stated that he just uses the cutter; he was not told about it being a violation, he just found that it was the only way that he could do it. The cutter replaced him pushing down with his thumb and ripping off the tape. Petitioner testified that he is still part time. Petitioner has had no other accidents or injuries involving his left thumb since he had developed the problem.

- Petitioner submitted into evidence various treating records and medical bills.

The Commission finds, regarding the issues of accident and causal connection, that there is no question that Petitioner had a pre-existing degenerative arthritic condition, however, Petitioner's unrebutted testimony of a mechanism of repetitive injury is supported in the records. Furthermore Dr. Weisburger opined a causal relationship to an aggravation of his arthritic condition. Respondent's examiner, Dr. Vender, opined Petitioner had a degenerative condition that was longstanding; he indicated activities can induce symptoms but opined no causal relationship. Petitioner clearly testified of the type of force he had to use to open the boxes as Respondent did not want merchandisers to use box cutters (that would be understandable as Respondent would not want the cookie/cracker packages to be cut). The evidence and unrebutted testimony finds that Petitioner met the burden of proving a repetitive work injury that arose out of and in the course of his employment and further met the burden of proving a causal relationship to his current condition of ill-being (at least an aggravation of his pre-existing condition) and to the treatment. The Commission finds the decision of the Arbitrator as not

contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding of accident (Repetitive trauma), and further, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission further finds, regarding the issue of temporary total disability (TTD), evidence of Petitioner's treatment and time off work to support that Petitioner met the burden of proving entitlement to the TTD award as is. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding as to total temporary disability.

The Commission, regarding the issues of medical expenses and Respondent's credit under §8(j) of the Act, further finds evidence of Petitioner's treatment and time off work to support that Petitioner met the burden of proving entitlement to the medical expense benefits but herein modifies to deny medical expenses not supported with medical records or that are duplicative. The Commission notes that the Neurologic Associates bill for March 27, 2013 for $220.00 ($167.03 per fee schedule) to be not supported with records and therefore denied; further, there are three Midwest Anesthesiologists bills for December 31, 2012, the latter two being for $1,050.00 each ($1,094.24 per fee schedule each) as duplicative for the procedure; therefore those bills are denied. The Commission reduces the medical expense award per the fee schedule by those amounts for a total medical expense award, per the fee schedule, totaling $26,756.06. The Commission finds the decision of the Arbitrator as not totally contrary to the weight of the evidence, and herein, modifies to deny those expenses unsupported in the record or apparent duplicative medical bills, and otherwise affirms and adopts the Arbitrator's finding as to the other medical expenses, pursuant to the fee schedule.

Further, as to Respondent's claimed credit, Petitioner did not have the group health insurance via Respondent for Respondent to be entitled to said credit under §8(j) of the Act. Petitioner was covered via his wife's group health insurance, albeit through Respondent, but as 'dependent' coverage; Respondent would not be entitled to the credit if Petitioner's wife was covered by a different employer, so Respondent failed to prove entitlement to the credit here. It is not relevant that by happenstance, Petitioner's spouse worked for the same company and had their group health insurance as it was not Petitioner who was 'covered' as an employee. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding to deny Respondent credit under §8(j) for those bills paid via Petitioner's wife's insurance.

The Commission, regarding the issue of permanent partial disability (PPD), nature and extent, further finds the evidence of Petitioner's treatment and time off work to support that Petitioner met the burden of proving entitlement to the PPD award. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein affirms and adopts the Arbitrator's finding as to Permanent partial disability.

15IWCC0210

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 14-2/7 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 $253.00 per week for a period of 20.5 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the loss of 10% of Petitioner's left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $26,756.06 for medical expenses under §8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. (No credit for bills paid via Petitioner's wife's group insurance.)

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 5 2015
o-1/22/15
DLG/jsf
45

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFCHAK, JAMES
Employee/Petitioner

Case# 12WC043741
15IWCC0210

MONDELEZ INTERNATIONAL
Employer/Respondent

On 8/1/2014, 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 0.05% 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

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
DANIEL EGAN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0210

James Jefchak
Employee/Petitioner

v.

Mondelez International
Employer/Respondent

Case # **12** WC **43741**

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 **New Lenox**, on **July 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. ☒ 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 15IWCC0210

On **October 24, 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 **60** 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 **$518.65** for other benefits, for a total credit of **$518.65**.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 14 2/7 weeks, commencing December 31, 2012 through April 9, 2013, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay to the petitioner reasonable and necessary medical services of $29,111.57, subject to the fee schedule as provided in Section 8(a) of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 20.5 weeks, because the injuries sustained caused the 10% loss of the left hand, as provided in Section 8(e) of the Act.

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

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

7/31/14
Date

AUG -1 2014

FINDINGS OF FACT

The petitioner has been employed by the respondent as a merchandiser since 2007. This job requires him to travel to various grocery stores to process and stock cookies and crackers. He is also required to build displays for these products. The petitioner is a part-time employee who works 32 hours per week divided into four 8-hour shifts.

The petitioner's job required him to open cardboard cartons containing boxes of cookies. He was instructed to do this without using a box cutter, so he would press down on one side of the carton with his left thumb to break the seal of the masking tape, grasp the tape with his dominant right hand and rip it off the carton. He was required to process at least 35 cases per hour in this fashion. The petitioner testified that his 8-hour shift did not included his commute time to and from work, but it did include any travel between stores during the work day.

The petitioner testified that he gradually began to experience the onset of pain in his left thumb. In late 2011, he saw his primary care physician who initially prescribed anti-inflammatory medication and who subsequently referred him to Dr. Jose Perez-Sanz, an orthopedic surgeon.

The petitioner saw Dr. Perez-Sanz on December 5, 2011 complaining of pain at the base of his left thumb of a few months' duration. Dr. Perez-Sanz diagnosed basal joint arthritis and prescribed a brace and warm soaks. (PX 1) When the petitioner returned on December 29, 2011, Dr. Perez-Sanz administered a steroid injection to the left thumb. The petitioner testified that this relieved his symptoms for a couple of months, but that the pain recurred.

On October 24, 2012, the petitioner returned to Dr. Perez-Sanz with renewed pain in his left thumb. Dr. Perez-Sanz recommended surgery. On December 28, 2012, the petitioner underwent an EMG of both hands which revealed mild demyelinating polyneuropathy. On December 31, 2012, the petitioner underwent surgery by Dr. Michael Weisburger--Dr. Perez-Sanz's partner--consisting of a left thumb ligament reconstruction, tendon interposition, trigger thumb release and carpal tunnel release. (PX 1) Post-operative physical therapy was administered. Dr. Weisburger released the petitioner to return to work effective April 10, 2013. (PX 1) On July 11, 2013, Dr. Weisburger discharged the petitioner at MMI.

On May 23, 2013, Dr. Weisburger prepared a narrative report in which he indicated that repetitive heavy activities "could definitely aggravate any pre-existing arthritis." Specifically with regard to the petitioner's job setting up store displays and "heavy pinch and load" activities, Dr. Weisburger felt that these activities could have aggravated or exacerbated the petitioner's arthritis and his trigger thumb. Finally, Dr. Weisburger was uncertain of any causal link between the petitioner's work activities and his carpal tunnel syndrome. (PX 2)

On July 24, 2013, the petitioner was examined at the request of the respondent pursuant to Section 12 of the Act by Dr. Michael Vender. (RX 1) Dr. Vender felt that the petitioner had long-standing and pre-existing degenerative arthritis at the base of his left thumb which was not caused by his work activity. He felt that trigger thumbs commonly accompany cases of degenerative arthritis and that the petitioner did not have carpal tunnel syndrome. He felt that the petitioner had a 9% impairment of his left upper extremity based on the 6th edition of the AMA Guides to the Evaluation of Permanent Impairment.

The petitioner's medical expenses were submitted to and paid by his wife's group health insurance carrier. The petitioner's wife is also employed by the respondent. As a part-time worker, the petitioner did not have group health insurance coverage of his own.

15IWCC0210

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the supporting medical evidence. The petitioner described the activities associated with his job as a merchandiser, particularly the requirement that he manually open cases of cookies without the use of a box cutter by pressing down with his left thumb. These activities were subject to a quota of 35 cases per hour and, as such, can be characterized as "repetitive." The petitioner's part-time status did little to ameliorate the stress to which his left thumb was subjected because he worked four consecutive 8-hour shifts. These shifts did not include his commute time. The Arbitrator also notes that the petitioner might have had a manifestation date for his work-related condition of December 5, 2011 when he first consulted Dr. Perez-Sanz. This in no way reduces the legitimacy of the later manifestation date of October 24, 2012 when the petitioner returned to Dr. Perez-Sanz after a period of being asymptomatic following the steroid injection to his left thumb. Durand v. Industrial Commission, 224 Ill.2d 53, 308 Ill.Dec. 715 (2006). Accordingly, the Arbitrator concludes that the Petitioner sustained an injury to his left hand as the result of repetitive trauma, with a manifestation date of October 24, 2012.

2. On the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being, as it relates to his left hand are causally related to his employment activities. In support of this finding, the Arbitrator finds persuasive the opinions of Petitioner's treating physicians. The petitioner developed CMC arthritis at the base of his left thumb and triggering of his left thumb which required surgical intervention. Dr. Weisburger, the treating surgeon, is of the opinion that these conditions were at the very least aggravated by the repetitive manual activities associated with the petitioner's job. Dr. Vender, the respondent's Section 12 examiner, feels that no such relationship exists. It bears noting that Dr. Weisburger also diagnosed the petitioner with left carpal tunnel syndrome which he--Dr. Weisburger--was unable to link to the petitioner's work activities. Dr. Vender felt that the petitioner never had carpal tunnel syndrome.

3. Respondent shall pay the Petitioner TTD. The parties have stipulated that the petitioner was temporarily totally disabled from working for the 14 2/7 week period from December 31, 2012 through April 9, 2013. The respondent disputed its obligation to pay TTD benefits based on its dispute concerning the compensability of the petitioner's underlying condition. Having determined that the petitioner sustained a compensable accident due to the repetitive trauma affecting his left hand, the Arbitrator further concludes that the petitioner is entitled to have and receive from the respondent the sum of $253.00 per week for 14 2/7 weeks for temporary total disability.

4. Based on the Arbitrator's findings above, the Arbitrator finds that the Petitioner's medical treatment as set forth in the evidence was both reasonable and necessary to address his work related injuries. The petitioner introduced a packet of materials consisting of the itemized medical bills stemming from the treatment of his left hand and thumb, appended to which is a spreadsheet reflecting the original amounts billed ($46,133.00) and the amounts due and owing pursuant to the Medical Fee Schedule ($29,111.57). (PX 3) As with TTD benefits, the respondent's objection to the petitioner's medical bills is based on its dispute regarding liability for a work-related accident. Having determined that the petitioner's left hand and thumb condition resulted from a compensable accident, the Arbitrator further concludes that the petitioner is entitled to have and receive from the respondent the sum of $29,111.57 pursuant to Sections 8(a) and 8.2 of the Act, that being the amount due and owing for treatment under the Medical Fee Schedule. Since these medical expenses were paid through the group insurance carrier of Petitioner's wife and the Petitioner did not have any health insurance of his own, the Respondent is not entitled to credit for the expenses paid.

5. 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 the following: (i) the petitioner has an impairment rating of 9% of his left upper extremity according to Dr. Michael Vender (RX 1); (ii) petitioner's occupation was that of a merchandiser for the respondent at the time of his injury, which has not changed as a result of his accident; (iii) petitioner was 60 years of age at the time of his injury; (iv) there is no evidence to suggest that his future earning capacity will be affected on account of the injuries sustained; and (v) the medical evidence corroborates petitioner's disability, which includes ligament reconstruction, tendon interposition and trigger finger release surgery resulting in reduced grip in his left hand and complaints of numbness at the base of his left thumb. Based on the foregoing, the Arbitrator concludes that the petitioner has sustained 10% permanent disability to his left hand on account of his accidental injuries.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DIVISION
Petitioner,

vs.

NO. 11 INC 506

J&W DELIVERY SYSTEMS and
JOSEPH F. ORTO, individually and as
President and Secretary of
J&W SYSTEMS, INC.,
Respondent,

15IWCC0211

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act ("the Act") and Section 7100.100 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission ("the Rules"), codified as 50 Illinois Administrative Code, Chapter 11. Proper and timely notice was given to all parties.

An Insurance Non-Compliance Hearing was held before Commissioner Michael J. Brennan on December 12, 2014 in Chicago, Illinois. The Commission, after considering the record in its entirety and the applicable law, finds Respondent, J&W DELIVERY SYSTEMS (J&W) and JOSEPH F. ORTO, individually and as President and Secretary of J&W SYSTEMS, INC. willfully and knowingly violated Section 4(a) of the Act and Section 7100.100 of the Rules during the period of December 30, 2000 to March 1, 2009. As a result, the Respondent shall be held liable for its non-compliance with the Act and shall pay a penalty pursuant to the agreed stipulation and in accordance with Sections 4(d) of the Act and 7100.100(b)(1) of the Rules. The parties stipulated to a penalty of $1,464,000.00. The Commission having considered the record in its entirety assesses the penalty of $1,464,000.00 against the Respondent for the reasons set forth below.

15IWCC0211

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Joseph F. Orto filed Articles of Incorporation for J&W Delivery Systems, Inc. with the Illinois Secretary of State on December 29, 2000. Joseph F. Orto was listed as the registered agent for J&W Delivery Systems, Inc. PX.5.

2. On February 21, 2013, an Arbitration Decision (07 WC 50823) was entered in favor of Erika Moran, widow and next-of-kin to Michael Moran. The Arbitrator found Respondent, J&W was a delivery service that required "carriage by land, loading and unloading of luggage, the operation of a warehouse, and gasoline driven motor vehicles," and was therefore operating under and subject to the Act. The Arbitrator found that an employee/employer relationship existed between Michael Moran and J&W. Mr. Moran sustained a fatal injury on August 15, 2007, which arose out of and in the course of his employment. PX.1.

3. Respondent appealed the Arbitrator's Decision to the Commission. The Commission affirmed and adopted the Decision of the Arbitrator on April 1, 2014 (14 IWCC 248). PX.2. No appeal was taken and the Decision became final.

4. On November 14, 2011, a Notice of Non-Compliance was mailed to Joseph Orto, Individually and as President and Secretary of J&W Delivery Systems, Inc. The Notice alleged non-compliance of Section 4(a) of the Act from December 29, 2000 through November 14, 2011. The Notice required Mr. Orto to submit evidence of compliance with the provisions of Section 4(a) of the Act or otherwise respond in writing to the Commission within thirty days of the date of receipt of the Notice. An initial Insurance Compliance Hearing was scheduled for November 27, 2012. PX.9. The hearing was continued to December 12, 2014. PX.10.

5. A notarized affidavit dated December 13, 2012 from the National Council on Compensation Insurance, Inc. (NCCI Holdings, Inc.) was admitted into evidence. The affidavit was signed by Ms. Rhonda Garcia, Proof of Coverage Analyst for NCCI Holdings, Inc. The Illinois Workers' Compensation Commission has designated NCCI Holdings, Inc. as its agent for the purpose of collecting proof of coverage information on Illinois employers who have purchased workers' compensation insurance from carriers. The affidavit states that neither Joseph Orto nor J&W had workers' compensation insurance from December 30, 2000 to December 13, 2012. PX.3.

6. The Workers' Compensation Commission, Office of Self-Insurance Administration, submitted a certification from Maria Sarli-Dehlin. According to the certification, the Self-Insurance office had no record or certificate of approval to self-insure Joseph Orto or J&W Delivery Systems, Inc. PX.4.

7. According to the Illinois Department of Revenue Quarterly Withholding Tax Returns, Respondent had compensation of $42,521.20 for the quarter ending December 31, 2006; compensation of $58,772.55 for the quarter ending March 31, 2007; compensation of $98,195.90 for the quarter ending June 30, 2007; compensation of $77,201.40 for the quarter ending September 30, 2007; and, compensation of $68,506.38 for the quarter ending December 31, 2007. PX.7.

8. During the Insurance Non-Compliance Hearing of December 12, 2014, the Office of the Illinois Attorney General and Respondent's attorney, Mr. Frank M. Valenti stated on the record that the parties stipulated to a penalty of $1,464,000.00 to be entered against Mr. Joseph F. Orto, individually and as President and Secretary of J&W Delivery Systems, Inc. T.19.

9. Mr. Orto appeared at hearing with his attorney. Mr. Orto testified that he understood that the judgment was entered against him individually and against J&W. In exchange for the penalty, the Illinois Attorney General's Office would not proceed criminally against Mr. Orto. T.22. Mr. Orto consented to be bound by the agreement. T.23. Mr. Orto affirmed that he was not under any duress or medical condition that prevented him from understanding the proceedings against him. *Id.*

Pursuant to Section 3 of the Act, the provisions of this Act shall apply automatically to all employers engaged in any department of the following enterprises…: 3) Carriage by land…and loading or unloading in connection therewith; 4) The operation of a warehouse…; and, 15) Any business in which…gasoline power driven equipment is used in the operation thereof.

The Commission finds that Mr. Orto was President and Secretary of J&W. J&W was in the business of delivering lost luggage from the airlines to its owners. J&W stored the lost luggage in a warehouse and utilized employees who drove their own motor vehicles to deliver the luggage. The Commission finds that J&W was operating under and subject to the provisions of Section 3 of the Act. The Commission also takes judicial notice of the Commission's decision dated April 1, 2014 that found J&W to be operating under and subject to the Act. *See PX.2.*

The Workers' Compensation Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure of an employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or

> refusal after the effective date of this amendatory Act of 1989. Each day of such failure or refusal shall constitute a separate offense. The minimum penalty under this Section shall be the sum of $10,000. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 7100.100 of the Rules codifies the language of the Act, and additionally describes the notice on noncompliance required, as well as the procedures of the Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, has been provided to the Mr. Joseph Orto. Section 7100.100(d)(3)(D) of the Rules indicates that "A certification from an employee of National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 7100.30 shall be deemed prima facie evidence of that fact." Petitioner's exhibit 3 contains the certification from NCCI Holdings, Inc. and establishes that Mr. Orto had no workers' compensation insurance from December 30, 2000 to December 13, 2012. Mr. Orto offered no evidence establishing he had insurance as required under the Act.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the evidence establishes that Mr. Orto was aware of, and willfully ignored his statutory obligation to maintain worker's compensation insurance for a significant period of time. The quarterly withholding returns establish that J&W had compensation available to use for the purchase of workers' compensation insurance. No evidence was offered demonstrating that Mr. Orto did not have the ability to secure and pay for workers' compensation insurance. Mr. Orto offered no mitigating circumstances in this case.

15IWCC0211

The parties stipulated to a penalty of $1,464,000.00 in exchange for the Illinois Attorney General agreeing to not pursue criminal charges against Mr. Orto. The Commission finds that Mr. Orto knowingly and willfully failed to comply with the Act. Based on the significant period of time Mr. Orto failed to comply with the Act and the serious nature of the injury, the Commission assesses a penalty of $1,464,000.00 against Joseph Orto, individually and as President and Secretary of J&W Delivery Systems, Inc.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, J&W DELIVERY SYSTEMS and JOSEPH F. ORTO, individually and as President and Secretary of J&W SYSTEMS, INC. is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 7100.100 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $1,464,000.00 pursuant to Section 4(d) of the Act and Section 7100.100 of the Commission Rules.

Pursuant to Commission Rule 7100.100(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the State of Illinois; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Illinois Workers' Compensation Commission
Fiscal Office
100 West Randolph Street Suite 8-328
Chicago, Illinois 60601
1-312/814-6625

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: MAR 25 2015

MJB/tdm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

CRYSTAL PANZER,

Petitioner,

15IWCC0212

vs.

NO: 12 WC 34564

TRICARE REHAB,

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 jurisdiction, statute of limitations, employment relationship, accident, occupational disease, notice, causal connection, medical expenses, temporary total disability, permanent disability, wages, benefit rates and penalties and fees, and being advised of the facts and law, affirms and adopts, with changes, the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of fact and conclusions of law

The Commission finds:

1. Petitioner had been an Occupational Therapy Assistant for Respondent since 2006. Her duties required her to be able to push and pull 250 pounds and lift 150 pounds.

2. Petitioner earned $31.20 per hour, working 40 hours per week.

3. In the year before May 8, 2012 she earned $64,896.00.

4. On May 8, 2012, Petitioner was helping a patient along with the assistance of a co-worker. Petitioner was on her knees and had her arm around the patient attempting to help him up from a lying position to a sitting position. At that time the patient got angry with Petitioner and threw his entire weight back into her left shoulder, arm and neck. Petitioner felt immediate pain. She reported the incident to her supervisor.

5. Petitioner completed an Accident Report.

6. The following day, Petitioner was unable to complete her shift due to pain, swelling and reduced range of motion. She presented to the Emergency Room, where she was given an anti-inflammatory prescription and an arm sling.

7. Petitioner was referred to Dr. Welch, an orthopedic surgeon on May 14, 2012. Anti-inflammatories and therapy were recommended. On June 29, 2012 Dr. Mather, a neck and spine specialist recommended the same. Therapy helped Petitioner minimally.

8. A July 2012 MRI revealed subacromial impingement syndrome.

9. Petitioner was then referred to Dr. Gokhale, another orthopedic surgeon, on July 30, 2012. Dr. Gokhale performed a steroid injection. Petitioner underwent several additional injections through August 2012. Dr. Gokhale noted that Petitioner had decreased range of motion and positive impingement signs. He diagnosed rotator cuff syndrome and tendinosis. An MRI revealed fraying of the rotator cuff.

10. In October 2012 Respondent denied a myelogram that was recommended for Petitioner. Subsequently, Petitioner's own insurance paid for it. Surgery which was recommended by Dr. Gokhale was also denied.

11. Petitioner returned to work November 27, 2012, but was transferred to another location where she received assistance performing any work which was above her restrictions. She worked there until December 11, 2012. Respondent terminated such assistance for Petitioner on that date after receiving a work status from Drs. Gokhale and Mather.

12. Petitioner underwent shoulder surgery in January 2013. She was placed on physical restrictions of no lifting over 20 pounds, no overhead lifting and no pushing and pulling. Respondent never offered her work within these restrictions.

13. Petitioner's symptoms somewhat improved after surgery, but she still had trapezial and bicep pain.

14. Petitioner has worked for Presence Home Care since December 14, 2013. Initially she drove to patients' homes and observed employees caring for patients in their home. The day before trial she was allowed to go out and perform these tasks by herself at patients' homes. These tasks include bathing, cooking, laundry and transferring patients in and out of the bathroom.

15. Currently Petitioner takes pain meds for her neck before going to bed. She can lift her left arm above her shoulder, but cannot keep it there very long.

16. A Dr. Zillmer did note in December 2009 that Petitioner had left shoulder pain, but it was opined that this pain was likely brought on by biceps tendinitis and perhaps some subacromial impingement and inflammation. Subsequently, Petitioner was basically treating for her arm. Her complaints were of the lateral epicondylar region of the left elbow. She made no complaints of being unable to lift her shoulder above her head at that time. Such complaints did not begin until after the accident in question. Additionally, an April 2010 note from a Dr. Popper indicated that Petitioner was referred to him for evaluation of her elbow, forearm and wrist.

17. Dr. Gokhale was aware of this 2009 treatment, but said treatment did not alter his current opinion. He noted that all pre-accident symptoms subsided with conservative treatment. At most these previous issues simply made Petitioner more vulnerable to future impingement. Dr. Gokhale opined that the accident in question was a new accident and not a continuation of any previous injury. Petitioner was not a surgical candidate until after the accident in question. Further, prior to said accident, Petitioner had not sought any medical treatment related to her left arm for over 2 years.

18. A surveillance video offered by Respondent did not show Petitioner performing any acts that were outside of her physical restrictions.

The Commission specifically adopts the findings of fact and conclusions at law of the Decision of the Arbitrator, which is attached hereto and made a part hereof. However, the Commission corrects a clerical error made in regards to the benefits period for awarded temporary total disability and temporary partial disability benefits.

The Arbitrator awarded TTD benefits for the following dates:

May 9, 2011 through November 26, 2012; and
December 12, 2012 through December 13, 2012.

The Arbitrator awarded TPD benefits for the following dates:

December 14, 2012 through January 21, 2014.

However, the stipulated TTD dates on the *Request for Hearing* form are:

May 9, 2012 through November 26, 2012; and
December 12, 2012 through December 13, 2013

Likewise, the stipulated dates for TPD benefits are:

December 14, 2013 through January 21, 2014.

Based on the stipulations, the Commission corrects the Arbitrator's clerical error by awarding these benefits per the stipulated dates.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2014 is hereby affirmed and adopted, with provisions to insert the above-mentioned clerical changes.

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 $61,800.00. 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: MAR 25 2015
O: 1/22/15
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

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

PANZER, CRYSTAL
Employee/Petitioner

Case# **12WC034564**

15IWCC0212

TRICARE REHAB
Employer/Respondent

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:

0391 THE HEALY LAW FIRM
DAVID P HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
JOHN P CAMPBELL
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
19(b)

15IWCC0212

Crystal Panzer
Employee/Petitioner

v.

Tricare Rehab
Employer/Respondent

Case # **12** WC **34564**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **January 21, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0212

On the date of accident, **May 8, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,896.00**; the average weekly wage was **$1,204.88**.

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

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

Respondent, shall be given a credit of $ for TTD, **$0** for TPD, **$0** for maintenance, **$5,000.00** for an advance, and **$0** for other benefits, for a total credit of **$5,000.00**.

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 **$803.26**/week for **28 5/7^{ths}** weeks, commencing **May 9, 2011** through **November 26, 2012** and commencing **December 12, 2012** through **December 13, 2012** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **May 9, 2011** through **January 21, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner temporary partial disability benefits of **$138.67**/week for **5 3/7^{ths}** weeks, commencing **December 14, 2012** through **January 21, 2014**, as provided in Section 8(a) of the Act.

Respondent shall pay **$37,874.78** 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 due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Petitioner's claims for penalties and attorneys fees are denied for the reasons set forth in this decision.

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 11, 2014
Date

ICArbDec19(b)

APR 11 2014

FACTS

Petitioner worked as an occupational therapy assistant since 2006 for Respondent, a residential rehabilitation facility. Petitioner worked 40 hour per week at $31.20 per hour. Petitioner's job description shows that she was expected to be able to push 250 pounds, pull 250 pounds, lift 150 pounds, and carry 50 to 75 pounds (PX6, p308). Petitioner was able to perform all of her job functions on her accident date.

Petitioner testified that on May 8, 2012, while working with a coworker, she attempted to shift a patient who was laying on his side to an upright position. While doing so, the patient's full weight pushed back against Petitioner. Petitioner felt pain in her left shoulder, neck and left arm (T21-22) (PX5, pp299-300).

Petitioner notified Respondent, finished out the rest of her work day, could not finish the next work day, and was then seen in the emergency room. Subsequently she was treated by a number of physicians and medical professionals. One of her orthopedic surgeons, Dr. Rahul Gokhale, testified at an evidence deposition. He opined that Petitioner's symptoms are as a result of her May 8, 2012 incident. Dr. Gokhale testified that Petitioner had required shoulder surgery and that conservative measures such as physical therapy and injections had been unsuccessful. Dr. Gokhale performed arthroscopic surgery on Petitioner's shoulder which included debridement of the labrum and chondroplasty of the glenoid and a subacromial decompression. Dr. Gokhale removed an unstable cartilaginous flap which was not previously visualized on an MRI. Dr. Gokhale testified that the presence of a bone spur on Petitioner's acromion accounted for the impingement that she suffered. The cartilaginous flap he removed was the result of trauma and accounted for at least for symptoms.

Petitioner testified Respondent provided work within her physical restrictions on an informal basis. Petitioner testified that she was transferred from Respondent's Lemont facility to Respondent's Willowbrook

facility on November 27, 2012 and was assigned work that she was able to perform. However, this arrangement was ended by Respondent on December 11, 2012.

On December 13, 2013, Petitioner began working at a job which she found on her own at Presence Home Care as an occupational therapy assistant earning $26.00 per hour. Her duties include in home visits with patients requiring assistance in bathing, cooking and performing other tasks such as transferring from bed to chair and using the toilet. Petitioner testified that initially she worked with a partner who performed heavier work. Petitioner testified that the day before the hearing, she began working without a partner.

Respondent undertook surveillance of Petitioner. Respondent cross-examined Dr. Gokhale with a copy of the surveillance report. Dr. Gokhale testified that it did not change his opinion.

Although she initially denied it, Petitioner had been treated for her left shoulder prior to May 8, 2012. Petitioner then testified that her prior shoulder condition was for referred biceps pain. The records of Dr. Debra Zillmer show that in 2009 and 2010 Petitioner was treated for "left shoulder pain, which is likely brought on by biceps tendonitis"

Respondent obtained a medical examination from Dr. Shane Nho, who testified at an evidence deposition. Dr. Nho testified that he reviewed medical records and a surveillance report. His opinions have been formulated from those medical records and surveillance report. Prior to his deposition, a request had been made and a subpoena was served requesting, among other things, medical records and surveillance records. However, the medical records and surveillance report were not produced. The undisclosed medical records and surveillance report were first shown to Petitioner's attorney as everyone was sitting at the evidence deposition. Petitioner's counsel promptly objected and moved to strike Dr. Nho's testimony regarding materials and opinions not previously requested but not disclosed.

Respondent's video surveillance of Petitioner was shown at the hearing, and the investigator, Mr. Stephen Melville testified. The surveillance video and report are in evidence. Petitioner is not shown pushing, pulling, lifting, or carrying heavy items.

During the pendency of this matter a liquidation and injunction order including a stay of litigation had been entered (RX4). As a result, these proceedings were delayed.

CAUSATION

The medical treatment records and reports, the medical opinion testimony of Dr. Gokhale, and the sequence of events are consistent and corroborative of Petitioner's testimony that the traumatic episode of May 8, 2012 caused her injury.

Petitioner's counsel objection to Dr. Nho's opinion testimony is sustained and the motion to strike said opinion testimony is granted. All of Dr. Nho's medical opinions are inextricably based upon the medical records and surveillance report that were requested but not produced. When evidence is withheld, fairness is thwarted.

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

MEDICAL

Respondent's defense on this issue is predicated upon causation, which has been resolved in favor of Petitioner.

Therefore the claimed medical bills shall be awarded.

TEMPORARY TOTAL DISABILITY AND TEMPORARY PARTIAL DISABILITY

Respondent's defense on this issue is predicated upon causation, which has been resolved in favor of Petitioner.

Therefore the claimed temporary benefits shall be awarded.

PENALTIES AND ATTORNEYS' FEES

Petitioner's benefits have been delayed by a court ordered stay of proceedings, which was beyond Respondent's control. Additional, Respondent incorrectly believed that it had factual defenses to Petitioner's claim.

Based upon the foregoing, the Arbitrator finds that Petitioner has not met her burden of proof on this issue.

NATURE AND EXTENT

Respondent's proposed decision includes a permanency determination. However, the nature and extent of the injury is not in dispute (AX1). Furthermore, a permanency award is improper in an emergency proceeding.

Therefore, Respondent's improper permanency proposal is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emanuel L. Bibbs,

Petitioner,

15IWCC0213

vs.

NO: 09 WC 23435

Cook County Sheriff's Dept.,

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 February 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.

15IWCC0213

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

DATED: MAR 2 5 2015
o3/18/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BIBBS, EMANUEL L
Employee/Petitioner

Case# **09WC023435**

COOK COUNTY SHERIFF'S DEPT
Employer/Respondent

15IWCC0213

On 2/10/2014, 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 0.06% 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:

0704 SANDMAN LEVY & PETRICH
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0132 COOK COUNTY STATE'S ATTY OFFICE
INDUSTRIAL CLAIMS SECTION
500 RICHARD J DALEY CTR
CHICAGO, IL 60602

15IWCC0213

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

Emmanuel L. Bibbs
Employee/Petitioner

v.

Cook County Sheriff's Department
Employer/Respondent

Case # **09** WC **23435**

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 **November 14, 2013**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 25, 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 as explained *infra*.

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 **$60,779.68**; the average weekly wage was **$1,168.84**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **3** 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 **$63,000.02** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$63,000.02**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. *See* AX1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $779.23/week for 78 and 3/7th weeks, commencing May 26, 2009 through March 18, 2010 and January 28, 2011 through October 6, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 25, 2009 through November 14, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $63,000.02 for temporary total disability benefits that have been paid.

Medical Benefits

Respondent shall pay the reasonable and necessary medical services for bills submitted into evidence (Dr. Turk, Accelerated Rehabilitation Center, Parkview Orthopaedic Group, Sinai Urgent Care & Medical Centers, Midwest Open MRI, Advanced Medical Supplies) that remain unpaid as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 100 weeks, because the injuries sustained caused the 20% 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

February 5, 2014
Date

FEB 10 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Emmanuel L. Bibbs
Employee/Petitioner

v.

Cook County Sheriff's Department
Employer/Respondent

Case # **09** WC **23435**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing are accident, causal connection, Respondent's liability for certain unpaid medical bills, 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.

Background

Petitioner testified that he was employed by Respondent on May 25, 2009, and had been so employed for approximately 22 years, in the Department of Corrections as a security officer at the Cook County Jail located at 26th and California. He testified that on the date of accident he finished paperwork when his radio went off with a call for "all available." As he was going to get up from his chair, the right arm of the chair broke and he fell about two feet to right side on top of a milk crate that was there for the officers to put their feet up and avoid "critters." He estimated that the crate measured about 18 inches in height from the floor. Petitioner also testified that he hit his head on a steel locker.

Petitioner testified that he was not feeling right when he got up to the call location and his lieutenant asked him what was wrong. He replied that he didn't know. His back was stiffening up on him. Petitioner testified that he did not want an ambulance to take him out of the building so he walked out on his own to an immediate care center located ½ block away.

Petitioner testified that he later filed an incident report. PX1. The report reflect that Petitioner was about to respond to a call about a fight and, while attempting to get up from a chair, the right side of the chair collapsed and he fell to the ground and felt a pop in his back. *Id.* It further reflects that he notified his supervisor and went to Cermak health services to see a doctor. *Id.*

Medical Treatment

The Cermak Health Services medical records reflect that Petitioner presented reporting that a chair broke and he fell hitting his coccyx bone and lower back. PX8 at 3. He reported difficulty walking and an L4 disc injury eight years prior. *Id.* He was diagnosed with low back pain status post fall and advised to follow up with a medical doctor. *Id.*

Petitioner presented to Sinai Urgent Care & Medical Centers for an examination on May 28, 2009. PX6 at 9-10. He had initial complaints of low back pain shooting to his right leg and on-and-off severe headaches since

[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.

falling out of a chair at work on May 25, 2009. *Id.* He was given Ibuprofren 800mg for the pain and referred to physical therapy, for a CAT scan of his head, and an MRI of his back. *Id.* Petitioner began treatment that same day with Dr. Fred Turk and reported a consistent mechanism of injury. PX2 at 1-3. Dr. Turk initially diagnosed him with a lumbar strain. *Id.*

Petitioner then underwent the recommended lumbar spine MRI on June 5, 2009 which showed diffuse degeneration of the intervertebral disc at L2-3, L4-5 and L5-S1, a large herniation of the L4-5 intervertebral disc posteriorly and to the right and a small focal herniation of the L5-S1 intervertebral disc posteriorly and slightly to the left. PX2 at 26. The following day, on June 6, 2009, Petitioner returned to Dr. Alzein at Sinai Urgent Care who recommended continued physical therapy. PX6 at 8. On June 16, 2009, Dr. Alzein administered a 60mg Toradol injection, ordered some additional medications, and ordered continued physical therapy. PX6 at 6-7.

Petitioner continued to treat with Dr. Turk and saw him approximately 21 times from May 28, 2009 through August 20, 2009. PX2 at 27-30. On September 9, 2009, Dr. Turk authored a narrative report detailing his care of Petitioner. PX2 at 2-3. Dr. Turk ultimately diagnosed Petitioner with lumbar disc syndrome, acute lumbar strain, acute lumbar myositis and L4 and L5 disc herniations. *Id.* Dr. Turk noted that he instructed Petitioner to remain off work and to avoid unnecessary physical activities. *Id.* He further noted that Petitioner's physical therapy was satisfactory, but incomplete as of his last session on August 20, 2009 because Petitioner still had some residual mild low back pain. *Id.*

Section 12 Examination – Dr. Khanna

On September 15, 2009, Petitioner submitted to an independent medical evaluation with Dr. Rajeev Khanna at Respondent's request. RX1. Petitioner reported a consistent mechanism of injury regarding the broken chair at work and noted minimal improvement in his symptoms after seeing his chiropractor, Dr. Turk, and undergoing physical therapy. *Id.* After an examination and reviewing various medical records, Dr. Khanna diagnosed Petitioner with a lumbar disc herniation, lumbago and a paraspinal muscle spasm. *Id.* Dr. Khanna opined, "I am able to causally connect Mr. Bibbs' lower back pain to the work related accident on May 25, 2009." *Id.* However, he further noted that Petitioner's chiropractic treatment to date had been excessive, and that he only required four weeks of chiropractic care. *Id.* Dr. Khanna also opined that Petitioner should undergo a series of three epidural steroid injections two weeks apart, return to work with a ten pound lifting restriction, and he estimated that Petitioner would be at maximum medical improvement (hereinafter "MMI") within four weeks of completing the injections. *Id.*

Continued Medical Treatment

Petitioner then sought treatment with Dr. James Boscardin at Parkview Orthopaedic Group on December 22, 2009. PX7 at 3-4. After reviewing Petitioner's MRI and performing a physical examination, Dr. Boscardin diagnosed Petitioner with definite L5 radiculopathy most likely related to a large herniation at L4-5. PX7 at 3-4. He gave Petitioner a Medrol Dosepak and other medications, and ordered a new MRI of his lumbar spine. *Id.* Dr. Boscardin also indicated that Petitioner may be able to perform some light duty work, but that he could not return to full duty. *Id.* Lastly, Dr. Boscardin indicated that Petitioner's "present symptoms are causally related to his on the job injury." *Id.*

Dr. Boscardin saw Petitioner again on December 29, 2009 at which time he ordered a course of physical therapy. PX7 at 5. He also indicated that Petitioner should follow up with his nurse practitioner, Mr. Hanna, as needed if he was out of town. *Id.*

Petitioner saw Mr. Hanna on January 21, 2010 and was advised to continue physical therapy because it seemed to be helping, to use a Medrol Dosepak, and to remain off work. PX7 at 6. Mr. Hanna saw Petitioner again on February 12, 2010 and noted that he had not attended the recommended physical therapy because authorization had been denied. PX7 at 8. Mr. Hanna again recommended that Petitioner continue physical therapy for two more weeks. *Id.*

Petitioner saw Dr. Anis Mekhail at Parkview Orthopaedic Group for the first time on February 25, 2010 reporting right lumbar radiculopathy that was affecting his quality of life, causing him to be unable to perform his job, and continued pain. PX7 at 9. He recommended an epidural steroid injection. *Id.*

At Dr. Mekhail's referral, Petitioner presented to Dr. Neema Bayran for a pain management consultation on March 8, 2010. PX5 at 3-6. Petitioner reported that he injured his back at work when the arm of a chair broke causing him to fall. *Id.* He also reported continued low back symptomatology and radiating pain into the right leg. *Id.* Dr. Bayran scheduled Petitioner for right L4-5 and L5-S1 epidural steroid injections, which were performed on March 10, 2010. PX5 at 7-8.

Petitioner followed up with Dr. Bayran on March 17, 2010 and reported about 60% improvement from the injections. PX5 at 9-10. Following this appointment, Petitioner testified that he returned to work. Petitioner then returned to Dr. Bayran on April 12, 2010 at which time he recommended additional injections. PX5 at 11-12.

Due to ongoing pain in his low back radiating to the right leg, Petitioner returned to Dr. Mekhail on January 3, 2011. PX7 at 11. Dr. Mekhail recommended some medications, use of a Medrol Dosepak, and another course of physical therapy. *Id.* Petitioner returned to Dr. Mekhail again on January 10, 2011 at which time he recommended a right L4-L5 decompression, microdiscectomy, and possible annular repair surgery. PX7 at 12.

Petitioner underwent the recommended surgery on February 22, 2011. PX5 at 19-20. Pre- and post-operatively, Dr. Mekhail diagnosed Petitioner with a right L4-L5 herniated disk with right lumbar radiculopathy. *Id.* He performed a right L4-5 decompression laminotomy, foraminotomy, partial facetectomy and micro-diskectomy and an L4-5 annular repair. *Id.* Petitioner had an issue with bleeding at the wound and went to Christ Hospital later that day, which was addressed and Petitioner was discharged home. PX5 at 15-18.

Petitioner then followed up with the nurse practitioner, Mr. Hanna, for some time. PX7. At a follow up visit n March 3, 2011 Petitioner was advised to use a Medrol Dosepak and start post-operative physical therapy. PX7 at 13. Petitioner reported continued pain, but Mr. Hanna again recommended that Petitioner begin physical therapy at a follow up visit on March 11, 2011. PX7 at 14. On April 11, 2011, Mr. Hanna recommended Petitioner start work conditioning. PX7 at 15. Due to a setback noted at a visit on April 21, 2011 after Petitioner reached for something and he developed an extreme amount of discomfort, Mr. Hanna recommended that Petitioner stop work conditioning and go back to physical therapy for a time. PX7 at 16.

Petitioner saw Dr. Mekhail on May 9, 2011 at which time he ordered that Petitioner re-start work conditioning. PX7 at 17. At a follow up visit on June 6, 2011, Dr. Mekhail noted that Petitioner was progressing in work

conditioning, but that they recommended some additional sessions. PX7 at 18. He also noted Petitioner's report that he would try to go to the gym on his own and work out to see how that helped. *Id.*

On June 20, 2011, Dr. Mekhail noted some issues with Petitioner's nurse case manager that she believed that three weeks of work conditioning was sufficient, whereas Dr. Mekhail did not. PX7 at 19. He noted that Petitioner required an additional three weeks of work conditioning or a functional capacity evaluation to determine if he needed permanent restrictions. *Id.* Dr. Mekhail also noted that Petitioner wanted to return to work. *Id.*

Petitioner returned to Dr. Mekhail on July 21, 2011 at which time he ordered some anti-inflammatory medication and recommended a few more weeks of physical therapy followed by a functional capacity evaluation. PX7 at 20.

The functional capacity evaluation was supposed to take place on August 23, 2011, but had to be moved to August 30, 2011 due to an issue with Petitioner's blood pressure. PX4 at 13. Petitioner's functional capacity evaluation was performed on August 30, 2011 and showed that Petitioner gave full effort, and thus, the evaluator deemed the results valid and reliable. PX4 at 7-11. Petitioner was released to return to a medium category of work, which met the job demands of his position as supplied by the nurse case manager. *Id.*

Petitioner saw Dr. Mekhail one final time on September 12, 2011 reporting continued low back pain at a level of 5 on a scale of 1-10. PX7 at 21. He released Petitioner back to work within the functional capacity evaluation restrictions and discharged him from his care at maximum medical improvement. *Id.* Dr. Mekhail noted that Petitioner may require further treatment in the future due to the degeneration at L4-5, but did not indicate any specific recommendation at that time. *Id.*

Additional Information

Petitioner testified that he had no other visits with Dr. Mekhail and that he has been working full duty, although his job duties have changed a few times. Now, he works in a position with physical demands limited to maintaining order and bringing inmates back and forth.

Regarding his current condition, Petitioner testified that he is not able to tie shoes in morning and that he wakes up an hour earlier than he used to in order to get ready for work. Some days, Petitioner testified that he does not go to work. He does not know how he will feel until he gets up. Petitioner also testified that the surgery corrected the sciatic nerve issue, but that he still experiences stiffness. Regarding his activities, he testified that cannot perform coaching duties in baseball or football like he used to do because he cannot stand for long periods of time. He does yoga, which he finds to be good, and still takes medications for his back (Tramadol 75 mg) as prescribed by his primary care physician Dr. Weiss.

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 (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of her employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

Petitioner credibly testified about the details of his accident that he fell when the right side of his chair broke when he was getting up to respond to a call for assistance at work. Petitioner's testimony is corroborated by his incident report, treating medical records, and report to Respondent's Section 12 examiner, Dr. Khanna. Indeed, no evidence was proffered to the contrary.

Based on the foregoing, the Arbitrator finds that Petitioner did sustain a compensable accident involving his low back that arose out of and in the course of his employment with Respondent as claimed.

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:

As explained in the accident analysis above, the Arbitrator finds that Petitioner sustained a compensable accident at work as claimed. Moreover, Petitioner's treating physicians, Dr. Turk and Dr. Boscardin specifically relate Petitioner's low back condition to his injury at work, as does Respondent's 12 examiner, Dr. Khanna. Thus, the Arbitrator finds that Petitioner's claimed current condition of ill being is causally related to his accident at work.

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:

As explained more fully above, the Arbitrator finds that Petitioner's claimed current condition of ill being is causally related to his accident at work. Based on the record as a whole, the Arbitrator finds that the medical care rendered to Petitioner was reasonable and necessary to alleviate him of the effects of his condition and awards the medical bills incurred by Petitioner, that remain unpaid, and that were submitted into evidence to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

Respondent's dispute to Petitioner's claim of entitlement to the requested temporary total disability benefits lies in resolution of whether he sustained a compensable accident and whether his condition of ill being is causally related to his claimed injury at work. As explained above, these issues have been resolved in Petitioner's favor. Thus, based on review of the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as claimed.

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—which reflects that Petitioner sustained an injury to the low back necessitating pre-operative conservative medical treatment, a right L4-L5 herniated disk with right lumbar radiculopathy requiring surgical intervention in the form or a right L4-5 decompression laminotomy, foraminotomy, partial facetectomy and micro-diskectomy and an L4-5 annular repair, and post-operative physical therapy and work conditioning with continued symptomatology and activity modification—the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alfreda Bugaj,

Petitioner,

vs.

NO: 08WC 8587

Nylock Fasteners Corporation,

15IWCC0194

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 whether the arbitrator denial of reinstatement was improper and being advised of the facts and law, affirms and adopts the Order of Dismiss Case for Want of Prosecution of the Arbitrator .

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator entered on December 30, 2013, refusing to grant the Petitioner's Motion to Reinstate the Arbitrator's Dismissal on July 23, 2013, is hereby affirmed and adopted.

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

DATED: MAR 2 3 2015
o031815
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

Jonathan Jordan,
Petitioner,
vs.

NO: 11WC 14131

Calumet SD #132,
Respondent,

15IWCC0195

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, Section 11 Defense 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 3, 2014, is hereby affirmed and adopted.

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

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

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

DATED: MAR 2 3 2015
o031815
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JORDAN, JONATHAN
Employee/Petitioner

Case# **11WC014131**

CALUMET SD #132
Employer/Respondent

15IWCC0195

On 1/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% 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:

2706 EVAN A HUGHES LAW OFFICES
30 N LASALLE ST
SUITE 2950
CHICAGO, IL 60602

0863 ANCEL GLINK
ERIN BAKER
140 S DEARBORN 6TH FL
CHICAGO, IL 60603

15IWCC0195

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

Jonathan Jordan
Employee/Petitioner

v.

Calumet SD #132
Employer/Respondent

Case # **11** WC **14131**

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 **August 8, 2013** and **September 17, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for 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 **March 23, 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 as explained *infra*.

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 **$27,194.20**; the average weekly wage was **$881.29** as explained *infra*.

On the date of accident, Petitioner was **33** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$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 **$26,759.04** under Section 8(j) of the Act. *See* AX1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $587.53/week for 2 & 5/7th weeks, commencing March 24, 2011 through April 11, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 23, 2011 through September 17, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical services for bills submitted into evidence pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for 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: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $528.77/week for 50.6 weeks, because the injuries sustained caused the 20% loss of the left arm, 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

January 2, 2014
Date

JAN 3 - 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Jonathan Jordan
Employee/Petitioner

v.

Calumet SD #132
Employer/Respondent

Case # 11 WC 14131

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute are accident, causal connection, Petitioner's earnings and average weekly wage, Respondent's liability for certain unpaid medical bills, 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.

Background

Petitioner testified that he was a science teacher employed by Respondent at the Calumet Middle School on the claimed date of accident. His duties included receiving students, managing hallways, breakfast and lunch duties, taking initial attendance, and classroom instruction in science.

Petitioner was concurrently employed at Triton College which he reported this employment on his employment application and he testified that he discussed extensively at his interview with Respondent for the position at Calumet Middle School. *See* PX7. He testified that he found it important to talk about his position at Triton, which he held since 2004, because he had not otherwise worked as a teacher in 10 years and because his Triton job would prevent him from staying after school on Tuesdays and Thursdays from 6:00-8:45 p.m.

Petitioner testified that he received an offer for work in a contract for the 2010-2011 school year from Ms. Gwen Gray, the director of human resources, via email in a letter dated May 21, 2010. *See also* PX8. The salary offered was $37,554.00. *Id.* Respondent offered a wage statement reflecting that Petitioner received bi-weekly gross payments of $1,444.38 netting $1,075.56 per week. RX1. Petitioner also earned $4,007.00 working the fall semester for Triton. *See also* PX1. Petitioner testified that he received this amount each semester, but could not recall whether he worked in the spring semester (2011) at Triton.

Although Petitioner was a science teacher for Respondent, he testified that all teachers were expected to attended events, open houses, performances, and other after-school functions without pay; he considered these expectations to be inclusive of his job. Petitioner testified that he had not participated in a student/teacher basketball club before the claimed date of accident. He testified that the school principal, Mr. Levy, and a colleague told him that the basketball club was designed to reward students that were performing well in school. He testified that he liked the idea of building a rapport with the students, but he was slightly leery of playing basketball because of the chance of being injured. He testified that he was not a basketball player.

[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.

Petitioner testified that he was asked on several occasions to participate in the basketball club. First, Mr. Levy approached him and asked him to participate two weeks prior to a basketball game. He testified that the conversation took place in the doorway of his classroom at dismissal time. Petitioner testified that he did not participate in that game. Next, Petitioner testified that Mr. Levy approached him to participate in the following game. Petitioner testified that he told Mr. Levy that he could not participate that week.

Petitioner testified that he was then asked a third time by Mr. Levy to participate in the basketball club on the day before he played. He testified that he was signing out for the day and Mr. Levy asked him to come into his office. Petitioner testified that Mr. Levy asked him words to the effect of "are you packing a bag or not, are you coming tomorrow?"

Petitioner testified that at the time of these conversations, he had yet to receive a contract for the following 2011-2012 school year and that he had not yet received his performance evaluation which he expected to receive by the end of March. Petitioner testified that he was concerned that he would be on Mr. Levy's "bad side" or that failing to participate would negatively affect his evaluation or that his contract would not be renewed. Petitioner testified that he agreed to and did play in the game the following day.

March 23, 2011

On March 23, 2011, Petitioner testified that he participated in a student/teacher basketball game held immediately after school in the gym. He testified that this was a school-sponsored event with five students playing against five teachers, including Mr. Levy. Parents or guardians were not required to be there for the game. The school did not provide supervisors and the teachers were responsible for the students' well being (i.e., helping in case of a fire alarm, handling fights/disturbances, etc.). Petitioner testified that he believed that these were school "sanctioned" events and that he was still working despite the bell ringing and end of the school day.

During the game, Petitioner was making a jump shot when a student ran through his legs causing him to spin and fall down on his left arm. Another teacher took Petitioner to the hospital. Petitioner testified that he spoke to Mr. Levy, who called him that same day or the following day.

Medical Treatment

The medical records reflect that Petitioner was seen at Metro South Hospital where he was examined in the emergency room and underwent x-rays showing a left forearm fracture of the proximal shaft. PX2. He was placed off work for three days and instructed to follow up with an orthopedic surgeon. *Id.*

Petitioner then sought treatment on March 24, 2011 closer to his home with Dr. Park at DuPage Medical Group. PX3. Dr. Park examined Petitioner, diagnosed him with a displaced left radial shaft fracture, and performed an open reduction internal fixation of the left radial shaft fracture at Good Samaritan Hospital. PX3; PX4. He used a seven-hole plate and screws to fixate the fracture. *Id.* In addition, Dr. Park diagnosed Petitioner with a left elbow sprain, which he noted was stable post-operatively. PX3.

After the surgery, Petitioner underwent a course of physical and occupational therapy. *Id.* Dr. Park released Petitioner to return to work effective April 12, 2011, but Petitioner continued to follow up with Dr. Park who thereafter noted elbow flexion limitations and stiffness on examination. *Id.* At a follow up visit on June 13, 2011, Dr. Park ordered additional occupational therapy and noted that Petitioner had no clicking in the elbow.

Id. By July 25, 2011, Dr. Park noted that Petitioner's x-rays revealed, and diagnosed him with, delayed healing of the shaft fracture and a possible non-union. *Id.* He ordered a bone stimulator and additional occupational therapy. *Id.*
On January 16, 2012, Dr. Park noted that Petitioner had no bony tenderness, full elbow flexion and extension, limited elbow pronation to 60 degrees, and no radial shaft tenderness. *Id.* Petitioner's x-rays revealed that the radial shaft fracture had healed. *Id.* Dr. Park released Petitioner to full unrestricted duties and placed him at maximum medical improvement. *Id.*

physical therapy in August of 2011, the occupational therapist noted that the patient's progress was limited due to the slow rate of bone growth and the severity of the injury. The therapist did note that the Petitioner was performing functional tasks but with occasional modifications. (PX 3).

Petitioner testified that he did not return to work for Respondent in the 2011-2012 school year. He was not offered a contract. Petitioner testified that he returned to work as a teacher for another employer.

Regarding his current condition, Petitioner testified that he has pain every day and that cold weather causes pain inside the arm. He testified that he cannot pronate the left wrist completely and that his left elbow has mobility, but still causes pain. During rehab, Petitioner testified that he was originally unable to bend/pronate/turn his elbow, but that he now has almost full range of motion and some of that ability to pronate and turn his elbow back. He also testified that he has pain when doing any lifting with the left arm and that he cannot work on his house how he normally would. Petitioner also testified that he has difficulty typing, tying his shoes, general left arm lack of mobility and difficulty lifting heavy objects.

Steven Corley

Respondent called Mr. Corley as a witness. He testified that he was employed by Respondent on Petitioner's claimed date of accident as a special education assistant and is currently employed there as the coordinator of safety.

Mr. Corley testified that Petitioner broke his arm during after school basketball game with students and teachers. He testified that the game was an impromptu basketball game for students and teachers to challenge one another. Mr. Corley testified that he participated in the afterschool game and recruited other teachers to play. He added that his participation was a "one time thing" and that there were approximately 30-40 staff members at the school and that teachers were not required to participate, punished for not participating, or given incentives to participate. Mr. Corley testified that participation in the game was strictly voluntary. He did not believe that failure to participate would affect a teacher's year-end review and no poor reviews were given as a result of not participating in a game to his knowledge although he acknowledged that he would not know if anyone got a bad performance review for failure to participate in game. He further acknowledged that he was not sure about Petitioner's performance review, any proposal for a contract the following year, or why Petitioner did not return to the school the following year.

On cross examination, Mr. Corley also acknowledged that the basketball program was to allow students in 6th through 8th grade to play basketball under supervision if they had good behavior and good grades. Prior to the game in which Petitioner injured himself, Mr. Corley testified that he was a staff member supervising students after school along with another teacher Mr. Marinello. He testified that neither he nor Mr. Marinello were compensated, they did not sign any contracts, and that playing in the games was something that he was asked to do for the students. Mr. Corley also testified on cross examination that he was not absolved of his

responsibilities as a teacher during games, that if anything happened during the games he and Mr. Marinello were responsible for addressing issues (i.e., fire alarm, lock-down situation, fights between students, students injured), and that student spectators were not allowed. He further testified that he and Mr. Marinello proposed these games to Mr. Levy who allowed it.

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 (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Petitioner asserts that he sustained a compensable accident while participating in a basketball game between students and teachers on March 23, 2011. There is no dispute between the parties about the mechanism of injury (i.e., that a student ran into Petitioner during an afterschool basketball game causing him to fall on his left arm) or whether it was sustained in the course or arose out of his employment with Respondent in the usual analysis, but rather Respondent asserts that the voluntary recreational activities exception in the Illinois Workers' Compensation Act ("Act") applies and renders Petitioner's claim noncompensable.

Section 11 of the Act states in pertinent part:

> Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of the course of the employment even though the employer pays some or all of the cost thereof. This exclusion does not apply in the event the injured employee was ordered or assigned to participate in the program. 820 ILCS 305/11.

The Appellate court has addressed the scope of the voluntary recreation exclusion most recently in *Elmhurst Park District v. Illinois Workers' Compensation Comm'n*, 395 Ill.App.3d 404 (1st Dist 2009). In that case, the claimant was injured while playing in a wallyball game at a park district facility where he worked as a fitness supervisor. *Elmhurst Park District*, 395 Ill.App.3d at 405. In addition to finding that "recreation" was inherent in the claimant's responsibilities as a fitness supervisor, the court found "it appropriate to consider why claimant agreed to play wallyball on the date he was injured." *Id* at 409.

Similar to the facts in this case, the claimant in *Elmhurst Park District* had initially declined an invitation—albeit by a co-worker and not a supervisor as in Petitioner's case—to participate in a wallyball game which was held for the respondent's paying customers. *Id* at 406, 409. The claimant eventually agreed to play in one such game where he was injured after his co-worker informed him that it would otherwise be cancelled. *Id.* The court held that the Act's recreational activity exclusion did not apply and that the claimant's participation in the wallyball game was incidental to his employment given that his job description included promoting Respondent's programs and his testimony that "he felt that participating in the wallyball game was part of his job because one of the requirements of his position was to help out with any programs or classes respondent offered its patrons." *Id* at 410. The court found that the claimant's belief that such participation was required was reasonable in light of his job description. *Id.*

In this case, Petitioner testified that during his first year contracted as a teacher with Respondent he was asked on three separate occasions by the principal, Mr. Levy, to play in student-teacher basketball games. Petitioner explained that all teachers were expected to attended events, open houses, performances, and other after-school functions without pay and that he considered these expectations to be a part of his job duties. Indeed, both Petitioner and Mr. Corley testified that they were responsible for students' well-being during basketball games and that they were not relieved of their responsibilities as teachers during these games where other student spectators were not allowed and no parents or guardians of the 6th, 7th and 8th grade students participating were required to attend. Moreover, both Petitioner and Mr. Corley testified that the basketball games were designed to reward students that were performing well in school. Mr. Levy did not testify at this trial and Petitioner's testimony about his job duties and conversations with Mr. Levy remain uncontroverted. Moreover, after careful observation of Petitioner at trial and considering Petitioner's testimony in light of the documentary evidence and the testimony of Mr. Corley, the Arbitrator finds Petitioner's testimony to be credible and corroborated by the record.

Thus, similar to *Elmhurst Park District*, the evidence in this case establishes that Petitioner participated in the basketball game on March 23, 2011 upon Mr. Levy's third request to do so because he reasonably believed that his job duties required him to do so and because he wanted to avoid unfavorable action by Mr. Levy given that he expected to receive his first performance review and a contract for the upcoming school year by the end of that month. Based on all of the foregoing, the Arbitrator finds that Petitioner has established through credible evidence that his injury on March 23, 2011 arose out of and in the course of his employment for Respondent and that he was not engaged in a voluntary recreational activity as defined in Section 11 of the Act at the time of his injury.

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:

In addition to the accident analysis above, the Arbitrator finds that Petitioner's claimed current condition of ill being in the left arm is causally related to his injury at work. In so concluding, the Arbitrator notes the consistency of Petitioner's testimony with the medical records submitted into evidence which reflect that Petitioner sustained a left arm fracture and left elbow sprain as a result of his fall at the basketball game. No evidence was submitted establishing that Petitioner's left arm or elbow condition pre-existed his fall on March 23, 2011 or about any intervening cause breaking the causal connection chain. Based on all of the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is related to the injury sustained on March 23, 2011.

In support of the Arbitrator's decision relating to Issue (G), what were Petitioner's earnings/average weekly wage, the Arbitrator finds the following:

The parties stipulated at trial that Petitioner had concurrent earnings of $4,007.00 from Triton. Petitioner offered a copy of the employment offer reflecting that he would begin working on August 23, 2010 and that his yearly salary was to be $37,554.00. Respondent offered Petitioner's wage statement which reflects that he began his employment on August 18, 2010. The wage statement does not reflect the dates covered during each paycheck, rather it reflects that Petitioner was paid bi-weekly in checks issued on August 20, 2010 through March 18, 2011 earning a total of $23,187.20.

The parties dispute what Petitioner's earnings were and what divisor should be used in calculating the average weekly wage. Petitioner asserts that his average weekly wage should be calculated by dividing the total annual salary by the number of weeks actually worked by Petitioner before his injury. Respondent asserts that Petitioner's average weekly wage should be calculated by dividing the actual earnings divided by the number of weeks actually worked by Petitioner before his injury.

Section 10 of the Act states in pertinent part that the average weekly wage is to be computed based on the "actual earnings of the employee in the employment in which he was working at the time of the injury." 820 ILCS 305/10. The decisions in *Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Comm'n*, 409 Ill.App.3d 943 (1st. Dist 2011) and *Washington District 50 Schools v. Illinois Workers' Compensation Comm'n*, 394 Ill.App.3d 1087, 1090 (3rd Dist 2009) are instructive in this case and stand for the proposition that a teacher-claimant's average weekly wage should be calculated by dividing the actual earnings by the number of weeks actually worked prior to the date of injury.

Based on the record as a whole, the Arbitrator finds that Petitioner's actual earnings were $27,194.20 ($23,187.20 + $4,007.00) in the year preceding the injury, which divided by 30 & 6/7th weeks (the weeks actually worked by Petitioner beginning August 18, 2010 through March 23, 2011) results in an average weekly wage of $881.29.

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:

The Arbitrator finds that the medical records and Petitioner's testimony establish that the medical bills from the various providers that treated Petitioner for his left arm injury were reasonable and necessary to alleviate him from the effects of his injury at work. Thus, the Arbitrator awards the reasonable and necessary medical bills incurred by Petitioner and submitted as exhibits into evidence to be paid by Respondent as provided in Section 8(a) and pursuant to Section 8.2 of the Act.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

Petitioner claims entitlement to temporary total disability for the period of time that he was placed off work by his physicians after his injury on March 23, 2011 through April 11, 2011. The evidence submitted at trial establishes that Petitioner was placed off work by the emergency room hospital personnel or Dr. Park as a result of his injury at work through April 11, 2011 when he was released back to light duty work, which Respondent accommodated. Based on the facts and conclusions explained in detail above, the Arbitrator finds that Petitioner is entitled to the requested benefits for the temporary total disability period.

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—which reflects that Petitioner sustained a displaced left radial shaft fracture requiring surgery with implementation of a plate and screws and an elbow strain, post-operative physical and occupational therapy, a diminished range of motion, and continuing pain and weather sensitivity—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 20% loss of use of the left arm pursuant to Section 8(e).

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

Fernanda Ramirez,

Petitioner,

vs.

NO: 12WC 41709

CD One Price Cleaners,

15IWCC0196

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, incurred medical, prospective 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. 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 22, 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 $4,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2015
o031715
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

RAMIREZ, FERNANDA
Employee/Petitioner

Case# **12WC041709**

15IWCC0196

CD ONE PRICE CLEANERS
Employer/Respondent

On 11/22/2013, 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:

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

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

FERNANDA RAMIREZ
Employee/Petitioner

Case # 12 WC 41709

v.

15IWCC0196

CD ONE PRICE CLEANERS
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 October 29, 2013. 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. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On July 7, 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.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $1,330.07; the average weekly wage was $266.01.
- At the time of injury, the petitioner was 44 years of age, *single* with one child under 18.
- The parties agreed that the respondent paid $3,903.43 in temporary total disability benefits.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $253.00/week for 32-2/7 weeks, from July 8, 2012, through November 12, 2012, and November 26, 2012, through March 3, 2013, which are the periods of temporary total disability for which compensation is payable.
- The medical care rendered the petitioner for her left ankle through February 7, 2013, was reasonable and necessary. The medical care rendered the petitioner for her lumbar spine is not casually related to the injury 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 lumbar epidural steroid injections and a calcaneofibular surgery is denied.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Robert E. Williams

Signature of Arbitrator

November 22, 2013

Date

NOV 22 2013

FINDINGS OF FACTS:

The petitioner, a dry-clean inspector, notified the respondent on July 13, 2012, of injuries to her feet while walking and inspecting garment on July 7, 2012. She sought medical care for left ankle and head pain of one week duration at Active Foot & Ankle Associates on July 16, 2012. Most of their records are handwritten and of poor copy quality and cannot be read accurately. An MRI of her left ankle on October 30th revealed evidence of mild plantar fasciitis of the proximal central band of the plantar aponeurosis of the rearfoot, mild tenosynovitis of the distal posterior tibial tendon and mild tenosynovitis involving both the peroneus and brevis tendons. She had 24 physical therapy sessions through November 7th. The therapist's progress report on October 31st noted difficulty with standing greater than four hours and walking more than one to two hours, and an occasional feeling of a giving away of her ankle. The petitioner had a current dorsiflexion of 10 but a low quality of motion. On November 6th, the petitioner was released to return to work beginning November 12th.

The petitioner sought treatment at Nuestra Clinica with Dr. Joe Santiago and last followed up at Active Foot & Ankle Associates on November 26th. Dr. Santiago's impression was ankle sprain/strain for which he provided electrical stimulations, mobilization and cryotherapy for fourteen days through December 21st and off-work recommendations. Physical therapy was included with the other modalities on December 26th. The petitioner received chiropractic care with Dr. Santiago through August 6, 2013.

Pursuant to a referral from Dr. Santiago, Dr. John O'Keefe started treating the petitioner for severe back pain, left sciatica, left ankle pain, left knee pain and contusions on December 19th. On January 8, 2013, the petitioner reported neck, low back and left

elbow pain. X-rays of her lumbar spine revealed diminished lordosis and loss of disc height at L5-S1. Dr. Dixon opined that his EMG study of the petitioner's lower extremities on January 25, 2013, was abnormal and was indicative of a bilateral L5-S1 radiculopathy. At the request of the respondent, Dr. Dzwinyk evaluated the petitioner on February 7, 2013.

X-rays on May 23, 2013, revealed an abnormal flattening and diminished disc height at L5-S1 of her lumbar spine and a navicular fracture of her left ankle. MRIs of her left foot and ankle on July 13th revealed continued mild tenosynovitis of the distal posterior tibial tendon with no significant change since previous study, focal tenosynovitis of the peroneal tendons, mild plantar fasciitis of the proximal central band of the plantar aponeurosis of the rearfoot and findings consistent with a hallux deformity of the first ray and evidence of early degenerative osteoarthritis of the first metatarsophalangeal joint.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on July 7, 2012, arising out of and in the course of her employment with the respondent.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her left ankle through February 7, 2013, was reasonable and necessary. Dr. Dzwinyk opined on February 7, 2013, that no further treatment was necessary. The medical care rendered the petitioner for her lumbar spine is not casually related to the injury 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 her current condition of ill-being with her left ankle is causally related to the work injury on July 7, 2012. The petitioner failed to prove that her current condition of ill-being with her lower back is causally related to the work injury on July 7, 2012. The petitioner is not credible. The petitioner twisted her left ankle. She reported an injury to her feet to the respondent on July 13, 2012, and then sought out a foot specialist for the treatment of her ankle injury and head. She did not report or complain of back pain to Active Foot & Ankle Associates or request medical care for lumbar symptoms. The petitioner did not seek a referral to another medical provider for her back from Active Foot & Ankle Associates, nor did she seek or receive care for her lumbar spine from another provider prior to December 2012. Also, it is noted that the petitioner's application for benefits dated November 12, 2012, indicated an injury to her left foot only and was not amended to include her back until July 23, 2013.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was released to return to work beginning November 12, 2012, by doctors at Active Foot & Ankle Associates. On February 7, 2013, Dr. Dzwinyk opined that the petitioner was at maximum medical improvement for her left ankle by November 2012, that no further treatment was necessary and that she is able to perform unrestricted work.

The parties agreed that the respondent paid $3,903.43 in temporary total disability benefits and the financial logs in evidence indicate the payment of additional temporary

total disability benefits from November 26, 2012, through March 3, 2013, which totals $3,795.00.

The respondent shall pay the petitioner temporary total disability benefits of $253.00/week for 32-2/7 weeks, from July 8, 2012, through November 12, 2012, and November 26, 2012, through March 3, 2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner. The petitioner received $7,698.43 in temporary total disability benefits from the respondent.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the lumbar ESI and a calcaneofibular surgery is reasonable medical care necessary to relieve the effects of the work injury. The petitioner is not credible. The petitioner's request for the lumbar ESI and a calcaneofibular surgery 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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TANYA WOODS,

Petitioner,

vs.

NO: 02 WC 23779
05 WC 12783

BANK OF AMERICA,

15IWCC0197

Respondent.

DECISION AND OPINION ON REMAND
FROM THE CIRCUIT COURT OF COOK COUNTY

The Commission is in receipt of an Order of Remand from the Circuit Court of Cook County, relative to the above captioned matter, under its case number 13 L 050529, by which it reversed the Decision of the Commission under its case number 02 WC 23779, 05 WC 12783, finding that the Commission's Decision was erroneous as a matter of law.

As a result of the Circuit Court's Order of September 9, 2014, the Commission must find the "timely filing of a transcript is not a dispositive prerequisite to the Commission's obtaining jurisdiction."

The following is a brief procedural history of the case, in part as previously stated in the Commission's May 3, 2013 Order. On June 29, 2012, and July 3, 2012, this case was heard before Arbitrator Carlson. At the June 29, 2012, hearing, Petitioner's motion to reinstate the claim and Respondent's motion to compel enforcement of the settlement contracts were pending. On July 3, 2012, Arbitrator Carlson denied Petitioner's motion to reinstate her claim and Mr.

Wilson's motion to withdraw.

On August 1, 2012, Petitioner filed a Petition for Review of the Arbitrator's denial of Petitioner's petition to reinstate as well as Petitioner's attorney's motion to withdraw. On August 23, 2012, the Commission issued a "Notice of Return Date on Review" with a return date on review of October 12, 2012. The authenticated transcript thus had to be filed by October 12, 2012.

On October 17, 2012, the Commission issued a notice for Motion to Rule to Show Cause scheduled for November 29, 2012. The Commission's notice for Rule to Show Cause provided that if an authenticated transcript was filed with the Commission within 10 days of the date of the notice, no one need to appear on November 29, 2012, and the motion for Rule to Show Cause would be satisfied.

At the hearing before Commissioner Tyrrell, held on December 20, 2012, on Petitioner's Combined Motions, Mr. Wilson acknowledged that the authenticated transcript was due on October 12, 2012, but that "[s]omehow that was not appropriately noted in our office record" and that his staff did not diary the deadline. Mr. Wilson indicated in his Combined Motions that the reason Petitioner had not presented the authenticated transcript on the October 12, 2012, due date was because "the due date had not been docketed to the attorney's diary."

Also at the December 20, 2012, hearing, Mr. Wilson indicated that the Commission's notice for Rule to Show Cause was an "administrative extension" of time, which permitted Petitioner to file the authenticated transcript by October 27, 2012. Mr. Wilson indicated in Petitioner's Combined Motions that he did not secure the record from the Commission's court reporter until October 24, 2012.

It is undisputed that the authenticated record was not submitted until November 5, 2012. The following note was made on the authentication page in the record:

> "Though Respondent has aunthenticated [sic] the transcript, it does not agree or affirm that the transcript is being aunthenticated [sic] within the time limits set forth by the Illinois Workers' Compensation Commission or the Rules Governing Practice Before the Illinois Workers' Compensation Commission. Respondent received the transcript on October 30, 2012 and authenticated it on November 5, 2012."

On May 3, 2013, the Commission issued an order finding it did not have jurisdiction over Petitioner's claim as the timely filing of a transcript is a prerequisite to obtaining jurisdiction. We also denied Petitioner's "Combined Motions By Petitioner/Appellant For Leave To Submit The Authenticated Record; For Leave To Supplement The Record And For An Extension Of Time To File Petitioner/Appellant's Summary Brief." The Commission dismissed Petitioner's Petition for Review.

15IWCC0197

Petitioner then timely appealed the case to the Circuit Court of Cook County. On September 4, 2014, Judge Lopez Cepero reversed the Commission as a matter of law.

By order of the Circuit Court, the Commission has jurisdiction over the case and grants Petitioner's Motion for Leave to Submit the Authenticated Record and for an Extension of Time to File Petitioner/Appellant's Summary Brief. We will consider Petitioner's Motion for Leave to Supplement the Record upon presentation of Petitioner's additional material and comment from Respondent. We reverse our Order to dismiss Petitioner's Petition for Review. Petitioner's Petition for Review is accepted and will be set for a later date.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission filed May 3, 2013, is reversed as stated above.

No bond in indicated as no monetary value was awarded. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
TJT: kg MAR 2 3 2015
R: 2/17/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lamont Liner,

Petitioner,

vs.

NO: 07 WC 7404

Western Express,

15IWCC0198

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision/Order of the Arbitrator filed August 26, 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:
TJT:yl MAR 2 3 2015
o 2/3/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
STATE OF ILLINOIS

LAMONT LINER,
Petitioner,
v.
WESTERN EXPRESS,
Respondent.

Case No: 07 WC 7404

15IWCC0198

ORDER

THIS CAUSE, coming on to be heard on final trial date upon due and proper notice to the parties at prior hearing on May 8, 2013 relative to the same and via certified correspondence rejected by the Petitioner, and Respondent being represented:

The above captioned matter has been in a "must-go" status for over six (6) years. After numerous continuances, the matter was scheduled to proceed to trial on January 9, 2013. On the scheduled trial date, the Arbitrator was advised that Petitioner needed to see a doctor for evaluation and a request was made for yet another continuance. Said request was granted with the proviso that the evaluation had to be concluded and any accompany records generated from said evaluation had to be completed by February 28, 2013. The parties were advised to present before the Arbitrator on March 18, 2013 and report the status of the claim and to conduct a pretrial conference. The parties were also advised that the matter would be scheduled for a final trial date of May 8, 2013.

In the interim, Petitioner's counsel, Strom and Associates, filed a Motion for Withdrawl of Attorney.

On May 8, 2013, a hearing was held on the motion to withdraw. After lengthy discussions were held, the Law Office of Strom and Associates was granted leave to withdraw. Petitioner was also advised that his claim was continued to yet another final trial date of July 2, 2013.

On July 2, 2013, Petitioner failed to appear.

It is hereby Ordered, Judged and Decreed:

That this matter be and is dismissed for want of prosecution.

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

Arbitrator Date 8/23/13

15IWCC0198

AUG 26 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENNIS HAYES,

Petitioner,

vs. NO: 11 WC 45106

ILLINOIS BELL TELEPHONE CO., 15IWCC0199

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms the Arbitrator's findings and further explains the Arbitrator's permanent partial disability benefits award with respect to the five factors required in the Act.

According to Section 8.1(b) of the Act, for injuries that occur after September 1, 2011, 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 the AMA Guidelines;
2) The occupation of the injured employee;
3) The age of the employee at the time of the injury;
4) The employee's future earning capacity; and
5) Evidence of disability corroborated by the treating medical records.

1) The reported level of impairment pursuant to the AMA Guidelines

After examining Petitioner for a Section 12 exam, Dr. Graf rated Petitioner's impairment at 5% of the person as a whole. Dr. Graf stated that in his mind disability and impairment are interchangeable and he does not see a difference between those words. The Act clearly states that impairment does not equal disability. We considered that falsity when weighing Dr. Graf's assessment and opinions. At the same time, Dr. Graf fully described how he arrived at the 5% impairment rating. Dr. Graf clearly explained why Petitioner was in Class 1 and why his impairment was reduced – because he had no significant continued pain. Dr. Graf's 5% AMA impairment rating is taken into account, but it is not the same as a disability rating.

2) The occupation of the injured employee

Petitioner is a custom systems technician, meaning he goes out on calls for Respondent. He must climb ladders, lift and carry heavy equipment. Petitioner explained he can be required to life manhole covers weighing up to 100 pounds and carry other heavy equipment. Petitioner constantly uses his back while performing his job duties. This job is classified as medium duty. This factor increases Petitioner's permanent partial disability award.

3) The age of the employee at the time of the injury

Petitioner was 45 years old at the time of the injury. He still has many years left to work and will have to work with his back issues. This factor also would increase Petitioner's disability award.

4) The employee's future earning capacity

Petitioner did not submit any evidence regarding his future earning capacity. He returned to work full duty in the same position for Respondent. There is no indication his earnings will be reduced as a result of this injury. This factor has no bearing on the final award.

5) Evidence of disability corroborated by the treating medical records.

The medical records reflect that Petitioner injured his back at work, immediately sought treatment and then underwent surgery. Petitioner testified and the medical records reflect that his back pain was significantly reduced following surgery and physical therapy, but still occasionally bothered him. Petitioner's leg pain completely subsided following surgery. When Petitioner was discharged from physical therapy, the note reflects that he had made significant progress but continued to rate his pain at 2-3/10. Dr. Kazan explained that it is likely and expected that Petitioner will occasionally experience lumbar spine pain because of degeneration, and other issues. Dr. Kazan said these episodes can be treated conservatively. Petitioner testified he has good and bad days depending on the activity level and demands of the job that day. He gets some pain after lifting 100-pound manhole covers. He said he keeps Advil in his work truck and will take it every other day or so; yet, this is not prescription medication and he does not rely on it in order to perform his job duties. Petitioner did not testify to extensive ongoing issues following his surgery and return to work. He did describe some continued pain.

15IWCC0199

Based on the five required factors, we affirm the Arbitrator's award of 20% loss of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2013 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $53,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
TJT: kgg
R: 2/3/15
51

MAR 2 3 2015

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAYES, DENNIS
Employee/Petitioner

Case# **11WC045106**

ILLINOIS BELL TELEPHONE CO
Employer/Respondent

15IWCC0199

On 9/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0766 HENNESSY & ROACH PC
MITZI HENIFF
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

15IWCC0199

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

DENNIS HAYES
Employee/Petitioner

v.

ILLINOIS BELL TELEPHONE CO.
Employer/Respondent

Case # **11** WC **45106**

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 **New Lenox**, on **July 17, 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 _____

15IWCC0199

FINDINGS

On **11/7/2011**, 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 **$73,461.44**; the average weekly wage was **$1,412.72**.

On the date of accident, Petitioner was **45** 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 **$16,952.64** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,952.64**.

Respondent is entitled to a credit of **$26,999.69** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $941.81/week for 18 weeks, commencing 11/7/2011 through 3/11/2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 100 weeks, because the injuries sustained caused the 20% loss of the man as a whole, as provided in Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services of $10,717.47 as provided in Section 8(a) of the Act.

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

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

Oi George Lieder
Signature of Arbitrator

9-12-13
Date

SEP 16 2013

STATEMENT OF FACTS 11 WC 45106

Claimant, Dennis Hayes, was a 45-year-old technician for Respondent, Illinois Bell Telephone. His job was formerly known as a lineman. His duties included installing wire, telephone equipment, internet equipment, climbing up telephone poles, and carrying anything from a few ounces to a couple of hundred pounds.

On November 7, 2011, Petitioner began his workday at 8:00 a.m. and was assigned to make a service call at a customer's place of business. He arrived at the site around 10:00 a.m. and completed the install; he then returned to his truck to do his final checks. He bent over to pull a meter out from the middle shelf of his truck, twisting into an awkward position to retrieve the tool; as he did so, he felt a sharp sudden pain in his buttocks and right leg. Mr. Hayes finished his task and contacted his manager, Dave Kotchniksik, and reported that he had hurt himself and the pain was so severe that driving the truck would be difficult. Petitioner drove his vehicle back to the home office and left for the day.

The next day Mr. Hayes sought treatment from his family doctor, Dr. Sauerberg. The doctor noted that Petitioner had suffered another episode of back pain and was complaining of radicular type symptoms. After an exam, Claimant was given Vicodin, Flexeril, and Prednisone and taken off work. Petitioner followed up with Dr. Sauerberg three days later. The doctor determined that his symptoms remained and advised him to continue the medication and return in a week. Dr. Sauerberg next saw Mr. Hayes on November 16, 2011. Petitioner reported that he had a couple of good days but the pain going down his right leg persisted and was now in his back. The doctor prescribed an MRI which was accomplished on November 19, 2011 at Hinsdale Hospital.

This diagnostic study demonstrated that Claimant had a moderate sized right paracentral disc protrusion at L4-5 which was causing mild impingement upon the right L5 nerve root as well as moderate secondary right paracentral canal stenosis. Further disclosure was of a bilateral symmetrical unfused pars defect at L5-S1 forming bilateral pseudoarthroses which caused a mild Grade I anterolisthesis and moderate to severe biforaminal stenosis.

Mr. Hayes returned to see Dr. Sauerberg on November 23, 2011 to review the MRI results. Because the MRI revealed abnormal pathology and Claimant was having ongoing serious problems with his right leg, the doctor referred him to Dr. Robert Kazan.

The initial evaluation with Dr. Kazan took place on December 2, 2011. Dr. Kazan noted that he had performed a previous surgery on Claimant in 2005 as a result of an on-the-job injury; Mr. Hayes had "had a lasting good result" until the event on November 7, 2011. The doctor read the MRI scan as demonstrating an extruded disc on the right at L4-5 and spondylolisthesis at L5-S1. The doctor recommended a right L4-5 discectomy.

Dr. Kazan performed the surgical intervention on December 27, 2011 at Hinsdale Hospital and followed Claimant postoperatively after that. Mr. Hayes made progress subsequent to the surgery, ultimately commencing physical therapy on January 26, 2012 at ATI. Claimant returned to see Dr. Kazan on February 27, 2012. Dr. Kazan recommended completing the remaining five sessions of physical therapy; thereafter, as Mr. Hayes had done extraordinarily well, he hoped to return him to work effective March 5, 2012.

Petitioner finished therapy as directed and returned to Dr. Kazan on March 5, 2012; the doctor determined that Claimant could return to work the following Monday without restrictions and was directed to return as needed.

During the course of the care of this disputed claim, Respondent had Petitioner examined by Dr. Carl Graf on two occasions, initially on February 20, 2012 and a second examination two months later on April 30, 2012.

The Arbitrator notes that Mr. Hayes testified in a credible and forthright fashion. With respect to his work activities and the consequences of this latest surgical intervention, he advised that he has discomfort from time to time as he performs his Very Heavy job duties but he wants to continue working as he has been with Respondent for 26½ years. Petitioner testified that he does take over-the-counter pain medication and in fact keeps a bottle of them in his truck for the purpose of relieving symptoms that occur during his workday.

Claimant testified as to the medical providers and an exhibit was offered on his behalf which showed medical expenses totaling $47,564.16 with some of those bills being paid by group health insurance subject to §8(j) credit, but leaving a balance of $10,672.47 as well as unreimbursed out-of-pocket expenses of $45.00 incurred by Petitioner, for a total of $10,717.47.

CONCLUSIONS OF LAW

WITH REGARD TO THE ISSUE OF WHETHER OR NOT THE CLAIMANT SUSTAINED AN ACCIDENTAL INJURY THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

For workers' compensation purposes, a "traveling employee" is defined as an employee who is required to travel away from the employer's premises in order to perform his job. Jensen v. Industrial Commission, 305 Ill.App.3d 274 (1999). Here, Mr. Hayes is a technician: he travels to Respondent's customers' residences and places of business to perform installations and repairs. As his job necessitates that he travel to various customer locations, Petitioner clearly meets the definition of a traveling employee. In the case of a traveling employee, "an injury is compensable if the conduct which gave rise to the injury is reasonable and might normally be anticipated or foreseen by the employer." Howell Tractor & Equipment Co. v. Industrial Commission, 78 Ill.2d 567, 573 (1980). Mr. Hayes was a very credible witness. He testified that on November 7, 2011, he had traveled to a customer's place of business for a service call; after completing the equipment installation, he returned to the truck to retrieve a meter to perform the necessary post-installation tests. The meter was on a lower middle shelf in the truck and he had to bend in an awkward twisting fashion to retrieve the tool; as he did so, he felt a sharp sudden onset of pain in his right buttock going down to his leg. Petitioner's performance of his specific duties, i.e. using Respondent-provided tools to perform the requisite readings and tests to ensure proper installation, cannot be deemed unforeseeable or unanticipated. See, e.g., Wilson v. City of Peoria, 01 IIC 0355 (Patrol officer injured on grounds of mental facility while investigating assault sustained injury arising out of and in the course of his employment). The Arbitrator finds that Mr. Hayes was a traveling employee, and the conduct resulting in injury was reasonable and foreseeable.

The Arbitrator further notes that based upon many cases it has been determined by the Illinois Workers' Compensation Commission, and been affirmed by the Appellate Court, that when a petitioner suffers an injury which results from assuming awkward positions either on a single basis or in a repetitive activity, that this constitutes an accidental injury which arises out of and in the scope of the employment. A recent decision by the Illinois Appellate Court dealing with an elderly care LPN was compensable when she suffered a back injury while twisting to reach for a bar of soap that had fallen from its resting spot. Accolade v. Illinois Workers' Compensation Commission, 2013 IL App (3d) 120588WC.

Therefore, the Arbitrator finds that based upon Petitioner's status as a traveling employee, the description of the event as testified to by Mr. Hayes, as well as the medical records and the deposition of Dr. Kazan, Claimant suffered a compensable accidental injury as defined by the Act.

Based upon the totality of the evidence and a preponderance thereof, the Petitioner herein sustained an accident as alleged which arose out of and in the course of his employer at bar.

WITH REGARD TO WHETHER OR NOT PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY CONNECTED TO HIS INJURY OR EXPOSURE, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

It has long been the law in Illinois that a chain of events showing a prior condition of good health, followed by a sudden change after a work injury, can establish causation. Illinois Power Co. v. Industrial Commission, 176 Ill.App.3d 317 (4th Dist. 1988). The Arbitrator notes that after being released from care following his 2005 surgery, Mr. Hayes had "a lasting good result" and was able to continue performing his regular physically demanding job duties until the incident on November 7, 2011; after that, Petitioner was restricted from work and required surgical intervention.

There are conflicting medical opinions regarding causation. Dr. Kazan, who performed both surgical interventions on Mr. Hayes, gave a clear description of the objective evidence supporting his position that there was a change in the man's condition following the November 7, 2011 event and that the injury resulted in the need for the surgery. In contrast, Dr. Graf, who testified on behalf of Respondent that he could find no causal connection, indicated in his report that there were degenerative as well as postoperative changes noted and that based upon his review of the medical records provided, he was unable to attribute Mr. Hayes' condition to a work related incident. In so opining, the doctor stated that none of the records forwarded to him showed that this was a work-related event until many weeks after. Dr. Graf went on to testify that the previous L4-5 lumbar decompression brought about a recurrent disc herniation from the current event, and that the surgery was appropriate but not related to the injury. Dr. Graf was asked by Respondent's Counsel as to whether or not he had an opinion following his initial examination in February of 2012, whether a connection existed between the event of November 7, 2011 and the ultimate symptomology and treatment received thereafter; Dr. Graf responded that he did not have adequate information to answer that question. Thereafter the doctor performed a second examination where he concluded that Mr. Hayes had a preexisting condition which was unchanged from his initial surgery of February 2005 and that the events of November 7, 2011 had no bearing whatsoever to a confidence level of 100%.

The Arbitrator finds as a matter of material fact t Dr. Graf's opinions regarding Petitioner's condition as of 2005 are unpersuasive given that they are contrary to those of Dr. Kazan, the treating physician who actually performed the 2005 surgery. The Arbitrator finds that Dr. Kazan's testimony was more credible and in keeping with the Workers' Compensation Act and the decisions rendered thereunder, specifically Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003), and Twice Over Clean, Inc. v. Industrial Commission, 214 Ill.2d 403 (2005), wherein the Illinois Supreme Court definitively held that even though a petitioner may have a preexisting condition, if the work activity is "a" cause of the condition of ill-being and the resulting need for medical treatment, then a causal connection exists. This law is longstanding back to the Supreme Court survey of the law in Goldblatt, Bros. Inc. v the Industrial Commission.

Therefore, based upon the totality of the evidence the Arbitrator finds that Petitioner has proven by a preponderance of the evidence a causal connection between the events as testified to as occurring on November 7, 2011 and the current condition of ill being , the resulting lost time and medical care rendered therein.

WITH REGARD TO WHETHER OR NOT THE UNPAID MEDICAL BILLS ARE REASONABLE AND NECESSARY AND ALLOWABLE, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner offered into evidence an exhibit that demonstrated that he incurred medical expenses totaling $47,564.16, portions of which had been paid by his group carrier, leaving a balance of $10,672.47 plus $45.00 in out of pocket expenses paid by Mr. Hayes.

The Arbitrator finds as a matter of law and fact based upon the totality of the evidence including t based upon the medical records offered on behalf of Petitioner and the testimony elicited at arbitration, Respondent shall be liable for the payment of $10,717.47 as and for medical expenses reasonably incurred by Petitioner. Said payment shall be paid to the Petitioner and his attorney under section 8.2 if applicable.

WITH REGARD TO WHETHER OR NOT PETITIONER IS ENTITLED TO ANY TEMPORARY TOTAL DISABILITY BENEFITS, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Mr. Hayes suffered an accidental injury on November 7, 2011 and was deemed unable to return to work, initially by his family doctor, Dr. Sauerberg, and later by Dr. Kazan. Those doctors restricted him from all work as of the date of the initial visit on November 8, 2011 through the discharge and return to work date of March 11, 2012, a period of 18 weeks. In lieu of Temporary Total Disability benefits, Claimant was paid a total of $16,952.64 as and for disability benefits paid through a plan provided by the employer. The amount of compensation Petitioner is entitled to pursuant to Section 8(b) of the Act would be identical to the amount claimed as credit by Respondent. Therefore the Arbitrator finds that Respondent has met its obligation consistent with Section 8(b) of the Act.

Based upon the totality of the evidence and a preponderance thereof, the Petitioner is entitled to temporary total disability as shown on the IWCC Award.

15IWCC0199

WITH REGARD TO WHETHER OR NOT PETITIONER IS ENTITLED TO PENALTIES AND ATTORNEY'S FEES PURSUANT TO SECTIONS 19(k), 19(l) AND SECTION 16, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Respondent took the position of objecting to the mechanics of the event of November 7, 2011, however, did provide access to medical treatment through its group health plan as well as the payment of group disability benefits. Therefore, the Arbitrator finds as a matter of law that the facts of this case and the evidence adduced herein do not warrant the imposition of penalties under Sections 19(k), 19(l) or attorney's fees under Section 16.

WITH REGARD TO THE ISSUE OF WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner testified as to the work activities that he engaged in as well as the difficulties that he has experienced since this latest traumatic event. Mr. Hayes testified that he has ongoing discomfort and problems given the heavy nature of his work. The nature of his work was commented on in Dr. Kazan's records. It is understandable that Claimant would attempt to continue working since he has a relatively high-paying job and has been an employee for many years, however one cannot ignore that this insult that occurred on November 7, 2011 did alter the architecture of Petitioner's lower spine requiring a discectomy which could lead to further problems.

Dr. Graf performed an AMA rating upon Petitioner at the second visit, determining that the impairment rating was 5%. In reviewing the deposition of Dr. Graf, however, the Arbitrator finds that the doctor argued that an impairment rating and a disability determination are identical and that the distinction was nothing more than semantics. Obviously, Dr. Graf's conclusion is completely at odds with the clear language of the Act; to the contrary, it is indisputable that there is a critical difference drawn between an impairment rating and a disability finding. Further, Dr. Graf's testimony as to modality of approach used to evaluate this individual was somewhat convoluted and the Arbitrator gives little credence to the doctor's conclusions and findings relative to the AMA standards. The Arbitrator finds that based upon this Doctor's explanation above his opinion is not at all credible from a legal point of view.

Based upon Mr. Hayes' unrebutted and credible testimony, as well as the deposition of Dr. Kazan and the operative report, the Arbitrator finds that a significant surgery was imposed on Petitioner and that he has suffered permanent damage to his lower spine which may impede his activity levels going forward. Further, he has ongoing symptoms which continue to nag him to the extent that he keeps a container of pain medications in his work truck so he can function and carry out his duties for Respondent. Mr. Hayes is in his late 40s and therefore has a fairly long life expectancy remaining, over the course of which he will be forced to endure continuing pain and symptoms.

Therefore, the Arbitrator concludes as a matter of fact and law that Petitioner sustained permanent partial disability to the extent of twenty per cent under section 8(d) 2 of the Act, as amended..

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MBAMBI NDUMBA,

Petitioner,

vs. NO: 07 WC 21026

McLEAN COUNTY NURSING HOME,

Respondent.

15IWCC0200

DECISION AND OPINION ON REVIEW

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

We note that the Arbitrator awarded Petitioner temporary total disability benefits for 187-6/7 weeks, commencing November 7, 2006, through May 31, 2007; and again from May 14, 2008, through April 1, 2011. The Commission agrees with the Arbitrator's dates of disability. However, we calculated the periods of disability to total 180 weeks. We therefore award Petitioner temporary total disability benefits for 180 weeks.

The Arbitrator awarded Petitioner permanent partial disability benefits of 40% loss of the person as a whole. We modify the Arbitrator and award Petitioner permanent partial disability benefits of 50% loss of the person as a whole.

Petitioner suffered a severe work injury when she was kicked in the chin and left shoulder area by a resident. She injured her jaw, shoulder and cervical spine as a result of the injury and has undergone multiple surgeries and years of physical therapy and various pain management measures. Petitioner has since developed myofasical pain syndrome, among other issues. She testified to the extensive issues she faces during her activities of daily living. While Petitioner is never pain free and she rates her average pain at 5/10, it will wax and wane and is often more intense than the 5/10 pain rating. Petitioner explained she needs her husband to help her care for their children and with regular household chores. For example, Petitioner can only lift light clothes and cannot do heavy laundry or grocery shop by herself. Additionally she has trouble getting dressed and doing her hair, and sleeping is very painful. She testified that she has difficulty eating hard foods and her jaw is painful to touch and swollen. Petitioner's life is limited by the pain she constantly experiences.

Petitioner's career has also been greatly affected by her work injury. Petitioner is unable to return to her previous employment with Respondent as a certified nursing assistant. She was given permanent work restrictions of not lifting more than 25 pounds and no repetitive overhead work. A functional capacity examination found Petitioner capable of working at the light to sedentary capacity. A labor market survey was prepared and suggested Petitioner would be capable of working as an unskilled cleaner, housekeeper or unskilled cashier. Petitioner testified that she attempted to return to work in the food service industry and as a cleaner but was unable to keep those jobs due to increased pain. The physical therapy notes reflect that she complained of additional pain after working, but there is no other evidence or physician note to support she ended her employment specifically because of her work related injuries.

Petitioner is extremely limited in her personal and professional life as a result of this work related injury and multiple medical issues. Therefore we award Petitioner permanent partial disability benefits of 50% loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $272.98 per week for a period of 180 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 $245.68 per week for a period of 250 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 50% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical bills referenced in Petitioner's Exhibit 26 per the Fee Schedule under §8(a) of the Act.

15IWCC0200

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: MAR 2 3 2015
TJT: kgg
R: 1/27/15
51

Thomas J. Tyrrell

Michael J. Brennan

PARTIAL CONCURRENCE AND DISSENT

While I would concur with the majority's decision to modify the Petitioner's temporary total disability benefits, I would respectfully dissent from the majority's decision to award permanent partial disability benefits of 50% loss of the person as a whole. I would affirm the remainder of Arbitrator McCarthy's well reasoned decision in its entirety and without further modification.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NDUMBA, MBAMBI
Employee/Petitioner

Case# **07WC021026**

McLEAN COUNTY NURSING HOME
Employer/Respondent

15IWCC0200

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:

0564 WILLIAMS & SWEE LTD
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

15IWCC0200

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

MBAMBI NDUMBA,
Employee/Petitioner

v.

MCLEAN COUNTY NURSING HOME,
Employer/Respondent

Case # **07 WC 21026**

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 **McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **3/26/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0200

FINDINGS

On **November 6, 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 $**9,561.97**; the average weekly wage was $**409.47**.

On the date of accident, Petitioner was **34** years of age, ***married*** 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 $**20.083.54** for TTD, $**0** for TPD, $* 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 $272.98/WEEK FOR 187 6/7 WEEKS, COMMENCING NOVEMBER 7, 2006 THROUGH MAY 31, 2007; AND AGAIN FROM MAY 14, 2008 THROUGH APRIL 1, 2011, AS PROVIDED IN SECTION 8 (B) OF THE ACT.

RESPONDENT SHALL BE GIVEN A CREDIT OF $20, 083.54 FOR TEMPORARY TOTAL DISABILITY BENEFITS THAT HAVE BEEN PAID.

RESPONDENT SHALL PAY RELATED MEDICAL CONSISTENT WITH THE ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW PURSUANT TO SECTIONS 8 AND 8.2 OF THE ACT.

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $251.32 FOR 200 WEEKS, BECAUSE THE INJURIES SUSTAINED CAUSED 40 % LOSS OF THE PERSON AS A WHOLE, AS PROVIDED IN SECTION 8 (D) (2) OF THE ACT.

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

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

D. Dyla McCarthy
Signature of Arbitrator

May 15, 2014
Date

ICArbDec p. 2

MAY 20 2014

FINDINGS ON DISPUTED ISSUES:

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

The parties have stipulated to an accident on November 6th of 2006 and the petitioner provided detailed testimony regarding that accident at arbitration. On that date, the petitioner was working as a CNA and was working with a combative patient. The combative patient kicked the petitioner in the left shoulder and jaw area. It wasn't exactly clear based upon the petitioner's testimony and motions at trial as to what portion of her body sustained the blow, but it was generally in the upper torso and jaw area on the left side.

The petitioner testified that on the date of the occurrence, she went to Healthpoint to treat and then was taken from Healthpoint to the emergency room. Based upon treatment to the shoulder, neck, and jaw, the petitioner testified to continued problems with pain and discomfort which have prohibited her from full activity, including an ability to work unrestricted. At all times throughout the course of her treatment, she has experienced problems with pain in her jaw, shoulder, and upper neck area, and at the time of trial, testified to continued pain which limits her strength and movement when moving or lifting her arms above shoulder level.

The petitioner did testify to a desire to work, and an ability to work if her restrictions are accommodated. She testified at the time of trial, that if restricted duty work which she believed she could do were offered to her, she would return to work at this time. The petitioner did testify to work she has undertaken since the date of the injury. She testified to working for Corporate Cleaning Systems doing office cleaning work from March until May of 2008, and again from June until July of 2011. She also worked as a cook for Uris Dining Services, which is a food service company housed at State Farm. She worked in that job from June of 2011 until October of 2011, primarily preparing pizzas. She also worked at Illinois State University from October of 2011 until April of 2012 as a prep cook in a cafeteria. When questioned on cross examination, the petitioner also testified that in November of 2010, she went to McLean County Nursing Home and talked to Matt Riehle about returning to work. She testified that she wanted to return to work in a capacity where her restrictions would be accommodated.

The petitioner also testified with regard to her efforts to find other work. The petitioner testified to petitioner's exhibit #45, which outlines various employers she contacted in an effort to obtain work. The petitioner also testified with regard to petitioner's exhibit #51, which outlines additional employers she contacted for purposes of obtaining work. On all occasions, she advised the prospective employers that she was looking for restricted duty work.

The petitioner's husband, Didier Mafwala Pembele also testified. He testified to the difficulty the petitioner has had since her injury. He testified that the petitioner does some light housework, but cannot do all of it and he needs to help with many of the house chores. He further testifies that he notices a swelling in her face which was not there previously. He did testify on one occasion for approximately a year they moved to Atlanta while he was exploring other employment opportunities.

Both the petitioner's husband and the petitioner testified that following the accident, the petitioner became pregnant and gave birth to their third child.

The respondent presented testimony from Matt Riehle, the Director of Nursing at McLean County Nursing Home and the Administrator of McLean County Nursing Home for all periods following the petitioner's injury. Mr. Riehle testified that he remembered the injury and initially had a conversation with the petitioner about treating at Healthpoint. He also recalled that after the injury the petitioner was returned to work full duty by Dr. Rink and attempted to return to work for one day, but after a half day's work claimed she could not do the work.

Mr. Riehle also testified to two other job offers which were made to the petitioner. Follwing a review of all of the medical evidence, Mr. Riehle was involved in a decision to offer the petitioner an opportunity to return to work as a CNA in August of 2009. Mr. Riehle testified that he instructed his attorney to send a letter to the petitioner's attorney on August 25th of 2009 offering the petitioner the opportunity to reapply for a position as a CNA. (Respondent's Exhibit #4).

Mr. Riehle further testified that in November of 2010, the petitioner showed up at the nursing home to speak to Mr. Riehle about returning to work. She said that she wanted to return to work and said nothing about wanting to return to work in a restricted duty capacity only. She seemed very anxious about returning to work. Mr. Riehle instructed her he would be in touch with the attorneys with regard to the return to work issue. Thereafter Mr. Riehle again instructed his attorney to make an additional offer for the petitioner to return to work as a CNA. Mr. Riehle instructed his attorney to send the letter to petitioner's attorney dated December 23rd of 2010, offering the petitioner an opportunity to return to work. (Respondent's Exhibit #5).

Mr. Riehle further testified to the fact that in order to reconfirm the County's desire to bring the petitioner back to work in a CNA capacity, he authorized his attorney to forward an additional letter making the offer to return to work on January 11th of 2011. (Respondent's Exhibit #6).

The petitioner originally treated at Healthpoint on November 6th of 2006. There was a concern for a head injury based upon complaints the petitioner was making, so she was immediately referred to the emergency room. (Petitioner's Exhibit #9 and Respondent's Exhibit #1). The emergency room records establish a kick to the face. The petitioner's complaint of pain was 10 out of 10. (Petitioner's Exhibit #8). The petitioner ultimately was referred to and came under the care of Dr. Rink at Carle Clinic.

The petitioner originally treated at Carle Clinic on November 8th of 2006 with Dr. Liang. The petitioner was referred to Dr. Rink for physical therapy. When Dr. Rink first saw the petitioner on November 13th of 2006, she was improving. He prescribed anti-inflammatory medication and physical therapy. The petitioner continued with such treatment with Dr. Rink through May 30th of 2007 when Dr. Rink released her to full duty. He noted that she had just began her physical therapy, and the notes indicate she continued in therapy until June 19. (Petitioner's Exhibits #10; 25 and Respondent's Exhibit #2). She did not return to work with the respondent, as she had been terminated on March 15, 2007. She returned to Dr. Rink on July 30, 2007, with continued tenderness in the left trapizial region. He

suggested that she not work in a job requiring repetitive use of the left shoulder, and released her on an as needed basis. (Id)

Dr. Rink made a referral to Dr. Holmes, a dentist, for purposes of evaluating the TMJ condition. The petitioner first saw Dr. Holmes on January 8th of 2007. Dr. Holmes diagnosed a piper 1 left and a piper 3a right condition in the jaw and recommended a mandibular hard occlusal splint. Ongoing treatment for the TMJ condition ensued through Dr. Holmes. (Petitioner's Exhibit #11).

In this same time frame, the respondent made a referral for a Section 12 IME to Dr. Robert Martin. Dr. Martin initially saw the petitioner on February 6th of 2007 and based upon his exam and review of the records, came to the conclusion the petitioner suffered from a post concussion syndrome, a right TMJ dislocation, and mild multi level degenerative disc disease of the cervical spine. The doctor related all of those conditions to the petitioner's described injury and did not believe the petitioner was at a position where she could return to work. He was concerned about further follow up on the TMJ and on the potential concussion injury. He recommended an MRI of the brain. After the MRI was completed, he prepared an updated report on February 23rd of 2007. He noted that the MRI did not show anything which represented chronic post traumatic changes from the November 6th of 2006 injury. He felt she should see a neurologist, but didn't believe there was any ongoing central nervous system problems related to the described injury. He ultimately prepared an additional report on March 12th of 2007 in which he indicated the petitioner had reached maximum medical improvement from any concussion associated with the injury, and still needed to treat for her TMJ condition. He did indicate that the petitioner as of March 12th of 2007 could do unrestricted work as a CNA. (Respondent's Exhibit #13 and associated exhibits 1-4). The respondent stopped the petitioner's TTD benefits shortly after the Martin exam on March 14, 2007.

The petitioner continued to treat with Dr. Holmes for her TMJ condition, and testified that his splint treatment did not reduce the petitioner's pain and popping in the right jaw. He referred her to Dr. Efaw to perform an arthroscopic procedure to clean out the joint, and that procedure was performed on May 3, 2007. Dr. Holmes testified that the procedure also was not effective, so he referred the petitioner to Dr. Piper for a surgical repair of the joint. (Pet. Ex. 1 at 19) He testified that he chose Dr. Piper because he is the leader in the field of surgical treatment for the condition.

The petitioner was seen by Dr. Piper on November 19, 2007. Following his examination, the doctor recommended a reconstructive arthroplasty of the right TMJ joint.

The respondent did not authorize the procedure and sought an IME, which was performed by Dr. Kenneth Rotskoff on March 12, 2008. Dr. Rotskoff came to the conclusion that the reconstruction of the TMJ joint suggested by Dr. Piper was the appropriate treatment. (Respondent's Exhibit #3). As a result, the respondent authorized treatment through Dr. Piper, and he performed a microscopic reconstruction arthroplasty of the petitioner's right temporo mandibular joint on July 31, 2008. She was taken off work by Dr. Piper, and TTD benefits were reinstated as of August 2, 2008.

With regard to the petitioner's ability to work during his treatment, Dr. Piper testified that she would have been unable to work for nine months following her surgery for her TMJ condition. (Pet. Ex. 27 at

41) He then continued to restrict her from full work duties due to her cervical irritation and complex regional pain syndrome, which both he and, several years later, Dr. Li, related to her right sided facial injuries. (Id at 34, 46; Pet. Ex. 39) The petitioner has remained under various work restrictions through the date of arbitration.

After Dr.Piper's treatment essentially ended in early to mid 2010, petitioner returned to Dr. Rink for follow up care. Dr. Rink reinitiated an ongoing course of treatment that proceeded off and on all the way up through the date of Arbitrator. This treatment has consisted of therapy, injections, and medication. He ultimately had an FCE performed which identified restrictions which he felt were permanent. After iit became clear that many years after the accident, the petitioner was still treating with Dr. Rink for the trapezius and cervical muscle strain, the respondent had an additional IME performed with Dr. Ryon Hennessy. Dr. Hennessy evaluated the voluminous medical records and prepared a detailed report. In his deposition, he testified that as a result of the November 6th of 2006 injury, the petitioner suffered a cervical strain. Dr. Hennessy noted that there was no objective evidence of any condition of the cervical spine at the time of his examination on October 8th of 2012. He further noted that based upon his review of the medical treatment records, the petitioner would have been at MMI in need of no additional treatment for her cervical strain injury as of March 12th of 2007. (Respondent's Exhibit #12).

During the same time frame when the petitioner began treating with Dr. Piper, she was also seen by Dr. Seidl, an orthopedic surgeon, on referral from Dr. Rink. On May 6, 2008, he performed an exam and reviewed MRI films of the petitioner's left shoulder. He diagnosed an impingement syndrome and a partial tear of the rotator cuff. He performed surgery on May 14, 2008, decompressing the subacromial space and debriding the partial thickness tear. (Pet. Ex. 2 at 10,11) The petitioner did well following surgery and she was released to work for those conditions on August 11, 2008. (Id at 13) The petitioner testified that she continued to have some pain and weakness in the shoulder, and Dr. Seidl saw her again on April 21, 2009. At that time he found a normal range of shoulder motion, but pain at extremes of motion and weakness. He testified that those symptoms likely would not improve, but recommended no further shoulder surgery. He suggested home exercise. The petitioner was seen next by Dr. Seidl's physician assistant on November 12, 2009 with complaints of ongoing pain in the shoulder and the left side of the neck. His examination revealed edema of the left trapizius, and he provided an injection. He suggested that she avoid heavy lifting with the left arm and a return to work in a non lifting job. (Pet. Ex. 20)

Dr. Seidl testified concerning the causal relationship between the accident and the condition which he treated. First of all, he understood by way of history that the petitioner had been kicked during an assault and sustained a neck injury. (Pet. Ex. 2 at 7,8) His understanding is consistent with the histories provided by the petitioner to her initial treatment providers, Healthpoint and Dr. Liang. (Pet. Ex. 9,10) He also understood, consistent with all of the other evidence, that the petitioner had no symptoms of neck, shoulder or upper left trapizius pain prior to her accident. He explained that the initial neck pain could have caused the petitioner to change her posture, which in turn could have lead to weakness and irritation to the upper arm and trapizius when performing daily activities with an altered posture. In time, this could have lead to an impingement. (Pet. Ex. 2 at 23)

Dr. Rink explained the causal relationship in a similar fashion. He said the impingement developed from tightness or spasm of the shoulder muscles resulting in an "altering or changing of her mechanics..." (Pet. Ex. 34 at 48) As a result of the ongoing tightness, Dr. Rink said the rotator cuff tendon could have gotten irritated, leading to impingement. (Id at 49)

The respondent had the shoulder condition evaluated by both Dr. Jay Pomerance and also by Dr. Hennessy during his evaluation of the cervical spine condition. Dr. Hennessy clearly rendered the opinion that the shoulder condition was unrelated to the work accident. (Respondent's Exhibit #12). Dr. Pomerance initially was equivocal in his report of October 6th of 2012, as to whether or not the shoulder condition was related, and in his report of February 23rd of 2013, Dr. Pomerance came to the conclusion that since there was no evidence of a pre-existing shoulder complaint, there would be some relationship between the petitioner's shoulder condition on an aggravation/acceleration basis. (Respondent's Exhibits #8 & #9).

The Arbitrator finds the opinions of Dr. Seidl and Dr. Rink persuasive on the issue of causation as it pertains to the petitioner's left shoulder treatment. There is really no dispute as to the issue of causation between the petitioner's TMJ and the accident and the evidence established that relationship as well. For the past several years, the petitioner's treatment has centered around her right sided facial pain and pain in the left side of the neck and upper trapizius. Her complaints of pain to Dr. Rink since he resumed her care in 2010 have been consistent, (Pet. Ex. 30) he describes her condition as chronic cervical, upper shoulder myofascial pain with associated occipital neuralgia. (Id on July 3, 2013) Dr. Piper saw her last on May 14, 2012 and diagnosed cervical sympathetic pain. (Pet. Ex. 31) Nerve studies performed in late 2012 and August 2013 both revealed chronic left cervical radiculopathy at C 7-8. (Pet. Ex. 41, 43) While some of her symptoms are admittedly subjective, she did perform a valid FCE on May 2, 2012 establishing her limitations from those conditions. (Pet. Ex. 30) The above evidence supports a finding of causation between the petitioner's accident and her ongoing conditions of ill being.

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

The Arbitrator refers to the findings on disputed issues contained in the section above addressing causal relationship. Based upon those findings, the Arbitrator notes that the respondent has already paid $81,943.87 in medical bills. The evidence documents that the respondent has paid all medical associated with the petitioner's TMJ condition and no additional medical is therefore awarded for that condition. To the extent there remain unpaid medical bills for treatment to the shoulder rendered by Dr. Seidl, the respondent will pay those medical bills. Based upon the causation findings above, the Arbitrator finds that the respondent is also responsible for any claimed unpaid medical bills associated with the cervical spine or trapezius muscle strain, along with any treatment related to her CRPS diagnosis. The respondent is ordered to pay the bills referenced in petitioner's exhibit 26, pursuant to the Fee Schedule.

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

Dr. Rink and others had the petitioner off work from the date of accident through May 31, 2007. After that, she was only restricted from repetitive work by Dr. Rink's note of July 31, 2007. Dr. Holmes did not restrict her work after January 2007, and though she did initially see Dr. Piper at his request in November 2007, his records and testimony do not establish that he had her off or restricted at that time. Dr. Seidl had her off again beginning on May 14, 2008. She remained either off work or under restriction while she was active in treatment through April 1, 2011, when Dr. Rink placed her on restrictions which he said were permanent in nature. (Pet. Ex. 34 at 28) Shortly after that date, the petitioner began working under those restrictions. Accordingly, considering the Arbitrator's earlier findings on causation, the petitioner is entitled to TTD benefits from November 7, 2006 through May 31, 2007, and again from May 14, 2008 through April 1, 2011, a period of 187 6/7 weeks. Respondent obviously gets credit for the weeks of TTD it had paid.

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

With regard to nature and extent, the Arbitrator incorporates the findings outlined in the causation section above. In addition, the Arbitrator notes the parties both submitted additional evidence with regard to the petitioner's ability to return to work. The Arbitrator notes the petitioner's testimony with regard to her job search, and the exhibits submitted at trial supporting her job search. The petitioner is claiming an inability to work and presumably is seeking a perm total or wage differential award.

In that regard, the petitioner also submitted evidence from vocational rehabilitation consultant, Dennis Gustafson. Gustafson noted that the petitioner's ability to work is somewhat limited by her command of the English language. He ultimately came to the conclusion the petitioner can work, but her work would need to be in the light or sedentary work capacity. He believes the petitioner can work in jobs including housekeeping, childcare, non-farm animal caretakers, personal and homecare aids, production occupations, and food preparation workers. He believes that the job market would allow the petitioner to work in the range of $8.50 to $9.50 per hour. He also notes that the medical records establish the petitioner may initially be unable to perform full time work for eight hours, and part time work initially may be advisable to determine the true extent of her work capabilities. Consultant Gustafson also notes the petitioner's work since her employment at McLean County Nursing Home, including work cleaning offices for Corporate Cleaning Systems, working as a cook for a food service company at State Farm Insurance, and working as a prep cook at Illinois State University. (Petitioner's Exhibit #38).

The respondent also presented a labor market survey prepared by Jim Ragains. Mr. Ragains was asked to perform his labor market survey, assuming the petitioner's only work capacity was that identified by the functional capacity evaluation recommended by Dr. Rink on May 2nd of 2012. Based upon these assumptions, Ragains came to the conclusion that there was a stable job market for the petitioner as an unskilled cleaner, a housekeeping worker, or an unskilled cashier. He believed the labor market would provide wages in the range of $8.50 to $9.50 per hour.

It was stipulated at trial by the parties that in the event the petitioner were working at full capacity as a CNA, she would be earning approximately $12.00 per hour in today's market.

The Arbitrator has considered all of this evidence and determines that the petitioner's permanency award should be for a percentage man as a whole to address her various injuries. Given the medical evidence outlined above, particularly the valid FCE done on May 2, 2012, the Arbitrator believes that the petitioner is no longer able to perform her usual job as a certified nurse's assistant. The petitioner demonstrated an ability to work cleaning offices, working as a food prep clerk, and working preparing pizzas. While she claimed subjective difficulties in doing this at trial, there is no evidence to support that the reason for her ending those various employments was related to her injuries. Also, while she did submit extensive records concerning a job search since July 2013, the jobs she has pursued and the jobs which she did perform, referenced above, appear to be the same type of jobs referenced by both vocational experts which fall within her restrictions set forth in the FCE. According the evidence does not support an odd lot permanent and total.

As a result, the Arbitrator finds that the petitioner sustained injury to the extent of 40 % person as a whole pursuant to Section 8 (d) (2) for her injuries.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- ☐ 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

MARTIN AGUILAR,

Petitioner,

vs.

NO: 06 WC 22358

ELECTRO-MOTIVE DIESEL, INC.,

15IWCC0201

Respondent.

DECISION AND OPINION ON REMAND
FROM THE CIRCUIT COURT OF COOK COUNTY

The Commission is in receipt of an Order and Opinion from the Circuit Court of Cook County, relative to the above captioned matter, under its case number 13 L 050523, by which it remanded the Decision of the Commission under its case number 13 IWCC 0483, finding that the Commission's Decision lacked an explanation and instructing the Commission to provide reasoning for its Decision.

On September 18, 2012, Arbitrator Thompson-Smith issued an Order denying Petitioner's Motion to Reinstate. On May 2, 2013, the Commission issued a decision affirming and adopting the Arbitrator's order. The case was then timely appealed to the Circuit Court.

Judge Lopez Cepero wrote:

> "The Court notes that neither the Arbitrator nor the Commission provided an explanation as to why Plaintiff's Motion to Reinstate was denied. Without such information, the Court cannot perform its duties on Administrative Review. The Court is constructively shielded from analyzing whether the Commission's

15IWCC0201

decision is against the manifest weight of the evidence or clearly erroneous. Therefore, the matter is remanded to the Commission with instructions to provide an explanation as to why Plaintiff's Motion to Reinstate was denied."

FINDINGS OF FACT

The Commission finds the following facts.

On May 22, 2006, Petitioner filed an Application for Adjustment of Claim. On December 22, 2009, Petitioner's claim was dismissed for want of prosecution. Petitioner's Motion to Reinstate the claim was granted on February 23, 2010. Petitioner then filed two substitutions of counsel on April 28, 2010, and June 22, 2011, respectively. On February 2, 2012, Petitioner's counsel informed the Arbitrator he had no had contact with Petitioner and the claim was again dismissed for want of prosecution.

Petitioner's counsel received notice of the dismissal on March 23, 2012. Petitioner's counsel asserts a Motion to Reinstate was filed on March 28, 2012. No such Motion is of record.

Petitioner then re-established contact with his counsel on July 2, 2012. His counsel filed a Motion to Reinstate on July 31, 2012 and it was to be presented on the August trial cycle. The reasoning to reinstate the claim per the petition was "That when this case was last before the arbitrator on the 7th of February the Petitioner had been out of contact with his attorney. That a motion to reinstate was timely filed on March 28, 2012 within the 60 day time limit as prescribed by law. (Pet Ex #1) That the Petitioner has a valid case. This motion was filed within 60 days receipt of notice of the dismissal order. That Petitioner had re-established contact with his attorney and the case is ready to proceed." In the interim, Petitioner filed his own Motion to Reinstate and he attempted to present it on August 1, 2012, however the Arbitrator withdrew the Motion. The Arbitrator also assigned a briefing schedule and hearing date was given to both attorneys to determine whether the matter should be reinstated.

On August 29, 2012 the parties held a hearing before Arbitrator Thompson-Smith. Petitioner's counsel alleged he filed a Petition to Reinstate on March 28, 2012, however that Motion is not in the Commission's computer system and was not presented to the Commission. A copy of the July 31, 2012 Petition to Reinstate is recorded in the Commission's system. The Arbitrator issued an Order on September 18, 2012 denying Petitioner's Petition to Reinstate. The matter was timely appealed to the Commission.

The Commission heard oral arguments on the matter on April 16, 2013. Petitioner argued in his brief that he timely filed the Petition to Reinstate. He further argued Respondent was not prejudiced by a three month delay and since Petitioner re-established contact with his attorney, he has remained active and committed to the matter. The Commission issued a Decision on May 2, 2013, affirming and adopting the Arbitrator's Order.

CONCLUSIONS OF LAW

The Commission affirms its previous decision and denies Petitioner's Motion to Reinstate.

The Commission rules set forth the procedure for claims before they are dismissed for want of prosecution. The Commission's rules provide that written notices will be sent to the parties only for the initial status call setting on arbitration. 50 Ill. Adm. Code § 7020.60(a) (2002). Thereafter, the cases are continued at three-month intervals until the case has been on file with the Commission for three years, set for trial, or otherwise disposed of. 50 Ill. Adm. Code § 7020.60(a) (2002). When a case has been on file with the Commission for three years or more, the parties or their attorneys must be present at each status call on which the case appears. 50 Ill. Adm. Code § 7020.60(b)(2)(C)(i) (2002). If the claimant or the claimant's attorney fails to appear at a status call upon which the case appears, then the case shall be dismissed for want of prosecution except upon a showing of good cause. 50 Ill. Adm. Code § 7020.60(b)(2)(C)(ii) (2002).

After a case has been dismissed from the arbitrator's call for want of prosecution, Section 7020.90 allows for parties to file Petitions to Reinstate. "When a cause has been dismissed from the arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a petition for reinstatement of the cause onto the arbitration call. Notices of dismissal shall be sent to the parties." 50 Ill. Adm. Code § 7020.90(a). The rules also require the Petition to Reinstate be in writing and "The petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. **The petition must also set forth the date on which Petitioner will appear before the Arbitrator to present his petition. A copy of the petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 7020.70.**" 50 Ill. Adm. Code § 7020.90(b). Lastly, the rules state "Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the petition. **The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by Petitioner, the objections of Respondent and the precedents set forth in Commission decisions.**" 50 Ill. Adm. Code § 7020.90(c).

The Appellate Court has consistently held, "In a petition for reinstatement before the Industrial Commission, the burden is on the petitioner to allege and prove facts justifying the relief prayed. **The granting or denying of the petition to reinstate rests in the sound discretion of the Commission.**" Bromberg v. Indus. Com., 97 Ill. 2d 395, 400, 73 Ill. Dec. 564, 566, 454 N.E.2d 661, 663 (1983). We find that Petitioner failed to meet his burden in this case.

First, the rule allows the parties 60 days from notice of the dismissal to file a petition to reinstate. Petitioner's counsel admits he received notice that Arbitrator Thompson-Smith dismissed the claim for want of prosecution on March 23, 2012. Petitioner's counsel alleges he filed a petition to reinstate on March 28, 2012, which would be in the filing period. However,

this allegation is not supported by the record. There is no record of his alleged filing in the Commission's system and Petitioner's counsel failed to ever produce a copy of the alleged filing when he had ample opportunity to do so. The next petition to reinstate was not filed until July 31, 2012. This was filed long outside of the 60 day time period allowed for filing.

Second, the March 28, 2012, alleged petition was not served on the other side as required by the rules of the Commission. It thus fails another required of the Commission's rules regarding petitions to reinstate. Third, Petitioner failed to set a final date and place for the hearing on said matter.

Finally, we find Petitioner failed to show how the "standards of fairness and equity" justified his claim being reinstated. In Richter v. Ill. Workers' Comp. Comm'n (Archer Daniel Midland Co.), 2012 IL App (4th) 110618WC-U, the Appellate Court upheld the arbitrator's dismissal of the claim that had been pending for eight years. The Court stated:

> Nor did the claimant demonstrate that "standards of fairness and equity" justified reinstatement. He presented no colorable excuses for the lengthy delay in prosecuting his case, and he cannot explain why it was unfair to dismiss his claim for want of prosecution. In fact, because the case had been pending for eight years, the Commission might reasonably have concluded that the equities favored dismissal and that reinstatement would be unfair to the employer. See, *e.g.*, *Banks*, 345 Ill. App. 3d at 1141-42 (affirming Commission's denial of petition to reinstate case that had been pending for five and one-half years when it was dismissed, and noting that "[a]fter a lengthy delay witnesses may be unavailable or their ability to recall the incident may be diminished" and that "as the delays mounted, the potential for prejudice to employer increased").

Id. ¶ 19. Similarly, the Commission holds the "standards of fairness and equity" do not require us to overturn the Arbitrator's denial of the petition to reinstate. Petitioner originally filed his Application for Adjustment of Claim in May 2006. The case was dismissed for want of prosecution for the first time in December 2009. Petitioner was not in contact with his attorneys throughout this period until July 2012, six years after his claim had originally been filed. Petitioner's counsel offers no valid reason why the "standards of fairness and equity" require reinstatement in his case. The Petition itself merely states that Petitioner has re-established contact with his attorney, without offering any explanation as to why he fell out of contact, and that Petitioner has a valid claim. Petitioner's counsel also claimed Respondent was not prejudiced or harmed by the delay in the case and it was not his fault the alleged March 2012 Petition to Reinstate was not entered into the system. Again, Petitioner's counsel has been unable to present this alleged Petition.

The Appellate Court has expressed its frustration with claims lingering and being indefinitely continued and reinstated. The Appellate Court in Bromberg stated "he is not entitled to assume that, in the face of his apparent lack of interest, a benevolent commissioner will

15IWCC0201

automatically continue the case, fix a new hearing date and notify him thereof." Id. at 402, 567, 664. We echo that sentiment and cannot find that the Arbitrator incorrectly dismissed the claim for want of prosecution when Petitioner failed to meet his burden in the Petition to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order on September 18, 2012, is 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: MAR 2 3 2015
TJT: kgg
R: 2/2/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SUSAN BIDSTRUP,

Petitioner,

vs.

NO: 12 WC 42235

NORTHERN ILLINOIS UNIVERSITY,

15IWCC0202

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

The Commission finds Petitioner's injury resulted from an idiopathic fall, which is not a compensable injury under the Act, and further explains its reasoning. The courts have denied compensation for idiopathic falls, which result from an internal, personal origin. See Elliot v. Indus. Com., 153 Ill. App. 3d 238, 242, 106 Ill. Dec. 271, 274, 505 N.E.2d 1062, 1065 (1987)

Petitioner did not prove that her injury arose out of and in the course of her employment with Respondent. The act of stepping onto a single step alone and experiencing knee pain is not a compensable accident. Although Petitioner would not have been at that staircase but for her employer, putting her there is not enough for an injury to be compensable. See "The mere fact that the duties take the employee to the place of the injury and that, but for the employment, he would not have been there, is not, of itself, sufficient to give rise to the right to compensation. Caterpillar Tractor Co. v. Indus. Com, 129 Ill. 2d 52, 63, 133 Ill. Dec. 454, 458, 541 N.E.2d 665,

669 (1989). Petitioner was required to show that something particular to her employment contributed to the risk of hurting herself on the stairs, and she failed to do so.

In this case, Petitioner was merely walking down the stairs and nothing particular to her employment contributed to her injury on the step. We distinguish Petitioner's situation from other cases where claimants injured themselves traversing stairs while also carrying a heavy object for their employers. For example, in Nabisco Brands v. Indus. Comm'n (Prendergast), the claimant injured himself while carrying large knives down stairs. The Appellate Court explained "It is true there was no evidence of the stairs being defective or of anything being on the stairs to cause claimant's fall. It is also true the act of walking down stairs at employer's place of business by itself does not establish a risk greater than those faced outside the work place. And, the need to walk down stairs certainly is not unique to claimant's employment. What was unique, however, was the need to carry three bakery knives, three knives which together weighed some 50 pounds and were over a yard in length. Even if the fall were purely idiopathic in nature, the knives greatly increased the dangerous effects of the fall." (citation omitted) Nabisco Brands, 266 Ill. App. 3d 1103, 1107, 204 Ill. Dec. 354, 358, 641 N.E.2d 578, 582 (1994).

Unlike the claimant in Nabisco, Petitioner merely testified "I stepped up onto the first step, and I heard my knee pop or crack, and I had instant pain and couldn't put any pressure on it." Petitioner failed to prove anything particular to her employment contributed to her injury. She was not distracted by something involving her work and was not carrying anything that would burden her or increase her risk of falling. Petitioner was not exposed to a risk greater than the general public by walking down stairs unburdened.

Petitioner also failed to prove there was a defect in the stairs that would have contributed to her fall. Petitioner admitted on cross examination that her foot did not get caught in any gap in the stairs. There was no evidence presented at trail showing the two steps were uneven or abnormally high. Even though Respondent directed Petitioner to use those particular stairs, there was nothing inherently wrong or abnormal with the stairs that would have contributed to her injury. Petitioner failed to prove her knee injury resulted for a risk distinctly associated with her employment. Therefore we affirm the Arbitrator and find Petitioner failed to prove she suffered a work related injury arising out of and in the course of her employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 19, 2013 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.

15IWCC0202

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

DATED: MAR 2 3 2015
TJT: kgg
R: 2/3/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BIDSTRUP, SUSAN
Employee/Petitioner

Case# **12WC042235**

NORTHERN ILLINOIS UNIVERSITY
Employer/Respondent

15IWCC0202

On 11/19/2013, 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:

0657 TURNER LAW OFFICES
ALICE SACKETT HENRIKSON
107 W EXCHANGE ST
SYCAMORE, IL 60178

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

5145 ASSISTANT ATTORNEY GENERAL
KATHARINE ARISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0904 STATE UNIVERSITY RETIREMENT SYS
PO BOX 2710 STATION A*
CHAMPAIGN, IL 61825

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

NOV 19 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SUSAN BIDSTRUP
Employee/Petitioner

v.

STATE OF ILLINOIS,
NORTHERN ILLINOIS UNIVERSITY
Employer/Respondent

Case # 12 WC 42235

Consolidated cases: _____

15IWCC0202

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **August 9, 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 **September 4, 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 **$41,892.94**; the average weekly wage was **$805.63**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** 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

Having found that Petitioner failed to prove that she sustained an accidental injury arising out of and in the course of her employment with Respondent, her claim for compensation is hereby denied.

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

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

Signature of Arbitrator

11/6/13
Date

ICArbDec p.

NOV 19 2013

FINDINGS OF FACT

On September 4, 2012, Petitioner was 56 years old, married with no dependents. Petitioner was an Assistant Coordinator of Parking and Traffic for Northern Illinois University.

Petitioner testified that she was injured on September 4, 2012 while attempting to enter the employee entrance to the parking services building after making a payroll delivery. Petitioner stated she was ascending the stairs outside the entrance when she felt and heard her knee pop and crack. Afterwards she felt pain in her knee, leaned against the building wall and another employee helped her into the office. Petitioner provided that she did not trip on the steps nor did she get her foot stuck in any gaps between the steps.

Petitioner testified that the entrance she used was for employees only and not a general means of ingress and egress. Petitioner had a key fob for this entrance and was instructed to use this door when the parking department was busy. Petitioner provided that the date in question was a busy day in the parking department as it coincided with the beginning of the school year at Northern Illinois University. Only employees with a code combination or key fob had access to this door.

Subsequent to the incident, Petitioner provided notice to her supervisor, the Director of Parking. She also filed a Notice of Injury detailing that on September 4, 2012, she "[w]ent outside to give payroll to enforcement for delivery to HR east entrance- put up right foot on first step- pain shot up behind knee-heard sound pop?" (RX 1)

On September 5, 2012, Petitioner presented at Kishwaukee with a history that "[y]esterday …she was walking up into her office. It was 2 steps and she extended her right leg and placed it on top of the step and as soon as she shifted her weight to the right leg and started to climb up the stairs, she felt a "crack" on the paterior aspect of her right knee…" (PX 1) X-rays taken were negative for acute findings. She was prescribed Flexeril for the pain and diagnosed with right hamstring strain. Petitioner was advised to follow-up with Dr. Gannon Brodner and returned to "min. work using right knee." (PX 1)

Petitioner testified that she did not seek additional treatment until December 7, 2012. At that time she saw Dr. Bodner of Midwest Orthopaedic Institute. Petitioner provided that on September 4th she was going into a building at work and when she went up to step and felt a sharp pain, possibly a pop from the back of her right knee. The orthopedic doctor assessed a posterior knee injury three months ago with a possible ruptured Baker's cyst or a root tear of the back meniscus. Dr. Bodner recommended a cortisone injection and physical therapy. Dr. Bodner noted Petitioner rejected further treatment noting she wanted mostly just to get a report of the findings for her attorney to evaluate. The doctor indicated she should continue with anti-inflammatories, home exercises, and ice when necessary. (PX 2)

Petitioner returned to work full duty. Petitioner testified that she is able to perform her work duties. She testified that she continues to experience pain and cannot put pressure on her knee. Petitioner testified she has difficulty with stooping, kneeling and standing for prolonged lengths of time. Petitioner currently does not receive treatment for her injury.

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

A claimant has the burden of proving all of his or her case by a preponderance of the evidence. *Chicago Rotoprint v Industrial Comm'n*. 157 Ill.App.3d 996 (1987). Liability cannot rest upon imagination, speculation or conjecture.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (West 2006). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). In order to determine whether a claimant's injury arose out of her employment, we first must categorize the risk to which she was exposed. Risks to employees fall into three groups: (1) risks distinctly associated with the employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102 (2006). An injury resulting from a neutral risk to which the general public is equally exposed does not arise out of the employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 59 (1989).

For an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the falls stemmed from a risk associated with her employment. *First Cash Financial Services*, 367 Ill. App. 3d at 106; (citing *Builders Square Inc. v. Industrial Comm'n*, 229 Ill. App. 3d 1006 (2003)). Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling. *First Cash Financial Services*, 367 Ill. App. 3d at 106.

In this case, Petitioner did not present any evidence explaining the cause of the pain in her leg. She merely testified that she attempted to walk up the stairs when she felt pain in her leg, which caused her to lean against a wall. There was no evidence of any defect in the steps or sidewalk causing her injury. *See First Cash Financial Services*, 367 Ill. App. 3d at 106.

Based on the above, the Arbitrator finds that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent on September 4, 2012. As such, all remaining issues are rendered moot.

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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan A. Acevedo,

Petitioner,

vs. NO: 12 WC 24079

Bloomington-Normal Seating Company,

15IWCC0203

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Petitioner herein and notice given to all parties, the Commission after considering the issues of medical expenses, temporary total disability benefits, and prospective 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 further remands this case to the Arbitrator for additional 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 has proved entitlement to temporary total disability benefits from October 27, 2012 through June 5, 2013 and to prospective medical in the form of medical branch injections recommended by Dr. Rink.

The Commission notes that the Arbitrator denied Petitioner's claim for temporary total disability benefits from October 27, 2012 through June 5, 2013, based on the fact that Petitioner was terminated from his employment with Respondent on October 26, 2012. The Arbitrator also

noted that Petitioner had not seen Dr. Rink since June 29, 2012, about four months before Petitioner's employment was terminated.

In *Interstate Scaffolding, Inc. v. IWCC*, 236 Ill. 2d 132, 142 (2010), the court explained that:

> "[i]t is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement. *Westin Hotel v. Industrial Comm'n, 372 Ill. App. 3d 527, 542, 865 N.E.2d 342, 310 Ill. Dec. 18 (2007)*; *Land & Lakes Co. v. Industrial Comm'n, 359 Ill. App. 3d 582, 594, 834 N.E.2d 583, 296 Ill. Dec. 26 (2005)*; *F&B Manufacturing Co. v. Industrial Comm'n, 325 Ill. App. 3d 527, 531, 758 N.E.2d 18, 259 Ill. Dec. 173 (2001)*. See also *Archer Daniels Midland Co. v. Industrial Comm'n, 138 Ill. 2d 107, 118, 561 N.E.2d 623, 149 Ill. Dec. 253 (1990)* [**272] (TTD compensation is provided for in *section 8(b)* of the Workers' Compensation Act, which provides, '[W]eekly compensation *** shall be paid *** as long as the total temporary incapacity lasts,' which this court has interpreted [***12] to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit). Further, the period during which a claimant is temporarily totally disabled is a question of fact to be resolved by the Commission, whose determination will not be disturbed unless it is against the manifest weight of the evidence."

The court further explained that:

> "[l]ooking to the Act, we find that no reasonable construction of its provisions supports a finding that TTD benefits may be denied an employee who remains injured, yet has been discharged by his employer for 'volitional conduct' unrelated to his injury. A thorough examination of the Act reveals that it contains no provision for the denial, suspension, or termination of TTD benefits as a result of an employee's discharge by his employer.

> Nor does the Act condition TTD benefits on whether there has been 'cause' for the employee's dismissal. Such an inquiry is foreign to the Illinois workers' compensation system. *Interstate Scaffolding* at 146.

The Commission notes that Petitioner was still on restricted duty when he was fired on October 26, 2012. (PX2,PX6) The Commission further notes that Dr. Rink's records indicate that the reason Petitioner did not return to Dr. Rink after June 28, 2012 was because all of Dr. Rink's treatment recommendations were denied by Respondent's workers' compensation insurer and there was nothing more Dr. Rink could do for Petitioner based on the lack of authorization for additional treatment. Petitioner has not worked since he was fired on October 26, 2012 nor has Dr. Rink released Petitioner from his restrictions. Therefore, based on the totality of the evidence presented and *Interstate Scaffolding*, the Commission finds that Petitioner is entitled to temporary total disability benefits from October 27, 2012 through June 5, 2013, the date of the arbitration hearing.

As for the medical branch injections recommended by Dr. Rink, the Commission notes that Dr. Rink recommended the injections not only as treatment, but as a diagnostic tool. Dr. Rink explained in Petitioner's medical records how previous injections had worked in treating Petitioner's symptoms and expressed his annoyance with the insurance company's denial of authorization for the medial branch injections. (PX2,PX6) During his evidence deposition on January 18, 2013, Dr. Rink testified that the injections would help "with making—determining if that—if the facet joints are the source of the pain." (PX3-pgs.41-42) Dr. Rink explained that the injections would help identify the source of Petitioner's ongoing pain. Dr. Rink testified that he was still "trying to identify where the pain is actually coming from. So that's what part of all these injections are going for." (PX3-pg.18) He further explained: "Although, we can't guarantee that these injections are going to beneficial because we are looking at them from a diagnostic standpoint, the next step is trying to look at getting him better." (PX3-pg.19) Therefore, based on the evidence in the record and Dr. Rink's findings and opinions, the Commission finds that the injections are not solely to alleviate Petitioner's subjective complaints, but also a diagnostic tool in order to determine the exact source of Petitioner's ongoing pain. As such, the Commission finds that Petitioner has proven entitlement to prospective medical care in the form of the medial branch injections recommended by Dr. Rink.

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 Respondent shall pay to the Petitioner the sum of $433.33 per week for a period of 31-5/7 weeks, from October 27, 2012 through June 5, 2013, 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.

15IWCC0203

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $25,917.91 for medical expenses under Sections 8(a) & 8.2 of the Act. Respondent is entitled to a credit of $25,917.91 pursuant to Sections 8(j) & 8(a) of the Act, towards the medical services awarded in this matter.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical care in the form of the medical branch injections recommended by Dr. Rink pursuant to Sections 8(a) & 8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under 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 $13,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2015
MJB/ell
o-01/26/15
52

Michael J. Brennan

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority. Arbitrator Fratianni's findings are both thorough and well reasoned. This decision is correct and should be affirmed

Kevin W. Lamborn

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

ACEVEDO, JUAN A
Employee/Petitioner

Case# **12WC024079**

15IWCC0203

BLOOMINGTON-NORMAL STAFFING COMPANY
Employer/Respondent

On 10/29/2013, 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:

0190 LAW OFFICES OF PETER F FERRACUTI
THOMAS M STROW
110 E MAIN ST
OTTAWA, IL 61350

2904 HENNESSY & ROACH PC
CRAIG COLBROOK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

15IWCC0203

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JUAN A. ACEVEDO,
Employee/Petitioner

v.

BLOOMINGTON-NORMAL SEATING COMPANY,
Employer/Respondent

Case # 12 WC 24079

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 consolidated with claim no. 12 WC 02619 and heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 5, 2013.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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: _____

15IWCC0203

FINDINGS

On the date of accident, **June 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 **$33,800.00**; the average weekly wage was **$650.00**.

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

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

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 $ **25,917.91** under Section 8(j) of the Act, and under Section 8(a) of the Act.

ORDER

Respondent shall pay to Petitioner reasonable and necessary medical services in the amount of **$25,917.91**, pursuant to the medical fee schedule as created by Section 8(a), and Section 8.2 of the Act.

Respondent is entitled to a credit of $25,917.91 pursuant to Section 8(j) of the Act and Section 8(a) of the Act, towards the medical services awarded in this matter.

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

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

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

Signature of Arbitrator JOANN M. FRATIANNI

October 18, 2013
Date

ICArbDec19(b)

OCT 29 2013

15IWCC0203

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

Petitioner works for Respondent as a production operator. This job requires him to assemble seats on a line for automobiles. Petitioner works the 6:00 a.m. to 3:00 p.m. shift, five days a week. Petitioner testified that he works with over 200 seats per shift, with each one weighing approximately 40 pounds. Petitioner would rotate between four different positions o the line. A written job description was also introduced into evidence. (Rx1)

Petitioner testified that on June 7, 2011, while performing his regular work on the line, a car seat came down the line that was not centered correctly. Petitioner testified that a robot arm would normally be used to adjust the seat, but occasionally he had to use his hands. Petitioner described the adjustment process as normally being very easy, but this time it was more difficult. Petitioner testified the seat became stuck as he tried to adjust it manually, forcing him to move it back and forth to get a center lock adjusted. After a minute spent trying to push the seat manually back and forth, he experienced severe pain in his back.

Following this incident, Petitioner testified he had a difficult time trying to get back up, and he then reported the incident to his employer.

Mr. Ed Catton, the HR manager for Respondent, was called to testify. Mr. Catton testified on behalf of Respondent. Mr. Catton testified his job included handling employee benefits to workers' compensation issues. Mr. Catton testified he was familiar with Petitioner's job tasks, but that he did not work on the assembly line since 1988. Mr. Catton testified it was possible for the synchro-lock to get off on the seat when it came down the line and also verified that Petitioner worked with over 200 seats daily that weighed 40 pounds each. Mr. Catton testified that Petitioner's job duties included operating tools and the physical pushing and pulling of seat covers. Mr. Catton testified that it would take a lot of force to move the seat once placed in the machine fixture. Mr. Catton testified he became aware of Petitioner's injury on June 7, 2011 from a production manager.

Based upon the above, the Arbitrator finds that on June 7, 2011, Petitioner sustained an accidental injury that arose out of and in the course of his employment by Respondent.

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

See findings of this Arbitrator in "C" above.

Petitioner suffered a prior back injury in early 2008 and was released to return to full duty regular work in April of 2008. (Px4) He also sustained a mild thoracic spine contusion after slipping in a parking lot on January 12, 2010. After an initial doctor visit, he was released to return to full duty regular work. (Px4)

Petitioner testified that prior to June 7, 2011, he was not experiencing any symptoms to his back and was not under any medical restrictions.

Following his injury of June 7, 2011, Petitioner sought initial treatment with OSF St. Joseph Occupational Health Clinic on June 13, 2011. At that time, Petitioner complained of lower back pain that radiated down his right lower extremity. Following examination, Petitioner was diagnosed with low back and right thigh pain and placed on restricted work duty of repetitive bending, stopping or twisting and no lifting over 15 pound. (Px4)

Following that office visit, Petitioner worked light duty. On June 21, 2011, OSF clinic kept him on the same work restrictions and prescribed physical therapy. Petitioner underwent physical therapy commencing June 28, 2011 through August 19, 2011, and remained under the care of the OSF clinic. During this period of time he continued working light duty. (Px4)

An MRI was prescribed and performed on July 22, 2011. This revealed a small right paracentral disc herniation at L5-S1 that abuts and displaces the traversing right S1 nerve root in the right lateral recess along with spinal stenosis at L3-L4 and L4-L5. (Px4)

On August 19, 2011, OSF clinic referred Petitioner to Dr. Christopher Rink. Petitioner saw Dr. Rink initially on September 19, 2011. Dr. Rink compared the MRI of July 22, 2011 with an MRI from 2008 and felt the right paracentral disc herniation at L5-S1 displacing the traversing right S1 nerve root in the lateral recess along with spinal stenosis at L3-L4 and L4-L5 were new findings. Dr.Rink diagnosed an L5-S1 disc herniation to the right and a suspected aggravation of L4-L5 lumbar spinal stenosis. Dr. Rink prescribed oral steroids while awaiting authorization for steroid injections and continued the same work restrictions. (Px2)

Petitioner underwent an epidural steroid injection on September 29, 2011. (Px7) Following the injection, Petitioner returned to Dr. Rink on October 17, 2011. Petitioner reported no significant improvement following the epidural injection. Dr. Rink prescribed medial branch block injections and continued his work restrictions. (Px2)

Petitioner returned to see Dr. Rink on November 10, 2011. Respondent refused to authorize the medial branch block injections and demanded more conservative treatment, including therapy. Dr. Rink prescribed physical therapy geared toward lumbar facet syndrome along with disc herniation and myofascial pain. Dr. Rink was still of the opinion the medial branch block injections were appropriate and prescribed Skelaxin and Daypro, along with continuing the work restrictions. (Px2)

Petitioner next saw Dr. Rink on December 2, 2011. Dr. Rink noted that Petitioner had plateaued with regards to treatment. Dr. Rink diagnosed persistent low back pain with history of radiating leg pain, much improved following the June 7, 2011, with evidence of disc herniations, spinal stenosis and facet arthritic changes. Dr. Rink continued to prescribe medial branch block injections. (P2)

Petitioner then saw Dr. Rink on December 29, 2011 with continuing complaints of back pain. Dr. Rink previously had prescribed more aggressive injections that Respondent refused to authorize. Dr. Rink explained to Petitioner that he could not guarantee the injections would be beneficial and indicated he had plateaued from a treatment standpoint. (Px2)

Petitioner then saw Dr. Julie Wehner on February 13, 2012. This examination was at the request of Respondent. Dr. Wehner is an orthopedic surgeon. Dr. Wehner testified by evidence deposition (Rx3) that approximately 25% of her practice is performing examinations for insurance carriers. Dr. Wehner did not dispute that an injury occurred on June 7, 2011 but felt it was a low impact injury that would at most caused a back strain. She did not know how much force was required to manually move the seat, and testified "I can't imagine anything that would require that much force." Dr. Wehner felt that Petitioner was magnifying his symptoms and felt medial branch block injections were not warranted. Dr. Wehner felt that Petitioner should be "transitioned" back to full duty work with an expected maximum medical improvement date within six weeks. (Rx2)

The Arbitrator finds that with regards to the work activities and accidental injury in this case, Dr. Wehner has engaged in complete speculation rendering her opinions less than reliable.

Petitioner then saw Dr. Rink on February 28, 2012. Dr. Rink diagnosed either facet joint related or discogenic lower back pain in nature. Petitioner continued to see Dr. Rink through June 29, 2012. At that time Dr. Rink prescribed a new epidural steroid injection. (Px3)

Dr. Rink testified by evidence deposition (Rx3) that he is board certified in physical medicine and rehabilitation and with pain management. Dr. Rink testified that approximately 75% of his patients treat with him due to back pain. Dr. Rink testified that the injury of June 7, 2011 resulted in a progression of degenerative arthritis in his lumbar spine.

Based upon the above medical evidence, the Arbitrator finds that Petitioner's condition of ill-being to his lumbar spine is causally related to the accidental injury of June 7, 2011.

J. Were 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 medical charges which were incurred after this accidental injury:

Advanced Rehabilitation	$ 2,486.00
Empire Anesthesia	$ 1,020.00
OSF Medical Group	$ 2,075.00
OSF Occupational Health	$ 730.92
OSF St. Joseph Medical Center	$ 3,491.00
Center for Outpatient Medicine	$16,042.00
Pharmacy Prescription Receipts	$ 72.99

These charges total $25,917.91.

See findings of this Arbitrator in "C" and "F" above. The above charges were paid by Respondent through its group health insurance carrier and by the workers' compensation insurance carrier, for which Respondent is entitled to receive credit. Respondent shall hold Petitioner safe and harmless at all attempts at reimbursement by the group health insurance carrier in accordance with Section 8(j) of the Act.

K. Is Petitioner entitled to any prospective medical care?

Petitioner claims that the prescribed medial branch injections represent reasonable and necessary medical care in this case. Dr. Rink testified (Px3) that these injections would have little effect with the disc herniation and would not be necessary to treat the disc herniation. Dr. Rink testified he was only prescribing those injections in response to Petitioner's subjective complaints of pain.

Based upon the above, the Arbitrator finds that Petitioner has failed to prove that such treatment would represent reasonable and necessary medical care designed to cure or relieve the condition of ill-being caused by this accidental injury, and declines to order Respondent to authorize and pay for same.

15IWCC0203

L. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "F" above.

Petitioner testified his last day of work for Respondent was October 26, 2012. Petitioner was fired by Respondent on January 13, 2013, over a dispute regarding his return to work from a vacation.

Petitioner claims entitlement to temporary total disability benefits subsequent from his termination date through the date of this arbitration hearing.

Mr. Catton testified Petitioner was fired after he failed to return from a leave of absence. Petitioner had a scheduled vacation and was set to return on a particular date. Petitioner reported back to work on the third day after his leave ended. Petitioner was immediately terminated.

Mr. Catton further testified he thought Petitioner had some kind of work release as of December 17, 2012, although it could have been January 17, 2013. As far as Petitioner and Mr. Catton are aware, Petitioner was still on restricted work for his back at the time of his termination. Petitioner last saw Dr. Rink for treatment on June 29, 2012. There were no treating medical records introduced that indicate continuing treatment after June 29, 2012.

Based upon the above, all claims for temporary total disability benefits made by Petitioner 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

15IWCC0214

Michael Gunderson,

Petitioner,

vs.

NO: 08 WC 38147

Weiss Memorial Hospital,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. In a January 29, 2015 order the Circuit Court remanded this case to the Commission to clarify its May 27, 2014 decision awarding additional permanent partial disability benefits for the left hand and not the left arm or the person as a whole under §8(d)(2) of the Act. In an arbitration decision dated August 24, 2010, the Arbitrator found that as a result of the work related accident on August 8, 2008, Petitioner sustained a 37.5% loss of use of the left hand; the arbitration decision was not appealed. Soon after arbitration, Petitioner resumed treatment for his left hand and subsequently underwent additional surgeries consisting of a left wrist diagnostic arthroscopy and partial synovectomy and a matched resection of the distal ulnar head; arthrodesis of the wrist joint; removal of the previously placed distal radius volar plate and post-reduction fixation.

Petitioner sought additional benefits under the Act by filing a Petition for Review under §19(h) and §(8)(a). A hearing before the Commission was held on July 25, 2013. After considering all of the evidence, the Commission found that Petitioner was entitled to the sum of $664.72 per week for an additional period of 35.875 weeks, as provided in §8(a) of the Act, for the reason that the Petitioner sustained a material increase of his work related disability representing an additional 17.5% loss of use of the left hand.

The Commission's award under §8(a) of the Act was suited to the facts of the case where Petitioner sustained permanent injury to the left hand but failed to prove permanent injury to the

left arm or a resultant loss of occupation. It is undisputed that Petitioner voluntarily retired from his employment by Respondent on October 26, 2009 and moved to Arizona prior to the arbitration hearing. Petitioner was working full duty for Respondent when he retired and he was not under any restrictions. Petitioner testified at the August 2, 2010 arbitration hearing that after relocation he sought employment at Intel and Arizona State University. He testified that he did not believe that he was physically capable of performing CPR as purportedly required at Intel and therefore he left that job. He further testified that he did not believe that he was physically capable of lifting seventy-five pounds as purportedly required at Arizona State University and he left that job as well. Less than two months after arbitration hearing, Petitioner commenced treatment for his left hand with Dr. Mahoney in Arizona and ultimately underwent additional surgeries.

At the July 25, 2013 §19(h) and §(8)(a) hearing before the Commission, Petitioner displayed his surgical scars. An indentation approximately three inches long was noted on the palmar side of the left wrist; within that indentation there was a scar approximately one inch long and containing three stitch marks. (T. 11) On the top of the left hand, a three-fourths of an inch long scar extended upward from the knuckle of the long finger. One inch above that, a thin four inch long scar extended upward along the middle of the wrist. (T. 13) Petitioner testified that following surgery he wished to do his own therapy rather than participate in formal therapy and Dr. Mahoney prescribed exercises to improve wrist mobility. (T. 18-19) Petitioner last saw Dr. Mahoney in April of 2013. Petitioner indicated to Dr. Mahoney that he experienced pain in the back of the forearm with wrist rotation and had stopped trying to perform that motion. (T. 20) Petitioner testified that activities such as buttoning his pants and using a drive-up ATM are difficult due to his lack of left wrist mobility. Petitioner testified that his left wrist mobility is currently worse than prior to the additional treatment; at the time of arbitration he was still able to rotate his left wrist. (T. 23)

We do not find any evidence in the record to support a separate award for permanent partial disability of the left arm. We note that Petitioner's subjective complaints are with respect to left wrist mobility and we note that the surgical procedures involved his left hand and wrist and not significantly the left arm. We further find that Petitioner failed to prove a loss of occupation as a result of the August 8, 2008 accident. We acknowledge the possibility that limited left wrist mobility could be a consideration for future employment, even though Petitioner is right-handed. However, it would be relying on mere speculation to find that Petitioner has in fact incurred a loss of occupation. We note that no doctor has opined that Petitioner is unable to return to his former occupation as a stationary engineer as a result of his left hand injury. We acknowledge the Work Status Form dated April 16, 2013 in the records of Dr. Mahoney indicating via check marked box that a ten pound lifting restriction applied. However, the treatment note from the last examination of Petitioner on April 2, 2013 indicated that Petitioner was released from care without addressing work status or restrictions. Petitioner did not obtain Dr. Mahoney's deposition or a narrative report. Petitioner refused formal physical therapy post-operatively and did not undergo functional capacity evaluation testing or vocational testing. Without more, we do not accept the Work Status Form as conclusive evidence of a permanent ten pound lifting restriction for the left hand.

Furthermore, Petitioner did not testify that he attempted to find work following his

release by Dr. Mahoney in April of 2013. Misleadingly, Petitioner was questioned on redirect examination at the July 25, 2013 §19(h) and §8(a) Commission hearing about his brief employment at Arizona State University. Petitioner testified that after two days he decided it was too painful to use his left wrist and he stopped working. (T. 34-35) We find this testimony immaterial as it clearly pertains to a work attempt that occurred prior to arbitration, as evidenced by the arbitration decision. We find nothing in the record that shows that Petitioner took any steps to reenter the workforce following his release by Dr. Mahoney in April of 2013.

THEREFORE, the Commission hereby clarifies its Decision dated May 27, 2014 as stated above and pursuant to the January 29, 2015 remand from the Circuit Court of Cook County.

DATED: MAR 2 5 2015
RWW/plv
46

Ruth W. White

Michael J. Brennan

David L. Gore

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

Gary Destri,

Petitioner,

vs.

NO: 12 WC 9406

15IWCC0215

Vandermeersch Lawn 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, notice, 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 March 18, 2014, is hereby affirmed and adopted.

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

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

DATED: MAR 25 2015
TJT:yi
o 1/27/15
51

Kevin W. Lamborn

Michael J. Brennan

15IWCC0215

DISSENT

I write separately as I believe the Petitioner has proven a compensable claim by the preponderance of the evidence. In my view, while I agree that the Petitioner had a preexisting history of prostate problems, it is clear to me that the Petitioner's very heavy job duties were a contributing factor in aggravating the preexisting condition.

The Arbitrator found basically that he did not believe that Petitioner and Dr. Schwartz discussed whether his bleeding was related to his work duties in November 2011, that Petitioner did not report to Chad Vandermeersch in November 2011 that his problem was related to work, and that Petitioner's wife was not credible in relating that Petitioner reported a work injury to Vandermeersch in November 2011. He accurately noted that both Dr. Schwartz and Dr. Sohn agreed that the enlarged prostate was unrelated to the work duties. He then noted that Sohn testified that almost any strain could have caused the bleeding, and that "while it certainly could also occur as the result of the type of work the Petitioner was performing . . . the proof of such an occurrence is lacking."

In my view, this is a compensable accident. The Petitioner was working doing heavy work in power washing at wind farms. This included filling 6 gallon fuel tanks, carrying them over a distance to his truck, lifting them to chest high level and pushing them into the truck. He had to unroll long fire hoses, fill the water truck, and then clean the mud off and re-roll the hoses. He would have to walk through thick mud, where his boots would stick to it while walking. The rest of the time he would use a power washer to pressure wash at a wind farm. His testimony was essentially unrebutted, as the Respondent's Vandermeersch testified that he agreed with most of Petitioner's testimony regarding the work duties he performed, as well as that he was rarely onsite while Petitioner was working for him, and thus has no first-hand knowledge of what Petitioner was doing. Petitioner performed these duties from November 5 to November 18, 2011.

As stated in Sisbro v. Industrial Commission, 207 Ill. 2d 193; 797 N.E.2d 665 (2003):

> "It is axiomatic that employers take their employees as they find them. When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being."

Petitioner was doing work which could cause an abdominal-type straining, and both treating surgeon Dr. Schwartz and Respondent's record reviewer Dr. Sohn agree that straining can cause a preexisting pressurized or irritated blood vessel to bleed. The Petitioner sustained accidental injury arising out of and in the course of his employment with Respondent.

While Respondent has a reasonable argument with regard to whether Petitioner provided proper notice, the Petitioner testified he told Vandermeersch: "I told him that I was urinating blood and just what happened." Vandermeersch confirmed this in his testimony. Section 6(c) of the Workers' Compensation Act, Ill. Rev. Stat. ch. 48, para. 138.6(c), states, in part that notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. Provided: No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy. Notice of the accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing. "The giving of the notice within 45 days of the accident is jurisdictional and a prerequisite of the right to maintain a proceeding under the Workers' Compensation Act, Ill. Rev. Stat. ch. 48, para. 138.1 et seq. However, this rule applies where no notice is given to the employer. Where some notice is given but a defect or inaccuracy exists, the second paragraph in § 6(c) of the Workers' Compensation Act, Ill. Rev. Stat. ch. 48, para. 138.6(c), is applicable, and the employer must prove he is unduly prejudiced." Luckenbill v. Industrial Commission, 155 Ill. App. 3d 106; 507 N.E.2d 1185 (1987).

There is no evidence indicating that any defect in the notice Petitioner provided to Vandermeersch resulted in undue prejudice to Respondent. As such, the notice provided by Petitioner was sufficient under the law.

With regard to causation, again, I believe the evidence is in Petitioner's favor. Treating surgeon Dr. Schwartz testified that he believed the straining Petitioner did at work exacerbated the preexisting enlarged prostate and caused the vessels to bleed. Respondent's record reviewer Dr. Sohn agreed that such activity could have caused the bleeding – the defense presented by Sohn was that almost any type of straining could have caused the bleeding given the preexisting condition. Under Sisbro, I don't believe it matters whether any straining *could* have caused this, so long as the straining at issue *did* cause it. The Petitioner initially presented on 11/21/11 after noting he had blood in his underwear after work and was peeing blood. The contemporaneous reporting of this, even if not in the medical report, was confirmed by Vandermeersch. Thus, it seems quite logical that it was the significant straining at work that at least contributed to this problem. There is no evidence the Petitioner had any blood in his urine between April 2008 and November 2011. I find it very relevant that the last time Petitioner had a similar occurrence in 2008, he reported the same activities caused the problem then – working at the wind farm.

It is my impression, based on the evidence, that the accident caused the bleeding and the need for surgery. This would not include the post-operative burning and frequent urination, which Dr. Schwartz testified was not related. However, Schwartz also testified that the burning and frequent urination were related to "all this", so his position is somewhat unclear in this regard. In my view, this case would properly be found to be an exacerbation of a preexisting condition, and as of the July 17, 2012 report of Dr. Schwartz, Petitioner had reached maximum medical improvement, and any ongoing sequelae after that would be related to the preexisting condition.

I would reverse the decision of the Arbitrator and remand the matter to determine Petitioner's entitlement to benefits under the Act.

Thomas J. Tyrrell

NOTICE OF ARBITRATOR DECISION

DESTRI, GARY
Employee/Petitioner

Case# **12WC009406**

VANDERMEERSCH LAWN SERVICES
Employer/Respondent

15IWCC0215

On 3/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 LOO SCHWEICKERT & GANASSIN LLP
MARK M WILSON
2101 MARQUETTE RD
PERU, IL 61354

0560 WIEDNER & McAULIFFE LTD
RANDALL W SLADEK
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CHICAGO, IL 60606

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

15IWCC0215

☐ 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

Gary Destri
Employee/Petitioner

v.

Vandermeersch Lawn Services
Employer/Respondent

Case # **12 WC 09406**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **February 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

15IWCC0215

FINDINGS

On **11/18/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,880.76**; the average weekly wage was **$1,074.63**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$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 has failed to prove an accident arising out of and in the course of his employment with the respondent. Claim denied.

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

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

Date March 12, 2014

MAR 18 2014

Findings of Fact

15IWCC0215

Petitioner testified that on November 18, 2011 he returned home from work at which time he observed blood in his underwear and blood while urinating. At that point, he contacted his employer, Chad Vandermeersch, to advise of what was happening and advise he was seeking medical attention. Petitioner, according to his and his wife's testimony, obtained an appointment for November 21, 2011 with Dr. Schwartz with whom he had previously treated.

In regards to previous treatment, on March 13, 2008 petitioner presented to the emergency room complaining of left lower back pain and chills. He stated he had pressure and burning with urination along with hematuria (blood in urine). It was noted at that time that petitioner had an enlarged prostate. Dr. Bernal noted petitioner "having some prostate issues in 1999 with irritation, urinary symptoms." Petitioner had difficulty initiating a urinary stream and had been on medication for the condition.

The following day, Dr. Schwartz performed cystoscopy for hyperplasia (increased cell production) of the prostate. Dr. Schwartz, post-surgery, assessed "Gross hematuria" which he suspected was "in relationship to an enlarging prostate."

On February 18, 2009, petitioner returned to St. Margaret's and Dr. Bernal for left elbow treatment. At that time, petitioner stated that he worked for Vandermeersch Lawn Improvement and had slipped and fallen on December 3, 2008.

Petitioner and his wife testified that they had moved into their current residence in the fall of 2011. They did not hire movers. Petitioner denied any heavy lifting as part of the move. His wife said that the lifting connected with the move was done by the petitioner, their son, neighbors and friends.

Returning to the current claim, on November 21, 2011, petitioner was evaluated by Dr. Schwartz for "blood in the urine." Dr. Schwartz diagnosed gross hematuria and recommended that petitioner continue terazosin and Avodart (both prescribed for an enlarged prostate). The doctor noted petitioner's previous hematuria from 3-4 years prior with abnormal blood vessels and fulguration. Petitioner was also instructed to quit tobacco products. There was no mention of petitioner's work or any physical activities in the doctor's notes. (PX 5)

The next day, November 22, 2011, petitioner underwent a CT urogram which showed no abnormality to account for the hematuria and identified simple renal cysts. Dr. Bernal assessed chronic back pain, hypertension, benign prostatic hyperplasia and hyperlipidemia.

Dr. Schwartz released petitioner from care the following day. He recommended petitioner continue Avodart, push of fluids, increase of activity and return if gross hematuria were to return.

According to the testimony of petitioner and Vandermeersch, petitioner did return to work for one day after the Thanksgiving break. Vandermeersch testified that he terminated the employment at the request for the general contractor.

For approximately three months, from November 24, 2011 through February 22, 2012, petitioner did not seek any medical treatment. On February 23, 2012, petitioner returned to Dr. Schwartz for treatment of hematuria. Petitioner did not have blood in his urine, had not seen blood clots, did not have burning with urination and was not in pain. It was noted in this record that bleeding developed at work with straining, lifting and pushing. Petitioner advised he was no longer working and the bleeding had resolved. Petitioner nonetheless appeared to be moving toward ablation of his prostate.

Petitioner completed his Application For Adjustment of Claim on March 8, 2012 and filed on March 15, 2012. He claimed a date of accident of November 18, 2011 in relation to lifting and pulling at the jobsite.

He returned to Dr. Schwartz on March 12, 2012. His condition had not changed since February 23, 2012 as in he did not have blood in his urine, had not seen blood clots, did not have burning with urination and was not pain. Nonetheless, the following day, March 13, 2012, petitioner proceeded with cystoscopy and greenlight laser ablation of the prostrate in relation to recurrent hematuria, benign prostatic hyperplasia and bladder outlet obstruction.

Dr. Schwartz evaluated petitioner again on April 12, 2012 "for an enlarged prostate after surgical intervention." It was noted that petitioner had undergone laser turp for treatment of his lower urinary tract symptoms due to his benign prostatic hyperplasia. Petitioner was to increase activity as tolerated and return in one year.

Petitioner returned one month later, on May 15, 2012, and reported pain or burning while urinating. The symptoms had surfaced 5 days prior and he now had blood in his urine. Dr. Schwartz diagnosed dysuria, nocturia and microscopic hematuria.

On June 19, 2012, petitioner returned for more treatment in relation to his enlarged prostate. He had blood in his urine, pain and burning with urination, and had observed blood clots. Petitioner reported an episode of gross hematuria with clot passage 2-3 weeks prior following strenuous physical activity. At that point, Dr. Schwartz recommended avoidance of strenuous activities that increase abdominal pressure.

The next month, on July 17, 2012, petitioner reported that he had not had an episode of gross hematuria since the last visit and that the nocturia and dysuria had resolved. His treatment over the next few months related to an overactive bladder.

On request, Dr. Schwartz issued a chart summary narrative on May 23, 2012. The doctor noted petitioner's initial treatment in March 2008 for gross hematuria and the inability to urinate. The petitioner was next seen in November 2011 with recurrent bouts of gross hematuria. The doctor acknowledged that "aggravating and alleviating factors at that time were not well documented." The doctor summarized that petitioner had a long-standing history of intermittent bouts of gross hematuria that may have been exacerbated with heavy lifting and straining.

The doctor was deposed on March 27, 2013. When asked about a causal relationship between work activity and the gross hematuria, Dr. Schwartz noted petitioner's firm belief that work had caused the bleeding. (Px 7, p. 13) The doctor stated that patients with enlarged prostates and abnormal blood vessel development, the straining, lifting, pushing creates bleeding, and I do believe that the bleeding that he experienced was related to the work that he did. (Px 7, p. 13) The doctor noted that he made no recommendation on work in November 2011. (Px 7, p. 14) When asked about causal relationship in general, the doctor stated there was "no doubt in [his] mind that this man has an enlarged prostate. It's his prostate. He grew it. That is unrelated to work" (Px 7, p. 23) When asked about continuing symptoms in relation to work activity, the doctor responded "I'm going to say no. I believe that the symptoms that he currently complaints of, frequency, urgency, are related to the sole fact that he had an enlarged gland. And the issue of the gland bleeding did not result in any bladder damage that would result in frequency, urgency complaints." (Px 7, p. 23)

On cross-examination, the doctor stated that petitioner's bouts of hematuria were related back to the intial bout in 2008. (Px. 7, p. 38) In the doctor's words, "the patient has this similar problem, prostatic enlargement, prominent prostate tissue, periods of, you know, straining or lifting, increased venous pressure. Bleeding vessels

bleed – vessels, prominent vessels bleed. So, to me, this problem has been the same problem." (Px. 7, p. 38-39) As far as petitioner's eventual laser ablation, he agreed it was also related to the 2008 problem. (Px. 7, p. 39)

Dr. Sohn conducted a records review on July 16, 2013. In his narrative report and testimony, the doctor found petitioner had a long history of prostatitis with increased vascularity in the prostate causing bleeding. The doctor believed that the bleeding described by petitioner could happen at any time but could be due to straining. However, straining could entail a hard bowel movement, walking, running or any other activity. He did not believe petitioner's condition was due to his work in November 2011 because he saw no record of the petitioner reporting a work related problem in Dr. Schwartz' office notes. (RX 2 at 23)

Conclusions of Law

Did an accident occur that arose out of and in the course of petitioner's employment with Respondent?

Petitioner treated with the same doctor he saw for his current treatment, Dr. Schwartz, in 2008. At that time, he was working for the same employer doing essentially the same type of work. At that time, he noticed blood in his urine. He went to Dr. Schwartz and discussed with him his work duties at the wind farm. He received the same type of treatment.

Petitioner is now alleging the same type of work produced the same type of symptoms. However, despite having the knowledge as to what happened just three years earlier, he did not tell his boss, Mr. Vandersmeesch, anything about his work duties when he called him soon after he noticed the blood. The petitioner testified that on November 18, he only told his employer that he had blood in his urine and that he needed to see a doctor.

Further the Arbitrator does not believe the petitioner discussed his work duties with Dr. Schwartz when he initially saw him on November 21, 2011. Certainly, there is no history in the doctor's notes to indicate such a discussion took place. Contrary to Dr. Schwartz' first treatment note with the petitioner in March 2008, the current records are silent. Similarly, there is no reference to a discussion about the petitioner's work duties when the doctor next saw him two days later to perform a cystoscope. There was a discussion four months later on February 23, 2012, as the doctor's notes so indicate. While Dr. Schwartz said that he may have discussed work with the petitioner in November 2011, he could not be sure. It appears to the Arbitrator that if such a discussion had taken place, there would be some record of it in the notes. Further, if work were an issue, Dr. Schwartz would have likely taken the petitioner off for a few days to see if his bleeding would stop. Instead he testified that work status was not addressed after his examination on November 21. The doctor concluded that it wasn't discussed because the petitioner likely didn't bring up his work during that visit. (PX 7 at 15)

As the Arbitrator does not believe the petitioner and Dr. Schwartz discussed his work and its relationship to his condition on November 21, the Arbitrator also does not believe that the petitioner told his employer that evening that his doctor said his condition was work related. Mr. Vandersmeesch said that a conversation took place, at which time the petitioner told him what the doctor said about his condition. He said the petitioner requested the rest of the week off to see if the bleeding would stop, and that he agreed with that request. If he had been told that the petitioner's doctor said his condition came from his work, it is unlikely that he would have contacted the petitioner four days later, on Friday, and asked him to work a full shift the following Monday.

The Arbitrator also discounts the testimony of the petitioner's wife that she heard her husband tell his boss that he had been hurt at work and was taken off work by his doctor during their phone conversation on November 21. She testified that they had been married for 23 years, yet she had no knowledge that he had been having prostate problems since 1999, which were established by Dr. Schwartz' records. (PX 4)

The petitioner's condition was bleeding from an enlarged prostate. Both doctors testified that the enlarged prostate was not work related. Dr. Sohn credibly explained that bleeding from such a prostate could result from any type of pressure, including a bowel movement or riding a bike. While it certainly could also occur as the result of the type of work the petitioner was performing, as it likely did in 2008, the proof of such an occurrence is lacking. The petitioner must prove an accident arising in the course of his employment resulting in injury. It is not the respondent's obligation to prove that the work did not result in an injury. In this case for the above reasons, the petitioner has failed to meet his burden of proof. As such, the claim is denied.

All other issues are thus 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LUIS VASQUEZ,

Petitioner,

vs.

NO: 09 WC 9453

15IWCC0216

JAMES MCHUGH CONSTRUCTION,

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, temporary total disability (TTD), and permanent partial disability (PPD) and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

Mr. Vasquez sustained an undisputed work-related injury when he fell 12 feet to the ground and lost consciousness on May 23, 2008. His injuries consisted of a lacerated spleen that required a splenic artery embolization, an orbital fracture, facial bone fractures, left lung pneumothorax, a maxillary sinus fracture, and a concussion. The medical records reveal that the fractures had healed as of August 25, 2008; however, Petitioner continued to experience migraine headaches through May 2012. Petitioner testified that he continues to experience headaches once a week, which can be severe at times. Based on the significant injuries, the Commission finds Petitioner sustained 30% loss of use pursuant to Section 8(d)(2) of the Act.

15IWCC0216

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 1, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,053.57 per week for a period of 19 weeks, May 27, 2008 through June 17, 2008 and May 12, 2009 through August 30, 2009, 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 $636.15 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 the loss of use of 15% man-as-a-whole.

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

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

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: MAR 2 6 2015

MJB/tdm
O: 2-3-15
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VASQUEZ, LUIS
Employee/Petitioner

Case# **09WC009453**

JAMES McHUGH CONSTRUCTION CO
Employer/Respondent

15IWCC0216

On 10/1/2013, 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 0.04% 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:

4678 PARENTE & NOREM PC
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CHICAGO, IL 60601

1109 GAROFALO LAW FIRM
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

15IWCC0216

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

Luis Vasquez
Employee/Petitioner

v.

James McHugh Construction Co.
Employer/Respondent

Case # **09** WC **9453**

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 **July 17, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 23, 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, in part, to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$54,785.12**; the average weekly wage was **$1,580.35**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$20,168.26** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,168.26**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,053.57/week for 19 weeks, commencing May 27, 2008 through June 17, 2008 and commencing May 12, 2009 through August 30, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 23, 2008 through July 17, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $20,168.26 for temporary total disability benefits that have been paid.

Medical Benefits

As explained more fully in the Arbitration Decision Addendum, Petitioner failed to prove causal connection between his claimed current neurological, psychological, cervical, or left shoulder conditions of ill being and his work accident on May 23, 2008 or that the medical bills were for reasonable and medically necessary treatment of any causally related condition. Thus, Petitioner's claim for payment of the unpaid medical bills is denied.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/week for 75 weeks, because the injuries sustained caused the 15% 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

September 30, 2013
Date

OCT 1 - 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Luis Vasquez
Employee/Petitioner

v.

James McHugh Construction Co.
Employer/Respondent

Case # **09** WC **9453**

Consolidated cases: **N/A**

15IWCC0216

FINDINGS OF FACT

The issues in dispute include causal connection, medical bills, Petitioner 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.

Background

Petitioner testified that he is a journeyman carpenter and has been so employed for approximately 13 years since March of 2000. Prior to his injury at work, Petitioner testified that he was a lead man and foreman overseeing the work of others. Petitioner also did concrete framing, which was physical work that required him to be quick on his feet.

Petitioner testified that he was working on a scaffold approximately 10-12 feet high at a residential project and framing a wall so that it would be ready for concrete. He testified that someone asked him for something and he turned around trying to grab it for them and slipped. Petitioner testified that the next thing he knew, he was in the hospital.

Medical Treatment

Petitioner testified that he was at Northwestern Memorial Hospital for four days. He understood that he fractured his left eye socket, had a bilateral rib fracture, and a spleen laceration. Petitioner also testified that his neck and back hurt. He testified that he spent some time in a neck brace.

The emergency room medical records reflect that Petitioner reported a 12 foot fall while he "[w]as working at construction site and fell into hole, landed on his left side." PX5. Petitioner lost consciousness at the time of the accident and reported pain to emergency room personnel including pain in the "left chest/flank, around L eye/swelling, and neck pain[,]" shortness of breath, headaches and blurred vision. *Id.* Petitioner underwent a head CT, a spine CT, chest/abdomen/ pelvis CT, and a pelvis x-ray. *Id.* Petitioner had a bilateral 1st rib fracture, mild cervical degenerative changes, extensive/complex spleen laceration with active extravasation, a small left pneumothorax, several facial bone fractures, a very small orbital forehead fracture and a maxillary sinus fracture. *Id.* Petitioner underwent a visceral angiogram, splenic artery embolization and remained in the hospital for observation. *Id.* He also had a plastic surgery consultation; however, there was no acute indication for plastic surgery. *Id.* Petitioner was discharged on May 26, 2008 with prescriptions for pain medications and

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Joint exhibits are denominated "JX." Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

instructions to follow up with his own physicians and the emergency room if necessary. *Id.* Petitioner was released to return to full duty work effective Monday, June 9, 2008. RX1.

Petitioner testified that he was off work on May 27, 2008 and remained off work until June 23, 2008. Petitioner testified that he chose to seek medical treatment with Dr. Demaertelaere at the Hedges Clinic.

Dr. Demaertelaere first saw Petitioner on June 6, 2008. PX2 at 38-41. Petitioner reported significant pain in the left side and shoulder, requested Norco, and reported pain when breathing deeply. *Id.* Petitioner also reported that he slept in a recliner. *Id.* After an examination, Dr. Demaertelaere diagnosed the Petitioner with fractured ribs, a fractured orbital, a concussion and a traumatic spleen tear. *Id.*

On June 16, 2008, Petitioner returned to Dr. Demaertelaere reporting improved pain levels, but still has bad days with regard to his ribs, continued headaches although less frequent, continuing to sleep in a recliner, and feeling frustrated more easily. PX2 at 31-34. Dr. Demaertelaere ordered physical therapy for the left first rib fracture, neck pain, and shoulder pain for one month. *Id.* Petitioner underwent physical therapy at ATI beginning on June 18, 2008 and was upgraded to a work conditioning program as of July 2, 2008. PX2 at 26; PX8 at 30, 41.

Petitioner returned to Dr. Demaertelaere on July 3, 2008 reporting improvement with regard to the rib fractures, having returned to work performing mostly sedentary, paperwork, and driving tasks (which Dr. Demaertelaere noted Petitioner seemed to enjoy), minimal shortness of breath with one episode of tight chest pain lasting 45 minutes the prior weekend, and improving mood. PX2 at 27-30.

On July 24, 2008, Dr. Demaertelaere noted that the Petitioner stated that he "felt great," but still felt sore at the end of the day. PX2 at 20-23; RX2. He also reported that he had not needed any anxiety medication for well over a week and that his mood was much better. *Id.* Dr. Demaertelaere noted that Petitioner felt much improved and that he was anxious to return to full duty work. *Id.* He cleared Petitioner for full duty work and set up a visit in three weeks, if necessary; otherwise Petitioner could return as needed. *Id.*

A work conditioning progress note dated July 25, 2008 reflects that Petitioner was functioning at a medium physical demand level while his carpenter position was deemed to be at the heavy physical demand level per the U.S. Department of Labor's Dictionary of Occupational Titles, but that Petitioner was working light duty while participating in work conditioning and that he appeared to be "very functional." PX2 at 18; PX8 at 9. Petitioner underwent work hardening at ATI for his left 1st rib fracture and neck pain from July 14, 2008 through August 1, 2008. PX8.

At trial, Petitioner testified that during this period of treatment he was experiencing headaches that were worsening, mood swings, depression, hyperventilation, and short term memory problems. Petitioner testified that on his release back to full duty work he thought that he was doing ok, but as he continued working his headaches became more intense and the depression became worse. Petitioner testified that he was not able to work as efficiently as before.

Petitioner returned to Dr. Demaertelaere on August 14, 2008 reporting feeling much better and working full duty without more than the occasional "twinge" regarding his rib pain. PX2 at 15-17; RX3. Petitioner also reported mood swings after he stopped taking his medicine, which made him worry excessively and get angry without reason. *Id.* Petitioner also reported a panic attack approximately 2 weeks after stopping the medicine and having to step away to be alone until the sensation went away. *Id.* Petitioner began taking his medication at

night and felt much better, however Dr. Demaertelaere indicated that if at Petitioner's return visit Petitioner had not seen significant improvement he should see a counselor/psychologist. *Id.*

In a note dated August 25, 2008, Dr. Demaertelaere indicated that Petitioner's fractures were healed. PX2 at 14.

On September 29, 2008, Petitioner returned to Dr. Demaertelaere reporting that his chest pain had resolved and he almost never got pain anymore, however Petitioner also reported feeling depressed at times and more nervous and anxious at work. PX2 at 11-13. Petitioner reported that he was able to handle only one thing at a time whereas he used to be able to handle "10 things at once[.]" *Id.* Dr. Demaertelaere referred Petitioner to a psychologist, Dr. Moran[2]. *Id.*

Section 12 Examination

Petitioner was evaluated by Dr. Shenker at Respondent's request on January 14, 2009. RX4-RX5. At the time of his examination, Petitioner reported headaches over the top of his head which extended to the occipital area and were more marked on the right side where he noted a pressure sensation. RX5. Petitioner also reported nonstop headaches over the prior three weeks, intermittent dizziness with fast moves and bending over, some intermittent visual blurring with headaches, and trouble focusing/concentrating/remembering things, which he attributed to having a constant headache. *Id.* Petitioner also reported not sleeping well, waking up 3 to 5 times a night, feeling tired in his legs with associated numbness and tingling, feeling short tempered with irritability and mood swings although that was improving, cramps in his right hand, and no hearing, speech, level of consciousness, taste, or smell problems. *Id.*

Dr. Shenker noted that his "neurologic examination at that time failed to reveal any objective evidence of neurologic impairment." RX4. Additionally, Dr. Shenker noted his review of Petitioner's treating medical records and that "[a]t this point, I do not believe that there is a neurologic explanation for this patient's complaints of worsening short-term memory, given the fact that the incident at work occurred eight months ago. Neither do I believe that his complaints of progressively increasing headaches would fit into the normal chronology of post-traumatic intensity." *Id.* Dr. Shenker recommended a brain MRI with and without contrast for the sake of thoroughness, but indicated that Petitioner was able to work in a full duty capacity as he had been doing for some time. *Id.*

Dr. Shenker diagnosed Petitioner with a head injury with loss of consciousness accompanied by both retrograde and antereograde amnesia that qualified him as having suffered a cerebral concussion, bilateral rib fractures, a left pneumothorax, lacerations of the spleen, and you will about the left orbital floor for which there was no indication for surgery. RX5. Dr. Shenker opined that these diagnoses were related to his work injury sustained on May 23, 2008, but that Petitioner's current headaches were not related to the incident on that date because of the length of time that had elapsed. *Id.* Dr. Shenker also opined that Petitioner did not need any additional treatment or diagnostic studies as it related to his work injury sustained on May 23, 2008, that he did not require any work restrictions and could work full duty, and that he was at maximum medical improvement. *Id.*

[2] The Arbitrator notes that it is unclear whether Petitioner ever saw Dr. Moran and no treating records were submitted from this physician.

Continued Medical Treatment

On January 20, 2009, Petitioner underwent a brain MRI with and without contrast as referred by Dr. Demaertelaere. PX6; RX6. The interpreting radiologist noted several punctuate areas of T2/FLAIR hyper intensity seen in the subcortical and periventricular white matter which may represent early microvascular ischemic changes or post inflammatory change, but an otherwise normal MRI. *Id.*

On February 5, 2009[3], Petitioner saw his primary care physicians, Dr. Singla or Dr. Gutta, reporting that he had "migraines all the time, was in an accident from work, May '07, blury [sic] vision. pain management[.]" PX3 at 5; PX4 at 27. He provided a history that he sustained a work-related fall landing on his head in May of 2007 when he fell 10 feet from a scaffold and that he was off work for one month and sustained for broken ribs, a left eye socket fracture, a punctured lung, and a spleen rupture. *Id.* He also reported headaches which he did not notice at first, increased pain over time, that over-the-counter medications were not helping, and that his headaches became unbearable in December of 2008 and he could not work. *Id.* Petitioner also reported blurry vision in both eyes only when his headaches were severe, that he was awaiting a follow up with the neurologist, and that he "'can't take it anymore[.]'" *Id.*

Dr. Shenker – Addenda & Continued Medical Treatment

Respondent's Section 12 examiner, Dr. Shenker, issued an addendum report dated February 13, 2009 in which he indicated his review of additional materials including Petitioner's January 20, 2009 brain MRI. RX7. Dr. Shenker noted that the microvascular ischemic changes seen in the MRI were not related to Petitioner's injury at work, there was no evidence of brain contusions that would have been consistent with cerebral trauma, and that such microvascular disease was not attributable to trauma. *Id.* Dr. Shenker further noted his review of Dr. Demaertelaere's January 27, 2009 record in which he referenced Petitioner's ongoing headache complaints and referred Petitioner to a neurologist for consultation. *Id.* Dr. Shenker reiterated that Petitioner did not require further diagnostic testing or treatment is related to his injury at work, specifically a cerebral contusion, and that Petitioner could return to work as a carpenter without limitations. *Id.*

On February 17, 2009, Dr. Singla or Dr. Gutta, diagnosed Petitioner with migraine headaches. PX4 at 26.

Respondent's Section 12 examiner, Dr. Shenker, issued another addendum report dated March 2, 2009 after reviewing additional treating records to that date. RX8. Dr. Shenker maintained his opinion that Petitioner required no further medical treatment and could work without restrictions, that he sustained a cerebral concussion, but had no evidence of ongoing neurological problems, and that Petitioner's headaches and complaints of worsening short term memory were not related to his injury at work on May 23, 2008, noting that progressive increasing headaches "would not fit into the normal chronology of posttraumatic headaches."

On April 14, 2009, Petitioner was admitted to Provena St. Joseph Medical Center for management of daily headache syndrome and intractable postconcussive headaches. PX9 at 19-20. Petitioner reported that he had intractable pain and "[h]e apparently was at a job site and fell several stories and landed on his head. This was associated with loss of consciousness. Since that time he has had persistent severe headaches which initially began shortly after his fall. He had been through multiple treatments in the past; however, has not been able to

[3] The Arbitrator notes that it appears that this progress note continued onto the back of a double-sided page, but it was not submitted into evidence.

get any relief and subsequently was admitted for nausea, vomiting, abdominal pain and severe dysfunction in his life secondary to the headaches." PX9 at 21.

Petitioner also had an in-patient neurology consultation while at the hospital with Dr. Gulati on April 15, 2009. PX9 at 22-23. He reported having daily headaches in the morning and at bedtime since his accident at work that were pounding, throbbing, and severe to a level of 10/10 with nausea, but no vomiting, and photophobia. *Id.* Petitioner denied neck pain or preceding aura or associated neurological symptoms, no associated TMJ symptoms, relief with use of Relpax, and a few occasions of lightheadedness and some blurred vision associated with the headaches. *Id.* On examination, Dr. Gulati noted normal cervical spine movements, no myofascial or TMJ tenderness, normal Fundi and visual fields, no papilledema, normal eye movements, no nystagmus or facial asymmetry, normal language and speech functions, no pronator sign, normal muscle tone/strength/ordination/gait, normal balance, symmetrical reflexes, no Babinski's sign, and normal sensation. *Id.* Dr. Gulati noted that Petitioner had a normal neurological examination, diagnosed him with post traumatic syndrome of daily headaches sometimes severe throbbing disabling headaches and symptoms of impaired concentration/memory and panic-like attacks, and ordered additional prescription medications. *Id.*

Petitioner was discharged on April 18, 2009 with a final diagnosis of daily headache syndrome, post traumatic headache disorder and good improvement with use of Reglan and DHE. PX9 at 19-20. Petitioner was instructed to follow up with Dr. Gelbort for further neuropsychological testing. *Id.*

On April 24, 2009, Petitioner returned to Dr. Gulati for evaluation of symptoms of headaches that he reported that he had since his injury at work. PX10 at 23-24. Petitioner provided an accident history and reported that he was at work on May 23, 2008 on a scaffold about 10 feet in the air when "he apparently fell and was injured and was unconscious for a few minutes." *Id.* Petitioner reported that "[h]e first remembers a co-worker talking to him and ambulance was called. He remembers being 'in and out' of consciousness at that time and was out of work for about three weeks. [Petitioner] has had daily headaches since. He awakens in the morning with a headache and goes to bed with a headache; headache is bi-frontal to posterior head with pounding, throbbing headache was sharp pains at times in the top of head. Headache is often as severe as 10 on a scale of 0-10 with nausea though without vomiting, often with photophobia. He denies any neck pain associated or ear pain though occasionally has TMJ pain. He will obtain some relief with use of Relpax. He is unaware of any headache precipitants. He does not seem to consume much of any of the headache precipitants. The remainder of neurologic review of systems is negative except for intermittent ringing tinnitus, occa-sional lightheadedness and sometimes blurring of vision in Association with headaches. Patient has no prior history of headaches." *Id.* Dr. Gulati noted that Petitioner had a normal neurological examination and that Petitioner's May 23, 2008 CT scan was negative. *Id.* He diagnosed Petitioner with post-traumatic syndrome of daily headaches sometimes severe, throbbing, disabling headaches and symptoms of impaired concentration/memory and panic-like attacks since his injury, and adjusted Petitioner's prescription medications. *Id.*

On May 12, 2009, Dr. Singla or Dr. Gutta diagnosed Petitioner with post-concussive syndrome and headaches. PX4 at 24. On June 9, 2009, Petitioner reported poor memory. PX4 at 23. On June 16, 2009, Petitioner saw Dr. Gulati and reported seeing a therapist for panic attacks. PX10 at 20.

During this treatment, Petitioner began seeing Elizabeth Zavodny, Psy.D ("Dr. Zavodny") on May 5, 2009. PX7. Petitioner testified that he saw Dr. Zavodny as referred by Dr. Singla for depression, mood swings and panic attacks.

Dr. Zavodny authored a report dated June 25, 2009 covering Petitioner's treatment with her from May 5, 2009 through June 23, 2009. PX7 at 3-6. Petitioner "...reported continued difficulty with concentration, anxiety, decreased self-care, increased outbursts of anger, frequent headaches, loss of self-confidence and prior (but post-incident) sleep difficulties." *Id.* Petitioner also reported suicidal thoughts, with no well-formed plan or intention, occurring after meeting with Ms. Jackson and that the severity levels of his symptoms were much greater than he previously reported to either Dr. Grimm or Ms. Jackson. *Id.* Dr. Zavodny recommended 2-3 additional psychotherapy sessions to assist with sleep difficulties and to maintain or improve his other symptoms, and an additional 4-5 sessions after Petitioner was released to work by his physician to help him handle the transition back to work. *Id.*

Section 12 Examination – Dr. Grimm

On July 3, 2009, Petitioner saw Bill Grimm, Ph.D ("Dr. Grimm") at Respondent's request for a neuropsychological evaluation. RX9. Dr. Grimm authored a report dated July 17, 2009 after examining Petitioner, reviewing various treating medical records, and in which he rendered various opinions. *Id.*

Among other treating records, Dr. Grimm referenced a neuropsychological evaluation of Dr. Gelbort on April 29, 2009 and May 13, 2009[4] in which Dr. Gelbort noted that "'[Petitioner] has endorsed many items as a result of tending to over report upset and symptomatology also feeling feelings of emotional distress, anxiety, a strong tendency to worry, and that emotional sensitivity'. In any event, [Dr. Grimm noted that] Dr. Gelbort thought that [Petitioner] had suffered a concussion as a result of his work-related accident, but that he has essentially recovered from that. He also thought that [Petitioner's] anxiety was the most limiting factor, and appeared to suppress his capacity for attention and concentration. He thought that continued counseling and medical treatment was warranted." *Id.* Dr. Grimm also reviewed Dr. Zavodny's reports, but noted that her daily progress notes were not provided to him. *Id.*

Dr. Grimm also noted Petitioner's report that "[s]ince the last evaluation on 10-22-08, [Petitioner] tried to follow through with some psychotherapy with one person, but reported that individual was not able to accommodate his scheduling issues. Instead of immediately seeking treatment elsewhere, he stated that he put the counseling/psychotherapy on hold in order to address some very troubling headaches which became very severe at times." *Id.*

Petitioner also reported that "[s]ince last seen, [Petitioner] stated that he quit drinking alcohol altogether about 8 months ago. He specifically commented about recalling an item from the Personality Assessment Inventory concerning whether other people thought he was drinking too much. He stated that previous to 8 months ago, he answered 'yes' to such an item, and openly acknowledged that his alcohol consumption was an issue between himself end [sic] his wife. Since he stopped drinking about 8 months ago, he indicated his response to the PAI item would currently be 'no'." *Id.*

Petitioner further reported that "[s]ince last seen in October, 2008, [he] reported additional stress within his life. Approximately 1 month ago, he said that his wife had lost her job as a unit secretary at Provena St. Joseph Medical Center, and was currently looking for a new job. He also reported that his mother-in-law had been hospitalized about a month ago, and that his wife had to take care of her. His father-in-law also reportedly has significant health problems, which [Petitioner] described as something in his chest which might explode, possibly referring to an aneurysm. In response to these stressors, [Petitioner] stated that he checks in on his in-

[4] The Arbitrator notes that Dr. Gelbort's records from these dates were not submitted into evidence.

laws to make sure they are safe. He commented that 'it's like having another child'. He stated that his wife was thinking about divorcing him, and by December, 08, he became aware that she had already contacted a divorce attorney. He stated that it was during that period of time that he experienced increased anxiety, headaches, and mood swings. It was also before he stopped drinking." *Id.*

Ultimately, Dr. Grimm noted that Petitioner's current neuropsychological test results were worse and in performance of various concentration and attention deployment test as compared with prior tests obtained in October of 2008 and worse than testing conducted only a few months ago, which he noted did not conform with known recovery from an uncomplicated concussion especially one which was experienced over a year ago. *Id.* Thus, Dr. Grimm opined that it was unrelated to his work accident on May 23, 2008. Dr. Grimm also noted that "[o]ther evaluation findings included significant evidence of over-reporting of symptoms or symptom magnification, probably reflective of a naive cry for help instead of blatant dissimulation." *Id.* Dr. Grimm further noted that the most significant finding at Petitioner's evaluation was the "convergence of multiple [unrelated] sources of stress impacting [his] sense of well-being[,]" including marital discord, concern over his drinking, financial matters associated with his wife's recent unemployment, and stress associated with ongoing supervision and care of elderly extended family members. *Id.*

Dr. Grimm reiterated that Petitioner was reporting "extreme levels of stress to such an extent that his current life circumstances would appear to be in a state of intense turmoil" and that the "aforementioned indications of symptom magnification probably represent an unsophisticated attempt to amplify his concerns as a cry for help, and not necessarily reflective of blatant dissimulation." *Id.* Dr. Grimm noted that it "was indeed surprising that there was no mention of not only the stresses impacting [Petitioner], problematic alcohol use, or the fact that his wife was threatening to divorce him, in the reports of Drs. Gelbort and Zavodny[,]" and he noted Petitioner's indication that "he and his wife were hoping to move towards reconciliation, and have agreed to seek out marital counseling" which he opined was unrelated to Petitioner's injury at work. *Id.*

Ultimately, Dr. Grimm opined that Petitioner was at maximum medical improvement and that his ongoing psychological conditions were unrelated to his accident at work. *Id.*

Continued Medical Treatment

From July 9, 2009 through May 25, 2010, Petitioner continued to see Dr. Singla or Dr. Gutta reporting some improvement, no change in his memory, and during which time his diagnoses remained the same. PX4 at 15-22.

On August 11, 2009, Petitioner returned to Dr. Gulati reporting improving headaches which were not daily anymore and mild at the top of his head for which he did not take medication. PX10 at 19. Petitioner also reported occasional severe headaches that were responsive to prescription medication and a significant complaint of ringing in the ears for which Dr. Gulati referred Petitioner to Dr. Kron. *Id.* Petitioner also provided a headache diary which showed too bad headaches and one mild headache to that date in the month of August. *Id.* Petitioner's physical and neurological examinations were normal. *Id.* Dr. Gulati increased Petitioner's Topamax to 100 mg and released him to return to work full duty effective August 31, 2009. *Id.*; RX10.

Petitioner testified that his last visit with Dr. Zavodny was on August 20, 2009. He testified that there were other problems and mood swings and panic attacks where he would yell at his kids for no reason. Petitioner

testified that he has two children aged 21 and 13 years old. Petitioner also testified that, after the headaches and panic attacks increased, he started drinking alcohol more.

Petitioner testified that he received a full duty release back to work from Dr. Gulati on August 31, 2009 and that he went back to work, but was not hired. On the same date, August 31, 2009, Dr. Zavodny authored a report dated covering Petitioner's treatment with her on August 6 and 20, 2009. PX7 at 7-13.

As with her first report, Dr. Zavodny dedicated much of her second report to identifying what she considered were errors and omissions in the reports authored by Dr. Grimm without indicating much objective or unbiased information on which she based her assessments or treatment recommendations. *Id.* Dr. Zavodny noted that Petitioner's sleep disturbances had improved and were manageable and she agreed with Petitioner's release back to full work by his physician at the end of August. *Id.* Petitioner testified that he found the meetings with Dr. Zavodny helpful and that further visits after August 20, 2009 were not authorized.

Petitioner saw Dr. Gulati on November 5, 2009 reporting one mild headache monthly for which he took no medication. PX10 at 18. Approximately 3 ½ months later, Petitioner returned to Dr. Gulati on February 16, 2010 reporting "[decreased] memory c/o 'hallucinations' – daydream – Dr. Singla d/c'd the Armitrip. of speaking to wife & during sex c/o HA – 'very mild' ha – 'Not at all' 'memory issues' 'has to keep reminding self' [.]" PX 10 at 17. Dr. Gulati noted that Petitioner was much improved symptomatically. *Id.*

On June 11, 2010, Petitioner saw Dr. Gulati reporting headaches 3 to 4 times per week that started two weeks after discontinuation of Topamax, "- Anxiety - has learnt to deal with it, - seen therapist, - depression - feels memory not influenced by Topamax[.]" PX10 at 16. Dr. Gulati noted that Petitioner "first returned to work today[.]" He referred Petitioner to Dr. Singla for depression, increased Petitioner's Topamax to 50 mg, and scheduled a follow-up visit in two months. *Id.*

On June 15, 2010, Petitioner returned to his primary care physician (Dr. Singla or Dr. Gutta) reporting anxiety, depression, mood swings, feelings of helplessness, lack of motivation, difficulty getting things done around house, and anhedonia. PX4 at 14. He was diagnosed with major depressive disorder and referred to Dr. Gulati for anti-depressants. *Id.*

On September 21, 2010 and October 12, 2010, Petitioner saw Michael Gelbort, Ph.D ("Dr. Gelbort") as referred by Dr. Singla. PX1 at 5-6. Petitioner reported that he "had headaches and other complaints since falling 8 to 10 feet off a wall in May 2008. HE was diagnosed with a concussion and left orbital socket fracture. He had complaints of poor short-term memory and mood swings with panic attacks at the time of his original evaluation." *Id.* Dr. Gelbort noted that Petitioner previously underwent evaluation in April and May of 2009. *Id.* At the time of his evaluation, Petitioner reported continued photophobia and noise sensitivity with constant tinnitus, poor appetite and weight loss, no drug or alcohol use, for cigarettes per day, difficulty with organization and that the " 'biggest factor is memory it is so bad.' " *Id.* Petitioner also reported reading and comprehension difficulty, problems with attention and concentration, slow processing speed, and distractibility. *Id.* Dr. Gelbort noted that Petitioner "presents much like patients who benefit from and if they are able to take psycho stimulant medications." *Id.*

After administering IQ tests and other examinations, Dr. Gelbort noted that Petitioner was describing moderate to severe emotional distress with anxiety and anhedonia, frequent worrying about something or someone, perceived difficulty with attention and concentration, and difficulty making poor decisions. *Id.* He further noted that Petitioner's emotional condition was much more limiting than the mild cognitive suppressions and he

showed indication of symptoms of a major depression as well as a mild tendency to somatize. *Id.* He recommended medical treatment for depression and cognitive behavioral psychotherapy. *Id.*

Petitioner continued to see his primary care physicians from July 13, 2010 through November 29, 2011 regarding his headaches. PX4 at 4-13. Petitioner also saw Dr. Gulati on September 7, 2010, November 23, 2010, March 1, 2011, and August 26, 2011 during which time Dr. Gulati maintained his posttraumatic headache syndrome diagnoses with additional diagnoses of depression and memory disturbances. PX10 at 12-15. On August 26, 2011, Dr. Gulati noted that Petitioner was under "a lot of stress (daughter [with diagnosis] of lymphoma)[.]" PX10 at 12.

Approximately eight months later, on April 17, 2012, Petitioner saw his primary care physician reporting left shoulder pain. PX4 at 3. Petitioner had decreased shoulder range of motion and a left shoulder MRI was ordered. *Id.* On April 28, 2012, Petitioner underwent the recommended left shoulder MRI. PX4 at 29-30. The interpreting radiologist noted showed a focal full thickness tear involving anterior footprint of supraspinatus tendon with more extensive articular surface tearing involving the remainder of the transverse thickness of the supraspinatus tendon, abnormal signal posterior superior labrum could represent labral degeneration or subtle tear, no focal para-labral cyst, and mild hypertrophy of the acromioclavicular joint. *Id.* Petitioner also underwent orbit x-rays which showed no evidence of radiopaque foreign body. PX4 at 28.

On January 17, 2012, Petitioner returned to Dr. Gulati for follow-up regarding his posttraumatic headache syndrome. PX9 at 72; PX10 at 10-11. Petitioner reported doing much better than before, no severe headaches or new symptoms since his last visit in August of 2011, and working full time and keeping very busy. *Id.* Petitioner's physical and neurological examinations were normal. *Id.* Dr. Gulati diagnosed Petitioner with posttraumatic headache syndrome with headache disorder consistent with posttraumatic vascular or common migraine headaches that were managed well with current medication dosages. *Id.*

Petitioner testified that Dr. Singla referred him to Dr. Puppala. Petitioner testified that he had problems moving his arms, and numbness and pain.

On April 28, 2012, Petitioner underwent a left shoulder MRI as ordered by Dr. Singla which the interpreting radiologist noted showed a focal full thickness tear involving the anterior foot print of the supraspinatus tendon with more extensive articular surface tearing along the remainder of the transverse thickness of the supraspinatus tendon, abnormal signal posterior superior labrum which could represent labral degeneration or a subtle tear, no focal paralabral cyst, and mild hypertrophy at the acromioclavicular joint. PX9 at 83-84. Petitioner also underwent an orbital foreign body MRI which showed no radiopaque foreign body. PX9 at 85.

On May 15, 2012, Petitioner returned to Dr. Gulati for follow-up regarding his post traumatic headache syndrome. PX9 at 70; PX10 at 8-9. Petitioner reported no bad headaches, feeling quite well, no neck pain, speech difficulty, visual disturbance, or extremity symptoms, and working without any problems. *Id.* Petitioner's physical and neurological examinations were normal. *Id.* Dr. Gulati diagnosed Petitioner with daily headache syndrome with migraine-like headaches of posttraumatic origin much improved now. *Id.*

On May 26, 2012, Petitioner underwent a cervical spine MRI without contrast as ordered by Dr. Puppala. PX9 at 80-81. The interpreting radiologist noted the following: (1) mild to moderate spinal stenosis scattered along the cervical spine most pronounced at C3-C4 and C5-C6 where there was, at most, a slight anterior impression on the cord at these levels without cord edema, spinal stenosis related to disc bulging, posterior lateral osteophytes, and hypertrophy of the posterior elements; (2) mild to moderate foraminal narrowing scattered

along the mid to lower cervical spine related to degenerative changes; and (3) a 12 mm focus of increased T1 signal noted along the posterior midline of the nasopharyngeal wall and may represent a complex cyst although it was not well evaluated and should be clinically correlated possibly with a follow-up MRI. *Id.* Petitioner also underwent another orbital foreign body MRI which showed no metallic foreign bodies in the orbits. PX9 at 82.

On November 20, 2012, Petitioner returned to Dr. Gulati for follow-up regarding his post traumatic headache syndrome. PX9 at 68; PX10 at 7. Petitioner reported he had no headaches since his last visit, no new complaints, and no neck pain, numbness, speech difficulty, or balance difficulty. *Id.* Petitioner's physical and neurological examinations were normal. *Id.* Dr. Gulati diagnosed Petitioner with posttraumatic headaches syndrome with common migraine and daily headache syndrome now much result; "He is currently headache free." *Id.*

Additional Information

Started working for another employer and began working full time 40 hours per week when he was able to, but testified that he then works 25-30 hours per week because he was not able to physically do 40 hours a week due to headaches and pain in the neck. On cross examination, Petitioner testified that since his return to work to Saachi (not Respondent) he has also worked for another company, Araiza Construction, as a journeyman carpenter.

Regarding his current condition, Petitioner testified that he still has headaches once per week that last between 1 and 4 hours. Petitioner testified that he is able to work when the headaches are not so severe but when they are, he has to take time off. Petitioner testified that he does not take any prescription medication for the headaches, but takes Tylenol as needed. He also testified that his ribs are tender particularly when he leans against something or when it is humid. Petitioner also testified that he sometimes has difficulty breathing. Regarding his depression, Petitioner testified that he still takes medication for depression including Prestig as prescribed by Dr. Gulati or Dr. Singla who manage the medical treatment for that condition. Regarding his spleen injury, Petitioner testified that he does not take any medication. Petitioner testified that his spleen is dead; that it was cauterized. He also testified that scratches are easily infected.

Petitioner testified that he had no problems with re-occurring severe headaches, depression, nausea, vomiting, and that he had no rib, broken bones, neck, back, shoulder or abdominal injury before his accident at work. He also testified that he had not visited any psychiatrist, psychologist or therapist before his accident at work.

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 has established causal connection between his accident at work on May 23, 2008 and several injuries from which he recovered. Namely, Petitioner sustained a fractured rib, a lacerated spleen, a suspected left eye orbital fracture that did not require surgery, a left lung pneumothorax, a concussion, and neck and shoulder pain. In so finding, the Arbitrator notes that the emergency room records contain objective diagnostic and clinically correlated evidence of such injuries. Petitioner continued to treat with his primary care physicians and was released back to full duty work after a short course of physical therapy and work conditioning. Indeed, Petitioner was released to full duty work by Dr. Demaertelaere as of July 24, 2008 and by the time he returned to see Dr. Demaertelaere on August 14, 2008, Petitioner reported feeling much better and working full duty without more than the occasional "twinge" regarding his rib pain. Thus, the Arbitrator finds that Petitioner established causal connection between these conditions and his accident at work through his return to full duty work and discharge from care by Dr. Demaertelaere.

While Petitioner argues that he also sustained a torn left rotator cuff and has cervical bulges attributable to his May 23, 2008 work accident, the Arbitrator notes that there is a large gap in time, of years, between Petitioner's initial neck and shoulder pain complaints (which the records reflect had resolved and after which Petitioner returned to full duty work for Respondent and then two other employers) and the diagnostic films taken in April and May of 2012. Thus, the Arbitrator finds that Petitioner failed to prove that he sustained any disc bulges in the cervical spine or a torn left rotator cuff as a result of his injury at work in 2008 or any causal connection between these conditions and his work accident on May 23, 2008.

Aside from the aforementioned conditions, Petitioner has been diagnosed with psychological and neurological conditions including depression and posttraumatic headaches based almost, if not entirely, and exclusively on his subjectively reported symptoms. The Arbitrator finds that Petitioner failed to prove any causal connection between these conditions and his accident at work. In so concluding, the Arbitrator finds that Petitioner's testimony at trial was not credible and notes that his reports to various treating physicians and Section 12 examiners about the accident itself and his subsequent symptoms are inconsistent. These reports also became magnified and, indeed, wholly localized to the head as his treatment progressed, which is contradicted by initial emergency room and early treating records. Moreover, Petitioner's complaints about headaches, memory loss, anger, depression, and difficulty concentrating only increased as time went on after periods of no headaches or minimal headaches which, notably, coincide with the onset of marital discord, increased drinking, his wife's loss of her job, and ongoing increased care being rendered to his in-laws. Petitioner's reliance on the opinions of Dr. Zavodny is misplaced.

The Arbitrator is not persuaded by the opinions of Petitioner's treating physicians, or Dr. Zavodny in particular, given the conclusory nature of her opinions and lack of progress notes which would reveal specific issues discussed in Petitioner's psychological treatment sessions. In both of her reports, Dr. Zavodny dedicated much effort in identifying what she considered were errors and omissions in the reports authored by Dr. Grimm and submitted a bill including a $200 charge for "evaluation of prior records[.]" Dr. Zavodny failed to specify

credible or objective medical information, if any, leading to her conclusions about Petitioner's condition and the objective bases for her treatment recommendations based on her individual assessment of Petitioner; rather, she devoted the majority of her reports to disagreeing with Dr. Grimm, assigning blame to Respondent's insurer (AIG) for delays in treatment which is contradicted by Petitioner's reports to Dr. Grimm, unquestionably accepting Petitioner's reports to her which are not documented in progress notes revealing Petitioner's actual reports to Dr. Zavodny and which were not submitted at trial, and basing her opinions and conclusions, in part, on the hearsay reports of Petitioner's wife. Given the foregoing, the Arbitrator finds that Dr. Zavodny's reports are lacking in objective evidence to support her conclusions and notes that they appear to have been prepared for the purpose of litigation instead of for purely medical assessment or treatment.

To the contrary, the Arbitrator finds that opinions of Dr. Shenker and Dr. Grimm are persuasive in this case. These physicians note the complete lack of objective evidence of any neurologic impairment of Petitioner in any diagnostic tests, their neurologic examinations, or the neurologic examinations of Petitioner's treating physicians and Petitioner's tendency toward symptom magnification, which is evident when comparing Petitioner's testimony at trial with documentary record evidence.

Also, the Arbitrator notes that Petitioner failed to submit into evidence the neuropsychological evaluations of Dr. Gelbort from April 29, 2009 and May 13, 2009, which Dr. Grimm noted reflected Dr. Gelbort's notations of Petitioner's tendency to over-report symptomatology and that, while Petitioner "had suffered a concussion as a result of his work-related accident[...] he has essentially recovered from that." The Arbitrator infers that these reports would have been adverse to Petitioner's position that his claimed psychological and neuropsychological conditions are work-related to any degree.

Thus, in light of the record as a whole, the Arbitrator finds that Petitioner's claimed neurological or psychological conditions of ill-being are not related to his work accident on May 23, 2008.

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 submitted medical bills from Provena Medical Center ($3,628.00), Provena St. Joseph Medical Center ($485.00), Dr. Gelbort ($1,597.28), and Dr. Singla ($235.10). As explained above, Petitioner failed to establish any causal connection between his claimed current neurological, psychological, cervical spine, or left shoulder conditions of ill-being and his work accident. Thus, the Arbitrator finds that these medical bills are not for reasonable and necessary medical care for conditions related to his accident at work. Petitioner's claim for payment of these outstanding medical bills is denied.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

The parties have stipulated that Petitioner was temporarily and totally disabled from May 27, 2008 through June 17, 2008 after which time the Petitioner was authorized to return to work. The parties also stipulated that Petitioner was temporarily and totally disabled from May 12, 2009 through August 30, 2009. Thus, Petitioner is entitled to temporary total disability during these periods of time. However, Respondent disputes that Petitioner was disabled from January 31, 2009 through May 11, 2009.

As explained above, the Arbitrator finds that Petitioner failed to establish causal connection between his

claimed neurological or psychological conditions and his work accident. The Arbitrator also finds Respondent's Section 12 examiners', Dr. Shenker and Dr. Grimm, opinions and conclusions to be credible and consistent with the medical evidence as a whole, which reflect that Petitioner suffered no neurological or psychological injury as a result of his work accident as evidenced by the negative CT scan upon Petitioner's original hospitalization, his consistent and repeatedly normal neurological examinations conducted by Dr. Gulati (Petitioner's treating physician) and Dr. Grimm. Thus, Petitioner's claim for temporary total disability from January 31, 2009 through May 11, 2009 is denied.

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—which reflects credible and objective evidence that Petitioner sustained multiple injuries including a surgically repaired spleen laceration, an orbital bone and facial fractures that required no surgical intervention, broken ribs and associated ribs, neck and shoulder pain that were treated conservatively all of which the medical records show healed/resolved, and which reflects that Petitioner returned to full duty work as a carpenter months after his accident—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 15% loss of use of the person as a whole pursuant to Section 8(d)(2).

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

Gaetano Lazzara,

Petitioner,

vs.

NO: 08 WC 39958

Gem Construction,

15IWCC0217

Respondent.

DECISION AND OPINION PURSUANT TO SECTIONS 19(h) & 8(f)

This matter comes before the Commission on Respondent's Petition for Review pursuant to Sections 19(h) and 8(f) filed on June 5, 2013. No question has been raised concerning the timeliness of the petition.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective.

After reviewing the record in its entirety, the Commission finds that Respondent has failed to prove that Petitioner's condition has materially diminished or ended and that Petitioner is able to return to gainful employment within his permanent restrictions and earn as much as he did before the June 7, 2008 accident. Therefore, the Commission hereby denies Respondent's Petition for Review under Sections 19(h) and 8(f).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner originally sustained injuries to his lower back on June 7, 2008. An Application for Adjustment of Claim was filed on September 10, 2008. The case was tried before Arbitrator Robert Falcioni on July 19, 2011. The issues in dispute at the Arbitration Hearing were causation, maintenance benefits, and permanent disability.

In his decision, filed on August 11, 2011, Arbitrator Falcioni found that Petitioner's work accident, which occurred while Petitioner was shoveling concrete, resulted in Petitioner suffering a low back injury consisting of herniated discs at L4-L5 and L5-S1 with radiculopathy. As a result of the accident, Petitioner underwent spinal decompression and fusion surgery at L4-L5

and L5-S1. After undergoing post-operative treatment, Petitioner was found to have reached maximum medical improvement on September 25, 2009, and the following permanent restrictions were imposed: no lifting/carrying more than 15 lbs., no squatting/standing/climbing/extensive walking, and only work light duty. The Arbitrator found that Petitioner's condition of ill-being was causally related to the June 7, 2008 accident. Arbitrator Falcioni awarded Petitioner temporary total disability benefits and maintenance benefits, found Petitioner to be permanent and totally disabled, and granted permanent total disability benefits.

Respondent filed a Petition for Review which was heard on March 15, 2012. The Commission affirmed and adopted the Arbitrator's Decision in its entirety on March 20, 2012. The Commission Decision was not appealed and became final.

On June 5, 2013, Respondent filed a Petition for Review under Sections 19(h) and 8(f) seeking termination of Petitioner's permanent total disability benefits due to a claimed change in Petitioner's condition. A hearing on the petition was held before Commissioner Michael Brennan on July 11, 2014.

Section 19(h) of the Act reads, in pertinent part:

> "An agreement or award under this Act providing for compensation in installments, may at any time within 18 months after such agreement or award be reviewed by the Commission at the request of either the employer or the employee, on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.
>
> However, as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement or award may at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.
>
> On such review, compensation payments may be re-established, increased, diminished or ended." 820 ILCS 305/19(h) (2013)

Section 8(f) reads, in pertinent part:

> "If any employee who receives an award under this paragraph afterwards returns to work or is able to do so, and earns or is able to earn as much as before the accident, payments under such award shall cease. If such employee returns to work, or is able

> to do so, and earns or is able to earn part but not as much as before the accident, such award shall be modified so as to conform to an award under paragraph (d) of this Section. If such award is terminated or reduced under the provisions of this paragraph, such employees have the right at any time within 30 months after the date of such termination or reduction to file petition with the Commission for the purpose of determining whether any disability exists as a result of the original accidental injury and the extent thereof." 820 ILCS 305/8(f) (2013)

By its brief, at hearing and at Oral Argument, Respondent argued that Petitioner was no longer permanent and totally disabled as of August 7, 2012. (T.5) In support of its allegation, Respondent relied on surveillance reports and videos from August 2012 through October 2012 (RX1 & RX2), Dr. Avi Bernstein's Section 12 examination report, addendum report, and evidence deposition (RX3), and the Vocational Rehabilitation File Review report and Labor Market Survey, dated May 11, 2013, prepared by Julie Bose, a vocational rehabilitation consultant, and her evidence deposition (RX4). However, Respondent relied most heavily on the surveillance video and reports.

The surveillance video of Petitioner was taken on six days over a two month period. The Commission notes that the video shows Petitioner, occasionally, wiping down tables and chairs and loading and unloading supplies, the weight of which was never established, as well as sweeping and throwing things out in dumpsters at his son's restaurant. The great majority of the time Petitioner is shown smoking, sitting, standing, walking and talking to other people. None of the activities performed by Petitioner in the surveillance video exceeded Petitioner's permanent restrictions of performing only light duty work and not lifting/carrying more than 15 lbs. The Commission notes that the activities performed by Petitioner on the surveillance videos are activities of daily living (taking a car to the garage, running errands, taking food home, etc.) and, on rare occasion, helping out at his son's restaurant with slight activities that do not exceed his restrictions. The surveillance video does not show a person who performs work activities consistently for an eight hour period, five days a week. As previously noted, the majority of the time Petitioner is talking to, eating with, and smoking with a companion at the restaurant.

Respondent also alleges that Petitioner was "likely" paid for his "work" at his son's restaurant. The Commission does not deal in suppositions. Respondent failed to provide any evidence of its claim that Petitioner was paid for any activities performed at his son's restaurant. There is nothing in the record to indicate that Petitioner has worked since the arbitration hearing.

Finally, the Commission notes that the medical records indicate that any change that had occurred regarding Petitioner's condition has been for the worse. On September 5, 2012, Dr. Tuttle performed a disability evaluation and found that Petitioner's condition had not changed since 2011. (PX1) Dr. Tuttle noted that Dr. Yen had restricted Petitioner's activities "even more in regards to lifting activity." Dr. Tuttle further found that Petitioner could not sit for a full eight hours and, "therefore, cannot work at sedentary level."

Dr. Bernstein, Respondent's Section 12 examiner, opined in his report that light duty restrictions were reasonable, basically affirming the permanent restrictions previously placed on

Petitioner. (RX3-ERX2) On September 6, 2013, Dr. Mannion diagnosed Petitioner as having persistent, recurrent symptoms of low back pain, left lower extremity paresthesias, and radicular-type symptoms. (PX1) During his October 13, 2013, evidence deposition, Dr. Bernstein acknowledged that diagnostic exams establish that Petitioner still suffered from chronic L5 radiculopathy. The Commission finds that there is nothing in the medical evidence to indicate that there has been a material change for the better in Petitioner's condition or disability.

The record is devoid of any evidence demonstrating that Petitioner's medical condition, disability or employability has improved materially in any way. As such, based on the entirety of the record, and considering the Act, law and facts of the case, the Commission finds that Respondent has failed in its burden to prove a material improvement in Petitioner's condition and that Petitioner has or is able to return to work pursuant to Sections 19(h) and 8(f) of the Act. Therefore, the Commission denies Respondent, Gem Construction's Petition for Review under Section 19(h) and 8(f) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petition for Review brought by Petitioner under Sections 19(h) and 8(f) is denied.

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

DATED: MAR 2 6 2015
MJB/ell
O-02/03/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Louis E. Jogmen,

Petitioner,

vs.

NO. 11WC 10049

15IWCC0218

City of Park Ridge Police Department,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. The circuit court reversed the Commission's decision on the accrual of benefits and remanded the matter to the Commission "for a determination of benefits in accordance with this Opinion and Order" for injuries to sustained to Petitioner's left shoulder and left elbow sustained while moving file cabinets for respondent City of Park Ridge. The Commission hereby complies with the order of the circuit court.

The following evidence is pertinent on remand. The evidence adduced at the arbitration hearing shows Petitioner underwent medical treatment that included a course of conservative therapy followed by arthroscopic left shoulder surgery on October 27, 2011. He received TTD benefits from October 27, 2011 through February 5, 2012 related to the left shoulder and returned to full duty.

Petitioner later underwent surgery to his left elbow on July 2, 2012. He received TTD benefits from July 2, 2012 through July 26, 2012. Petitioner returned to modified work at full salary on July 27, 2012. Petitioner was determined by his treating physician, Dr. Vitosky, to be at MMI with respect to both conditions on February 26, 2013, and Petitioner was discharged from care. This was not disputed and hence is the law of the case.

Petitioner is left hand dominant. The arbitrator awarded PPD benefit for the loss of 20% of the Petitioner's left arm pursuant to section 8(e) and the loss of 12% of the person-as-a-whole pursuant to section 8(d)(2) of the Act with respect to the left shoulder injury. She ordered as follows:

> "Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 50.6 weeks, because the injuries sustained caused the 20% loss of the left arm as provided in Section 8(e) of the Act.
>
> Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 60 weeks, because the injuries sustained caused the 12% loss of the person as a whole, as provided in Section 8 (d) 2 of the Act.
>
> Respondent shall pay Petitioner the permanent partial disability benefits that have accrued from February 26, 2013 through April 16, 2013, and shall pay the remainder of the award, if any, in weekly payments."

The arbitrator found that the date of accrual for both awards was February 26, 2013, that being the date of MMI relating to both injuries as determined by Petitioner's physician, Dr. Visotsky who released Petitioner from treatment on that date. The Commission affirmed and adopted the arbitrator's decision on June 3, 2014.

On judicial review, the circuit court entered an opinion and order on November 13, 2014 which stated:

> " A. The decision of the Illinois Workers' Compensation Commission is reversed and remanded for determination of benefits in accordance with this Opinion and Order."

The circuit court ordered that the accrual of benefits would commence at the time TTD benefits were terminated. Thus the circuit court ruled PPD would begin accruing on the shoulder injury on February 5, 2012 and for the arm injury on July 27, 2012. No further appeal from the circuit court's ruling was taken.

The Commission notes with respect to the award of 20% loss of use of the left arm that the circuit court's award had fully accrued by July 18, 2013, whereas the Commission's award would have fully accrued by February 17, 2014. Regarding the award of 12% of the person as a whole the circuit court's award would have fully accrued by March 31, 2013, whereas the Commissioner's award would have fully accrued by April 22, 2014.

The circuit court referenced two cases in support of its ruling that in the present case the Petitioner's awards under sections 8(e) and 8(d)(2) should begin to accrue at the dates of termination of TTD. Both of the cited cases: *Lester v. Industrial Commission*, 256 Ill. App. 3d 520 (1st Dist. 1993) and *Greene Welding and Hardware v. Workers' Compensation Comm'n,* 396 Ill. App. 3rd 754 (4th Dist. 2009) involve an amputation which is dramatically different from the injuries sustained in the present case. The full nature and extent of an amputation injury is obvious immediately at the time of occurrence. This is not the case with the injuries sustained by Petitioner in the present case. See 7 Larson's Workers' Compensation Law §86.02 ("The typical

15IWCC0218

schedule provides that, after the injury has become stabilized and its permanent effects can be appraised, benefits described in terms of regular weekly benefits for specified numbers of weeks shall be paid…").

Although the Commission may not necessarily agree with the circuit court's analysis we are mandated to follow it. That having been said, this matter is now moot as the period of accrual has been fulfilled under either analysis.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent immediately pay to Petitioner the remaining permanency award, if any.

No bond is required for removal of the 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 the Circuit.

DATED:
SM/msb
o-4/17/14
44

MAR 2 6 2015

Stephen J. Mathis

Mario Basurto

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF)
MCHENRY

☐ 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

ALBA SANCHEZ,

Petitioner,

vs.

NO: 11 WC 26386

JOSEPH'S MARKETPLACE,

15IWCC0219

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses 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 takes issue with the medical expenses awarded by the Arbitrator, and finds that a portion of the medical award should be reduced. Respondent's Exhibit 2 is a Utilization Review with regard to the reasonableness and necessity of various aspects of the care provided to Petitioner. Pursuant to same, the Commission finds that multiple treatments provided by these providers were excessive and unnecessary.

We first address the chiropractic care rendered. The noted Utilization Review indicates that the medical records showed no documented functional benefit after the initial six chiropractic visits, from July 8 through July 14, 2011. Based on same, the Commission finds that Respondent is not liable for the chiropractic treatment provided to Petitioner subsequent to July 14, 2011, and that all such subsequent treatment was excessive and unnecessary.

The Utilization Review indicates that while hot and cold packs were reasonable treatments, such treatments could have been performed by Petitioner at his home, and in fact

doing so at home would have been more beneficial as they could have been used multiple times per day instead of just at the medical or chiropractic office. This is a common sense approach, particularly when the charges for each of these treatments at the medical facility was $37.00. Additionally, per the Utilization Review, ultrasound is not a recommended treatment for neck complaints. The Commission finds that the Respondent is not liable for any and all charges for ultrasound and hot and cold packs made by Grandview Health Partners, and further specifically finds that such treatments were excessive and unnecessary under the circumstances.

Respondent argues that work conditioning in November 2011 was: a) not prescribed by her orthopedic surgeon, Dr. Freedberg; and, b) not reasonable and necessary since it was prescribed at the same time she was being taken off work pending approval of carpal tunnel surgery, and is meant as the last stage of recovery prior to returning to work. We agree. It's clear that Petitioner was not going to be returning to work pending surgery, and thus there was no basis for work conditioning at that point. The Utilization Review states that such treatment is not supported if it does not simulate the claimant's work activities and merely involves therapeutic exercises. The evidentiary record reflects a lack of documentation as to what was performed in the work conditioning. In fact, we found no records whatsoever in evidence with regard to work conditioning. The Petitioner has the burden to prove entitlement to medical benefits. As she has completely failed to do so, the Commission must conclude that all such treatment was excessive and unnecessary.

With regard to the billing of Accredited Ambulatory Care, the Commission denies three charges of $275 each for non-emergency transportation. There is no evidence in the record whatsoever supporting the medical necessity of this treatment. Additionally, the Commission notes that this charge for round trip transportation, on its face, appears excessive for round trip transportation. The remainder of the bill is awarded, with the bills being awarded pursuant to the fee schedule, and with Respondent entitled to credit for all amounts previously paid.

With regard to the billing of Chicago Pain & Orthopedic Institute, the following charges are denied: 1) $275.00 transportation charge on July 21, 2011; 2) $275.00 transportation charge on August 9, 2011; 3) $300.00 drug testing charge on September 13, 2011; and, 4) $212.70 drug testing charge on April 7, 2012. There is no evidence in the record to support the reasonableness and necessity of these charges. Additionally, the Commission denies the $1,520.23 charge on July 21, 2011 for a right wrist MRI. The Commission finds no indication whatsoever on the initial date of treatment by this facility to obtain a right wrist MRI. We find the prescription for all the MRIs prescribed on that date, including the neck and bilateral shoulders, to be questionable as they were made on the very first visit with Dr. Morgan. The Commission reviews medical records and treatment protocols on a daily basis. We find it tremendously unusual that such testing would be prescribed without any attempt whatsoever at conservative treatment. We will give the benefit of the doubt to the provider with regard to the MRIs of the shoulders and the cervical spine in this case. However, the number of times we have seen a wrist MRI ordered in the context of carpal tunnel-like symptoms is extraordinarily rare. We find that the prescription for the right wrist MRI this early in the examination process to be unreasonable and unnecessary, and the charge for same is denied.

15IWCC0219

With regard to the charges of Grandview Health Partners, we rely on the Utilization Review in denying the following treatment charges: 1) all chiropractic care subsequent to the initial 6 treatments; 2) all work hardening in November 2011; 3) all charges for paraffin bath; 4) all charges for hot/cold packs; 5) all charges for self care/home management; and, 6) all charges for "unusual travel". Further, with regard to the $150.00 charges for "unusual travel" indicated in the charges of Grandview Health Partners, such charges are denied as being excessive and unnecessary under the Act. Additionally, we note billing charges for "Self care/Home Management." As these charges are not explained in any way within the records of Grandview Health, such charges are denied.

With regard to the $990.77 charge of JMS Supplies Corporation, the coding for this charge indicates it was for a TENS unit on December 20, 2011, or some similar TENS-like device. In a thorough review of all of the medical records in evidence, we could not locate any prescription for such a unit in late 2011. As such, we find that this charge is unrelated to this case, and it is denied.

With regard to the charges of Pinnacle Pain Management, the Commission wishes to note that there were two charges for a December 20, 2011 epidural injection: $1,129.92 for what appears to have been the injection itself, and $412.94 for what appears to be fluoroscopic guidance. However, we also note that the records of Accredited Ambulatory Care indicate a charge of $1,412.39 for an epidural injection on the same date. If these are properly separate charges pursuant to medical bill coding protocol, the Pinnacle Pain Management bill remains awarded. If this constitutes a double charge for the same procedure, the bill of Pinnacle is denied as duplicative.

With regard to the denied charges noted above, other than the potentially duplicative charges for the December 20, 2011 epidural, and the $990.77 TENS unit charge which is denied based on a failure to prove a valid prescription for same, the charges are all denied as being excessive and unnecessary. Pursuant to Section 8.2(e) of the Act, the applicable providers shall not bill or otherwise attempt to recover from the Petitioner for medical services or treatment that have been determined by the Commission to be excessive or unnecessary. The Commission finds its support for this finding in the Utilization Review report submitted by Respondent as Exhibit 2.

The Commission notes that several bills in evidence indicate charges for non-emergency transportation. These transportation charges are denied. While the Respondent appears to have paid some of these charges, they are entitled to credit for any such payments made prior to hearing, against any amounts still owed to the providers who made these transportation charges.

The Commission discourages the practice of medical providers in Illinois who attempt to bill for non-emergency transportation charges. Such charges made by providers in this case were upwards of $275 per round trip. Not only do we find there to be no basis to find that such transportation was reasonable and necessary, we note that the charges themselves are excessive on their face. When there is no significant evidence supporting a medical need for such transportation, not only will such charges be denied, they create a significant degree of skepticism by the Commission with regard to the credibility of the facility making these charges.

The credibility of a medical provider necessarily can then impact our review of all of such facilities' treatments and charges.

While we affirm the decision of the Arbitrator, the Commission wishes to further clarify the basis for the permanency award in this case. The claimant was working for Respondent earning less than $400.00 per week. She testified that she has located alternative employment cleaning a bank. While she didn't testify to her earnings in that alternative employment, it would be difficult to earn less per hour than she did with Respondent. Thus, we see minimal impact on Petitioner's future earning capacity. We specifically note the January 15, 2013 report of Dr. Freedberg, wherein he notes his belief that Petitioner has a low pain tolerance. The objective MRI testing in July 2011 reflects mild findings in both shoulders and the cervical spine. While we don't agree with Dr. Zoellick's opinion that the Petitioner's subjective shoulder and neck complaints are unrelated to the accident, we do agree with his conclusion that the shoulder and neck conditions are preexisting and degenerative, not acute. We believe that the objective evidence of ongoing disability is minimal versus the Petitioner's subjective complaints. Therefore, we agree with the Arbitrator's determination regarding permanency, and affirm the awards of 5% of the person as a whole and 15% of each hand.

Based on the Arbitrator's award, the bond on appeal to the Circuit Court would be the maximum allowable amount of $75,000.00. This is based on a total award of approximately $90,804.00. The Commission is unable to calculate the exact amount by which the medical award has been reduced based on our findings above. However, based on our review of said bills, we believe that at this point the proper bond would remain $75,000.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is modified as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $258.00 per week for a period of 39-5/7 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 $232.20 per week for a period of 89.5 weeks, as provided in §§8(d)(2) and 8(e) of the Act, for the reason that the injuries sustained caused the loss of 5% of the person as a whole (cervical and shoulders), and the loss of use of 15% of the left hand (carpal tunnel) and 15% of the right hand (carpal tunnel).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses awarded by the Arbitrator under §8(a) of the Act, other than the medical expenses the Commission has denied, as noted above.

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.

15IWCC0219

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: MAR 27 2015
TJT: pvc
o 2/2/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANCHEZ, ALBA
Employee/Petitioner

Case# **11WC026386**

JOSEPH'S MARKET
Employer/Respondent

15IWCC0219

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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

15IWCC0219

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

- [ ] 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

Alba Sanchez
Employee/Petitioner

v.

Joseph's Market
Employer/Respondent

Case # 11 WC 26386

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 **Woodstock**, on **8-7-2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **6-27-2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,124.00**; the average weekly wage was **$387.00**.

On the date of accident, Petitioner was **44** 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 **$10,209.32** for TTD, $ for TPD, $ for maintenance, and **$10,209,32** for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $258/week for 39 5/7 weeks, commencing 7-8-2011 through 4-10-2012, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $5,456.77 to Accredited Ambulatory Service, $6609.09 to Chicago Pain and Orthopedic Institute, $35,411.74 to Grandview Health Partners, $990.75 to JMS Medical Supplies, $1542.86 to Pinnacle Pain Management, $890.00 to Suburban Orthopedics, and $7878.98 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $232.20/week for 64.5 weeks, because the injuries sustained caused the 15% loss of the left and right hands, as provided in Section 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $232.20/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.

Carl Lee 10/17/13

Signature of Arbitrator Date

OCT 21 2013

Alba Sanchez v. Joseph's Marketplace
Case No.: 11 WC 26386

Statement of Facts

Petitioner, Alba Sanchez was employed by Respondent, Joseph's Market on June 27, 2011. She had been so employed since 2005. She worked as a baker. Petitioner described two main job duties. She put Gonella breads on racks to prepare for baking and she decorated cakes. She also described waiting on customers and other bakery duties.

Petitioner prepared the creams that were used for decorating cakes. She then filled pastry tubes and squeezed the buttercream onto the cakes. She also applied flowers and other decorations. She testified that unless the cream was watery she would have to use force to squeeze the cream through the tube. She would decorate as many as 20 cakes per day. In using the tube she held the tube aloft with her arm out to the side and the tube held at chest level. She used both arms for decorating cakes.

Petitioner is 4'7" tall. The bakery racks are 6'0" tall. Petitioner marked on Respondent's Exhibit 5 a spot where she came up to along the rack. She filled 7-8 of these racks with breads. It is clear that she had to lift 4-5 trays of breads over her chest and then head level to put them on the racks. This is after bringing out numerous boxes of frozen breads from the freezer. She then put those breads on the trays and racks before they rose and were wheeled into the oven.

Petitioner's Manager, Dale Heine testified that little was above shoulder. However, Mr. Heine is 6'1". He would not have to do much above his chest or shoulder level. He admitted that Petitioner's hands and arms would be in motion most of the day. He estimated that the boxes of breads were 20-25 lbs. He did not think they weighed 35 lbs.

Petitioner began feeling pain in her hands after having worked for Respondent for about four years. Eventually, this pain was felt up Petitioner's arm and in her neck. She occasionally asked her supervisor, Joan, to help her decorate the cakes when her hands were hurting. On June 27, 2011 she informed the owner, Mike that her hands and arms were hurting from her job. She continued to perform her duties.

On July 8, 2011 Petitioner went to see a chiropractor, Dr. Nellie Christ, DC. Dr. Christ diagnosed rotator cuff syndrome and cervical radiculitis and took Petitioner off of work. An EMG revealed a left C7 neuritis and moderate bilateral carpal tunnel syndrome. Dr. Christ referred Petitioner to an orthopedist, Dr. Freedberg. Dr. Freedberg first saw Petitioner on August 9, 2011. He noted that Petitioner had pain for two years and decorated a lot of cakes. He diagnosed impingement in both shoulders with the left being worse than the right and biceps tendinitis. He did an injection. Petitioner had undergone an MRI that was interpreted by Dr. Morgan as showing a protrusion at C5/6 without significant stenosis or neural foraminal narrowing.

Respondent had Petitioner evaluated by Dr. Zoellick on September 27, 2011. Dr. Zoellick noted that Petitioner had rotator cuff tendonitis and impingement along with a cervical strain. He also found bilateral carpal tunnel syndrome. He was given information that Petitioner decorated a lot of cakes. He agreed that the carpal tunnel syndrome was work related but found the other conditions were not work related.

Petitioner underwent cervical epidural steroid injections with Dr. Morgan in November and December of 2011. She had a surgery on the right wrist on November 30, 2011. Dr. Freedberg did carpal tunnel and Guyon's canal releases. He did the same surgery on the left wrist on February 29, 2012. Petitioner had physical therapy during this time. Dr. Freedberg released Petitioner to work on April 10, 2012. He saw her a month later and she told him that she was still getting therapy and it was helping. She was only working four hours per day.

Dr. Freedberg wrote on September 4, 2012 that the work activities were a causative factor in the carpal tunnel syndrome. He also stated that the shoulder impingement and cervical radiculitis were causally related. He saw her in November, 2012 and January, 2013. He notes that she was at maximum medical improvement but was not normal. She still had pain.

Petitioner is only working four hours per day. She works cleaning a bank and described her duties as easier than her duties with Respondent. She gets cramping in her hands. If she grabs things she has pain in her hands. She has pain in her neck and shoulders when she stretches or puts her arms over head.

In support of the Arbitrator's decision relating to F the Arbitrator finds the following facts:

Petitioner's bilateral carpal tunnel syndromes, impingement tendinitis and cervical radiculitis are all causally related to her work activities. There is no dispute as regards the carpal tunnel syndrome. The arbitrator finds Dr. Freedberg's opinion, based on Petitioner's description of her job, more persuasive than that of Dr. Zoellick which was based on Respondent's Exhibit 1. The Arbitrator finds that Petitioner spent significant time with her arms reaching at or above shoulder height. She had to reach up to put breads on the higher levels of the rack in Respondent's Exhibit 5. Also, she held her arm in an elevated fashion as she decorated cakes. She would have to hold her arm up in order to keep it from hitting the cake. This could impact the neck and shoulders. Further she carried numerous boxes of bread from the freezer to the area where she put the loaves of bread on racks. Dale Heine admitted that Petitioner's arms and hands were moving most of the day at work.

In support of the Arbitrator's decision relating to L the arbitrator finds the following facts:

Petitioner has sustained bilateral carpal tunnel syndrome, bilateral shoulder impingement and cervical radiculitis. She continues to have difficulty with her arms, hands and neck. The arbitrator awards a 15% loss of use of the left and right hands and a 5% disability to the person as a whole.

In support of the Arbitrator's decision relating to J the arbitrator finds the following facts:

Having found that the shoulder impingement and cervical spine radiculitis are causally related the arbitrator awards the bills associated with those conditions. The bills for bilateral carpal tunnel syndrome had been paid but none of the bills for the other conditions had been paid. Petitioner credibly testified that she obtained relief from the therapy that was provided.

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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVE SUTTON,

Petitioner,

vs.

NO: 11 WC 33205

G & D INTEGRATED,

15IWCC0220

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, maintenance, vocational rehabilitation 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 in all respects except for the determination of the permanency award. With regard to permanency, the Commission increases the award from 10% of the man as a whole to 12.5% of the man as a whole, for the following reasons.

The Petitioner worked as a forklift operator for Respondent when, on February 15, 2011, he developed a hernia. He unfortunately had a preexisting skin condition which led to a delay in surgery, a subsequent infection, and an increased risk of problems post-surgically. It is axiomatic in Illinois workers compensation law that an employer takes their employees as they find them. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 199, 266 Ill. Dec. 836, 775 N.E.2d 908 (2002). As such, the impact of Petitioner's pre-existing skin condition on his ultimate post-hernia condition must be taken into account in this case.

Petitioner was 47 years old at the time of his injury, and has a significant working life left. He has applied for social security disability benefits, but none had been awarded by the time this matter went to hearing. While Petitioner testified that his application for disability included conditions that were not related to the hernia, he also testified that at least part of the basis was the sequelae from his hernia and subsequent surgery. Both treating surgeon Dr. Wyffels and examining physician Dr. Boghossian agreed that Petitioner required permanent restrictions (30 pounds with no excessive bending, pulling or stretching). (Petitioner's Exhibits 6 & 7). Dr. Boghossian added that if Petitioner developed a recurrent hernia requiring an additional surgery, it would be debilitating for him. (Petitioner's Exhibit 7).

The Commission agrees that the Petitioner did not sustain his burden of proof with regard to entitlement to additional vocational rehabilitation and/or a wage differential award, however we do believe that his permanent condition is significantly worse than the vast majority of hernia cases reviewed at the Commission level. As such, we believe the Petitioner sustained permanent disability to the extent of 12.5% of the man as a whole.

We note that the body of the Arbitrator's decision awards temporary total disability from February 16, 2012 through September 4, 2012, as well as maintenance benefits during his participation in vocational rehabilitation from January 21, 2013 through May 16, 2013. In the Arbitrator's form findings, these awards are not specified, while the credits to Respondent for payment of same are specified. As such, we wish to clarify that the Petitioner is entitled to these noted periods of TTD and maintenance, and that Respondent is entitled to credits as follows: $9,011.41 for TTD, $4,862.80 for maintenance, and $1,124.20 for other benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $312.28 per week for a period of 28-5/7 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 $312.28 per week for a period of 16-4/7 weeks, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $281.05 per week for a period of 62.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the permanent loss of 12.5% of the man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,510.39 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.

15IWCC0220

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 $21,300.00. 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: MAR 2 7 2015
TJT: pvc
o 2/17/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUTTON, STEVE
Employee/Petitioner

Case# **11WC033205**

G & D INTEGRATED
Employer/Respondent

15IWCC0220

On 6/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

0264 HEYL ROYSTER VOELKER & ALLEN
VICTOR M BOYLE
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

15IWCC0220

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

Steve Sutton
Employee/Petitioner

Case # **11** WC **33205**

v.

G & D Integrated
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 **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 **Vocational Rehabilitation**

15IWCC0220

FINDINGS

On **February 15, 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 **$24,357.84**; the average weekly wage was **$468.42**.

On the date of accident, Petitioner was **47** 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 **$9,011.41** for TTD, **$0** for TPD, **$4,862.80** for maintenance, and **$1,124.20** for other benefits, for a total credit of **$14,998.41**.

ORDER

Respondent shall pay reasonable and necessary medical services of **$4,510.39**, as provided in Section 8(a) of the Act and subject to the limitations of the Medical Fee Schedule provided for in the Act..

Respondent shall pay Petitioner permanent partial disability benefits of **$281.05**/week for **50** weeks, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Arbitrator Anthony C. Erbacci

May 29, 2014
Date

JUN - 2 2014

FACTS:

On February 15, 2011, the Petitioner was employed with the Respondent as a Materials Handler and he had been so employed there since June 14, 2010. The Petitioner testified that on February 15, 2011, he was assisting a coworker with the lifting/moving of heavy objects when he felt pain in the left side of his groin. He testified that he became sick and was taken to the hospital via ambulance.

The Petitioner was taken to OSF St. Francis Medical Center where he was treated for his injury. While there, the Petitioner reported that he had boils "for many years, but they have just been acting up lately." He also reported that he has had an inguinal hernia by description that he has been able to reduce easily. A CT of the abdomen was taken which revealed a left inguinal hernia and a fat containing right inguinal hernia. The Petitioner was diagnosed with a left inguinal hernia and a lower urinary tract infection. He was released to return home with pain medication and antibiotics. He was also advised to follow up with a surgeon within the next week. He was also cleared to return to work with a 5 pound lifting restriction.

The Petitioner was seen for a surgical consultation at the Peoria Surgical Group with Dr. Julius Bonello and Dr. David Crawford. Dr. Crawford advised surgical repair, but indicated surgery could not take place until the Petitioner's skin infections resolved. The Petitioner's primary care physician, Dr. Daniel Brune with Creve Coeur Family Practice, referred the Petitioner to Dr. Eric Elwood with Illinois Plastic Surgery for treatment related to the skin infections around the abdomen and groin. Dr. Elwood recommended localized excision of the infected areas and a penniculectomy to excise redundant skin. In order to proceed with these procedures, the Petitioner was advised to quit smoking. Dr. Elwood drafted a later dated April 12, 2011 to Dr. Brune detailing his evaluation, recommendations, and the importance of complete smoking cessation before proceeding with the recommended procedures.

On May 24, 2011, the Petitioner followed up with Dr. Elwood. It was noted that the Petitioner reported that he had only stopped smoking within the last few days and Dr. Elwood advised that if the Petitioner was unable to quit smoking for at least six weeks before and after the surgery, the surgery would have to be cancelled and/or delayed. Dr. Elwood also noted the Petitioner had been disruptive with his office staff on multiple occasions and he had to reinforce the importance of being compliant with medical management. The Petitioner verbalized his understanding of everything and a follow-up appointment was scheduled in three weeks.

The Petitioner followed up with Dr. Elwood again on June 7, 2011. At this time, the Petitioner had a positive urine test for nicotine use. As a result, the surgery was delayed an additional six weeks. Dr. Elwood advised the Petitioner that he would see him back at his discretion once he had stopped smoking. The Petitioner never returned for follow up with Dr. Elwood and as a result, his surgery was postponed indefinitely.

The Petitioner testified that he continued to work for the Respondent within the

recommended work restrictions until he was terminated on August 17, 2011 for tampering with a seatbelt on his forklift.

The Petitioner began treatment with Dr. Patrick Wyffels in August of 2011 following a referral from Dr. Brune. Dr. Wyffels treated the Petitioner for his incarcerated left inguinal hernia and his skin conditions. Dr. Wyffels indicated the skin conditions would need to be addressed prior to surgery due to risk of further infection(s), other complications and the risk of hernia recurrence. He prescribed antibiotics.

On November 18, 2011, the Petitioner was seen and examined by Dr. Stephen Boghossian at the request of the Respondent. Dr. Boghossian opined that the Petitioner's hernia was related to the Petitioner's work with the Respondent and he recommended surgical intervention; however, he advised the Petitioner needed to get his comorbid skin conditions under control before proceeding with surgery as serious complications and/or infection could occur.

The Petitioner continued to treat with Dr. Wyffels and remained unemployed. The Petitioner's skin conditions improved over the next few months and he eventually underwent surgery to repair the left inguinal hernia on February 16, 2012. Following surgery, the Petitioner continued treating with Dr. Wyffels for wound care.

On April 26, 2012, the Petitioner was seen again by Dr. Boghossian at the request of the Respondent. Dr. Boghossian opined that the surgery was reasonable and necessary and that, at the time of the surgery, the Petitioner was in an appropriate condition to have the surgery performed. Dr. Boghossian maintained his causation opinion and indicated the surgery performed by Dr. Wyffels was related to the work injury. He further opined that the Petitioner was not able to return to work at full duty at that time due to the open wound. He advised light duty restrictions were appropriate as of this time – no lifting more than 20 pounds, no repetitive bending, stooping, or stretching, and no act of physical motion that strain the core abdominal musculature.

On or about August 3, 2012, Dr. Wyffels indicated that the Petitioner had reached maximum medical improvement and he released the Petitioner to return to work with permanent restrictions of no lifting more than 30 pounds.

On January 22, 2013, the Petitioner was seen for a third time by Dr. Boghossian. Dr. Boghossian confirmed that the Petitioner had reached maximum medical improvement and he agreed with Dr. Wyffels' restriction of no lifting more than 30 pounds. Dr. Boghossian opined, however, that the Petitioner would not be able to return to his previous employment and would need long term restrictions due to the hernia repair and to multiple other comorbities, including but not limited to obesity and immunosuppression.

Vocational rehabilitation efforts were commenced following Dr. Boghossian's final examination and the Respondent also commenced payment of maintenance benefits at this time. Vocational rehabilitation efforts were undertaken from March 8, 2013 through May 16,

2013, when those efforts were discontinued.

Daniel Minnich, a Certified Vocational Counselor retained by the Respondent testified as to the vocational rehabilitation efforts that were undertaken to assist the Petitioner. Mr. Minnich opined that there were jobs available for the Petitioner in the Peoria area and that vocational assistance was appropriate for the Petitioner. Mr. Minnich testified that on May 9, 2013 he met with the Petitioner in furtherance of those vocational rehabilitation efforts and that the Petitioner advised him that he had returned to Dr. Wyffels and there was no way he would be able to go back to any kind of work. Mr. Minnich testified that the Petitioner further advised that he was applying for Social Security Disability benefits. Mr. Minnich testified that following that meeting, he spoke with Dr. Wyffels and the doctor advised that the pain the Petitioner was having would prevent him from working. Mr. Minnich testified that based upon his conversations with the Petitioner and Dr. Wyffels, vocational rehabilitation efforts on behalf of the Petitioner were terminated.

The Petitioner testified that, following the termination of vocational rehabilitation efforts, he began a job search on his own. The Petitioner offered Petitioner's Exhibit 9 as proof of the self directed job search he conducted. The Petitioner testified that he did not begin his job search until November of 2013 and Petitioner's Exhibit 9 indicates that the Petitioner made 66 contacts between November 18, 2013 and April 2, 2014, a period of approximately 19 weeks.

The Petitioner testified that he has applied for Social Security Disability benefits and that his application is pending. The Petitioner denied that he told Mr. Minnnich that he was not able to work at all and he testified that Dr. Wyffels did not restrict him from participating in vocational rehabilitation efforts. The Petitioner testified that he wants to participate in a vocational rehabilitation plan and wants to obtain a G.E.D. and computer training. The Petitioner testified that he would comply with vocational rehabilitation efforts and would attend any necessary classes.

The Petitioner testified that his left side currently continues to be bothersome and that excessive bending, stretching, and walking causes him to experience a "burning sensation" and a "pulling sensation" in the left side of his abdomen.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Petitioner sustained undisputed injuries that arose out of and in the course and scope of his workplace activities with the Respondent on February 15, 2011. The Petitioner

was diagnosed with a left inguinal hernia and ultimately underwent surgical repair of that hernia. Dr. Boghossian, the Respondent's examining physician, opined that the Petitioner's hernia was related to the Petitioner's work with the Respondent and that the medical care and treatment rendered to the Petitioner was reasonable and necessary. Dr. Boghossian agreed with the 30 pound weight restriction imposed by Dr. Wyffels and also recommended against excessive bending, pulling or stretching. Dr. Boghossian opined that the Petitioner is at a higher risk for recurrence of his hernia and that the Petitioner would not be able to return to his previous employment. Dr. Boghossian opined that the Petitioner would need long term restrictions due to the hernia repair and to multiple other comorbities, including but not limited to obesity and immunosuppression.

Evidence of the following medical expenses incurred by the Petitioner was admitted into the record:

East Peoria Fire Department	$878.00
OSF ST. Francis	$312.00
OSF St. Francis	$175.84
Proctor Hospital	$47.98
Proctor Hospital	$133.55
Proctor Hospital	$106.84
Proctor Hospital	$284.61
Peoria Tazewell Pathology	$47.30
Dr. Patrick Wyffels	$2768.88
Peoria Surgical Group	$40.00
Total Medical Bills	$4510.39

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the injury of February 15, 2013. The Arbitrator further finds that the medical care and treatment rendered to the Petitioner as a result of his left inguinal hernia, and the charges therefore as noted above, was reasonable, necessary and causally related to the Petitioner's injury. The Arbitrator finds that the Respondent is liable for payment of the above charges subject to the limitations of the Medical Fee Schedule provided for in the Act.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, and (O.), Is Petitioner entitled to Vocational Services, the Arbitrator finds and concludes as follows:

The parties stipulated that the Petitioner was temporarily and totally disabled from February 16, 2012 through September 4, 2012, a period of 28 5/7 weeks, and that all appropriate Temporary Total Disability benefits were paid to the Petitioner for that period. The Petitioner also claims that he is entitled to Maintenance benefits for the period of January 21, 2013 through the date of hearing, as well as the reinstatement of Vocational Rehabilitation

services.

Following his injury on February 15, 2011, the Petitioner continued to work for the Respondent until he was terminated for violation of a safety rule on August 17, 2011. The Petitioner was not medically taken off work until he underwent surgery to repair his hernia. Following that surgery on February 16, 2012, the Petitioner was kept off work completely until August 3, 2012 when Dr. Wyffels indicated that the Petitioner had reached maximum medical improvement and he released the Petitioner to return to work with a permanent restriction of no lifting greater than thirty pounds. Dr. Wyffels noted that he had reviewed the job description of the Petitioner's job with the Respondent and that the Petitioner was okay to return to work at that level.

On January 22, 2013, Dr. Boghossian confirmed that the Petitioner had reached maximum medical improvement and he agreed with Dr. Wyffels' restriction of no lifting more than 30 pounds. Dr. Boghossian opined, however, that the Petitioner would not be able to return to his previous employment and would need long term restrictions due to the hernia repair and to multiple other comorbidities, including but not limited to obesity and immunosuppression. Thereafter, the payment of Maintenance benefits was commenced and vocational rehabilitation efforts began. Those benefits were discontinued on May 16, 2013.

Daniel Minnich, a Certified Vocational Counselor, opined that there were jobs available for the Petitioner in the Peoria area and that vocational assistance was appropriate in order to find employment for the Petitioner. Mr. Minnich testified regarding his efforts in preparing the Petitioner for direct job placement and he testified that some of the Petitioner's conduct was counterproductive towards him obtaining employment within his restrictions. Specifically, Mr. Minnich testified that the Petitioner missed some scheduled appointments, and resisted compliance with recommendations regarding his personal appearance. Mr. Minnich also testified that the Petitioner reported that Dr. Wyffels had increased his work restrictions and that there was no way he was going to be able to work. Mr. Minnich further testified that Dr. Wyffels advised him that the pain the Petitioner was having would prevent him from performing any type of work. Mr. Minnich testified that based upon his conversations with the Petitioner and Dr. Wyffels, vocational rehabilitation efforts on behalf of the Petitioner were terminated.

While the Arbitrator notes that the Petitioner denied telling Mr. Minnich that he was not able to work at all, the Arbitrator cannot ignore Mr. Minnich's testimony. Mr. Minnich has no apparent interest in the outcome of this matter and, in fact, as Mr. Minnich was being paid for his services, discontinuance of his services would appear to be contrary to his interests. Similarly, while the Petitioner testified that Dr. Wyffels did not restrict him from participating in vocational rehabilitation efforts, Mr Minnich testified that he spoke with Dr. Wyffels and the doctor advised him that the pain the Petitioner was having would prevent him from working. Although there is nothing in Dr. Wyffels' records, or any of the other medical records for that matter, which indicates the Petitioner is unable to work, the Arbitrator cannot ignore Mr. Minnich's testimony.

Additionally, the Arbitrator notes the Petitioner's physical condition as reported in the medical records, the six-month gap in time before he resumed his self-directed job search, the limited nature and duration of that self-directed job search, and the fact that the Petitioner has applied for Social Security Disability benefits. All of these factors, together with the testimony of Mr. Minnich, are cause for suspicion with regard to the Petitioner's ability and motivation to participate in a rehabilitation program or vocational assistance. Similarly, the Petitioner's testimony that he lacked the ability to use a computer and that he lacked access to a computer are cause for suspicion with regard to the Petitioner's ability and motivation to participate in a rehabilitation program or vocational assistance and the likelihood of success of any such program. Considering the totality of the evidence presented, the Arbitrator question's the Petitioner's willingness to fully comply with a vocational rehabilitation plan or engage in a bone fide job search, whether self directed or assisted.

The Petitioner's report to Mr. Minnich that there was no way he would be able to work, and Dr. Wyffels' report to Mr. Minnich that the Petitioner's pain prevented him from working, served to sabotage the vocational rehabilitation services that were being provided to the Petitioner and, taken along with the Petitioner's failure to fully comply with the vocational assistance being provided to him, justified the termination of the maintenance benefits that were being provided to the Petitioner.

While the Petitioner testified that he wants to participate in a vocational rehabilitation plan and that he would be willing to attend any classes that would be suggested, he provided no specific proposed vocational rehabilitation plan nor any evidence that such a plan would likely be successful. Aside from the Arbitrator's questions as to the Petitioner's earnestness, the Arbitrator finds that the Petitioner failed to provide sufficient evidence from which to conclude that vocational rehabilitation would be appropriate in the instant matter.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that he is entitled to vocational rehabilitation services or maintenance benefits after May 16, 2013.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The parties agreed that, if appropriate, the Arbitrator should issue a Decision relating to the nature and extent of the Petitioner's injuries.

The Arbitrator notes that the Petitioner was diagnosed with a left inguinal hernia and ultimately underwent surgical repair of that hernia. On August 3, 2012, Dr. Wyffels, the Petitioner's treating surgeon, indicated that the Petitioner had reached maximum medical improvement and he released the Petitioner to return to work with permanent restrictions of no lifting more than 30 pounds. Dr. Boghossian, the Respondent's examining physician, agreed that the 30 pound lifting restriction was appropriate and he opined that, due to the hernia repair and to his multiple other comorbidities, the Petitioner would not be able to return

to his previous employment.

The Arbitrator notes that no physician has opined that the Petitioner is totally disabled from working and the Petitioner is not obviously unable to work. Daniel Minnich, a certified vocational counselor, opined that there are jobs available for the Petitioner within his restrictions. While the Respondent's examining physician has opined that the Petitioner is not able to return to his previous employment and is in need of permanent restrictions, no evidence was presented regarding a diminution in earning capacity. The Arbitrator finds that the Petitioner has failed to prove that he is permanently and totally disabled and has failed to prove he is entitled to a wage differential award.

The Petitioner has permanent work restrictions of no lifting more than 30 pounds and the Respondent's examining physician, opined that, due to the hernia repair and to his multiple other comorbidities, the Petitioner would not be able to return to his previous employment. The Petitioner testified that his left side currently continues to be bothersome and that excessive bending, stretching, and walking causes him to experience a "burning sensation" and a "pulling sensation" in the left side of his abdomen.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's injuries resulted in a 10% disability to the Petitioner's whole person.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert D. Long,

Petitioner,

vs.

NO: 14 WC 24108

Piasa Oils Transport, LLC,

15IWCC0221

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, 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 September 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: MAR 27 2015
TJT:yl
o 3/10/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

LONG, ROBERT D
Employee/Petitioner

Case# **14WC024108**

PIASA OILS TRANSPORT LLC
Employer/Respondent

15IWCC0221

On 9/11/2014, 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 0.04% 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:

5441 NORBERT J GOETTEN
ATTORNEY AT LAW
105 N STATE
JERSEYVILLE, IL 62052

2337 INMAN & FITZGIBBONS LTD
KEVIN J DEUSCHLE
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

15IWCC0221

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert D. Long
Employee/Petitioner

v.

Piasa Oils Transport, LLC
Employer/Respondent

Case # 14 WC 24108

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 14, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, May 15, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $79,144.05; the average weekly wage was $1,522.00.

On the date of accident, Petitioner was 59 years of age, married with 0 dependent child(ren).

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

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

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

ORDER

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)

September 8, 2014
Date

SEP 11 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 May 15, 2014. According to the Application, Petitioner was exiting a truck cab when his right leg struck the pavement awkwardly which caused an injury to Petitioner's right knee. Respondent disputed liability on the basis of accident, notice and causal relationship. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits.

Petitioner testified that he worked for Respondent for approximately 33 years. From 2001 to 2014, Petitioner worked for Respondent as a dispatcher. On May 2, 2014, Petitioner began working for Respondent as a truck driver.

Petitioner stated that on May 15, 2014, he was delivering a load to a Moto Mart in Carrollton, Illinois, at approximately 1:30 PM. When Petitioner stepped out of his truck onto the pavement, he experienced pain and numbness in his right knee. Petitioner did not sustain any type of slip/fall or twisting injury to his right knee at that time.

Subsequent to Petitioner's experiencing the right knee symptoms, he completed his job duties and went home. Petitioner was limping and he applied heat to his knee and went to bed at approximately 5:30 PM. When Petitioner woke up at midnight to return to work, his right knee was still painful. When Petitioner went to the Respondent's office in Hartford, he refueled his truck and picked up the paperwork for his next job assignment for that day in a drop box.

Petitioner proceeded to drive the truck to a terminal also located in Hartford where he picked up the load to be transported. He then drove to Hermann, Missouri, and arrived there at approximately 4:45 AM. Petitioner's right knee pain progressively worsened and he then proceeded to drive to Mexico, Missouri, to pick up another load. When Petitioner got to Kingdom City, Missouri, he took a 30 minute break and called his boss, Matthew Schrimpf. Petitioner testified that he informed Schrimpf that he had injured his right leg/knee when getting out of his truck of the preceding day. Petitioner stated that Schrimpf instructed him to unload his vehicle at the terminal before going to a doctor.

Petitioner then drove his truck to the terminal in Hartford where he parked his truck and then proceeded to walk across the parking lot. Because of the right knee pain Petitioner was experiencing, he was unable to walk up some stairs so the terminal manager walked down the stairs to deliver some paperwork to him. After receiving the paperwork, Petitioner began to walk across the parking lot and, when he did so, he felt a couple of "pops" in the right knee. Petitioner testified that the parking lot was in a good state of repair and that there was nothing in the lot which caused him to fall, slip, trip or otherwise cause the pain in his knee.

Petitioner sought medical treatment at the ER of Alton Memorial Hospital on May 16, 2014. According to the records, Petitioner gave a history of "...right knee pain for a few hours. He was walking through the parking lot at work when he felt a pop x 2 in his knee." (Petitioner's Exhibit 11). The records did not contain any statement of Petitioner having injured his right knee while

stepping out of his truck on the preceding day. At trial, Petitioner testified that this record was incomplete because he did inform the ER personnel of his injuring his right knee while stepping out of the truck the day before.

Petitioner testified that while he was in the ER, he contacted Becky Farmer, Respondent's insurance coordinator, and advised he had sustained an injury to his right knee on May 15, 2014, when he stepped out of his truck. Petitioner stated that the purpose of the conversation was to advise Farmer of the information concerning his accident so that she could complete the appropriate accident report.

Petitioner testified that he was interviewed by Michelle Gudewicz, a claims representative for Respondent's insurance carrier on May 19, 2014. Petitioner was made aware of the fact that the interview was recorded and he gave his consent to same. A copy of Petitioner's recorded statement was received into evidence at trial.

In the recorded statement, Petitioner initially said that the accident occurred on May 16, and that he was walking across the parking lot when he felt a couple of pops in his knee and sharp pain in his leg. He confirmed that the surface was not wet and that he did not step on anything or twist his knee (Respondent's Exhibit 1; pp 5-6). Later in the recorded statement, Petitioner said that he had experienced some trouble with his leg the day before and, when asked if there was a specific accident, Petitioner stated "No, no, there was nothing specific there either." (Respondent's Exhibit 1; p 12).

Petitioner subsequently sought medical treatment from Dr. Matthew Smith, an orthopedic surgeon, who saw Petitioner on May 27, 2014. According to Dr. Smith's record, the history Petitioner provided to him was that "He had an acute episode of pain when he stepped awkwardly off a truck." (Petitioner's Exhibit 12).

Dr. Smith ordered an MRI scan which was performed on May 30, 2014, which revealed a torn medial meniscus. Dr. Smith authorized Petitioner to be off work and performed arthroscopic surgery on June 11, 2014, and the procedure consisted of a medial meniscectomy (Petitioner's Exhibits 11 and 12).

Petitioner testified that he is still under Dr. Smith's care, is still receiving physical therapy and that another MRI scan was scheduled for August 18, 2014. According to Petitioner, Dr. Smith has not released him to return to work.

Matt Schrimpf testified on behalf of the Respondent and stated that he had worked for Respondent since 1995 and, in 2008, he became the President. He confirmed that Petitioner called him on the morning of May 16, 2014, and that Petitioner informed him that he began to experience pain and numbness in his right knee on May 15, 2014; however, Schrimpf denied that Petitioner informed him that the right knee pain/numbness was because of any work-related accident, including stepping out of his truck on May 15, 2014.

Becky Farmer testified on behalf of the Respondent and stated that she had worked for Respondent for seven years and that, for the preceding three years, she was Respondent's

insurance coordinator. She confirmed that Petitioner called her on May 16, 2014, following his ER visit and that he informed her that he hurt his right knee on May 16, 2014, while walking across the parking lot. Farmer specifically denied that Petitioner informed her that his right knee pain was because of an accident he sustained while stepping out of a truck on May 15, 2014.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on May 15, 2014.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds Petitioner's testimony in regard to the alleged accident of May 15, 2014, not to be credible for one or more of the following reasons:

Petitioner's testimony is contrary to the history contained in the ER record of Alton Memorial Hospital of May 16, 2014, which stated that Petitioner had experienced right knee pain for a few hours after walking through a parking lot when he felt two pops in his knee.

Matt Schrimpf testified that Petitioner informed him of having right leg pain that began on May 15, 2014, but that Petitioner did not inform him of having sustained a work-related accident.

Becky Farmer testified that Petitioner informed her of having hurt his right knee on May 16, 2014, while walking across the parking lot and that he reported nothing about experiencing knee pain when he stepped out of his truck on May 15, 2014.

When Petitioner gave his recorded statement, he initially described the "accident" as having occurred on May 16, 2014, when he was walking across a parking lot, but he later stated that he had experienced knee pain the day before but that there was no specific accident on either date.

Dr. Smith's record of May 27, 2014, was the first medical record that suggested Petitioner experienced right knee symptoms when he stepped out of a truck.

The Arbitrator further finds that even if Petitioner's description of the circumstances that caused him to experience symptoms in his right knee were to be accepted, that it would still not constitute an accidental injury arising out of and in the course of his employment for Respondent.

Petitioner did not describe a specific event or accident on either May 15, or May 16, 2014, just simply that his knee started to hurt while he was walking. There was no slip/fall or any twisting of the knee. Further, there was no evidence that Petitioner was subjected to a risk of injury greater than that to which the general public is subjected. Caterpillar Tractor Co. v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989).

In regard to disputed issues (D), (E), (F), (J), (K) and (L) the Arbitrator makes no conclusions of law because these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Yolanda Shavers,
Petitioner,
vs.

15IWCC0222

NO: 09 WC 25313

Elgin Mental Health/State of Illinois,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, penalties, vocational rehabilitation and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 12, 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.

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

DATED: MAR 27 2015
KWL/vf
O-3/23/15
14

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0222

SHAVERS, YOLANDA
Employee/Petitioner

Case# **09WC025313**
09WC025314

ELGIN MENTAL HEALTH/ST OF IL
Employer/Respondent

On 5/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

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

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
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

MAY 12 2014

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0222

Yolanda Shavers
Employee/Petitioner

v.

Elgin Mental Health / State of Illinois
Employer/Respondent

Case # **09** WC **25313**

Consolidated cases: **09 WC 25314**

An *Application for Adjustment 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 **4/2/14**. 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 **Vocational Rehabilitation**

FINDINGS

On the date of accident, **4/5/09 & 4/6/09**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$39,000.00**; the average weekly wage was **$750.00**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$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 meet her burden of proof on the issue of causation and therefore, her claim for benefits 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.

Gerald A. Granado

Signature of Arbitrator

5/6/14
Date

MAY 12 2014

FINDINGS OF FACT

Petitioner testified in April 2009 she was employed as a Mental Health Technician-2 at the Elgin Mental Health Center (hereinafter, "EMHC"). Her duties involved providing care for mentally disabled adults in a residential setting. Although she testified that she is not currently employed, Petitioner worked at EMHC for 11 years. On April 5, 2009, the date of the first injury in this case, Petitioner was working the night shift and was attacked by a female patient while inside the EMHC. This patient kicked and punched her until assistance arrived. Petitioner could not recall how long this first incident lasted. Petitioner testified she felt scared and fearful as the attack was going on. Petitioner acknowledged she was able to continue her shift after the first attack.

On April 6, 2009, after midnight, Petitioner was attacked again by the same patient. She testified this attack lasted much longer. Staff was not immediately available during the attack. During the April 6th incident, Petitioner was kicked, punched, slapped, slammed against the wall, and scratched. She did not know exactly how long this attack lasted. Petitioner testified, that she thought she was going to die during this attack. She also testified that she was thinking about her family and children while she was being attacked, and that during the attack, she remembered opening and closing her eyes, in and out of consciousness.

Petitioner testified she had never been attacked before at EMHC. She further testified she was in an extreme amount of pain, was throbbing, was bleeding from her nose, and had pain in the back of her head. Concerning her mental state after the attack, Petitioner described that she was scared and feared her life was unstable. She went to Elgin Physical Health Center for follow-up care for her physical injuries, where she was diagnosed with cephalgia, cervical strain/sprain, and right shoulder strain/sprain.

Petitioner testified that prior to 2009 she sought out a mental health professional for mild depression. She was seeing Dr. Steven Resis for medication and counseling. Petitioner was able to function at work and in society before the accident. After the attacks she started having problems sleeping, with flashbacks, with panic attacks, and her anxiety level would get to a point where she could not control it. In Petitioner's flashbacks, she would see the patient's face that attacked her. She testified she had no issue sleeping prior to these attacks and after the attacks she has to take medication to sleep. Petitioner denied having these issues prior to these attacks

Petitioner described at trial that she had previously been in a TJ Maxx store and thought she had seen the patient that attacked her. She testified that she loved working for Elgin and she loved working for the State. Petitioner testified she feels fear and she has not returned to EMHC since the attacks. The records from Dr. David Hartman indicate Petitioner was offered a job in the mailroom, with assurances that patients would not have access to the area. Petitioner told Dr. Hartman, "I don't want to work with mental health patients anymore. It doesn't matter whether its Dietary, Groundkeeping, or in the Mail Room." (*Dr. Hartman's Report*, pg. 5). Petitioner testified Dr. Resis has not released Petitioner from his care and that she sees him every 30-60 days. Petitioner takes Lexapro and Diazepam currently. Diazepam helps Petitioner with her anxiety and sleep.

Petitioner testified she tried to find other employment with the State of Illinois. Petitioner testified she would consider non-state employment opportunities. Petitioner admitted she had not applied to any jobs outside of the State since April of 2009. She met with a vocational counselor in preparation for trial and that vocational counselor developed a plan for vocational rehabilitation. Petitioner testified she still has lower back pain and she takes Tylenol or uses a heat wrap. Petitioner was found to be employable by Cari Stafseth, a vocational

counselor that testified at trial. Petitioner admitted on cross-examination she received her full salary from EMHC up through October 22, 2009.

Petitioner testified that directly after the attacks her feeling of fear and dread did not go away. She receives social security disability benefits, which she began receiving in 2010. However, she could not explain why she receives SSDI benefits.

Petitioner's Pre-Accident Psychiatric Records

Petitioner's psychiatric records date back to 2005, approximately four years prior to these incidents. Those records indicate Petitioner has a history of hearing things in her mind. (*Dr. Resis Note*, 4-21-08). The diagnosis at the beginning of Petitioner's treatment was Axis I: Major Depression, in remission, with associated anxiety; Axis II: Deferred.

Petitioner's evaluation of August 30, 2005 describes significant mood instability since the age of 16, with racing thoughts and problems concentrating. This evaluation describes many struggles including with Petitioner's son being a self-mutilator and significant work related issues.

A note from Dr. Janeen Paul from October 20, 2005 states:

> "Patient called stating that she is having a lot of difficulty at work. She is still feeling extremely agitated and feeling very anxious and down. She called in tears stating that she could not feel she could go back into work due to the persecution that she is getting from her boss. We discussed family medical leave and obtaining paperwork to start a leave of absence beginning immediately and to have the paperwork transferred to Dr. Resis. We also discussed increasing her Abilify to 7.5 mg/day from 5mg. I also asked her to page her therapist, Dr. Green, to talk through some relaxation techniques to help her to calm down more immediately…"

On December 6, 2005, Petitioner was struggling with ongoing difficulties with intense anxiety and also with difficulty functioning. She was struggling with work related issues, was crying on a regular basis, and continued to have low energy. That note concludes, "she's unable to work at this time but hopefully will be able to return to work in the next few weeks."

The medical notes from 2008 reveal the following: September 23, 2008: Petitioner's three teenage cousins moved in and Petitioner was struggling with that, as well as having interpersonal problems at work. April 21, 2008: Petitioner was under tremendous stress due to a close friend/coworker being found dead. Petitioner reports she has been hearing some noises in her mind and can differentiate this from reality.

On December 10, 2008, Petitioner reported she could not reapply for FMLA until January 2009. Petitioner was having ongoing conflicts with a new supervisor and some individuals at work. The note goes on to say, "If she needs a day off work she can call and a letter will be written on her behalf."

On January 27, 2009, Petitioner was having more difficulties with increased stress at work due to double shifts and was also having difficulties with her son getting into trouble. Petitioner had ongoing conflict with her

supervisors at this time. This note states, "we have agreed to continue the Family leave Act so when she is overstressed it does not get to the point where she is in danger of herself." (*Dr. Resis Note*, January 27, 2009)

Petitioner's Post-Accident Psychiatric Records

Following her attacks, Petitioner saw her psychiatrist, Dr. Resis, on April 7, 2009, whose record from that date states:

> "She reports she has struggled with a couple of incidents with an aggressive female patient who attacked her physically. She is hopeful that there will be better staffing ratios or she may need to look for work in a different line. Otherwise, she reports things are going well with the medications and with her family, other than some issues with her 18 year old son."

A note of September 15, 2009 shows Petitioner was dealing with deep regret over her DUI arrest.

A note of February 23, 2010 states:

> "She reports that it is highly unlikely that she will be able to return to this facility due to the flashbacks and terrible recollections she has of being attacked by the same patient on two separate occasions. We reviewed how it may be possible, if she was in an office location off site where there were no patients or dangerous patients, she may be able to do some type of office work. She reports that does not appear to be an option for her."

The note of August 3, 2010 shows Petitioner was dealing with ongoing issues with her two sons, but things were fairly stable for Petitioner with her medications.

A note of September 9, 2011 shows Dr. Resis "encouraged her to resume some individual counseling, which she was reluctant to do."

The note of April 10, 2012 shows ongoing issues Petitioner was having with her mother, her three children, and the issue of her son moving out. Despite this, her mood was reported as quite stable with the combination of medications. A note of March 5, 2013 concludes Petitioner can do some employment, but not with hostile or violent patients. A note of December 4, 2012 shows Petitioner was suffering from anxiety about taking a road trip with a significant other.

Dr. Resis noted on October 9, 2012:

> "The patient reports that she has been struggling with taking a couple of classes at the local junior college. She reports being very rusty in her English skills. She is enjoying the human services class. We reviewed that her anxiety level may be too high as she is currently drinking two or three cups of coffee a day to try to pay attention in class. I have asked her instead to try lowering the Valium from 20mg a day to 10mg a day and reduce her caffeine intake. I have asked her to continue the current dosage of the Wellbutrin that would certainly help her focus and concentrate..."

Petitioner's Diagnostic Testing

On March 15, 2010, Petitioner underwent diagnostic testing performed by neuropsychologist Dr. David Hartman. Dr. Hartman concluded Petitioner is motivated by secondary gain and is malingering. Dr. Hartman notes it is "imperative in any case where secondary gain motivations may be relevant e.g., receipt of disability income, civil litigation, avoidance of work) to determine whether a claimant's responses reflect actual strengths and weaknesses, or if she is deliberately worsening performance on some or all tests." (*Dr. Hartman's Report*, pg. 5).

Dr. Hartman found Petitioner

> "produced malingering-level test responses on several independent, objective measures including the Word Memory Test, the Morel Emotional Numbing Test, the Structured Inventory of Malingered Symptomatology, the Memory Complaints Inventory, and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Repeated exaggeration of cognitive and emotional dysfunction on objective testing constitute a reasonably consistent attempt by Ms. Shavers to deliberately exaggerate (malinger) for motivationally-based secondary gain, i.e. work avoidance." (*Dr. Hartman's Report*, pg. 5).

Petitioner's Memory Complaint Inventory score was "above those individuals with brain injury or psychiatric disorder, and in the context of the malingered test results, appears to be self-serving with respect to work avoidance." (*Dr. Hartman's Report*, pg. 7)

Dr. Hartman found Ms. Shavers' MMPI-2 test, which contains validity measures,

> "showed an exaggerated and invalid approach to symptom admission; clinical scales showed extreme symptom admission levels on scales related to depression, psychosis, paranoia, ruminative thinking and almost all other clinical scales. If valid, Ms. Shavers would have presented as acutely psychotic and in need of hospitalization, in contrast to her oriented and calm presentation during almost 7 hours of assessment and observation." (*Dr. Hartman's Report*, pg. 11)

Dr. Hartman noted that Ms. Shavers "did not include significant family or supervisory conflicts in her current attributions of difficulty, as these would likely not be considered posttraumatic stress-related and could not be used to avoid work return." (*Dr. Hartman's Report*, pg. 12)

Dr. Hartman found that the SIMS test showed Ms. Shavers'

> "total score, which estimates feigning/exaggerating symptoms of psychiatric and cognitive dysfunction, was well above the cut-off for a malingered protocol indicating that Ms. Shavers was willing to admit to severe sounding symptoms, regardless of whether they occur in actual patients. She exaggerated symptom self-report on 4 of 5 SIMS scales, including those related to neurological claims, depression/anxiety, psychosis and memory dysfunction. Ms. Shavers' pattern of symptom admission where she endorsed exaggerated, bizarre, illogical, rare, and/or

> inconsistent symptoms in these areas, regardless of whether they occur in real patients. Such a pattern implies that Ms. Shavers' is an unreliable narrator of her symptoms and that treaters who rely on her self-report may be misled into overdiagnosing or misattributing her difficulties. (*Report of Dr. Hartman*, 7).

Based on the results from the Morel Emotional Numbing Test. Dr. Hartman found that

> "[i]n an apparent attempt to "prove" severe PTSD, Ms. Shavers produced an error pattern far above the malingering cut-off and most similar to diagnosed malingerers; her score was approximately *8 times* higher than that scores of genuine PTSD patients (see graph). Ms. Shavers' extreme score on the MENT indicates that she is attempting to fake extreme PTSD in a manner that is not found in real PTSD patients and therefore not credible." (*Report of Dr. Hartman*, 8)

Dr. Hartman testified, "...if she thinks it's going to enhance her claim of PTSD, she's going to make as many errors as she thinks will produce that, many more than would be produced by actual PTSD patients. (*Deposition of Dr. Hartman*, 32-22). Real PTSD patients do not get more than a couple errors on the Morel Emotional Numbing Test. Dr. Hartman testified, "It suggests someone who is simply trying to agree with anything that they think will strengthen their diagnostic claim of posttraumatic stress disorder. It doesn't suggest that she has real PTSD, because real PTSD people don't get more than a couple errors on this.

Dr. Hartman testified that Petitioner is malingering and that Petitioner's claim of PTSD was inconsistent with her being able to take her children. Dr. Hartman found,

> "When you talk to her about going back to work, she's fairly clear about a lot of her decision on this is related to not severe fear and disturbance so much as being with patients that remind her of her own condition, because she has a pre-incident psychiatric condition. And, as such, she doesn't want to make mental health a career anymore, whether it's in the mail room or in any situation with non-patient contact. And I think what you're dealing with there is a choice to change careers rather than something that is motivated by severe fear and trauma. (*Deposition of Dr. Hartman*, 34-35).

Dr. Hartman went on to testify,

> "She appears to be taking care of her three children. She appears – at least I see no reason to doubt that she is capable of doing her day-to-day activities. She is not withdrawn from the people that she takes care of. She is not in some way becoming an incompetent mother. So the things which would go along with PTSD, that severe emotional disturbance in the real world are not there. And from that I am extremely doubtful that Ms. Shavers has a diagnosable case of PTSD as a result of the events that she reports took place." (*Deposition of Dr. Hartman*, 34).

Dr. Hartman's report from March 15, 2010 (See Hartman Deposition Transcript, RX. 1, Exhibit 2, pg. 5) indicates that the Petitioner reported she was offered a job in Respondent's mailroom with assurances that no patients have access to that area, and she indicated that she would not go back to work for the Respondent at the EMHC in any capacity.

Dr. Resis concluded Petitioner struggles across facets of her life, including sleeping and nightmares, and that she suffers from posttraumatic stress disorder. (*Deposition of Dr. Resis*, 53-54.) Dr. Resis testified at an evidence deposition he has treated five or ten people with PTSD. (*Deposition of Dr. Resis*, 47). He acknowledged Petitioner did not go days without really being able to take care of her children. (*Deposition of Dr. Resis*, 58). On his amount of study of the subject of posttraumatic stress disorder Dr. Resis stated, "I don't know if I could put it in hours. I mean it was discussed in my residency. Probably went to – you know, a couple of classes where they talked about it." (Deposition of Dr. Resis, 52). Dr. Resis confirmed that he does not do psychological testing himself. He was vaguely familiar with the Word Memory Test and admitted he did not know much about it. (*Deposition of Dr. Resis*, 60). Dr. Resis did not know what percentage of posttraumatic stress cases lead to a person being off work as long as Ms. Shavers. (*Deposition of Dr. Resis*, 64). Dr. Resis acknowledged Petitioner's troubles "transcends home, work, family." (*Deposition of Dr. Resis*, 53). Dr. Resis had originally predicted Petitioner could return to work on November 30, 2009, so long as counseling was progressing. That return to work never occurred.

CONCLUSIONS OF LAW

1. The parties stipulated and the Arbitrator fully agrees that the Petitioner had accidents stemming from assaults at work on April 5, 2009 and April 6, 2009. And the records clearly show that the Petitioner has ongoing psychological issues. However, the main issue in dispute is whether the Petitioner's current psychological conditions are causally related to her work accidents. After carefully reviewing all the evidence, particularly the expert testimony, the Arbitrator finds that the Petitioner's current condition of ill being is not causally related to her accidents from April 5, 2009 and April 6, 2009. This finding is based on the Petitioner's lack of credibility when comparing her testimony to the medical evidence. In support of this finding, the Arbitrator notes the blaring inconsistencies between the Petitioner's testimomy and the medical evidence. At the outset, Petitioner testified that she was never assaulted before. Yet the report from Dr. Hartman noted that the Petitioner was involved in two prior assaults in 2001 and 2005. Petitioner also described her second assault to appear as if she was beaten to unconsciousness. However, on closer inspection, the initial medical records show that she did not lose consciousness and that her resulting physical injuries were sprains and strains. And her visit with her psychiatrist, immediately following the assaults do not reflect her vivid testimony that she felt like she was going to die. The Arbitrator finds it blatantly incredible that the Petitioner would not mention that she thought she was going to die to her psychiatrist two days after her accident. Petitioner also denied that her prior psychological had any impact on her work. However, the records from her own treating psychiatrist show that she had quite a few problems that resulted in her psychiatrist assisting her in completing FMLA paper work prior to the April, 2009 incidents. Furthermore, the Arbitrator notes that the Petitioner's memory seemed to fade during cross-examination as her responses were "I can't recall" to many of the questions posed by Respondent's counsel. When asked about increased anxiety and family stress , Petitioner could not recall anything substantive about her past mental health struggles with family and at home. The Arbitrator asked Petitioner about her receiving social security disability, and she could not recall why she was receiving these benefits.

The Arbitrator also finds persuasive the opinions of Dr. Hartman on this issue. While both Dr.Resis and Dr. Hartman provided credible testimony in this case, it is abundantly clear that Dr. Hartman was provided with more information with regard to the Petitioner's employment history. Dr. Hartman also conducted a

batter of psychological tests, with which Dr. Resis was only vaguely familiar, as he has only treated 5 or 10 patients with PTSD in his 21 year career.

Based on the above, the Arbitrator concludes that because of the Petitioner's lack of credibility, she has failed to meet her burden of proof on the issue of causation.

2. Based on the Arbitrator's findings regarding the issue of causation, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Hatchett,
Petitioner,
vs.

15IWCC0223
NO: 11WC 40802

Aramark,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respodent 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 April 3, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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:
KWL/vf MAR 2 7 2015
O-3/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0223

HATCHETT, JAMES
Employee/Petitioner

Case# **11WC040802**

ARAMARK
Employer/Respondent

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

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

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

5019 SEIDMAN MARGULIS & FAIRMAN LLP
RYAN A MARGULIS
500 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
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

15IWCC0223

JAMES HATCHETT
Employee/Petitioner

Case #11 WC 40802

v.

ARAMARK
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 20, 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 August 18, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $57,200.00; the average weekly wage was $1,100.00.
- At the time of injury, the petitioner was 61 years of age, married with no children under 18.
- The parties agreed that the petitioner received all reasonable and necessary medical services.
- The respondent agreed to pay the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner if found liable based on a finding of a compensable accident and a casual relationship.
- The parties agreed that the respondent paid $23,027.91 in medical bills through its group medical plan and $40,391.66 in short and long term disability benefits and is entitled to a Section 8(j) credits for the amounts.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $733.33/week for 82-17 weeks, from August 22, 2011, through March 18, 2013, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $660.00/week for a further period of 125 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 25% of the person as a whole.

- The respondent shall pay the petitioner compensation that has accrued from August 18, 2011, through March 20, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The respondent shall pay for necessary medical services, as provided in Section 8(a) of the Act. 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.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 3, 2014

Date

APR 3 - 2014

FINDINGS OF FACTS:

The petitioner, a custodial manager, saw his primary care physician, Dr. Habib, of Heather Medical Associates on August 8, 2011, for pain in his low back and right leg for one month. He was prescribed medication, exercises and warm compresses for lumbago. The petitioner sought emergency care on August 21st at Advocate Suburban Hospital and complained of back and right leg pain but no medication for his pain. Their diagnosis was acute back pain for which he received Morphine and Tomadol injections. The petitioner returned to Dr. Habib on August 22nd for his two-week follow-up and reported continued low back and radiating right leg pain of the same intensity for six weeks until four days earlier, when his back pain worsened and tingling and numbness started in his right ankle and foot while helping a coworker lift 70 pounds. An MRI on August 31st revealed diffuse degenerative changes significant at L4-5 and L5-S1. The petitioner saw Dr. Martin Luken of Neurological Surgery on October 7, 2011, and reported sciatica a few years earlier that had resolved satisfactorily but gradually recurred a month or so earlier. He had primarily right buttock and leg pain, minor back pain and no left leg pain. Dr. Luken opined that the petitioner's symptoms were due to compressive lumbar radiculopathy resulting from degenerative changes at L4-5 motion segment. He followed up with Dr. Habib on October 31st, who noted that Dr. Luken would treat the petitioner conservatively before considering surgical options. An EMG on October 24th showed evidence of moderate chronic right-sided S1 root level involvement. Dr. Adeel Ahmad administered right L5-S1 transforaminal epidural steroid injections on December 28, 2011, March 14, 2012, and April 11, 2012.

Dr. Luken performed a right L4-5 and L5-S1 interlaminar laminotomies, partial facetectomies and foraminotomies on June 29, 2012. Physical therapy was started on July 9th. Dr. Luken noted at his last examination on March 18, 2013, the petitioner's complaints of back and right leg pain of equal severity.

Dr. Luken opined on August 5, 2012, that the petitioner's work activities on August 18, 2011, aggravated his long-standing lumbar condition and that the acute anatomical change that day was the development or significant enlargement of a facet joint synovial cyst. Dr. Julie Wehner evaluated the petitioner at the request of the respondent on December 7, 2011, and opined that the MRI showed a degenerative condition, not an acute condition and that the activities on August 18, 2011, did not worsen or accelerate the petitioner's pre-existing condition. Dr. Wehner opined on November 28, 2012, that the August 31st MRI did not reveal a synovial cyst, that synovial cysts develop over time and that there is no support for an acute development of a synovial cyst by any type of lifting.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on August 18, 2011, arising out of and in the course of his employment with the respondent. On August 22, 2011, the petitioner reported to Dr. Habib that his low back and radiating right leg pain was of the same intensity for six weeks until August 18, 2011, when his back pain worsened and tingling and numbness started in his right ankle and foot while he was helping a coworker lift 70 pounds. The

medical evidence is consistent with the petitioner's testimony of feeling back pain on August 18, 2011, while lifting.

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 injury on August 18, 2011.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was taken off of work by Dr. Habib on August 22, 2013, and his last treatment with Dr. Habib was March 18, 2013. The respondent shall pay the petitioner temporary total disability benefits of $733.33/week for 82-1/7 weeks, from August 22, 2011, through March 18, 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 complains of the need for a cane for long walks. He has lower back pain into his buttocks and right leg. He takes Ibuprofen for pain. The petitioner did not look for any employment and is currently receiving social security disability benefits. The respondent shall pay the petitioner the sum of $660.00/week for a further period of 125 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 25% of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELIZABETH RAY,

Petitioner,

15IWCC0224

vs.

NO: 12 WC 14942

APOSTOLIC CHRISTIAN SKYLINES,

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 casual connection, average weekly wage, benefit rate, medical expenses, temporary total disability benefits, and prospective medical, 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).

Based upon a review of the record, the Commission modifies the Arbitrator's finding as to causal connection, and finds that on November 30, 2012, Petitioner sustained an intervening accidental injury at home when she fell on a step and landed on her right side, breaking the chain of causation. The Commission specifically finds Petitioner's testimony less than credible with regard to her November 30, 2012 injury at home, the mechanics of her fall, the injuries from her fall, and the treatment she sought following her fall. Accordingly, the Commission vacates the Arbitrators award of temporary total disability and medical expenses subsequent to November

30, 2012, and further vacates the Arbitrator's award of prospective medical in the form of an SI joint fusion surgery recommended by Dr. Kube.

Petitioner testified that she did have an incident the first week of December 2012, that while she was "walking down the stairs outside to go to therapy I had just a stumble and skinned up my knees, went down on my knees and skinned them up, but I didn't have to have no medical treatment, no nothing." Petitioner testified she did not feel the need to go back in to see Dr. Kube right away, and that she had no change in her symptoms in her low back or SI Joint/pelvic area following this stumble and fall onto her knees. (T21-23). On cross-examination, Petitioner specifically denied she advised Dr. Kube's office on November 30, 2012 that she had sharp pain from her fall on the last step as she went to turn, that she landed on her right side, and that the last time she had pain like that was two months ago. Petitioner specifically denied: falling onto her right side; an increase in right SI joint pain as a result of the fall; an increase in low back pain as a result of the fall; or, presenting to the ER, but leaving. (T59-61). The November 30, 2012, Quick Note from Dr. Kube's office, authored by Nurse Allison Blood, reflects that Petitioner "has sharp pain and fell on the last step as she went to turn right. Landed on her right side. Last time was 2 months ago with sharp pain. Has right SI pain. Currently taking soma QID, Mobic, tramadol, and Prilosec. She is in pain. Suggested cold compresses or warm showers, whichever gives her the most relief. If she was in severe pain she would need to go to the ER. She is willing to keep her appointment on Tuesday w Dr. Kube."(PX10).

Although Petitioner denied seeking medical treatment at the ER or with any medical provider as a result of her fall off a step at home, the November 30, 2012, Methodist Medical Center ER records reflect Petitioner arrived at 1:49 p.m., and that she gave an extensive history of her current medications, and a history of the following patient problems: nausea, kidney stone, hematuria, pneumonia, flank pain. The ER chart further reflects that at 2:31 p.m. Petitioner signed an AMA form and verbalized understanding of consequences, and left the ER without being seen by a medical provider. (PX7).

Petitioner further disputed the history recorded in the December 03, 2012, Physical Therapy Progress Note, which reflected that "she missed her Friday therapy because she fell while stepping off the bottom step at her home as she was turning. She landed on her right side. She states she did go to ER but left AMA since there was such a long wait." The Physical Therapist further noted "She did have increased complaints of pain during her exercise which she described as being due to the fall. Multiple position changes during treatment. She is at the point she feels something more needs to be done for her condition." (PX10).

Although Petitioner denied she sustained an injury at home on November 30, 2012, that she fell onto her right side, or that she had any increased SI joint or low back complaints as result thereof, the office notes of Dr. Kube, the physical therapy notes, and the Emergency Room records Methodist Medical Center, fail to support this testimony.

Dr. Kube's office visit note of December 04, 2012 reflects Petitioner was still complaining of significant right SI joint pain, and also had a complaint of numbness in the anterior quadriceps region on the right side. Dr. Kube noted they were still waiting for SI joint authorization, and further ordered an MRI of the lumbar spine to rule out a lumbar issue. The December 05, 2012 Quick Note from Dr. Kube's office reflects that Petitioner reported increased pain from walking at work, that she sought care at Proctor ER for a Toradol shot and a script for Ultram, and that she would follow-up with Dr. Kube following her MRI of the lumbar spine. (PX10). Petitioner underwent an MRI of the lumbar spine on December 10, 2012, suggesting disc bulging and degenerative changes, mostly at L4-L5. Petitioner followed-up with Dr. Kube on December 11, 2012, at which time he reviewed the lumbar MRI, noted it was unremarkable, opined her complaints were likely related to inflammation of SI joint affecting sciatic notch, and indicated he planned on moving forward to "fix her SI joint in near future." The January 15, 2013 office visit note of Dr. Kube reflects that Petitioner was there to discuss surgery, and her history was noted to be unchanged. On that date, Dr. Kube indicated the "plan is still for minimally invasive SI joint fusion." (PX10).

The November 06, 2012 office visit note of Dr. Kube reflects Petitioner reported immediate but short relief, 90 to 100%, as a result of the recently performed SI joint injection. Dr. Kube recommended continued conservative care, an additional month of physical therapy, and that "If that is insufficient, then we are probably looking at surgical intervention as she moves forward." (PX10). Dr. Kube testified that an SI joint fusion surgery was mentioned in early November 2012, at which time he recommended one additional month of rehabilitation, and if Petitioner was no better, then they would discuss surgery. Dr. Kube testified he reviewed no ER or medical records about Petitioner's fall on stairs at home, other than the December 03, 2012 Physical Therapy note he was presented with at the time of his deposition. (PX13, T96-98). On cross examination, Dr. Kube admitted that the December 03, 2012 Physical Therapy note reflected Petitioner fell at home and went to ER, but left against medical advice, and he further admitted it appeared there was an increase of symptoms of her condition in her low back at that time. Most significantly, when presented with the December 03, 2012 Physical Therapy note, Dr. Kube admitted on cross examination that the incident at home on the stairs could have been an aggravation of her condition of ill-being. (PX13, T95). Dr. Kube further admitted that as of the November 05, 2012 office visit, he had decided to attempt rehabilitation for one more month to avoid surgery, that December 03, 2012 Physical Therapy note reflects an intervening fall, which was prior to when he next saw Petitioner. (PX13, T98-99).

The Commission concludes that Petitioner's current condition of ill-being is not a natural consequence of the April 16, 2012, injury and that the accident of November 30, 2012, constituted an independent, intervening accident that broke the chain of causation. As such, the Commission finds that Respondent's liability for temporary total disability benefits and medical expenses ceased on November 30, 2012.

In order to establish causation under the Act, an employee must prove that some act or phase of his employment was a causative factor in his ensuing injury. Land & Lakes Co. v.

Industrial Commission, 834 N.E.2d 583, 592, 296 Ill. Dec. 26 (2005). "Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury." National Freight Industries. v. Illinois Workers' Compensation Commission, 993 N.E.2d 473, 373 Ill. Dec. 167, 169 (2013). Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred "but for" the original injury. International Harvester Co. v. Industrial Commission, 46 Ill. 2d 238, 245, 263 N.E.2d 49 (1970).

The evidence shows that: 1) Petitioner's fall while stepping off the last step of her stairs at home, landing on her right side, changed the nature of her injury, as she reported new and more extensive pain; 2) her treating physician documented and admitted that her symptomatology changed after that fall at home; and, 3) her new symptoms required more extensive testing and treatment, including an MRI of the lumbar spine, and a SI joint fusion surgery recommendation. Accordingly, the Commission, relying on International Harvester v. Industrial Commission, finds that Petitioner's condition was not caused by an event that would not have occurred but for her original injury, but that the November 30, 2012 intervening accident broke the chain of causation between her work related injury of April 16, 2012 and her condition of ill-being.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2014 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $310.90 per week for a period of 4-1/7 weeks, from April 24, 2012 through May 22, 2012, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits under §8(b) of the Act for the period of December 07, 2012 through May 20, 2014 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable, related and necessary medical expenses incurred from April 16, 2012 through November 30, 2012, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of §8(a) medical expenses covering the period of December 01, 2012 through May 20, 2014 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical under §8(a) of the Act, including the costs associated with the SI joint fusion procedure prescribed by Dr. Kube, is hereby 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.

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

DATED:
KWL/kmt MAR 2 7 2015
O-01/26/15
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority to modify the award. The Arbitrator had the opportunity to closely observe and listen to the testimony of the petitioner as she was asked to stand and explain to the Arbitrator where she noticed complaints of pain with respect to the low back and sacroiliac joint. The Arbitrator observed the petitioner point to a very specific area just above her right buttocks on the right side of what a lay person would describe as her tailbone. The description of the location of injury described by the petitioner is consistent

with the history recorded by Dr. Hauter, Dr. Chaddock, and Dr. Kube. The petitioner testified she was unfamiliar with the various diagnoses of the physicians and simply could point to the area where she noticed and felt pain. The Arbitrator felt the testimony of the petitioner was credible in this regard.

The petitioner was placed on light duty restrictions by Dr. Hauter. The respondent accommodated those restrictions until petitioner sought medical care from Dr. Kube, a doctor of her own choice. Dr. Kube took petitioner off work on April 24, 2012. Dr. Kube recorded a history of injury and complaints to the neck, low back, and sacroiliac joint. The petitioner received formal physical therapy as prescribed by Dr. Kube and followed up with Dr. Kube on June 4, 2012 and July 10, 2012 at which time Dr. Kube allowed and permitted an attempt to return to work full duty and released the petitioner from care as it relates to the cervical spine complaints.

Dr. Kube did not fully release the petitioner from care, but scheduled her for a follow-up appointment at which time the low back and the sacroiliac joint complaints could be addressed with greater specificity. The petitioner underwent a right SI joint injection with Dr. Kube on August 6, 2012.

The respondent has claimed and the Commission has found Petitioner less than credible with regard to her November 30, 2012 injury at home, the mechanics of her fall and the treatment sought following her fall. I disagree. The record as well as the specific findings of Arbitrator Erbacci is clearly at odds with the position of the respondent. The bottom line is that the petitioner was already receiving treatment for the SI joint, the fall was from one step, and required no medical treatment as it was nothing more than a "knee scrape", totally unrelated to her work related accident. Certainly pain associated with the passing of a "kidney stone" would not break the chain.

It is on this misplaced notion that the Commission would take away the majority of rightfully deserved temporary total disability benefits, the bulk of medical and future medical because the petitioner skinned her knee. That result is not the intervening accident that Vogel v.IWCC, 821 N.E.2d807 (2005) envisioned. The Illinois courts have held that for an employer to be relieved of liability because of an intervening accident, the intervening cause must break the causal connection between the work- related accident and the ensuing condition. The chain of causation was not broken or even loosened by the minor slip and scrape.

The petitioner acknowledged that the medical records of Methodist Medical Center emergency room demonstrate that the petitioner, in June 2012, sought treatment only for "the passing of a kidney stone". There was no history provided to any medical providers that the petitioner sustained any type of intervening event sufficient to break a chain of causation between her complaints and the work accident of April 16, 2012. There is merely a mention of fluctuation of pain during performance of activities of daily living and passing of a kidney stone.

Furthermore, I find no intervening event occurred as a result of a fall in December 2012 that would break the chain of causation. The petitioner acknowledged a fall occurring on December 4, 2012. However, the petitioner testified that she sought no medical care or treatment. She did not seek out immediate medical attention with Dr. Kube or any other personal health providers. She did not call her primary health physician. She did not seek assistance at a prompt care clinic. The petitioner testified that her back complaints in both her low back and pelvic area and the area that she described to the Arbitrator on the right side of her upper buttock toward the lower back remained the same both before and after the small fall on December 4, 2012. The petitioner's testimony is unrebutted by medical records or other evidence. Dr. Kube testified during his deposition that the petitioner was receiving treatment for her SI joint before December 2012 and stated in early November 2012 – before the fall – surgical intervention on the SI joint was already being contemplated as a therapeutic measure. This December 2012 event was clearly not an intervening incident and did not serve to break the chain of causation in the petitioner's case. It is for these reasons the evidence does not reveal any break in the chain as was so clearly articulated in the Vogel decision.

Thomas J. Tyrrell

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

15IWCC0224

RAY, ELIZABETH
Employee/Petitioner

Case# **12WC014942**

APOSTOLIC CHRISTIAN SKYLINES
Employer/Respondent

On 7/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0224

Case # 12 WC 14942

Elizabeth Ray
Employee/Petitioner

v.

Apostolic Christian Skylines
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **May 20, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 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 $**24,250.72**; the average weekly wage was $**466.36**.

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

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

Respondent shall be given a credit of $**1,048.14** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,048.14**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**310.90**/week for **79 5/7** weeks, commencing **April 24, 2012** through **May 22, 2012**, and from **December 7, 2012** through **May 20, 2014**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**1,048.14** for temporary total disability benefits that have been paid.

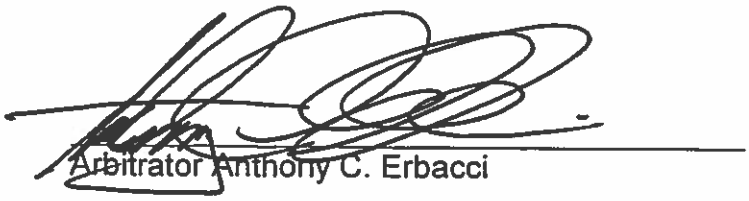
Respondent shall pay reasonable and necessary medical services of $**65,374.37**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary costs associated with the SI joint fusion procedure prescribed for the Petitioner by Dr. Kube, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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



Arbitrator Anthony C. Erbacci

July 17, 2014
Date

12 WC 14942
ICArbDec19(b)

JUL 22 2014

FACTS:

On April 16, 2012, the Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent, a nursing home. The Petitioner testified that she was employed by the Respondent as a CNA and that she had been so employed for one year prior to her injury. The Petitioner testified that on April 16, 2012, she was helping a resident into a chair when she turned and tripped on a floor mat. The Petitioner testified that she fell forward onto her outstretched right arm and that she struck her knees and right elbow on the floor when she fell. The Petitioner testified that after her fall, she noticed pain in her neck, right shoulder, right wrist, and her back.

The Petitioner reported the injury and an accident report and an incident report were completed. Both the accident report and the incident report that were completed reflect a consistent history of the injury and indicate that the Petitioner had complaints of hurting her right side shoulder, her neck, and her back. The Petitioner testified that she was directed to IWIRC for care and treatment and that she went to IWIRC that same day.

The Petitioner testified that she had a previous work injury to her back in 2009 for which she was treated at IWIRC from February 18, 2009 through March 2, 2009. The Petitioner testified that following her treatment at IWIRC for that injury, she was released to return to her regular work as a CNA, without any restrictions. The Petitioner testified that she did return to her regular work as a CNA, and that she continued to work, full duty, as a CNA, without any difficulty or problems, until her injury on April 16, 2012.

The IWIRC records demonstrate that the Petitioner was seen there on April 16, 2012 and gave a consistent history of injury. The Petitioner was noted to have complaints of pain in her right shoulder, neck, and right lower back. The assessment was right shoulder/trapezius strain and right lower lumbar strain, and the Petitioner was prescribed medication and restricted work. The Petitioner returned to IWIRC the next day and complained of an increase in her right shoulder and neck symptoms. The Petitioner's work restrictions were continued.

On April 24, 2012, the Petitioner sought treatment from Dr. Richard Kube at Prairie Spine and Pain Institute. Dr. Kube's records demonstrate that the Petitioner gave a consistent history of injury and complained of pain in her right shoulder, neck and low back. Dr. Kube's assessment was brachial neuritis, sprains and strains, and cervicalgia, and he prescribed medication and physical therapy. Dr. Kube also prescribed the Petitioner off work. Dr. Kube also noted that he concentrated on the Petitioner's cervical spine and that he would address the lumbar spine at a later visit.

On May 11, 2012, the Petitioner returned to IWIRC for a fitness for duty evaluation regarding her neck and shoulder pain. The assessment was cervical muscle sprain and symptom magnification and it was reported that the Petitioner was not safe to return to work for the Respondent unless her job could be modified to include light duty only and no safety

sensitive activities.

The Petitioner underwent the prescribed course of physical therapy and continued to follow up with Dr. Kube. On May 22, 2012, Dr. Kube noted that the Petitioner reported that she was "doing okay" but that any time she increased her activity level her pain level increased. Dr. Kube prescribed a cervical MRI and allowed the Petitioner to return to restricted, light duty, work. The Petitioner returned to light duty work on May 23, 2012 and on May 24, 2012, Dr. Kube restricted the Petitioner to sedentary work. On June 1, 2012 the prescribed cervical MRI was performed and was reported to reveal minor discogenic changes without disc herniation or central canal or foraminal compromise. On June 5, 2012, Dr. Kube prescribed aggressive rehabilitation and he allowed the Petitioner to continue to do light duty work.

On July 10, 2012, Dr. Kube noted that the Petitioner's neck pain was substantially diminished and he authorized her to return to full duty work. Dr. Kube indicated that if the Petitioner tolerated the full duty work she could be given a full release, otherwise, reevaluation would be necessary. The Petitioner was directed to return in one month. That same day, a return to work slip was generated by IWIRC which indicated that the Petitioner could return to work with restrictions of no lifting greater than 25 pounds, minimal bending and twisting of her back, and no safety sensitive duties. The restrictions were apparently accommodated by the Respondent.

The Petitioner returned to Dr. Kube on July 31, 2012 with complaints of pain in the mid low back and the SI joint on the right side. Dr. Kube noted that the Petitioner reported that she "has taken up a side babysitting job" and that "the babysitting flared up her back somewhat." Dr. Kube noted that "Her neck continues to be fine as are her arms, but the back pain she originally had that had subsided with the activity decrease has now flared back up again with the activity increase or the resumption of activity." Dr. Kube prescribed a diagnostic SI joint injection and physical therapy focused on the Petitioner's low back and SI joint. Dr. Kube also restricted the Petitioner to "moderate" activity.

The Petitioner testified that she was not employed or working as a babysitter in June or July of 2012 but she acknowledged that she did babysit for her granddaughter on occasion. The Petitioner testified that she was not injured in any way while she was babysitting and that she did not sustain any injury in July 2012. The Petitioner testified that although her neck symptoms had begun to subside by June of 2012, the low back and pelvic symptoms that she had continued. The Petitioner also testified that she did undergo treatment for a kidney stone in June of 2012.

On August 6, 2012, the Petitioner underwent the prescribed SI joint injection and on August 7, 1012, Dr. Kube noted that "it eliminated all of her pain." Dr. Kube further noted that as the analgesic wore off her pain came back and then calmed down again. Dr. Kube prescribed continued physical therapy focused on the SI joint and he continued the Petitioner's work status.

At the request of the Respondent, the Petitioner was examined by Dr. Morris Marc Soriano on August 15, 2012. Dr. Soriano reported and testified as to his exam findings and the records he reviewed and he indicated that his diagnosis was status post cervical strain and soft tissue injury low back pain. Dr. Soriano opined that the Petitioner's SI joint problems had no relationship to her April 16, 2012 work injury, that she had reached maximum medical improvement from her April 16, 2012 work injuries, and that, while the Petitioner's medical care and treatment through her release to full duty work by Dr. Kube on July 10, 2012 was reasonable and necessary, the Petitioner was in need of no further medical care or treatment as a result of her April16, 2012 work injury.

The Petitioner continued to follow up with Dr. Kube and she received another SI joint injection on October 29, 2012. On November 6, 2012, Dr. Kube noted that the injection provided immediate pain relief but it was short lived. Dr. Kube noted that treatment options, including surgical intervention, were discussed but he wanted to try one more month of rehabilitation. Dr. Kube indicated that if the rehabilitation was insufficient, "then we are probably looking at surgical intervention as she moves forward."

On November 30, 2012, the Petitioner called Dr. Kube's office and it was noted that she reported that "she has sharp pain and fell on the last step as she went to turn. Landed on her right side. Last time was 2 months ago from sharp pain. Has right SI pain." She was apparently advised to go to the emergency room if her pain was severe and she decided to keep her scheduled appointment with Dr. Kube. On December 4, 2012, Dr. Kube noted that the Petitioner "Still has significant SI joint pain." and "We are still waiting for authorization for the SI joint." Dr. Kube prescribed a lumbar MRI and restricted the Petitioner to light activity.

The Petitioner testified that while she did stumble and fall while walking down the stairs at her home, she was on the bottom step when she stumbled and she merely skinned her knees when she fell. She testified that she did not receive any medical treatment as a result of the stair incident. The Petitioner also testified that the Respondent stopped accommodating her light duty restrictions on December 7, 2012.

The prescribed lumbar MRI was performed on December 10, 2012 and, on December 11, 2012 Dr. Kube noted that it was an essentially normal MRI. The Petitioner followed up with Dr. Kube on January 15, 2013 and Dr. Kube indicated that "The plan is still for minimally invasive SI joint fusion." Dr. Kube continued the Petitioner's light activity restrictions.

At the request of the Respondent, the Petitioner's medical records were reviewed by Dr. Frank Phillips and Dr. Phillips issued a report of his findings and opinions on April 22, 2014. Dr. Phillips also testified to the records he reviewed and his finding and opinions. Dr. Phillips' diagnosed the Petitioner as having suffered a cervical and lumbar spinal sprain/strain injury as a result of her April 16, 2012 work accident and he opined that she had reached maximum medical improvement from her work injuries by June 14, 2012. Dr. Phillips opined that the medical care and treatment that the Petitioner received through June 14, 2012 was reasonable and causally related to the Petitioner's work injury but that none of the treatment she received after that date was related to the work accident. Dr. Phillips opined that, while

the Petitioner is an appropriate candidate for an SI joint fusion, the Petitioner's need for that procedure is not related to the work injury of April 16, 2012.

On May 15, 2014, Dr. Kube reiterated his recommendation for a minimally invasive SI joint fusion and he continued the Petitioner's light activity restrictions.

The testimony of Dr. Kube was admitted into the record as Petitioner's Exhibits 13 and 14. Dr. Kube testified as to the treatment that he rendered to the Petitioner and the course of her condition. Dr. Kube testified that the Petitioner's care and treatment was initially focused on her upper back, shoulder, and neck, and that as those areas improved, the focus of his treatment shifted to the Petitioner's low back complaints. Dr. Kube testified that the Petitioner continued to have underlying back issues and that engaging in more activity caused her back condition to flare up. Dr. Kube opined that there was a causal relationship between the Petitioner's work injury and the cervical, low back, and SI joint conditions for which he treated her. Dr. Kube further testified that there was a causal relationship between the Petitioner's work injury and the need for the SI joint fusion that he has prescribed for the Petitioner. Dr. Kube testified that the medical care and treatment that he has rendered to the Petitioner, and the SI joint fusion that he has prescribed for her, was reasonable and necessary medical care which is causally related to the Petitioner's work injury. Dr. Kube also opined that the Petitioner's work injury could have caused an aggravation of a preexisting condition sufficient to constitute a causative factor for the need for the SI joint fusion he prescribed for the Petitioner.

The Petitioner testified that she currently continues to experience pain in her back which she described as a dull aching pain when she is seated and a sharp stabbing pain when she is engaged in any activity. The Petitioner testified that she sits a lot in an attempt to control her pain and she continues to take medication prescribed for her by Dr. Kube. The Petitioner testified that Dr. Kube continues to prescribe an SI fusion for her and she would like to undergo that procedure. She testified that she is scheduled to undergo another SI injection but that she is no longer under any treatment for her neck.

With regard to her low back condition, the Petitioner testified that her low back pain continued from the date of her accident through the present time but that when she was inactive it was not as severe. She testified that the more activity she engaged in, the more severe her back symptoms would become. The Petitioner acknowledged that she complained of back pain generally and not specifically SI joint pain. The Arbitrator notes that when the Petitioner was asked during the hearing in this matter to point to the area of her body where her back pain was, she pointed to the area of her back just above her right buttocks and just to the right of her tailbone.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Petitioner testified that she had a previous work injury to her lower back in 2009 for which she was treated conservatively through March 2, 2009. The Petitioner testified that following her treatment for that injury, she returned to her regular work as a CNA and that she continued to work, full duty, as a CNA, without any difficulty or problems, until her injury on April 16, 2012. The Petitioner's testimony in that regard was credible and unrebutted.

On April 16, 2012, the Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent when she tripped on a floor mat and fell to the ground. The Petitioner testified that after her fall, she noticed pain in her neck, right shoulder, right wrist, and her back. The injury was reported and the written reports indicate that the Petitioner had complaints regarding her right side shoulder, her neck, and her back. The Petitioner was directed to IWIRC where she was seen that same day and complained of pain in her right shoulder, neck, and right lower back. The Arbitrator notes that the Petitioner indicated the area of her back just above her right buttocks and just to the right of her tailbone as the area where her back complaints were located.

On April 24, 2012, the Petitioner commenced a course of treatment with Dr. Kube who noted complaints of pain in her right shoulder, neck and low back. Dr. Kube treated the Petitioner conservatively with medication and physical therapy and he noted that his treatment was initially concentrated on the Petitioner's cervical spine and that treatment of the Petitioner's low back complaints was deferred. Following a course of physical therapy which was primarily directed towards the Petitioner's neck and arm complaints, the Petitioner's neck and arm condition improved.

On July 10, 2012, Dr. Kube released the Petitioner to return to full duty work and directed her to follow up with him in one month. Dr. Kube noted that he would advance the Petitioner to full duty and "If she tolerates this well over the next four weeks, then I think we can give her a full release. If she has a relapse, then we will have to reevaluate. We will see her in four weeks and go from there." Dr. Kube clearly did not release the Petitioner from his care at that time.

The Petitioner continued to participate in prescribed physical therapy after July 10, 2012 and she returned to Dr. Kube on July 31, 2012. At that time, Dr. Kube noted that "Her neck continues to be fine as are her arms, but the back pain she originally had that had subsided with the activity decrease has now flared back up again with the activity increase or the resumption of activity."

The Petitioner testified that following her injury on April 16, 2012, she had pain in her right shoulder, her neck and her low back. The Petitioner testified that her neck and arm symptoms subsided and ultimately resolved but her low back symptoms continued from the date of her injury through the present. The Petitioner testified that that her low back pain never resolved but that when she was inactive it was not as severe. She testified that the more activity she engaged in, the more severe her back symptoms would become. The Arbitrator notes that the Petitioner's testimony in that regard was credible and finds support in the physical therapy notes as well as Dr. Kube's notes.

With regard to the babysitting activities noted in Dr. Kube's record of July 31, 2012, the Petitioner testified that she was not working as a baby sitter but merely babysitting her granddaughter on occasion. She testified that she did not injure herself while babysitting and that any increase in her back pain after babysitting would have been consistent with the pattern of her pain increasing with activity. Similarly, with regard to the fall off the stairs noted in the record of November 30, 2012, the Petitioner testified that she merely skinned her knees as a result of that incident and she did not injure her back at that time. The Petitioner's testimony with regard to these two events was credible and unrebutted.

While the Arbitrator notes the opinions of the Respondent's examining physician, Dr. Soriano, and the Respondent's reviewing physician, Dr. Phillips, the Arbitrator finds that the opinions of Dr. Kube, the Petitioner's treating physician, are sufficiently credible, reliable, and persuasive in the instant matter so as to satisfy the Petitioner's burden of proof. Based upon the testimony of the Petitioner and the opinions of Dr. Kube, the Arbitrator finds that the current condition of ill-being in the Petitioner's SI joint is causally related to the work injury of April 16, 2012.

Additionally, the Arbitrator finds that the SI joint fusion prescribed for the Petitioner by Dr. Kube is reasonable and necessary medical treatment the need for which is causally related to the Petitioner's work injury of April 16, 2012. In so finding, the Arbitrator notes the opinions of Dr. Kube as well as the opinion of Dr. Phillips who opined that an SI joint fusion was appropriate for the Petitioner.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of causation are adopted and incorporated herein.

The Petitioner introduced as Petitioner's Exhibit 18, evidence of outstanding medical bills totaling $65,374.37, which were incurred as a result of medical care and treatment rendered to the Petitioner as a result of the work injury of April 16, 2012. The Respondent

denied liability for the payment of those bills based upon the disputed issue of causation. As the Arbitrator has found that the Petitioner's condition of ill-being is causally related to the work injury of April 16, 2012, the Arbitrator finds that the Respondent is liable for payment of the medical bills contained in Petitioner's Exhibit 18, subject to the limitations set forth in the Medical Fee Schedule provided for in the Illinois Workers' Compensation Act.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of causation are adopted and incorporated herein.

The Petitioner claimed to be entitled to Temporary Total Disability benefits from April 24, 2012 through May 22, 2012 and from December 7, 2012 through the present time. The Petitioner's testimony and the records of Dr. Kube demonstrate that Dr. Kube kept the Petitioner off work from April 24, 2012 through May 22, 2012 and that he kept the Petitioner on restrictions thereafter. The Petitioner testified that the Respondent accommodated her work restrictions through December 6, 2012 but that, after that date, no work within her restrictions was provided to her. The parties stipulated that the Respondent paid the Petitioner $1,048.14 in Temporary Total Disability benefits and that the Respondent is entitled to credit for that amount.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from April 24, 2012 through May 22, 2012 and from December 7, 2012 through May 20, 2014, the date of hearing, a total period of 79 5/7 weeks.

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

Joyce Reed,
Petitioner,
vs.

15IWCC0225
NO: 12 WC 7318
12 WC 7337

Aramark,
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 August 5, 2014 is hereby affirmed and adopted.

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

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

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

DATED: MAR 27 2015
KWL/vf
O-3/10/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0225

REED, JOYCE
Employee/Petitioner

Case# **12WC007318**

12WC007337

ARAMARK
Employer/Respondent

On 8/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2427 KANOSKI BRESNEY
KATHY OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

INMAN & FITZGIBBONS LTD
COLIN MILLS
201 W SPRINGFIELD AVE SUITE 10
CHAMPAIGN, IL 61820

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

15IWCC0225

Case # 12 WC 7318

Consolidated cases: 12 WC 7337

JOYCE REED,
Employee/Petitioner

v.

ARAMARK,
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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **7/17/14**. 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

On **10/7/10 and 4/26/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the alleged injuries, Petitioner earned **$18,373.16**; the average weekly wage was **$353.33**.

On the dates of alleged accidents, Petitioner was **55** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$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 **$6,194.38** under Section 8(j) of the Act.

ORDER

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained accidental injuries to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent on 10/7/10 and 4/26/11. The petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

8/1/14
Date

ICArbDec p. 2

AUG – 5 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year old dishwasher, alleges she sustained an accidental injury to her bilateral hands that resulted from repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 10/7/10 and 4/26/11. Petitioner has worked for respondent since 1987. For the first two years petitioner worked as a dishwasher for respondent. From 1989 to present petitioner has worked as a cook for respondent. Petitioner is right hand dominant.

Petitioner works at Milliken University as a cook for respondent. She works the 9 months of the school year and is off in the summer and whenever the University is on break, including Christmas and spring break. Petitioner works in the cafeteria where meals are prepared for students, staff and visitors. Petitioner works in the Wornick Dining Room and prepares the evening meal. Her hours are 12:00 PM-8:00PM Monday through Friday. Petitioner prepares the dinner meal, about 500-600 meals a day.

Respondent offered into evidence records from Community Health Improvement Center for petitioner from 3/9/07 through 10/1/09. On 3/9/07 petitioner gave a history of occasional stiffness in both of her hands. On 7/11/08 petitioner stated that she was smoking one pack of cigarettes per week. She denied any numbness or tingling in her hands. Dr. Oestreich assessed petitioner as overweight, with hypertension and tobacco abuse. On 12/2/08 petitioner presented to Dr. Oestreich complaining of numbness in her hands, with the right-hand, wrist, and arm being affected for eight months, and the left only for the past week. She stated that she performed repetitive work. She stated that she was a cook at a local college and it caused her a great deal of pain trying to lift pans. She stated that while sleeping at night her hands become numb. Petitioner stated that she is smoking less than a half a pack a day. She complained of numbness in her fingertips. She also stated that her hands become numb when she drives, making it very painful to drive. Dr. Oestreich noted positive Tinel's of both hands. Her Phalen's were negative. Dr. Oestreich's assessment was hypertension, parathesias of the hands, daytime somnolence startled awakenings, and tobacco abuse. Petitioner was given bilateral wrist splints and prescribed Naprosyn. On 2/3/09 it was noted petitioner was noncompliant with her hypertension medications. On 2/6/09 petitioner was admitted to the hospital for a hypertensive crisis. Petitioner was not smoking at this time. On 2/24/09 Dr. Oestreich again noted that petitioner's hypertension was uncontrolled due to her inconsistent medication use. On 3/10/09, 3/24/09, 9/10/09, 10/1/09 petitioner presented with regard to her blood pressure. Again, petitioner's hypertension was found to be uncontrolled.

On 2/22/10 petitioner presented to Dr. Oestreich at Community Health Improvement Center for follow-up of her hypertension. Petitioner noted that she was having a difficult time working. Dr. Oestreich noted that petitioner's last labs were in October 2009, and at that time she had an elevated LDL and total cholesterol.

Petitioner stated that she had not been taking lovastatin and had quit taking her fish oil. Petitioner stated that she smoked intermittently. Following an examination Dr. Oestreich assessed hypertension, improved; dyslipidemia; and tobacco abuse. Dr. Oestreich did not change petitioner's medications. She was instructed to monitor her blood pressure and contact the office if it was greater than 130/85. She was also encouraged not to smoke.

On 5/27/10 petitioner again returned to Dr. Oestreich for follow-up of her hypertension. At that time her hypertension was stable. Petitioner noted that she smokes six or seven cigarettes when she drinks. She complained of some right inner elbow pain. She reported that she cooks at Milliken University during the school year, and is off for the summer. During the summer she collects unemployment. Petitioner stated that she has to lift a lot of heavy boxes of food during the nine months when school is in session. Petitioner did not complain of any specific problems at that time. An examination revealed some tenderness on the right medial tendon of the right olecranon. Good hand strength was noted. Petitioner denied any numbness or tingling in her hands as she had in the past. Dr. Oestreich assessed hypertension, controlled; dyslipidemia, stable; tobacco abuse; and right medial tenosynovitis. Dr. Oestreich started petitioner on Naprosyn. She was also counseled that she could try a pillow brace that is worn 3 inches inferior to the elbow. Additional blood work was ordered.

On 10/7/10 petitioner followed up with Dr. Oestreich. Petitioner complained of bilateral hand and forearm pain. She also stated that they were numb. She stated that this had been going on for three months. She gave a history of being a cook at Milliken, who does a lot of repetitive work with her hands and wrists. An examination revealed positive Tinel's and Phalen's in both wrists. She had a fairly good hand grip. Dr. Oestreich added the diagnosis of bilateral hand and forearm pain with parathesia. Petitioner was given bilateral wrist splints to wear at night. A bilateral upper extremity EMG was ordered. Petitioner was instructed to continue using Naprosyn.

On 4/26/11 petitioner returned to Dr. Oestreich. She complained of some bilateral wrist pain, right worse than left. She also complained of left upper arm pain that radiates through her forearm and left little finger. Dr. Oestreich noted that she was also treating petitioner for hypertension and dyslipidemia. Petitioner stated that the right wrist splint did not really help. Following an examination, petitioner was assessed with bilateral wrist pain; left upper inner arm pain radiating through the forearm into the left little finger; vitamin D deficiency; dyslipidemia; and hypertension. Dr. Oestreich again ordered an upper extremity EMG. She also referred petitioner to Dr. Brustein.

On 5/6/11 petitioner underwent an EMG/NCS. Findings were indicative of bilateral carpal tunnel syndrome, severe in the right hand with right median nerve motor terminal latency prolonged and 8.6 ms and

mild in the left hand with left median nerve motor terminal latency prolonged at 4.5 ms. There was no evidence of radiculopathy noted in the left upper extremity. Dr. Collins was of the opinion that given the severity of the carpal tunnel disease in the right hand, petitioner would probably benefit from a carpal tunnel release. He recommended a wrist splint for the left carpal tunnel syndrome. On her intake questionnaire petitioner noted that she has had symptoms in her right hand for one year, and in her left hand for 2 to 3 months.

On 8/18/11 a job analysis for the position of cook with respondent was completed by Genex Services. The Job Summary stated "preparing and cooking food according to recipes; cleanup". The hours were listed as 12 PM to 7:30 PM, with a 30 minute lunch, and a 15 minute break. Job pace was identified as self-paced. The Physical Demand requirements of the job were identified as medium. The essential job tasks were identified as preparing meat, poultry or fish; preparing vegetables; handling fully prepared foods; and cleanup of utensils and prep area. With respect to preparing the meat, poultry or fish, the description states that based on the recipe selected meat, poultry, or fish boxes or bags are carried or moved via a plastic cart. Petitioner then uses nonstick spray to coat the pans and places the meat, poultry, etc. in the pan. She then adds seasonings, and covers the entree with wax paper and aluminum foil. She then carries and places it on the cart or has a coworker help take it to one of the ovens, and places it on the shelf, and slides it into the oven. Petitioner then closes the oven door and sets the temperature control on top of the oven. She sets the temperature on the oven for the required cooking time. She adds water, as needed, to the pan using a measuring cup. When cooking is complete she reverses the process to get the meat, etc. back to the prep table with a coworker. Using two pronged forks she lifts the meat from the pan in the oven into a pan on the cart. There she removes the paper and foil to slice or pull the meat apart. She then replaces the paper and foil to maintain the temperature of the meat per serving.

Petitioner prepares vegetables by following the menu and recipe. She puts a Kevlar glove on the nondominant hand and plastic glove over the Kevlar glove. She puts a plastic glove on the dominant hand. Petitioner carries canned, fresh and frozen vegetables, or places them on a plastic cart, to bring the items to the prep table from the freezer or cooler. Opens the vegetable packages with a knife and fingers, and carries them one at a time to a large steam kettle, and empties them into the kettle. She grabs pots from under the prep table and places a large pot on the table. She lays the cutting board on the table. Using a knife in hand and fingers she cuts/dices the vegetables up. She then scoops the vegetables into the large pot with hands and a measuring cup. She then removes the pan from under the table. She carries bags or boxes of vegetables from the cooler to the table, placing them on top, removing the tape with her fingers, and cutting the individual bags of peas open with a knife. She then empties them into two pans. She then walks over to the utensil rack above the prep table

and grasps the control knob and turns it before walking to the kettle and reaching and turning the valve stem. While standing she moves the water faucet lever to open and fills the kettle with water to the desired level. She then adds various vegetables and meats to the kettle per the recipe. She mixes seasoning or sauces in a saucepan with a small whisk and then adds those ingredients to the kettle a little at a time. She repeatedly carries cut vegetables from the table to the steam kettle using measuring cups. Occasionally she would use a large whisk or paddle to stir ingredients. When the vegetables are finished cooking petitioner removes the large pan with a handle from the shelf and carries it to the prep table. She selects measuring cups and carries both to the kettle. She places the pan on the edge of the kettle and with her left hand holds the cup and then and reaches down into the kettle scooping up the ingredients in the cup, and pouring them into the pan until the pan is full. Petitioner will then return with the pan to the table were further preparation is completed.

Petitioner also works with fully prepared foods. She removes them from the ovens and steam kettles, places them in two pans, adds final seasonings, and covers the pans with paper and aluminum foil. She then places them on carts for transporting to the dining area. With respect to cleanup of utensils and the prep area, large paddles and whisks are taken to the dishwashing area for cleaning. Pots and pans are also taken to dishwashing. Petitioner wipes off the prep table top with wet cloths.

The Genex job analysis did not identify any of petitioner's work duties as being performed constantly, or 67 to 100% of the time. Lifting from 0 to 25 pounds from waist to shoulder is performed 34 to 66% of the time. Horizontal reaching is also performed 34 to 66% of the time. Simple grasping and flexion/extension/deviation were identified as being performed 34 to 66% of the time with the right upper extremity. There was no indication how often these activities were performed with the left upper extremity. Lifting 26 to 50 pounds from floor to waist, and total body push/pull, bending/squatting, and twisting are performed at 6 to 33% of the time. Firm grasping of the right upper extremity was also identified as being performed 6 to 33% of the time. Shoulder to overhead lifting, upper extremity push/pull, overhead reaching, and fine manipulation with the right-hand, were performed 2 to 5% of the time. The job analysis indicates that lifting 51 -100 pounds, kneeling, supine lying, crawling, foot controls, vibration, and palm buttons are never performed.

On 8/31/11 petitioner underwent a Section 12 examination performed by Dr. Michael Vender. Petitioner gave a history of developing symptoms in her right upper extremity approximately a year ago. She stated that she had a feeling of swelling in the wrist, and developed numbness and tingling. Petitioner reported that in March 2011 she developed symptoms in her left upper extremity when she noted pain in the left wrist. Petitioner reported that she had utilized a right wrist splint, but still has continued complaints in both upper extremities. Petitioner complained of pain in the wrist, and pain throughout both upper extremities including

her arms and forearms. On the right side, petitioner reported numbness and tingling diffusely in the hand. She stated that it awakens her at night. On the left side she denied any numbness or tingling. Following an examination, record review and x-rays of the left and right wrist, Dr. Vender's impression was right carpal tunnel syndrome, and possible left carpal tunnel syndrome. He was of the opinion that it is possible that some of petitioner's arm pain could be secondary to a mild carpal tunnel syndrome. However, Dr. Vender had a suspicion about her left shoulder. He was of the opinion that it might be helpful to have a separate shoulder evaluation performed. Dr. Vender did not recommend any surgery for possible left carpal tunnel syndrome. He did not believe petitioner had reached maximum medical improvement. Dr. Vender was of the opinion that petitioner has risk factors for the development of carpal tunnel syndrome, that include her age, gender, hypertension, and smoking history. He also noted that petitioner had slightly elevated blood glucose levels which could be indicative of an abnormal glucose metabolism, and could be considered a potential contributing factor to carpal tunnel syndrome. With respect to petitioner's work activities as a cook, he believed petitioner could continue to perform her normal work activities without restrictions.

On 9/8/11 Dr. Vender drafted a letter after receiving a written job analysis for her position of cook. He also reviewed a video labeled "Specialty Risk Services Aramark, Cook Video Job Analysis, Joyce Reed, claim: 410151428." Dr. Vender was of the opinion that the videotape demonstrates a worker in a storage area picking up large cans of diced tomatoes. He also saw another worker in the same area moving produce from shelves to a cart. He noted one worker using a large knife to cut produce such as celery, and other workers present in the kitchen. Other activities being performed in the video included cutting activities, gathering of food, placing it into a cooking pot, dicing of an onion, peeling an onion, opening a bag of carrots and placing them into a bowl, placing the bowl of carrots into a larger cooking cauldron, chopping meat, stirring of the cooking pot, adding peas, putting in and taking out of the oven large pieces of meat, and cutting biscuits in half and placing them into a skillet. Dr. Vender was of the opinion that the work activities demonstrated on the video would be considered of limited repetitiveness. He was further of the opinion that there is very minimal exposure to any significant forceful use. He opined that the activities would not be contributory to the development of carpal tunnel syndrome.

On 9/14/11 petitioner returned to Dr. Oestreich. Dr. Oestreich noted that petitioner had a definite positive severe right carpal tunnel. Petitioner stated that her workplace would not let her have the repair surgery. Petitioner reported that the wrist splint that was ordered for her was not fitted to her hand, it hurt her thumb and she could not wear it at night. An examination revealed tremendous pain in her right wrist with any flexion and extension. She stated that it creates a burning and tingling pain going up her arm to her shoulder and neck.

Petitioner also had a diminished grip on the right. Petitioner was assessed with right wrist pain with parathesias of arm to cervical region; vitamin D deficiency; and hypertension uncontrolled due to lack of medicine. Dr. Oestreich instructed petitioner to take the wrist splint back to the equipment company and have it fitted to her, and for her to wear it at night.

On 12/19/11 petitioner presented to Dr. Brustein. She complained of bilateral hand numbness and tingling, right greater than left. She stated that the symptoms onset was gradual and ongoing. The date of incident was identified as 1/1/10. Following his examination Dr. Brustein diagnosed carpal tunnel syndrome, and indicated that he planned to proceed with the right carpal tunnel release. Attached to this medical report was a "history of injury" completed by petitioner. Petitioner claimed that she was being seen for carpal tunnel that began in 2010 or before. She stated that she did a lot of lifting, stirring, cutting meat at work, etc. She stated that her fingers get real numb and she has pain all the time when she writes or does anything. She stated that her left hand and arm hurt and the pain moves up and down her arm. She stated that she wakes up at night with pain in both hands and arms.

On 12/22/11 petitioner underwent a right carpal tunnel release performed by Dr. Brustein. Her postoperative diagnosis was right carpal tunnel syndrome. Petitioner followed up postoperatively with Dr. Brustein. On 1/5/12 Dr. Brustein released petitioner to full duty as of 1/16/12. On 1/10/12 Dr. Brustein restricted petitioner to no lifting, pushing or pulling greater than 10 pounds with her right hand until 2/3/12.

On 1/24/12 petitioner followed up with Dr. Oestreich. She stated that she had a right carpal tunnel release performed on 12/19/11 and had just been released back to work. She complained of having more pain in her left arm starting at her shoulder going down into her hand. She stated that the pain was an aching muscular type pain. Petitioner's hypertension was elevated on exam. Petitioner stated that she had not been taking her medicine. Following an examination Dr. Oestreich's assessment was pain in the left wrist radiating into the shoulder, hypertension, vitamin D deficiency. Petitioner was counseled on not letting herself run out of medication. Dr. Oestreich told petitioner that she could call Dr. Collins to see if there's anything he could do about her pain, or she could wait until school was out in May, so as not to have to take any more time off. Dr. Oestreich prescribed Naprosyn and Vicodin, as well as gabapentin.

On 2/22/12 petitioner followed up with Dr. Brustein. She stated that her numbness was much better, but she still had mild tenderness. She noted that she had returned to regular activities without issue. Petitioner also had moderate left carpal tunnel syndrome. Dr. Brustein was of the opinion that it would be reasonable to proceed with a left carpal tunnel release. On 2/22/12 Dr. Brustein released petitioner to full duty work without restrictions.

On 10/25/13 the evidence deposition of Dr. Brustein, an orthopedic surgeon who specializes in upper extremities, was taken on behalf of the respondent. Dr. Brustein testified that he probably took petitioner off work following the surgery on 12/22/11, but then stated that if the injury was a workers' compensation injury he would have released the patient to light duty the day after surgery. Dr. Brustein opined that the activities that petitioner indicated on her intake form might or might not have caused her carpal tunnel syndrome, but it would be reasonable to think that the activities that are vigorous with the hand, such as she described, could have aggravated or exacerbated her carpal tunnel syndrome. Dr. Brustein was of the opinion that the activities petitioner described seemed to be consistent with both repetitive and significant loading which can cause symptomatic compression of the median nerve. He stated that while it may not cause carpal tunnel it can certainly aggravate or exacerbate the symptoms therein. Dr. Brustein testified that he was not familiar with Aramark. After reviewing the document entitled Essential Job Functions and Physical Demands, prepared by Genex with a date of 8/18/11, Dr. Brustein was of the opinion that the information contained therein was consistent with his understanding of petitioner's work activities for respondent. He opined that these job duties could aggravate or exacerbate the condition of carpal tunnel since they were repetitive and loaded the median nerve. Dr. Brustein testified that he only had a vague idea, but nothing specific, with regards to the size and weight of the pots, pans or anything of that nature that would be used by a commercial cook. He further opined that the services he provided petitioner were reasonable and necessary, and medically appropriate. Dr. Brustein testified that he does not generally ask patients a lot of details about their work.

On cross-examination Dr. Brustein admitted that before being presented with the job description prepared by Genex, he had no information regarding what petitioner was required to lift while working for Aramark, except for what was in her intake form. He also stated that he did not know how often petitioner would have to lift, how long petitioner worked for respondent, how many hours per week she worked, how long she held various positions with respondent, what she would have to stir, what she would stir with, how often she would have to stir, or what she used to cut meats. Following this line of questioning Dr. Brustein stated that he did not understand petitioner's job in detail. Dr. Brustein testified that the last day he saw petitioner she was asymptomatic.

On 5/9/14 the evidence deposition of Dr. Vender, a hand surgeon, was taken on behalf of respondent. Dr. Vender opined that carpal tunnel syndrome is an abnormality of the median nerve and the carpal tunnel. He was of the opinion that things like smoking, diabetes, and increased body mass index affect the metabolism of the nerve and make it susceptible to abnormalities. Dr. Vender noted that petitioner had some of these things. After reviewing the video Dr. Vender was of the opinion that there were a lot of activities going on, varied in

nature, in the cooking environment. As a result he opined that there is limited repetitiveness, and essentially no forceful exertions demonstrated. Dr. Vender was of the opinion that petitioner's activities vary depending on what type of food was being prepared. He noted that most of the activities were limited in nature, meaning you cut and then you do something else. He was of the opinion that a wide variety of tasks were being performed, and the hands aren't active all the time. He noted downtime between activities. He stated that petitioner could cut and then walk, push a cart, pick up something, or put it into a container. As such, he was of the opinion that there was no one activity that was being performed consistently, and that by definition precludes the concept of repetitiveness. Dr. Vender opined that petitioner's work activities did not contribute to her development of carpal tunnel.

On cross-examination Dr. Vender noted that petitioner was 11 points over the maximum range for normal blood glucose levels. He noted that despite petitioner telling him that the symptoms in her left upper extremity began in March 2011, he did review a report from October 2010 when petitioner complained of bilateral hand and forearm pain, along with numbness for the past three months. Dr. Vender did not perform Tinel or Phalen tests, or a median nerve compression test because he does not find them to be reliable. He was of the opinion that no tests are reliable, and he based his diagnosis on the history and the electrodiagnostic findings.

Petitioner testified that the job description was somewhat accurate with regard to the jobs she does on a daily basis. Petitioner stated that she handles industrial cans of vegetables that weigh 10 pounds each. She also handles different sizes of pasta and rice that weigh 20 pounds each. Petitioner testified that she uses a can opener that is mounted to a table and is hand operated. She stated that she uses this can opener to open the industrial size cans. Petitioner testified that she also uses a meat slicer to cut the meat. This equipment is used by pushing the meat back and forth over a slicer. Petitioner stated that she does this activity with her right hand. Petitioner testified that the meals change on a daily basis. She testified that her activities will differ daily depending on what vegetables are served. Petitioner stated that she grates, slices and chops vegetables for everything that she prepares.

Petitioner testified that she prepares vegetables approximately 2 hours a day, prepares meats approximately 3 hours a day, and spends about one hour per day putting the food in the trades per day. She also stated that cleaning up her work area and the utensils she uses takes about one hour day. To perform this task petitioner uses scrubbing pads, washcloths, towels, and scrapers on the pots and pans and the stove tops. Petitioner testified that she uses her right and left hands throughout the day. The activities she performs with her hands include grasping with both hands, firm grasping with both hands, and flexion/extension/deviation with both hands. She stated that these activities are performed frequently. Petitioner testified that the video

only covered about 15 minutes of her activity. Although she stated that it accurately reflects what she does, it did not include some of the other things she does such as cleaning, preparing food, and putting it out. Petitioner testified that the video does not show her making 80 pounds of potatoes per day, and mashing the potatoes in a large cauldron using a hand masher with a 24 inch handle. She testified that it takes two hours to make potatoes and she is constantly adding water because they stiffen throughout the day.

Petitioner testified that she makes two types of meat each day. She stated that after the meat cooks she slices it, makes mashed potatoes, gets the vegetables and puts them in the steamer, then cleans the area and prepares for the next day. She stated that she takes the food in the pans to the line by hand three times a week. On the other days she uses a cart. Petitioner testified that she cuts of celery every other day, and chops onions every day. She testified that she does not pull chicken every day. She testified that she uses different tools throughout the day including a whisk, potato masher, and large ladles. Petitioner testified that she only works nine months of the year, and is off during the summer and on Christmas break.

Petitioner testified that after presenting to Dr. Oestreich in 2008 with complaints of hand pain, she was given splints and the symptoms resolved. She testified that when she presented to Dr. Oestreich in the fall of 2010 with complaints of numbness and tingling in her right and left hand, she was working and stirring mashed potatoes and felt a tingling and numbness in her upper arm.

Currently petitioner complains of tingling and numbness in her right hand, and a little pain in her index and long finger. She testified that the strength in her left hand is a little bit greater than in the right. She reported difficulty lifting 20 pound bags of chicken, boxes of potatoes, pasta, and cans of vegetables. She testified that her right hand is numb and painful when she brushes her hair. She complained of difficulty writing letters to her son who is incarcerated. She stated that the pain is up and down her right arm. Petitioner takes ibuprofen three times a day, or as needed. She also takes Aleve 4 times a day. Petitioner testified that she only smokes now when she drinks. From 12/22/11 and 1/15/12 petitioner received unemployment while off work following her surgery. Petitioner testified that she has been diagnosed with hypertension since at least 2008. Petitioner takes medicine for her high blood pressure and high cholesterol. She also stated that she was recently diagnosed with diabetes a few months ago and takes oral medicine for this condition.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers'

Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming an injury to her bilateral hands due to repetitive work activities, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

Petitioner is alleging manifestation dates of 10/7/10 and 4/26/11. Neither of these dates were the date the petitioner first sought medical attention for her condition. On 12/2/08 petitioner presented to Dr. Oestreich complaining of numbness in her hands, with the right hand, wrist and arm being affected for 8 months, and the left for the past week. She stated during that visit that she performed repetitive work as a cook at a local college and this caused her a great deal of pain. The arbitrator further finds that the first date petitioner was informed by a physician that her condition was work related was on 10/25/13 when Dr. Brustein opined a causal connection between her bilateral carpal tunnel and her work activities in his deposition. None of Dr. Brustein's or Dr. Oestreich's records prior to this date include a documented connection between her work activities and her bilateral carpal tunnel. Petitioner first became unable to work as a result of her condition on 12/21/11, the date she had surgery on her right wrist.

The arbitrator finds that 10/7/10 could be seen as the date her symptoms became more acute at work given the fact that on this date she presented to Dr. Oestreich complaining of bilateral hand and forearm pain, and numbness, and her physical examination was positive and Dr. Oestreich ordered an EMG/NCV. The arbitrator notes that on 4/26/11 Dr. Oestreich again ordered the EMG/NCV. He also referred petitioner to Dr. Brustein on this date.

Aside from determining a "manifestation date", it is imperative that the petitioner place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities. In the case at bar petitioner works as a cook for respondent 9 months a year during the school year. She is off in the summer and whenever the college is on break.

A job description for petitioner's position as a cook was completed by Genex Services. The essential job tasks were identified as preparing meat, poultry and fish; preparing vegetable, handling fully prepared foods; and cleanup of utensils and prep area. Detailed activities regarding were outline in the multi-page job description and were varied. The job description did not identify any of petitioner's job tasks as being performed constantly, or 67 - 100% of the time. Simple grasping and flexion/extension/deviation were performed 34-66% of the time with the right upper extremity. Nothing was noted with respect to the same for the left upper extremity. Firm grasping of the right upper extremity was identified as being performed only 6-33% of the time. Fine manipulation with the right hand was identified as being performed on 2-5% of the time.

A video depicting some of petitioner's job duties was offered into evidence. Petitioner agreed that this video depicted some of her job duties. Dr. Vender opined that the work activities demonstrated on the video would be considered of limited repetitiveness, and involved essentially no forceful exertions. He was of the opinion that there was a lot of activities going on, varied in nature depending on what type of food was being prepared. He further opined that there is very minimal exposure to significant forceful use. He stated that the persons hands were not active all the time. He noted that the video showed the cook cutting vegetable and then doing something else, and by definition precludes the concept of repetitiveness. He opined that these activities would not be contributory to the development of carpal tunnel. Dr. Vender also opined that petitioner had many risk factors for the development of carpal tunnel syndrome that include her age, gender, hypertension and smoking history. The arbitrator also notes that petitioner's glucose levels were high at times, and she was recently diagnosed with diabetes.

Dr. Brustein opined that the job duties on the Genex Services job description could aggravate or exacerbate the condition of carpal tunnel since they were repetitive and loaded the median nerve. He then went

on to state that he only had a vague idea, but nothing specific, with respect to the size and weight of the pots, pans or anything of that nature that would be used by a commercial cook. Dr. Brustein also testified that he does not generally ask patients a lot of details about their work. He admitted that before being presented with the job description prepared by Genex, he had no information regarding what petitioner was required to lift while working for Aramark, except for what was in her intake form. He also stated that he did not know how often petitioner would have to lift, how long petitioner worked for respondent, how many hours per week she worked, how long she held various positions with respondent, what she would have to stir, what she would stir with, how often she would have to stir, or what she used to cut meats. Following this line of questioning Dr. Brustein stated that he did not understand petitioner's job in detail.

Petitioner testified that she does a lot of lifting, stirring, and cutting meat at work. She also testified that her fingers get numb and she has pain all the time when she writes. She stated that the job description was somewhat accurate with regard to the jobs she does on a daily basis. Petitioner testified that she also uses a meat slicer to cut the meat. This equipment is used by pushing the meat back and forth over a slicer. Petitioner stated that she does this activity with her right hand. Petitioner testified that the meals change on a daily basis. She testified that her activities will differ daily depending on what vegetables are served. Petitioner stated that she grates, slices and chops vegetables for everything that she prepares.

Petitioner testified that she prepares vegetables approximately 2 hours a day, prepares meats approximately 3 hours a day, and spends about one hour per day putting the food in the trades per day. She also stated that cleaning up her work area and the utensils she uses takes about one hour day. To perform this task petitioner uses scrubbing pads, washcloths, towels, and scrapers on the pots and pans and the stove tops. Petitioner testified that she uses her right and left hands throughout the day. The activities she performs with her hands include grasping with both hands, firm grasping with both hands, and flexion/extension/deviation with both hands. She stated that these activities are performed frequently. Petitioner testified that the video only covered about 15 minutes of her activity. Although she stated that it accurately reflects what she does, it did not include some of the other things she does such as cleaning, preparing food, and putting it out. Petitioner testified that the video does not show her making 80 pounds of potatoes per day, and mashing the potatoes in a large cauldron using a hand masher with a 24 inch handle. She testified that it takes two hours to make potatoes and she is constantly adding water because they stiffen throughout the day.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Vender more accurately reflect the facts in the case and the job duties that petitioner performs. The arbitrator finds the opinions of Dr. Brustein are not based on a thorough understanding of petitioner's job duties. The arbitrato also

relies on the petitioner's own testimony as well as the video and job description completed by Genex Services and finds petitioner's job duties were more varied in nature, than repetitive in nature. In support of this the arbitrator relies on the varied tasks outlined in the Genex Services job description, and petitioner's own testimony regarding the multiple activities she performs on any given day, with none of them being performed for more than 2 hours a day. The arbitrator finds that the job duties petitioner performs are varied and intermittent which provides for frequent changes in petitioner's hands/arms.

The arbitrator also finds it significant that when petitioner presented to Dr. Oestreich on 10/7/10 she stated that her bilateral hand and forearm complaints had been going on for 3 months. The arbitrator notes that this would put the onset of her symptoms at a time when she was not even working for respondent, since she did not work in the summer. The arbitrator further finds it significant that when petitioner was off for extended periods of time her symptoms did not improve. The arbitrator also notes that petitioner's hypertension was frequently uncontrolled and she was also formally diagnosed with diabetes after a period of elevated glucose levels.

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained accidental injuries to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent on 10/7/10 and 4/26/11. The petitioner's claim for compensation is denied.

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

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

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

Having found petitioner has failed to prove by a preponderance of the credible evidence that she sustained accidental injuries to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent on 10/7/10 and 4/26/11, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ 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

15IWCC0226

Lee A. Kellum,
Petitioner,
Vs.

NO: 12 WC 36202
12 WC 36499

Dynegy Midwest Generation,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 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 $30,600.00. 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: MAR 2 7 2015
KWL/vf
O-2/17/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0226

KELLUM, LEE A
Employee/Petitioner

Case# **12WC036202**

12WC036499

DYNEGY MIDWEST GENERATION
Employer/Respondent

On 9/17/2014, 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:

5344 BROWN & BROWN
RICHARD SALMI
5440 N ILLINOIS SUITE 101
FAIRVIEW HEIGHT, IL 62208

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0226

Lee A. Kellum
Employee/Petitioner

v.

Dynegy Midwest Generation
Employer/Respondent

Case # **12** WC **36202**

Consolidated cases: **12WC36499**

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 **Collinsville**, on **July 25, 2014**. By stipulation, the parties agree:

On the date of accident, **July 10, 2012**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**84,198.40**, and the average weekly wage was $**1,619.20**.

At the time of injury, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

The parties have agreed that Respondent shall be liable for the medical bills found in Petitioner's Exhibit #6 and will hold Petitioner harmless regarding those bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act and/or will pay any outstanding medical bills pursuant to the medical fee schedule. The parties agree that Respondent shall receive credit for any bills already paid by it.

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 **$712.55**/week for a further period of **42.75** weeks, as provided in Section **8(e)(9)** of the Act, because the injuries sustained caused **12.5% loss of use of the right hand and 10% loss of use of the left hand.**

Respondent shall pay Petitioner compensation that has accrued from **May 15, 2013** through **July 25, 2014**, 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

9.12.14
Date

SEP 17 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner has two claims pending against Respondent alleging repetitive trauma and bilateral carpal tunnel syndrome. The cases were consolidated with the parties requesting one decision based upon a manifestation date of July 10, 2012. The only issue is the nature and extent of Petitioner's injury.

The Arbitrator finds:

Petitioner has worked for Respondent for thirty-two years, the last twenty-seven of which have been as a maintenance technician. While working for Respondent, Petitioner's job duties required him to dismantle, repair, and reassemble various machines throughout the power plant. This required the use of various hand tools including wrenches, hammers, air impact tools, chain falls, hoists, and other various tools. Petitioner testified that during the course of performing his usual job duties for Respondent he began to notice some problems with numbness and tingling in his fingers as well as pain in his hands.

Petitioner testified that he first sought medical treatment for his bilateral hand complaints on June 13, 2012, with the Marissa Medical Clinic. He was referred to Dr. Sawar, who performed nerve conduction studies on July 10, 2012. They revealed severe right carpal tunnel syndrome and mild left carpal tunnel syndrome. Petitioner was diagnosed with bilateral carpal tunnel syndrome.

Petitioner then came under the case of Dr. Tony Chien, who performed a right carpal tunnel release on August 31, 2012, and a left carpal tunnel release on September 14, 2012. Petitioner was released to return to full duty work on October 1, 2012, by Dr. Chien. He was told to return as needed. (PX 4) Following treatment with Dr. Chien Petitioner returned to see Dr. Sawar for complaints of osteoarthritis in the bilateral hands.

Dr. Sawar's medical records reveal an office visit of January 16, 2013. Petitioner reported significant relief of his numbness and tingling of the hands but he also had pain in both wrists, right more than left, aggravated by motion. (PX3) Physical examination revealed swelling and tenderness in the wrists, right more than left. Petitioner was diagnosed with osteoarthritis of the hands and bilateral carpal tunnel syndrome, status post carpal tunnel repair. Dr. Sawar injected the right CMC Joint with Kenalog and Lidocaine. (PX3)

Petitioner followed up with Dr. Sawar on February 15 with complaints of pain in the left wrist still aggravated by motion. The assessment remained osteoarthritis of the hands and bilateral carpal tunnel syndrome. Dr. Sawar performed an injection into the left CMC Joint. He last followed up for treatment by Dr. Sawar on May 15, 2013. At that time Petitioner's osteoarthritis was noted to be asymptomatic. Petitioner was to return in six months. (PX3)

Petitioner underwent an evaluation by Dr. David Brown on August 27, 2013. Petitioner described working 8 plus hours a day, 40 plus hours a week including the use of impact wrenches, jack hammers, hammers, chisels, screwdrivers, ratchet wrenches, combination wrenches, pry bars, come-a-longs. He described approximately 40% of his time feeling vibration in his hands using impact wrenches; 30% of his time using hammers weighing up to 25 pounds; 30% of the time he uses ratchet wrenches and combination wrenches; 10% chisels; 20% brooms; 30% screwdrivers; 10% poke rods; 20% pry bars; 20% large come-a-longs; 20% large chain falls; 20% heavy equipment operation; 20% shoveling, with these activities varying in frequency during the week, but on average these are percentages he might use these tools and do these types of activities during a particular week. (PX 1)

Petitioner informed Dr. Brown that he had complete resolution of the numbness and tingling in his hands except he still had numbness and tingling in his right index finger but it was improved from prior to surgery. PX1. Physical examination reveals very faint scars in both palms from his carpal tunnel releases. Right wrist motion was 44 degrees dorsiflexion to 19 degrees palmarflexion, 10 degrees radial deviation to 13 degrees ulnar deviation. Range of motion of the left wrist was 58 degrees dorsiflexion to 39 degrees palmarflexion, 19 degrees radial deviation to 24 degrees ulnar deviation. He had good active range of motion of the digits of both hands. Two point discrimination was 4 to 5 millimeters in the digits of both hands. (PX1)

Grip strength on the right was 54, 64, 67 and on the left 58, 79, 59. Key pinch on the right was 21, 25, 22 and on the left 21, 19, 19. Dr. Brown also noted SNAC wrist with evidence of avascular necrosis of the scaphoid with some collapse, complete loss of joint space between the scaphoid and distal radius at the radial carpal joint and complete loss of joint space between the capitate and lunate. X-rays of the left wrist also revealed a loss of joint space between the capitate and lunate and evidence of STT osteoarthritis. (PX1)

Petitioner appeared for an evaluation by Dr. David. S. German on December 11, 2013 on behalf of Respondent. Dr. German noted a history of numbness and tingling in his hands involving mainly the index finger. Dr. German's history notes resolution of the numbness and tingling with remaining soreness in his wrists and a weak grip. (RX1)

At the arbitration hearing Petitioner testified that he continues to work as a Maintenance Technician and his job duties are unchanged. Petitioner testified to some residual pain in his right palm at the incision site after doing heavy lifting. Petitioner describes some remaining numbness at times and perhaps weekly pain in the hand at the incision sight which he rates as a 3 or 4 of 10. He describes a significant loss of grip strength of perhaps 40% from his pre-injury level. Although Petitioner is able to perform his regular duties, he does have difficulty lifting heavier items. For example, one of the tasks he has to perform, perhaps on a monthly basis, is to change out the hammer mill. He describes this as 8 rows of 11 hammers each weighing 50 pounds. He will occasionally drop these hammers because of his reduced grip strength, whereas pre-accident, he did not have that problem. He also described problems using Chicago Fittings which requires forceful grip necessitating that he sometimes has to request a co-worker to assist him. Additionally, he uses his forearms to push items as pushing and lifting very heavy items results in discomfort in his wrist and over the incision sight from the carpal tunnel surgeries. In particular, days with particularly heavy lifting leave him with soreness in his hands. He notices

some problems with bowling and fishing activities and when he is performing impactful activities such as hoeing in his garden.

Petitioner is right hand dominant.

On cross-examination, Petitioner confirmed he is working full duty with no restrictions in his same job and at the same rate of pay. He has never been reprimanded and confirmed he provided truthful information to Dr. German.

The Arbitrator concludes:

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

Respondent has stipulated that Petitioner's current condition of ill-being in his hands is causally related to his work accident. Petitioner has been diagnosed with bilateral carpal tunnel syndrome, which was treated with surgical releases. The right carpal tunnel release was performed on August 31, 2012, and the left carpal tunnel release was performed on September 14, 2012. He has also been diagnosed with osteoarthritis in both hands for which he has received injections.

Pursuant to §8.1b of the Act, the following criteria and factors must be considered in assessing permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

The Act provides that no single enumerated factor shall be the sole determinant of disability.

With respect to these factors, the Arbitrator notes:

1. The reported level of impairment under the AMA Guides. Neither party submitted an impairment rating. This factor is given no weight.

2. The occupation of the injured employee. At the time of trial, Petitioner was working as a maintenance technician. This was the job he had been doing prior to seeking medical treatment

and he returned to do the same job after being placed at maximum medical improvement. Petitioner testified that this work involved assembling, repairing, and reassembling various machines and motors in the power plant. This work involved using various hand tools. Petitioner is able to perform his regular job duties but credibly testified to the need for some assistance when performing tasks requiring forceful gripping.

3. The age of the employee at the time of the injury. At the time of his accident, Petitioner was 53 years of age. No evidence was presented as to how Petitioner's age might affect his disability. However, the Arbitrator reasonably infers that due to Petitioner's age he may live and work with the residuals of his injury for a longer time than an older member of the workforce.

4. The employee's future earning capacity. Petitioner testified that he is working at the same job he did prior to the injury and that his rate of pay is higher now than it was prior to seeking medical treatment. No evidence was presented as to whether or not Petitioner's future earning capacity has been impacted by his work accident.

5. Evidence of disability corroborated by the treating medical records. Petitioner's treating physicians were Dr. Chien and Dr. Sawar. Petitioner testified credibly regarding some residual numbness and tingling in his right index finger, reduced grip strength in his hands, and some soreness at the end of a particularly hand-intensive workday. This testimony is consistent with the records of Dr. Sawar. The Arbitrator notes that Dr. Chien's office notes are very sparse with no notes being found for the September 28, 2012 full duty release.

After considering all of these factors, the Arbitrator concludes that Petitioner has sustained permanent partial disability in the amount of 12.5% loss of use of the right hand and 10% loss of use of the left hand.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Gwaltney,
Petitioner,
vs.

15IWCC0227

NO: 11 WC 1680

White County Coal 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 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 July 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: MAR 2 7 2015
KWL/vf
O-3/10/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0227

GWALTNEY, GARY
Employee/Petitioner

Case# **11WC001680**

WHITE COUNTY COAL CO
Employer/Respondent

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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG TAYLOR
617 E CHURCH ST SUITE 1
HARRISBURG, IL 62946

2742 HAZLETT & SHORT PC
KEVIN M HAZLETT
1167 FORTUNE BLVD
SHILOH, IL 62269

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 15IWCC0227

GARY GWALTNEY
Employee/Petitioner

v.

WHITE COUNTY COAL CO.
Employer/Respondent

Case # **11** WC **001680**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **June 4, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 3, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,513.60**; the average weekly wage was **$836.80**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **3** dependent children.

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

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

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

Respondent is entitled to a credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent is liable for the bill to Dr. Strickler for services rendered on February 3, 2010; however, the bill has been paid and, therefore, payment is not awarded. Respondent is given credit for all medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act and shall hold Petitioner harmless therefrom.

Petitioner failed to prove his current condition of ill-being is causally related to his accident of February 3, 2010 and Petitioner failed to prove he sustained any permanent partial disability as a result of his accident. 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.

Mary Lindsay
Signature of Arbitrator

July 27, 2014
Date

JUL 30 2014

15IWCC0227

Gary Gwaltney v. White County Coal
No. 11 WC 001680

FINDINGS OF FACT and CONCLUSIONS OF LAW

This case proceeded to a full hearing before the Arbitrator on June 4, 2014. The disputed issues were accident, causal connection, notice, average weekly wage, medical bills, temporary total disability benefits and nature and extent. Petitioner alleges he was injured on February 3, 2010 while working on a scrubber motor. Petitioner was the sole witness testifying at the hearing. Petitioner had five exhibits; Respondent, none.

The Arbitrator finds:

On February 4, 2010, Petitioner presented to Dr. David Stricklin at the Carmi Medical Center with sharp left lower quadrant abdominal pain located primarily in the left groin with some radiation to the left upper quadrant and left testicle. Petitioner noted that the pain began on February 3, 2010 while lifting, straining, and pulling. Petitioner described the pain as moderately intense and constantly there since its onset. Aggravating factors included exertion, general movement, walking, coughing, and straining. Petitioner could relieve the pain by applying pressure to the area. Associated symptoms included nausea and vomiting. Petitioner reported feeling a "knot" the size of a quarter the evening before. Petitioner's weight was recorded at 157 lbs. The initial diagnosis from Dr. Stricklin was left lower quadrant abdominal pain/strain. Petitioner was given light duty for two days. Dr. Stricklin saw no evidence of a hernia. (PX 1)

Four days later, on February 8, 2010, Petitioner presented to the St. Mary's Medical Center Emergency Room in Evansville, Indiana complaining of bloody stools for five (5) days as well as left lower quadrant pain. Petitioner described bright red blood per rectum with each bowel movement over the last five (5) days. Petitioner also reported a little bit of constipation with intermittent hemorroids. Petitioner denied any nausea or vomiting. On examination Petitioner had some soft mild tenderness in the left lower quadrant with a little bit of guarding. The Emergency Room Doctor, Dr. Christopher Marchino, provided a diagnosis of rectal bleeding and encouraged him to follow up with the on-call gastroenterologist. (PX 4)

On February 17, 2010 Petitioner presented to Dr. Gregory S. McCord of Tri-State Gastroenterology again complaining of bloody stools of two weeks duration. According to the Patient Information Form completed by Petitioner he denied any weight loss. Petitioner's weight was listed at 160 lbs. After examining Petitioner, Dr. McCord diagnosed Petitioner with an unspecified hemorrhage of the gastrointestinal tract and referred him for a colonoscopy. Petitioner was prescribed pain medication and released. (PX 2)

On February 25, 2010, Dr. McCord performed a colonoscopy on Petitioner. Dr. McCord provided a post-operative diagnosis of internal hemorrhoids. (PX 1, PX 2; PX 3)

Petitioner underwent no treatment between February 25, 2010 and July 6, 2010. He continued working full duty for Respondent.

Petitioner again presented to the St. Mary's Medical Center Emergency Room on July 6, 2010. Petitioner complained of severe rectal pain. Petitioner provided a history of chronic rectal pain over the preceding 24 hours. He had known hemorrhoids and had been seen multiple times in the past and undergone a colonoscopy. Petitioner reported he had been referred to a surgeon but had not followed up as advised. On examination

Petitioner was noted to have thrombosed internal and external hemorrhoids as well as urinary retention secondary to the swelling and discomfort. Petitioner was immediately scheduled for an emergency hemorroidectomy which was performed on July 6, 2014 by Dr. Syam S. Chilukuri. Petitioner was discharged from the Emergency Room on July 8, 2010. Dr. Chilukuri provided to Petitioner an off work slip from July 6, 2010 to July 27, 2010. Petitioner was returned to work without restrictions on July 27, 2010. At the time of his last examination with Dr. Chilukuri (July 26, 2010) Petitioner was noted to have almost complete resolution of all of his symptoms and no longer experiencing any pain, bleeding or drainage. He was to return to see the doctor if he had any problems. (PX 3, 4)

Petitioner signed his Application for Adjustment of Claim in this matter on December 21, 2010. (AX 2)

At arbitration Petitioner testified that he is 32 years of age and has worked for Respondent almost six years, having begun in October of 2008. Petitioner testified that on February 3, 2010 he injured himself working on a scrubber motor on a continuous miner. Petitioner testified that he was leaning over in an awkward position when he felt a pull/strain in his stomach area. Petitioner testified that on that date he gave notice of the accident to his supervisor, Jimmy Parkfield, and continued working, albeit in pain. He completed an accident report that night.

Petitioner testified that he went to see his doctor on February 3, 2010 complaining about lower stomach pain. He returned to work on February 4, 2010 testifying that the pain was "tolerable" that day but he had trouble sitting and lifting objects. Petitioner testified that he went to the emergency room five days later due to severe bleeding in the rectal area along with bloody stools. Petitioner testified he then had a colonoscopy but his symptoms continued to get worse and he was eventually diagnosed with internal hemorrhoids. Petitioner further testified that while he returned to work after the colonoscopy (for which he was off work one day) the pain and bleeding continued. Petitioner testified that he had trouble with both work and everyday activities as he was limited in what he could do and had difficulty mowing his lawn, sitting and eating.

Petitioner testified he continued to work and deal with the pain but it got so bad that he had to once again present to the St. Mary's Medical Center Emergency Room on July 6, 2010. Petitioner testified he underwent emergency surgery for a hemorroidectomy and was off work for three weeks during which time he received no workers' compensation benefits. Petitioner returned to work on July 25, 2010 with no restrictions. Petitioner added that he returned to work earlier than anticipated because he was broke.

Petitioner testified that he is not "great." He added that after the hemorroidectomy he no longer had bloody stools and he can now perform many of the tasks that he was unable to perform after his accident at work. Petitioner noted that he still is cautious in performing many of the tasks that he could perform without worry prior to the accident.

Petitioner testified that he has no outstanding medical bills as group paid it all. He did incur out-of-pocket expenses in the amount of $45.00 for prescriptions.

Petitioner further testified that he made $22.00-$23.00/hour at the time of the accident and worked a mandatory 50-58/60 hours per week. He did not bring any pay stubs with him to the hearing. He further acknowledged that while he felt there was mandatory overtime he had nothing with him at the hearing to establish that. On cross-examination Petitioner agreed that a normal work week was 40 hours without overtime. He further agreed that in 2010 he was earning $20.92/hour.

On further cross-examination Petitioner testified that his initial abdominal pain was in the upper abdominal area and that by the time he saw Dr. Stricklin on February 4, 2013 the pain had moved progressively down to his left groin area. He had no rectal or bleeding problems at that time. He agreed that five days later he was at the emergency room for hemorrhoids, then had a colonoscopy in February, and had no further treatment until July of 2010. He further acknowledged that he would not disagree with the history contained in St. Mary's ER record of July 6, 2010.

Petitioner also testified on cross-examination that prior to the ER visit on July 6, 2010 he and his family were on a vacation which had to be cut short due to the "acute onset" of problems which came on while on vacation.

Petitioner also testified that when he first went to the emergency room the doctor told him he needed surgery to correct his problem. He also acknowledged that Dr. Stricklin performed a thorough examination on February 4, 2010 and found no evidence of a hernia.

On redirect examination, and with lots of leading questions, Petitioner testified that his initial pain was in his lower abdominal area and then it progressed to his rectal area, resulting in the need for a colonoscopy. Petitioner agreed that he experienced rectal pain for five months which had "built up" since his accident and got worse and worse. Petitioner continued to work because he had to with four kids to care for. He believed he lost close to thirty pounds. Petitioner also testified that he though he averaged 8 to 10 hours of extra mandatory time during that period.

On additional cross-examination Petitioner was asked about his "substantial" weight loss. He believed he weighed about 150 -155 lbs. when he had surgery and that his normal weight varied from 165 - 180 lbs. Petitioner then testified that he maybe didn't lose 30 lbs. but he did lose a lot of weight.

The Arbitrator concludes:

1. Issue (C) Accident.

Petitioner sustained an accident on February 3, 2010, that arose of out of and in the course of his employment with Respondent. The Arbitrator bases her determination on Petitioner's unrebutted testimony regarding the completion of an accident report and giving of notice.

2.Issue (E) Notice.

Petitioner provided timely notice of his accident to Respondent. This conclusion is based upon Petitioner's unrebutted testimony concerning same.

3.Issue (F) Causal Connection.

Petitioner failed to prove his current condition of ill-being is causally related to his accident of February 3, 2010. The Arbitrator concludes that Petitioner suffered, at most, a minor abdominal strain as a result of his February 3, 2010 work accident. Petitioner failed to prove that any treatment or conditions after his February 3, 2010 accident were causally related to that accident. Petitioner did not offer any medical causation opinion nor can causation be established through a chain of events. With regard to the latter, the Arbitrator notes credibility concerns regarding Petitioner, a gap in treatment between March and July of 2010, Petitioner's ability to work full duty until July 6, 2010 (except for a one day absence for his

colonoscopy), and the history provided to the emergency room on July 6, 2010 in which Petitioner reported an "acute" episode while on vacation that preceded his trip to the emergency room. On the matter of Petitioner's credibility, the Arbitrator notes that Petitioner's testimony regarding his "substantial" weight loss after his accident was not corroborated by any medical records and while Petitioner finally acknowledged that maybe he didn't have a substantial weight loss he nevertheless suggested he lost "a lot of weight" which, again, was not borne out by the evidence. Petitioner's description of his weight loss suggests to this Arbitrator that he has a tendency towards exaggeration which, in turn, suggests his testimony about ongoing pain, limited activities, and worsening symptoms might not be entirely credible. Absent corroboration for his testimony, Petitioner's testimony alone will not support a chain of events.

4.Issue (G) Petitioner's Earnings.

The Arbitrator finds that Petitioner's earnings for the 52 weeks prior to the accident date are $$43,513.60 which provides an average weekly wage of $836.50. The Arbitrator bases her determination on Petitioner's testimony on cross-examination that he made $20.92 per hour and his testimony that his usual work week was comprised of forty hours. While Petitioner testified to additional mandatory hours, he provided no corroboration for his testimony and, again, citing credibility concerns as discussed above, Petitioner's testimony alone will not establish that his usual work week was anything more than 40 hours.

5.Issue (J) Medical Bills.

Petitioner testified that all of his medical bills have been paid by group. Consistent with her causation analysis, the only medical bill this Arbitrator would hold Respondent liable for would be Dr. Stricklin's office visit of February 3, 2010 ($114.00 - PX 5). Petitioner testified his only out-of-pocket expenses were for prescription medications; however, he did not submit any proof of incurring any out-of-pocket medication expenses for the February 3, 2010 visit with Dr. Stricklin. Respondent is held liable for the visit of February 3, 2010 with Dr. Stricklin and will be given a credit for its payment under Section 8(j) and shall hold Petitioner harmless therefrom.

6.Issue (K) Temporary Total Disability Benefits

Consistent with her causation determination the Arbitrator concludes Petitioner incurred no lost time on account of his work accident and she does not award any temporary total disability benefits.

7.Issue (L) Nature and Extent.

Petitioner failed to prove he sustained any permanent partial disability as a result of his February 3, 2010 work accident.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CINDY BAKER,

Petitioner,

15IWCC0228

vs.

NO: 12 WC 21954

ITW ZIPPAK,

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

Based upon a review of the record as a whole, the Commission modifies the Arbitrator's Decision and finds Petitioner failed to prove her current condition of ill-being with regard to her right shoulder is causally connected to her March 07, 2012 work-related injury. In so finding, the Commission relies on the symptoms, physical exam findings, diagnosis and work restrictions issued during Petitioner's office visit the day prior to her work injury, March 06, 2012, the inconsistencies in Petitioner's testimony, the incomplete history upon which Dr. Ho's causal connection opinion was based, and the more persuasive opinion of Dr. Verma.

On March 06, 2012, one day prior to her March 07, 2012 work-related injury, Petitioner sought medical care with Dr. Leshen, her personal physician. Petitioner testified she had no right shoulder injury prior to March 07, 2012. Petitioner further testified this March 06, 2012 office visit was a pre-scheduled appointment for a "feminine personal issue." She further testified that during that visit she advised the doctor of few issues going on with her, but that her right

shoulder complaints at that office visit were limited to "pain in the front part of my right shoulder. It was just like an ache, an achy pain. I had a little lump on the right side of my neck and I had like a stomach issue going on." Petitioner testified her complaints on March 06, 2012 were in front part of her shoulder, while her complaints after her March 07, 2012 injury were in the back of her shoulder. (T20-22).

The March 06, 2012 office visit note of Dr. Leshen indicates Petitioner complained of pain in her right shoulder, a painful right arm, and a "shocking pain down" her left arm. She was noted to have positive findings, including difficulty with range of motion and with raising her right arm. During that office visit, Dr. Leshen's "Chronic DX" was "Right rotator cuff tendinosis," cervicalgia with nerve impingement, and Petitioner was given restrictions of no overhead lifting for one month. (PX6).

Although Dr. Leshen's March 06, 2012 office notes reflect Petitioner complained of right shoulder pain and she was diagnosed with chronic right rotator cuff tendinosis, at the time of hearing Petitioner denied she had any issues or pain in her right arm or shoulder when she reported for work on March 07, 2012, and she further indicated she did not recall being given that diagnosis or any work restrictions during her March 06, 2012 office visit with Dr. Leshen. (T37, 44-45).

Dr. Ho, the orthopedic surgeon who began treating Petitioner on July 12, 2012, testified that Petitioner's work duties either caused, aggravated, accelerated or precipitated her right shoulder symptoms. Petitioner admitted she failed to advise Dr. Ho of her March 06, 2012 office visit and the diagnosis rendered on that date. Furthermore, Dr. Ho testified Petitioner did not report any symptoms or a chronic element to her right shoulder complaints at her initial office visit, or future office visits. (T47, PX1 at T24-25, and PX1 at T31-32). The Commission finds Dr. Ho's opinion on causal connection failed to address the chronic diagnosis made on March 06, 2012, and that he admitted that when he rendered his causal connection opinion it was rendered based upon the "chronicity on her MRI," and without an understanding as to the type of tools or equipment she used as part of her work activities. He also admitted Petitioner's only description of her job activities was that she used either a bolt cutter or turned lug bolts, and but he did not know for sure if she did this work at shoulder level, how often she performed this type of activity, how long she had performed that type of activity as part of her job duties, or how long she had been employed by Respondent. Dr. Ho admitted the only incidental detail he had about Petitioner's work duties is that at least on one occasion she used a bolt cutter or turned a lug bolt. (PX1, T56-58).

Dr. Verma, Respondent's Section 12 examiner, testified he examined Petitioner October 29, 2012, at which time Petitioner denied any right upper extremity problems prior to March 07, 2012, and that he reviewed Petitioner's March 06, 2012 office visit note, which indicated she had preexisting complaints that were made to him, made on March 07, 2012, and made on March 06, 2012, when she was noted to have pain with range of motion of the right shoulder and diagnosed with rotator cuff abnormality, tendonitis. (RX3, T8-10). Dr. Verma opined that his diagnosis of adhesive capsulitis was consistent with her preexisting history of symptoms prior to the date of her alleged injury, and that her work injury of March 07. 2012 did not cause or aggravate her adhesive capsulitis. (RX3, T13-14, RX2).

15IWCC0228

Based upon the above, the Commission finds Petitioner failed to prove her current condition of ill-being with regard to her right shoulder is causally connected to her March 07, 2012 work-related injury.

Based upon the Commission's finding on the issue of causal connection herein, the Arbitrator's award of temporary total disability benefits, for a period of 97 weeks, from March 17, 2012 through January 24, 2014, medical expenses of $5,331.00, and prospective medical award in form of a right shoulder MRI study and possible right shoulder arthroscopy, is hereby vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on April 11, 2014, is modified, as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of 97 weeks of temporary total disability benefits, for the period of March 17, 2012 through January 24, 2014, under §8(b) of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of $5,331.00 in medical expenses under §8(a) of the Act is hereby vacated.

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.

Based upon the Commission's reversal on the issue of causal connection and no award of benefits herein, no bond for the removal of this cause to the Circuit Court by Respondent is due. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 27 2015
KWL/kmt
O-02/03/15
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

15IWCC0228

BAKER, CINDY
Employee/Petitioner

Case# **12WC021954**

ITW ZIP-PAK
Employer/Respondent

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:

0307 ELFENBAUM EVERS & AMARILIO
KAROLINA M ZIELINSKA
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0766 HENNESSY & ROACH PC
PETER J PUCHALSKI
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

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)/8(a)

15IWCC0228

Cindy Baker,
Employee/Petitioner

v.

ITW Zip-Pak,
Employer/Respondent

Case # **12** WC **21954**

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 **Geneva**, on **1/24/14**. 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 _____

15IWCC0228

FINDINGS

On the date of accident, **3/7/12**, 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 **$32,432.40**; the average weekly wage was **$623.70**.

On the date of accident, Petitioner was **47** 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 **$2,282.40** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$2,282.40**.

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 $415.80 per week for 97 weeks, commencing 3/17/12 through 1/24/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 3/8/12 through 1/24/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $2,282.40 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $5,331.00, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner is entitled to prospective medical treatment in the form of a right shoulder MRI and possible right shoulder arthroscopic surgery as recommended by Dr. Ho, and Respondent shall pay the reasonable and necessary medical services associated therewith, as provided in §§ 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

4/8/14
Date

ICArbDec19(b)

APR 11 2014

STATEMENT OF FACTS:

The Arbitrator notes that at the commencement of trial the parties agreed to defer any rulings or determinations with respect to Petitioner's cervical spine complaints. As a result, the hearing held on January 24, 2014 was limited to issues regarding Petitioner's right shoulder condition.

Respondent, ITW ZipPak, is in the business of manufacturing resealable zippers for plastic bags. Petitioner testified that she worked as a Tech 1/Tech 2 for Respondent and has been employed at ZipPak for nearly 10 years. Petitioner's job duties consist of starting and running the production line, changing over the production line, and packaging materials. Petitioner testified her job is physically demanding as she works 12 hour shifts, lifts 50 pounds and does overhead work when changing zipper dies. Petitioner would change zipper dies on a daily basis, sometimes more than once per day. Petitioner testified she uses tools such as socket wrenches or breaker bars when changing zipper dies and removing bolts. In August 2011, Petitioner started working a new production line – US 3. Petitioner testified this new line had many complications and was more physically demanding. Petitioner had to use a stool and bend her body backwards in order to break off bolts.

In the 10 years prior to March 7, 2012, Petitioner testified she was able to complete all of her work activities without any problems involving the right arm. On March 7, 2012, Petitioner presented to work at approximately 6:45 am. She received instructions from her supervisor to complete a change-over on the line and to change a die lip on a die head. At approximately 10:00 am, Petitioner testified she was working on US 3 on top of a stepstool leaning back and using a breaker bar with her right arm trying to loosen a bolt when she heard a snap in the top, back part of her right shoulder. Petitioner felt immediate pain consisting of a burning sensation in her right shoulder.

Petitioner testified that the day before the incident, on March 6, 2012, she had visited her nurse practitioner to discuss personal medical issues. At that visit, she told her longtime nurse practitioner about a lump on her neck and stomach issues. She also discussed some aches in the front part of her right shoulder. Medical records from Family Medicine Associates note Petitioner was having pain and burning in her lower abdomen, anxiety, a lump on her neck, pain in the right shoulder and right arm, and pain in her lower left arm. (PX6, p. 8). Petitioner testified this was a previously scheduled appointment and not an emergency visit.

Petitioner testified that the pain she felt in her right shoulder when she was injured on March 7, 2012 was different than the pain she noted to her nurse practitioner on March 6, 2012. Petitioner's pain on March 7, 2012 was a sharp pain in the back portion of her shoulder. Petitioner's pain on March 6, 2012 was a dull ache in the front part of her shoulder.

Petitioner testified she had never injured her right shoulder prior to March 7, 2012 and had never had to leave work to seek medical attention for her right shoulder. Petitioner had never obtained x-rays or MRIs of her right shoulder prior to her work accident on March 7, 2012. Petitioner had never filed a workers' compensation claim prior to her March 7, 2012 injury.

Following her injury, Petitioner testified she stopped working and got down from the step stool. She notified her supervisor, Kris Harms, of her injury. Kris Harms then drove Petitioner to the company clinic, Riverside Corporate Health Services, to get medical attention.

The medical records reflect Petitioner presented to Riverside Corporate Health Services on March 7, 2012. (PX3). Petitioner reported she had right shoulder pain that started after pulling a bar at work earlier that day. (PX3, p. 2). Petitioner reported her regular job consists of pushing and pulling and that she has been working

with her employer for 10 years. Id. Petitioner noted pain mostly in the back of her right shoulder with some radiation down her right upper extremity and occasional pain up the right side of her neck. Id. On physical exam, Petitioner demonstrated tenderness to palpitation over the trapezius and rotator cuff capsule, pain with flexion and extension, and a positive Hawkins and Neer's test. Id. Right shoulder x-rays were taken. Id. Petitioner was diagnosed with a right shoulder strain. Id. Petitioner was returned to work with light duty restrictions and advised to begin a home exercise stretching program. (PX3, p. 3). Petitioner also provided a urine sample for a post-accident drug test at Riverside.

Petitioner returned to work thereafter. She testified that she filled out an incident report. (See PX8). Petitioner testified she was accommodated for light duty work from March 7, 2012 to March 16, 2012.

The results of Petitioner's post-accident drug screen at Riverside indicated Petitioner was positive for amphetamines. (RX4, p 1). Petitioner testified she had taken Adderall on March 7, 2012 and she did not have a prescription in her name for Adderall. Petitioner testified she took Adderall to try to focus more at work due to the stress that was going on in her life. Petitioner had used Adderall three to four times a week since mid-February 2012. Petitioner was terminated from employment on March 16, 2012 for failing her drug screen.

Petitioner returned to Riverside on March 22, 2012 for a follow-up. (PX3, p. 6). Petitioner reported continued right shoulder pain mainly over the trapezius area, the anterior rotator cuff capsule and the deltoid, especially with abduction and forward flexion. Id. Petitioner reported she had been doing her home exercises and they were not helping. Id. Petitioner was recommended to begin formal physical therapy. Id. Petitioner was given light duty work restrictions until her next follow-up appointment. Id.

On April 24, 2012, Petitioner returned to Riverside. (PX3, p 9). Petitioner reported that physical therapy had worsened her right shoulder pain and it now lasts up to 12 hours and then radiates down her arm with associated numbness and tingling. Id. On physical exam, Petitioner demonstrated restricted range of motion secondary to pain and positive impingement. Id. Petitioner was assessed with "right shoulder strain – worse." Id. A right shoulder MRI was ordered and Petitioner was given modified duty work restrictions. (PX3, p 10).

On May 4, 2012, Petitioner presented to Matteson MRI and underwent a MRI of her right shoulder. (PX3, p 14). The MRI impression interpreted by Dr. Joel Swartz showed moderate arthritic change, supraspinatus tendinopathy with a small partial-thickness under surface tear and a small amount of fluid in the subacromial/subdeltoid bursa. Id.

On May 9, 2012, Petitioner followed-up at Riverside post MRI. (RX4; PX3, p 15). Petitioner was referred to orthopedics and kept off work until restrictions were determined by an orthopedic surgeon. Id.

On July 2, 2012, Petitioner presented to orthopedic surgeon Dr. Sherwin Ho at the University of Chicago Orthopedic Surgery Department. (PX4, p. 3). Petitioner reported she injured her right shoulder at work in March. Id. On exam, Petitioner demonstrated decreased active and passive range of motion and numbness and tingling throughout the right upper extremity. Id. Dr. Ho reviewed the MRI and indicated it showed significant amount of undersurface, near full thickness tear of rotator cuff. Id. Dr. Ho recommended surgical repair and noted Petitioner should follow up in four weeks pending surgical approval by workers' compensation. Id. Dr. Ho recommended an injection to alleviate some pain should surgery not be approved. Id.

On October 29, 2012, Petitioner submitted to a §12 examination with Dr. Nikhil Verma at Respondent's request. (RX2).

On December 24, 2012, Petitioner returned to Dr. Ho with continued pain in the right shoulder with pulling or lifting activities. (PX4, pp. 5-6). Dr. Ho's medical records indicated Petitioner had not undergone any physical therapy or injections since her last visit in July 2012. Id. Dr. Ho noted Petitioner had not been able to return to work since her March 2012 injury. Id. Dr. Ho noted Petitioner continued to feel twisting and pulling in the right shoulder with occasional numbness and tingling down her right arm which Dr. Ho indicated that this was consistent with a "dead arm syndrome" often associated with rotator cuff injuries. Id. Dr. Ho noted in his records that Petitioner exhibited no evidence of frozen shoulder with a near full range of motion. Id. Dr. Ho injected Petitioner's subacromial bursa and referred her to a formal physical therapy program. Id. Petitioner was advised to return in six weeks post injection. Id.

On January 14, 2013, Petitioner presented to the Ryan Center for Hand Therapy for her initial evaluation. (PX5). Petitioner attended seven (7) therapy sessions from January 14, 2013 through March 5, 2013. Id. She testified the physical therapy was not helping and her right shoulder pain continued with numbness and tingling into both hands.

Petitioner returned to Dr. Ho on March 11, 2013. (PX4, p. 7). The medical records indicate Petitioner felt relief for only about a week and a half following her injection before her symptoms returned. Id. Petitioner reported right shoulder pain with any overhead positioning and lifting of the right arm. Id. On physical exam, Petitioner demonstrated a near full range of motion of the right shoulder, positive Neer's test and positive dead arm test with numbness and tingling. Id. Petitioner was assessed with continued right shoulder pain with a likely partial-thickness tear and continued subacromial impingement. Id. Dr. Ho recommended right shoulder arthroscopy and subacromial decompression and assessment of the rotator cuff with potential repair. Id.

On April 24, 2013, Petitioner followed-up with Dr. Ho at which time she continued to complain of pain in the right shoulder. (PX4, pp. 55-56). Given the patient's failure with conservative treatment for over a year, Dr. Ho felt she was a good candidate for shoulder arthroscopy, subacromial decompression and assessment of the rotator cuff. Id.

On June 10, 2013, Dr. Ho diagnosed Petitioner with partial thickness rotator cuff tear of the right shoulder with no evidence of a frozen shoulder. (PX4, pp. 65-66). Dr. Ho noted Petitioner remained a candidate for right shoulder arthroscopy. Id.

Petitioner was again examined by Dr. Ho in September 23, 2013 and December 2, 2013. (PX4, pp. 70-71, 75-76). Petitioner's right shoulder pain had not improved. Id. Dr. Ho continued his recommendation for right shoulder surgery. Id.

On September 4, 2013, Dr. Ho testified via evidence deposition. (PX1). Dr. Ho is a board certified orthopedic surgeon specializing in the treatment of shoulder and knee injuries. (PX1, p. 6). Dr. Ho testified that he first examined Petitioner on July 2, 2012 after Petitioner was referred to him by a nurse practitioner, Ruth Leshen, from Family Medicine Associates of Kankakee. (PX1, p. 9). Dr. Ho noted Petitioner had injured herself on March 7, 2012 when she noted an acute onset of tearing in her shoulder while using some type of instrument to work on bolts. Id. Dr. Ho's history indicated Petitioner complained of progressive and continuous right shoulder pain with overhead activity and night pain. Id. Dr. Ho testified that during his examination of Petitioner on July 2, 2012, he noted typical findings for a rotator cuff tear, including pain with elevation, or Neer's test, weakness on abduction strength, or Jobe's test, and limitations in range of motion. (PX1, pp. 12-13). Dr. Ho testified he reviewed the MRI films and again found classic findings of a rotator cuff injury including tearing of the rotator cuff, fat atrophy and acromial spurring. (PX1, pp. 13-14).

Following his review of Petitioner's medical records from Riverside Corporate Health Services, Petitioner's medical records from the Ryan Center for Hand Therapy, Petitioner's MRI scan in addition to the findings on physical examination, Dr. Ho opined Petitioner had an acute-on-chronic rotator cuff tear in her right shoulder on March 7, 2012 and it was more probable than not that Petitioner's job duties both caused and aggravated her rotator cuff tear. (PX1, pp. 14-15). Dr. Ho explained an acute-on-chronic event is the type of injury that is most often seen with laborers who have worked at the same job for a significant amount of time and sustain an acute injury that causes them to stop working and seek treatment. (PX1, p. 11). Dr. Ho noted that in most of these cases he finds evidence of wear and tear, or what is referred to as tendinopathy, or even fraying or partial tearing of the rotator cuff prior to that one incident that causes the individual to seek treatment. Id. Dr. Ho explained that an individual may have had some level of shoulder pain or may have taken an anti-inflammatory or a day off work prior to that one, traumatic incident that ultimately tears the rotator cuff. Id. Dr. Ho further explained that in a lot of these cases he finds that the rotator cuff tendon was already in a weakened state to some degree due to overuse activities at work and then that one, acute injury brings the patients in for treatment. (PX1, p. 12). As such, Dr. Ho opined that if Petitioner had some complaints prior to her March 7, 2012 injury, those complaints would be consistent with an acute-on-chronic event. Id.

Dr. Ho testified that Petitioner's treatment prior to his evaluation on July 2, 2012 was appropriate and necessary. (PX1, p. 15). Dr. Ho recommended that the rotator cuff be repaired surgically based on the fact that after four months of conservative treatment, including activity modification, rest and physical therapy, Petitioner's complaints continued. (PX1, p. 16). Dr. Ho testified that the fact that Petitioner had complete relief of her symptoms for a short period of time following the injection he administered on December 24, 2012, diagnostically shows that her rotator cuff is the likely source of her pain and that the tear is probably deep or full thickness. (PX1, p. 43). Dr. Ho again noted the injection was meant as only a temporizing measure. (PX1, p. 17). Dr. Ho testified that Petitioner's prognosis was good for a complete recovery following repair of her rotator cuff tear. Id. Dr. Ho explained that the rotator cuff may continue to undergo atrophy and the tear may become larger and worse over time if untreated. (PX1, p. 24). Dr. Ho testified that Petitioner's work activities did cause the complete or further tearing of the rotator cuff and that surgical intervention is the only way to relieve and cure Petitioner of her symptoms. (PX1, p. 24-26).

Dr. Ho explained that motorcycle riding could not lead to rotator cuff tendinopathy. (PX1, p. 61). Dr. Ho testified that he explained to Petitioner that if she wanted to ride motorcycles, pain should be her guide. Id. Dr. Ho noted that continuous motorcycle riding may aggravate an already torn rotator cuff and cause riding to be painful, but it could not tear a rotator cuff. (PX1, pp. 61 and 63). Dr. Ho testified that none of Petitioner's rotator cuff diagnoses had anything to do with her hobby of riding a motorcycle. (PX1, p. 63). Dr. Ho testified that during the course of his treatment of Petitioner, she was not capable of working at her old job without the appropriate modifications of her job due to her rotator cuff. (PX1, p. 22). Dr. Ho opined Petitioner's time off work since the injury is related to her injury and the tearing of the rotator cuff. (PX1, p. 26). Finally, Dr. Ho testified that Petitioner's intermittent use of Adderall would not have affected her rotator cuff tear, either the causation of it or the subsequent management of her rotator cuff tear. (PX1, pp. 27-28).

Respondent's §12 examining physician, Dr. Nikhil Verma, testified by way of evidence deposition on December 11, 2013. (RX3). Dr. Verma testified that Petitioner presented to his office with a history of being employed as a tech operator and using a large wrench in a lever-type fashion to loosen a bolt on March 7, 2012 when she felt pain in her right shoulder and shooting down her arm. (RX3, p. 8). Dr. Verma testified that he addressed with Petitioner whether or not there was a significant prior medical history of her right upper extremities and she denied a significant history. (RX3, p. 9). On exam, Dr. Verma indicated Petitioner had loss of range of motion with pain at end range of motion and mild weakness. (RX3, p. 9). Dr. Verma testified his impression of the MRI scan was that the rotator cuff was intact. (RX3, pp. 9-10). Dr. Verma did not know whether Petitioner

underwent an open or closed MRI. (RX3, p. 24). Dr. Verma agreed that both the radiologist, Dr. Swartz, and Petitioner's treating physician, Dr. Ho, noted a tear of the rotator cuff on MRI. (RX3, p. 25).

Dr. Verma testified that he placed significant weight on the March 6, 2012 note in that the patient had preexisting complaints of right shoulder and arm pain. (RX3, pp. 11-12). Dr. Verma opined that Petitioner's pain with range of motion on March 6, 2012 was consistent with her complaints at his examination on October 29, 2012. Id. Dr. Verma testified that the March 6, 2012 note did not report any acute injury and did not relate Petitioner's symptoms to a work injury. (RX 3, p. 12). Dr. Verma opined that Petitioner suffered from adhesive capsulitis, or frozen shoulder. (RX3, p. 13). Dr. Verma testified that adhesive capsulitis is a condition that is characterized by stiffness and pain in the shoulder joints. (RX3, p. 16). Dr. Verma explained that frozen shoulder goes through a series of three phases: the first being an inflammatory phase where the shoulder is painful; the second is a freezing phase where the shoulder loses range of motion; and the third is a thawing phase where the symptoms gradually resolve and pain as well as function returns to normal. (RX3, p. 13). Dr. Verma testified that on October 29, 2012 Petitioner was in the first, or inflammatory, phase because her shoulder was painful and stiff. Id. On cross examination, Dr. Verma testified that generally it takes weeks to months for a patient with adhesive capsulitis to progress from the initial inflammatory stage to the second, loss of range of motion stage. (RX3, p. 17-18).

Dr. Verma testified that he had not reviewed any of Petitioner's medical records after July of 2012 when forming his opinions in this case. (RX3, pp. 19-20). Dr. Verma admitted he did not know whether Petitioner had decreased range of motion on physical exam in November 2012, December 2012 and anytime in 2013. (Rx 3, pp. 21). Dr. Verma opined that Petitioner's adhesive capsulitis was not related to a work injury of March 7, 2012. (RX3, p. 14). Dr. Verma also opined Petitioner was not a candidate for an arthroscopic rotator cuff repair. (RX3, p. 15). Dr. Verma testified he based his opinion that Petitioner was not a surgical candidate on the fact that he did not think she had a rotator cuff tear. (RX3, p. 26). Dr. Verma also agreed that motorcycle riding would not be a contributing factor to Petitioner's right shoulder condition. (RX3, p. 27).

Petitioner has not worked since March 16, 2012. Petitioner has been kept on modified duty or off work status by her physicians at Riverside Corporate Health and by Dr. Ho since her injury on March 7, 2012. Petitioner testified she would have continued working light duty had she not been terminated.

Petitioner testified she continues to have pain in the back of her right shoulder and down her right arm. She can lift her arm and bring it up but it locks on her when she brings her arm back down. She continues to take prescription medication for her pain prescribed by Dr. Ho. If her right shoulder surgery was authorized, she would undergo that procedure.

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

Petitioner has been employed by Respondent for approximately 10 years. Prior to March 7, 2012, Petitioner testified she was able to complete all of her work activities without any problems involving the right arm. On March 7, 2012, Petitioner presented to work at approximately 6:45 am. She received instructions from her supervisor to complete a change-over on the line and to change a die lip on a die head. At approximately 10:00 am, Petitioner testified she was working on US 3 on top of a stepstool leaning back and using a breaker bar with her right arm trying to loosen a bolt when she heard a snap in the top, back part of her right shoulder. Petitioner felt immediate pain consisting of a burning sensation in her right shoulder. Petitioner's testimony along these lines was not refuted.

Furthermore, there would appear to be no evidence, or even suggestion, that Petitioner's admitted intermittent use of Adderall either caused or contributed to the accident in question. Dr. Ho, in fact, specifically testified that Petitioner's use of Adderall would not have affected her rotator cuff tear, either the causation of it or the subsequent management of her rotator cuff tear. (PX1, pp. 27-28).

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on March 7, 2012.

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

The Arbitrator finds that Petitioner's current condition of ill-being with respect to her right shoulder condition is causally related to her March 7, 2012 work accident. In so finding, the Arbitrator relies on the testimony of Dr. Sherwin Ho as well as Petitioner's credible testimony.

The Arbitrator finds the opinion of treating orthopedic surgeon Dr. Ho to be more persuasive than the opinion offered by Respondent's §12 examining physician, Dr. Verma, based on the MRI findings as interpreted by both Dr. Ho and Dr. Swartz, as well as the diagnostic findings post injection, Petitioner's credible testimony and the medical records taken as a whole.

Dr. Ho opined Petitioner suffered from an acute-on-chronic rotator cuff tear on March 7, 2012. Dr. Ho explained that Petitioner's past activities had likely begun to cause rotator cuff tendinopathy and that the March 7, 2012 work accident as described by Petitioner caused the complete or further tearing of the rotator cuff. Dr. Ho's opinion is consistent with Petitioner's testimony that in the 10 years of working for Respondent she never had to leave work to treat for right shoulder pain until March 7, 2012, and is also consistent with the March 6, 2012 medical note from Family Medicine Associates indicating some earlier aches in Petitioner's right shoulder and possible rotator cuff tendinitis.

Petitioner's rotator cuff tear is evidenced by Dr. Ho's testimony that he reviewed Petitioner's right shoulder MRI scan from May 9, 2012 and found classic findings of a rotator cuff injury including tearing of the rotator cuff, fat atrophy and acromial spurring. (PX1, pp. 13-14). Dr. Joel Swartz also indicated findings of a partial thickness tear. (PX3, p. 14). Moreover, as explained by Dr. Ho, the fact that Petitioner had complete relief of her symptoms for a short period of time following her injection is diagnostically consistent with Petitioner having a deep or full thickness rotator cuff tear. (PX1, p. 43).

Additionally, the Arbitrator puts greater weight on the testimony of Dr. Ho than Dr. Verma based on the fact that Dr. Verma's diagnosis is contradicted by his own testimony and contradicted by the findings contained within Petitioner's medical records.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that her current right shoulder condition is causally related to the accident on March 7, 2012.

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

Petitioner alleges the following medical bills were outstanding at the time of arbitration (PX7):

Riverside Corporate Health:	$1,154.00
Sherwin Ho, M.D.:	$1,476.00
Ryan Center for Hand Therapy:	$2,701.00
Total:	$5,331.00

Respondent disputed these bills on the basis of liability only.

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses as set forth above pursuant to §8(a) and subject to the fee schedule provisions of §8.2 of the Act.

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

Respondent's treating physician, Dr. Sherwin Ho, is recommending surgical repair for Petitioner's right shoulder consisting of right shoulder arthroscopy and subacromial decompression and assessment of the rotator cuff with potential repair. In order verify the diagnosis and need for surgery, Dr. Ho also recommended another right shoulder MRI. Dr. Ho testified that Petitioner's prognosis was good for a complete recovery following repair of her rotator cuff tear. Dr. Ho explained that the rotator cuff may continue to undergo atrophy and the tear may become larger and worse over time if untreated. (PX1, p. 24). Petitioner testified she wishes to undergo the surgical procedure recommended by Dr. Ho.

Respondent's §12 examiner, Dr. Verma, opined that Petitioner was not a candidate for an arthroscopic rotator cuff repair. However, Dr. Verma's opinion was not based on whether this surgery was reasonable or necessary for a patient with a rotator cuff tear. Rather, Dr. Verma's opinion that surgery was not necessary was premised on the fact that Petitioner had adhesive capsulitis and not a rotator cuff tear. As previously noted, the Arbitrator finds the opinion of Dr. Ho along these lines to be more persuasive.

Therefore, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to prospective medical treatment in the form of a right shoulder MRI and possible right shoulder arthroscopic surgery per the recommendation of Dr. Ho, and that Respondent shall be liable for the reasonable and necessary medical expenses associated therewith pursuant to §8(a) and fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The record shows that Petitioner was placed on modified duty work status on March 7, 2012 at Riverside Corporate Health. Petitioner testified she was accommodated for light duty work from March 7, 2012 to March 16, 2012. Petitioner was terminated from employment on March 16, 2012 because she tested positive for Adderall after undergoing her post-accident drug screen. (RX4, p 1). Petitioner testified she would have continued working light duty had she not been terminated.

Petitioner's physicians at Riverside Corporate Health and Dr. Sherwin Ho have kept Petitioner on modified duty work status since March 7, 2012. Dr. Ho testified that during the course of his treatment of Petitioner she was not capable of working at her old job without the appropriate modifications of her job. (PX1, p. 22). In his report, Respondent's §12 examiner, Dr. Verma, opined that work restrictions would be applicable. (RX2). Dr. Ho opined Petitioner's time off work since the injury is related to her injury and the tearing of the rotator cuff. (PX1, p. 26). Dr. Ho is recommending surgical repair as Petitioner requires further treatment.

The Arbitrator finds that Petitioner's medical condition has not stabilized and she remains temporarily totally disabled due to her work-related injury. Additionally, the Arbitrator notes that Petitioner's termination from employment does not relinquish Respondent of its obligation to pay TTD. (See *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132 (2010); holding that the determinative inquiry for deciding entitlement to TTD benefits to an injured employee is whether the claimant's condition has stabilized, and the employer's obligation to pay TTD benefits does not cease just because the employee had been discharged–whether or not the discharge was for "cause.").

Therefore, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from March 17, 2012 through January 24, 2014, the date of the hearing, for a period of 97 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEPHEN HARRIS,

Petitioner,

vs.

NO: 13 WC 4133
13WC 5821

ISLAND BAY YACHT CLUB,

15IWCC0229

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 medical expenses, causal connection, necessary treatment, 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 May 20, 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: MAR 2 7 2015
MJB/bm
o-1/26/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

HARRIS, STEPHEN
Employee/Petitioner

Case# **13WC004133**

13WC005821

ISLAND BAY YACHT CLUB
Employer/Respondent

15IWCC0229

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:

1189 WOLTER BEEMAN AND LYNCH
FRANK LYNCH
1001 S 6TH ST
SPRINGFIELD, IL 62703

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

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)

15IWCC0229

Stephen Harris
Employee/Petitioner

v.

Island Bay Yacht Club
Employer/Respondent

Case # 13 WC 4133

Consolidated cases: 13 WC 5821

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **March 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

15IWCC0229

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,480.00**; the average weekly wage was **$740.00**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **3** children under 18.

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

The parties agree that Respondent has paid the Petitioner temporary total disability benefits for all lost time attributed to Petitioner's injury to date.

ORDER

Respondent shall pay all reasonable and necessary medical services, 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 payments paid by group health insurance pursuant to Section 8(j) of the Act, if any, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent is entitled to a credit for all medical payments made by Respondent as reflected in RX 1 and 2.

Respondent is ordered to pay for all reasonable and necessary prospective medical care and diagnostic studies for Petitioner's left knee condition, subject to the fee schedule.

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

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

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

Signature of Arbitrator

May 16, 2014
Date

MAY 20 2014

15IWCC0229

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stephen Harris
Employee/Petitioner

Case Nos. 13 WC 4133
13 WC 5821

v.

Island Bay Yacht Club
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

These matters, 13 WC 4133 and 13 WC 5821, were consolidated at trial with the agreement of both parties. As such, the Arbitrator issues a single decision encompassing both claims.

FINDINGS OF FACT

On the date of accident, Petitioner was thirty four years of age. Arb. X 1. He had been employed by Respondent for fourteen years, and on April 26, 2012, he worked for Respondent as the building and grounds manager. Respondent maintains a large facility with a 75,000 square foot building sitting on thirteen acres, a portion of which was occupied by boats and boat trailers. As the building and grounds manager, Petitioner's job duties included general maintenance of the exterior buildings and grounds, as well as the repair of boats and boat docks, which involved squatting, lifting, stooping, and extensive use of his legs.

In 1999 or 2000, Petitioner injured his left knee while mowing grass at home in which he tore his anterior cruciate ligament. He was treated, and eventually underwent a reconstruction of that ligament. Petitioner testified that he recovered within six to eight weeks, and thereafter, he resumed his normal activities. He was working for Respondent at that time, and he testified that he was able to do his same job after he recovered from surgery. From the time of that incident until April 26, 2012, Petitioner testified that his left leg did not prevent him from doing any work or engaging in normal daily tasks, and it did not limit how much he could lift or run. He acknowledged the occasional ache in his left knee, but testified that any such aches were insignificant to the symptoms he now experiences. Petitioner did not receive any follow-up medical care prior to that injury, and never utilized a brace for his left knee.

On April 26, 2012, while attempting to step over a railing on a boat, Petitioner's left foot became caught on the railing, and Petitioner experienced a sharp pain on the inside of his knee. Petitioner testified that following the accident, he had some swelling all around the knee and the entire knee was somewhat enlarged.

Petitioner testified that Respondent sent him to Midwest Occupational Health Associates (MOHA) for treatment. PX 3. Petitioner was evaluated by Nurse Practitioner Tonya Heim on April 27, 2012. A physical examination revealed mild edema medially and pain with range of motion. A McMurray's sign was negative, and Petitioner was able to bear weight. Radiographs taken of the left knee revealed soft tissue swelling and postsurgical changes from an ACL reconstruction. Mild osteoarthritis was also identified. Petitioner was diagnosed with a left knee strain, and he was restricted to sit-down work only. PX 3.

On May 1, 2012, Petitioner returned to MOHA, at which time Petitioner reported improvement in his knee. He continued to experience pain at the end of the day. A physical examination revealed swelling on the medial aspect of the knee, and his diagnosis remained a left knee strain. Petitioner was prescribed medication, and physical therapy was ordered. He was also issued restrictions of no kneeling or squatting, no climbing stairs or ladders, and limited walking. PX 3.

On May 24, 2012, Petitioner again presented to MOHA. He reported doing some drilling at home the previous night when he tripped on a step. Petitioner did not have any problems or swelling at that time, and he was able to continuing working. He had pain in his left knee at the time of examination, as well as increased swelling on the inner part of the knee when he awoke in the morning. A physical examination showed minimal swelling to the medial surface of the patella, good range of motion, and no problems were noted. Petitioner was prescribed Bioskin and pain medication, and advised to continue his restrictions of light work, no kneeling or squatting, and no climbing stairs. PX 3.

An MRI of the left knee was performed on May 31, 2012, and it revealed postoperative changes following an anterior cruciate ligament graft, a strain or tendinopathy of the posterior cruciate ligament, complex tears of the medial meniscus and lateral meniscus, mild osteoarthritis, and an old longitudinal tear of the medial collateral ligament. PX 3.

Petitioner underwent physical therapy, but his condition did not improve. Dr. Jeffrey Brower referred him to Dr. Brett Wolters at Springfield Clinic, who diagnosed Petitioner with a new left knee medial meniscus tear and a lateral meniscus tear, a bone contusion of the left medial tibial plateau, and mild left knee degenerative joint disease. Dr. Wolters recommended an arthroscopic procedure to address the medial and lateral meniscus tears. PX 3.

Petitioner sought a second opinion from orthopedic surgeon, Dr. Michael Watson. Upon physical examination on June 19, 2012, Dr. Watson noted tenderness in the medial joint line, though no effusion was identified. Dr. Watson noted Petitioner's left knee to be stable, but a McMurray's maneuver was positive. Dr. Watson recommended an arthroscopic procedure on the left knee, and on September 6, 2012, Petitioner underwent a medial and lateral meniscus repair and surgical treatment for chondromalacia with chondroplasty. PX 1.

Following surgery, Petitioner remained off work, and he underwent physical therapy. PX 1.

On November 26, 2012, Dr. Watson noted Petitioner had significant improvement with his left knee. Petitioner still complained of occasional pain and of limping after walking for long distances. On examination, there was no effusion, and Petitioner had full range of motion. Petitioner complained of mild tenderness on the medial joint line. Dr. Watson recommended a

stabilizing brace for the knee. He discharged Petitioner from care and indicated Petitioner could return to work without restriction. PX 1.

Thereafter, Petitioner testified that he continued to have trouble with his left knee. Petitioner returned to Dr. Watson on February 26, 2013. Petitioner indicated that his pain never completely resolved, and reported suffering from severe pain along the medial joint line, as well as popping and intermittent locking episodes. On examination, Petitioner was noted to have a normal gait. McMurray's testing was negative, and all ligaments were thought to be stable. No effusion was noted, and the only finding was tenderness on the medial joint line. Radiographs were taken and revealed early degenerative disease. Dr. Watson diagnosed Petitioner with progressive chondromalacia with early degenerative arthritis. He recommended a series of Hyalgan injections, and allowed Petitioner to continue working without restrictions. PX 1.

Petitioner ultimately received the injections recommended by Dr. Watson from his primary care physician, Dr. Lewis. PX 3. Petitioner testified that after the injections were not approved by Respondent, he presented to Dr. Lewis, discussed Dr. Watson's recommendations, and he proceeded to undergo the injections with Dr. Lewis, which were paid by his health insurance provided through his wife's employment. Dr. Lewis then referred Petitioner for a second opinion to orthopedist, Dr. Hillard-Sembell. Petitioner presented to Dr. Hillard-Simbell on October 28, 2013, at which time she determined Petitioner's persistent pain could be related to the chronic osteoarthritis. PX 3.

The records from Springfield Clinic also indicate Petitioner suffered from facial fractures while playing football on Thanksgiving 2013. PX 3. Petitioner confirmed this information at trial.

On January 30, 2014, Dr. Hillard-Sembell reviewed Petitioner's prior ACL injury, his work injury of April 26, 2012, and Dr. Watson's surgery and his current recommendations for treatment. Dr. Hillard-Sembell stated that, given that Petitioner worked without restrictions and without pain for fourteen years prior to the work accident, Petitioner's meniscus tear was caused by the work accident of April 26, 2012, and his osteoarthritis was aggravated by same. She recommended an unloader brace and instructed him that he may need additional injections. Dr. Hillard-Sembell also ordered an MRI to determine if additional surgery is necessary, and discharged Petitioner from her care. PX 3.

Respondent obtained an examination pursuant to Section 12 of the Act with Dr. Richard Lehman. Following his examination of Petitioner and his review of the medical records and diagnostic studies, Dr. Lehman concluded Petitioner suffered from a strain as a result of the April 26, 2012 work accident. He also thought Petitioner was suffering from a neuroma at the medial portal which was due to the surgery performed by Dr. Watson. Dr. Lehman opined the tears of the medial meniscus and lateral meniscus were long-term and chronic in that they had cystic changes and were complex. Dr. Lehman further concluded Petitioner's knee strain resolved, and the need for further treatment was only related to the preexisting degenerative condition. He further opined that the ongoing soreness in the knee was consistent with a degenerative pattern. RX 3.

Dr. Lehman testified concomitantly with his report by way of evidence deposition on January 8, 2014. He opined that Petitioner suffered from a strain of the left knee as a result of the April 26, 2012 work accident, which had resolved as of the time of his examination on July 9, 2013. Dr. Lehman testified that nothing acute was noted on the MRI scan of May 31, 2012, and

consequently, he believed Petitioner reached maximum medical improvement with respect to the work injury as of that date. Dr. Lehman recommended additional treatment for Petitioner's knee, but he thought such treatment was to address Petitioner's degenerative arthritic condition in the knee and was unrelated to his work accident. Dr. Lehman expressly testified the work accident did not cause an exacerbation or an alteration of the preexisting degenerative condition, given the benign nature of the MRI and the chronicity of the changes on the diagnostic studies. Dr. Lehman explained that if Dr. Watson found a complex tear of the posterior horn of the medial meniscus in the face of an MRI that showed no fluid in his knee, it was virtually impossible to make a case for an acute process. RX 3.

Dr. Watson testified by way of evidence deposition on November 6, 2013. Dr. Watson testified that Petitioner's condition, and his need for ongoing treatment, are casually related to Petitioner's work accident of April 26, 2012. Dr. Watson acknowledged that Petitioner had a prior knee injury, but stated that Petitioner had a history of working full duty without pain for over ten years prior to the work accident. Dr. Watson opined that while part of the pathology of the Petitioner's left knee was degenerative in nature and the result of a prior injury, the work accident aggravated Petitioner's pathology so as to become symptomatic. Dr. Watson described the meniscus tears as being complex. He explained that a straight tear is usually from an acute injury, but he would not rule out that the complex tear could also be acute. Dr. Watson acknowledged that Petitioner's complaints of medial-sided knee pain would be inconsistent with the lateral meniscus tear, but he maintained the lateral meniscus tear was related to the work accident. He testified that in the absence of his work injury, Petitioner would not have required the original knee surgery and the post-operative treatment. PX 6.

At Arbitration, Petitioner testified that approximately a month after accident, he was walking into the door of his home when he tripped on a step. He does not recall if he suffered additional swelling in his left knee as a result of that incident.

Petitioner is currently working for Vibra Hospital, a long-term acute hospital in Springfield, as a maintenance technician. He has worked there since December 2012. Petitioner's job duties include outside maintenance, including picking up trash and repairing equipment on the roof, such as exhaust fans and chillers. He does not have to mow the lawn in his present position. He indicated that his present employment is not as strenuous was boat maintenance.

Petitioner testified that he is awaiting an unloader brace, an MRI, and an evaluation with Dr. Hillard-Sembell to determine if another surgery is indicated.

CONCLUSIONS OF LAW

The Arbitrator finds Petitioner to be credible, as he appeared truthful, sincere and forthright in his testimony and demeanor at Arbitration.

In regards to disputed issue (F), Respondent disputed Petitioner's condition of ill-being after May 31, 2012. Arb. X 1. In Illinois, it is well settled that employers take their employees as they find them. *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). An employee will not be denied recovery simply because of the presence of a pre-existing condition so long as it can be shown that the employment was also a causative factor. *Id.* "A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be

sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64 (1982).

The Arbitrator finds that Petitioner's condition of ill-being is causally related to Petitioner's work accident of April 26, 2012. In so finding, the Arbitrator finds significant that, despite Petitioner's prior injury to his anterior cruciate ligament nearly fourteen years prior, he resumed normal activities and returned to work for Respondent in a full duty capacity. No evidence was presented to indicate Petitioner had left knee complaints or treatment in any temporal proximity to April 26, 2012. The Arbitrator further finds that Dr. Watson's testimony and opinions appear to be credible and reliable, as do the opinions of Dr. Hillard-Sembell contained in her office note of January 30, 2014. The evidence from Dr. Watson and Dr. Hillard-Sembell recognize the unrebutted evidence that prior to the undisputed accident, Petitioner's left knee was asymptomatic and fully functional. The Arbitrator is not inclined to rely upon the opinions of Dr. Lehman, as his opinions fail to appreciate the significance of Petitioner's previous condition of good health in his left knee after having recovered from surgery to his anterior cruciate ligament for approximately fourteen years prior to the work accident, his ability to work for Respondent in a full duty capacity immediately up to and including April 26, 2012, and the change in his condition following the work accident.

Petitioner indicated having an incident at home approximately a month following his work accident in which he tripped on a step going into his home for which he sought treatment at MOHA on May 24, 2012. The Arbitrator does not find this event to be sufficient to interrupt the causal connection between the work accident of April 26, 2012 and his current left knee condition, as he was not yet at maximum medical improvement at that time, and there was no evidence presented to indicate that Petitioner's left knee condition or his symptoms significantly worsened, or that his treatment plan or prognosis changed as a result of that incident.

Based upon the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being in his left knee is causally related to the work accident of April 26, 2012.

In regard to the disputed issue (J), based upon the Arbitrator's findings with regard to disputed issue (F) and absent a dispute as to the reasonableness and necessity of the bills, the Arbitrator finds that Respondent is liable for medical bills relative to Petitioner's left knee condition contained in Petitioner's Exhibit 5, as said services were reasonable and necessary in the care and treatment of Petitioner. The Arbitrator finds the injections recommended by Dr. Watson and performed by Dr. Lewis were reasonable, necessary, and causally related to Petitioner's accident of April 26, 2012. Respondent shall pay all reasonable and necessary medical services, 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 payments paid by group health insurance pursuant to Section 8(j) of the Act, if any, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent is entitled to a credit for all medical payments previously paid as reflected in RX 1 and 2.

In regards to disputed issue (K), given the Arbitrator's findings with regard to disputed issue (F), the Arbitrator finds that Petitioner is entitled to prospective medical care and diagnostic imaging studies for Petitioner's left knee as recommended by Dr. Watson and Dr. Hillard-Sembell. Therefore, Respondent is ordered to pay for all reasonable and necessary prospective medical care and diagnostic studies for Petitioner's left knee condition, subject to the fee schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derondae Miller,

Petitioner,

vs.

NO: 09WC 19940

Buy-N-Save ,

15IWCC0230

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 5, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,421.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 7 2015

MJB/bm
o/03/24/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MILLER, DERONDAE
Employee/Petitioner

Case# **09WC019940**

BUY N SAVE COMPANY AND ILLINOIS WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0230

On 5/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

BUY N SAVE COMPANY
22240 GOVERNORS HWY
RICHTON PARK, IL 60471

5165 ASSISTANT ATTORNEY GENERAL
JEANNIE 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
CORRECTED ARBITRATION DECISION

Derondae Miller
Employee/Petitioner

v.

Buy N Save Company and
Illinois Workers' Benefit Fund
Employer/Respondent

Case # 09 WC 19940

Consolidated cases: _____

15IWCC0230

An *Application for Adjustment 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, IL**, on **March 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 _____

15IWCC0230

FINDINGS

On **March 19, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$14,105.00**; the average weekly wage was **$271.25**.

On the date of accident, Petitioner was **22** years of age, ***single*** with **0** children under 18.

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

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

Respondent 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

1. Respondent shall pay Petitioner temporary total disability benefits of $206.67/week for 4/7 weeks commencing March 27, 2009 through March 30, 2009, as provided in Section 8(d) of the Act.

2. Respondent shall be given a credit of $0 for temporary total disability payments that have been paid.

3. Respondent shall pay Petitioner permanent partial disability benefits of $206.67/week for 8.6 weeks because the injury sustained caused the 20% loss of use of the right index finger, as provided in Section 8(e) of the Act.

4. Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule, of $23,587.70 to St. James Hospital, $389.82 to Southland Bone & Joint, $497.59 to Consultants in Pathology, $4,964.93 to Henry Andoh, MD, $379.65 to Metro Infectious Diseases, $576.68 to Midamerica Cardiovascular Consultants, $248.00 to Chicago Heights Medical Center, $189.99 to Quest Diagnostics and $6,337.62 to Anthony Brown, MD.

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

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

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

Signature of Arbitrator

5/1/14
Date

MAY 2 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derondae Miller, **Petitioner,**	)	
vs.	)	**No. 09 WC 19940**
Buy-N-Save Company and **Illinois Workers' Benefit Fund** **Respondent.**	)	**15IWCC0230**

CORRECTED ADDENDUM TO ARBITRATION DECISION
Summary of Facts

Petitioner sought relief from Respondent-Employer, Buy-N-Save and from the Illinois Injured Workers' Benefit Fund because the employer did not maintain workers' compensation insurance. 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 22 years old and began working at the Buy-N-Save grocery store as a grocery bagger, cart pusher, and shelf stocker from 2004 until the date of the accident. Petitioner testified that he was hired by Mr. Zayyad who represented himself as the President of Buy-N-Save. Petitioner further testified that Mr. Zayyad functioned as Petitioner's supervisor. Petitioner testified that he worked 35-40 hours a week and was paid $7.75 per hour.

Petitioner testified that on March 19, 2009, he was single with no dependents working at Buy-N-Save. Petitioner was instructed by Mr. Zayyad to clean off the top of a shelving unit in the store. Petitioner testified that the shelving unit was steel and the top of the unit was covered with dirt, dust, and possibly feces from rodents. Petitioner testified that he was not wearing any gloves and he cut his right index finger on the shelving unit while he was cleaning. Petitioner testified that he continued to work for the remainder of his shift and did not tell anyone about the injury that day. Petitioner returned to work the next day. Petitioner testified that he noticed his finger was beginning to swell that morning and continued to swell throughout the day. Petitioner testified that while at work his finger began to hurt and he noticed the skin was darkening. Petitioner testified that he then told his supervisor that he injured his index finger the day before and would not attend work the next day, March 21, 2009, because he planned to go to the hospital to have his finger checked.

Petitioner visited St. James Hospital in Chicago Heights, IL on March 24, 2009. (PX 1). The records show that Petitioner presented with an infected right index finger that Petitioner told the ER staff "started off as a paper cut" and progressively worsened for two days. *Id.* Due to Petitioner's condition, the medical provider admitted Petitioner to the hospital that same day. The records reflect that Petitioner noticed a small cut to his right index finger five days prior and applied Neosporin and soaked the finger. *Id.* Petitioner was diagnosed with cellulitis and an abscess on his right index finger. (PX 1). An x-ray of the right index finger was normal and an examination revealed swelling of the proximal interphalangeal joint, restricted motion, and a raised brownish tender area on the radial aspect of the middle phalanx with surrounding swelling. *Id.*

On March 25, 2009, hospital records reflect that a surgical procedure was performed in which an incision was made to the injured finger in order to drain the abscess. The postoperative diagnoses were chronic necrotizing infection of the right index finger and septic arthritis of the proximal interphalangeal joint. *Id.* Dr. Charo examined Petitioner on March 26, 2009 and noted Petitioner had a Staphylococcus infection. *Id.* Dr. Charo ordered additional tests to rule out any other issues. Dr. Kamin provided a cardiology consultation due to Petitioner's abnormal electrocardiogram on March 26, 2009. Dr. Brown cleansed the wound and excised necrotic tissue he found in the wound on March 27, 2009. *Id.* Dr. Andoh consulted on the matter on March 27, 2009. (*Id.*; *see also* PX 3). Petitioner was discharged from St. James Hospital on March 28, 2009 and was told to follow up with Dr. Brown.

Petitioner returned to Dr. Brown on March 30, 2009. (PX 2). At that time Dr. Brown examined the wound and applied a peroxide soak. *Id.* Petitioner did not attend an apparently scheduled follow up appointment on March 31, 2009. *Id.* Petitioner testified that he has never sought any additional medical care for his injury since March 30, 2009.

Petitioner testified that he called his supervisor on April 1, 2009 to inform him that treatment for the injury was complete and that the supervisor told him that Petitioner's job had been filled and was no longer available.

Petitioner testified that he suffered no previous injuries to his right index finger. However, the records do reflect that Petitioner sustained an injury to his right ring finger in approximately 2003 which did result in hospitalization due to an infection. (PX 1). Petitioner testified that his right index finger is still somewhat stiff and bulges more than his left index finger. Petitioner also complained of a permanent scar on the finger. The Arbitrator examined Petitioner's finger and noted a flesh colored slightly raised scar approximately two to two and a half inches long. Petitioner testified that he currently works as a steward at Prestwick Country Club. His primary duties are food preparation and washing dishes. Petitioner testified that he notices less strength when gripping and preparing food. Petitioner testified that he has not returned to any doctor since March 30, 2009 for any complaints regarding his right index finger and at the time of the hearing had no scheduled appointments. Petitioner is not currently taking any prescription medications but did testify that he occasionally takes over the counter aspirin.

Petitioner submitted bills from the following medical providers for medical care related to his injury:

St. James Hospital, $23,587.70. (PX 4)

Southland Bone & Joint, $389.82. (PX 5).
Consultants in Pathology, $497.59. (PX 6).
Dr. Henry Andoh, $4,964.93. (PX 7).
Metro Infectious Disease, $379.65. (PX 8).
Mid America Cardiovascular Consultants, $576.68. (PX 9).
Chicago Heights Medical Consultants, $248.00. (PX 10).
Quest Diagnostics, $189.99. (PX 11).
Dr. Anthony Brown, $6,337.62. (PX 12).

CONCLUSIONS OF LAW

Respondent was operating under/subject to the Illinois Workers' Compensation Act
Petitioner testified that at the time of the accident he was employed by Buy-N-Save as a grocery bagger, cart pusher, and shelf stocker. Petitioner testified that he injured himself while cleaning a shelving unit in the store. Petitioner presented evidence showing that he received at least $3,130.23 in wages in the year preceding the work incident. (PX 13). The Arbitrator finds that the employer Buy-N-Save is subject to the automatic coverage provision of Section 3.17 of the Act.

An employee-employer relationship existed
Petitioner testified that he was hired by Jamel A. Zayyad in 2004. His paychecks had hourly earnings with the usual federal and state withholding taxes. Petitioner testified on cross-examination that he received W-2 forms from Buy-N-Save annually. Petitioner testified that Mr. Zayyad directed and controlled his daily activities including telling Petitioner to clean a dirty shelf on March 19, 2009.

The Arbitrator finds that an employer-employee relationship existed between Petitioner and Buy N Save Company on March 19, 2009.

An accident occurred that arose out of and in the course of Petitioner's employment by Respondent
Petitioner testified that Mr. Zayyad instructed Petitioner to clean off the top of a metal shelving unit in the store on March 19, 2009. Petitioner testified that he was not provided any gloves and the shelving unit was covered in debris, dirt, and possibly rodent feces. Petitioner testified he cut his right index finger on the metal shelving unit. The records of St. James Hospital of March 24, 2009 contain a history of a laceration sustained five days earlier. The Arbitrator observed Petitioner and found him to be a credible witness.

Based on Petitioner's credible testimony and the corroborating medical records, the Arbitrator finds that Petitioner sustained an accidental injury on March 19, 2009 which arose out of and in the course of his employment with Buy-N-Save Company.

Date of the Accident
Petitioner testified that the work accident occurred on March 19, 2009. The medical records support Petitioner's claim that he suffered an injury to his right index finger on or around that date. Therefore, the Arbitrator finds the accident occurred on March 19, 2009.

Notice
Petitioner testified that he informed Mr. Zayyad of his injury during his shift the day following the accident and that he would seek treatment the next day at the hospital. Petitioner further testified that he called Mr. Zayyad on April 1, 2009, to inform him that treatment for the injury was complete. The Arbitrator finds that Petitioner did provide timely notice of the accident to Buy-N-Save.

Causal Connection to the Injury
Petitioner testified that he cut his right index finger while cleaning off the top of a metal shelving unit. He further testified that his finger began to swell and hurt within one day of the accident. Petitioner testified that the day after the accident he noticed a discoloration on his right index finger. The medical records support Petitioner's testimony that he cut his right index finger which became infected and required surgery to clean the wound and remove all infected tissue. The Arbitrator finds Petitioner's injury is causally related to his work accident.

Petitioner's Earnings
Petitioner claimed he earned $15,600.00 in the year preceding the accident and had an average weekly wage of $300.00. Petitioner testified that he worked for Buy-N-Save since 2004 and was paid by check. Petitioner further testified that he was paid $7.75 per hour and worked 35-40 hours each week with an unpaid lunch. The Arbitrator finds that on the date of accident the Petitioner had an average weekly wage of $271.25 ($7.75 x 35 hours).

Petitioner's age at the time of the accident
Petitioner testified that he was 22 years old on March 19, 2009. The Arbitrator finds Petitioner was 22 years old on March 19, 2009.

Petitioner's marital status at the time of the accident
Based on Petitioner's testimony, the Arbitrator finds that Petitioner was single with no dependents on March 19, 2009.

Medical Services were Reasonable and Necessary
The Petitioner was admitted to St. James Hospital from March 24, 2009 to March 28, 2009, for treatment of an infection caused by the laceration to his right index finger. Petitioner underwent two surgical procedures to debride necrotic tissue from the right index finger. Petitioner followed up with the surgeon, Dr. Brown, on March 30, 2009. Based on the above, the Arbitrator finds that the medical and hospital services rendered were reasonable and necessary.

Petitioner presented medical bills which he testified were paid by his mother's group insurance carrier. There is no evidence that Respondent Buy-N-Save Company paid any portion of the medical bills.

The Arbitrator finds that Respondent shall pay to Petitioner the following medical expenses:

St. James Hospital, $23,587.70
Southland Bone & Joint, $389.82
Consultants in Pathology, $497.59
Henry Andoh, MD, $4,964.93
Metro Infectious Diseases, $379.65
MidAmerican Cardiovascular Consultants, $576.68
Chicago Heights Medical Center, $248.00
Quest Diagnostics, $189.99
Anthony Brown, MD, $6,337.62.

Temporary Benefits

Petitioner testified that he completed his shift on March 19, 2009 and that he worked the following day. Petitioner then sought treatment at St. James Hospital on March 24, 2009 where he was hospitalized until March 28, 2009. He last saw Dr. Brown on March 30, 2009 when he reached maximum medical improvement.

The Arbitrator finds that Petitioner was temporarily totally disabled for one week, from March 24, 2009, the first date of treatment, through March 30, 2009, the date of maximum medical improvement. After allowing for the 3 day waiting period pursuant to section 8(b) of the Act, the Arbitrator finds that the Petitioner is entitled to receive 4/7 of a week in TTD benefits from Respondent at the statutory minimum rate of $206.67

Nature and Extent of the Injury

Petitioner sustained a cut on his right index finger which ultimately became infected and required hospitalization and surgery to clean the infected wound. Petitioner was diagnosed with cellulitis and an abscess on his right index finger. Petitioner received treatment from March 24, 2009 through March 30, 2009. Petitioner testified that he has never sought any additional treatment since his last doctor visit on March 30, 2009.

Petitioner testified that his right index finger is still stiff and "bulges" a little compared to the left index finger. Petitioner also complained of a scar on his right index finger. The Arbitrator observed the finger and noted a flesh colored slightly raised scar approximately two to two and a half inches long on the right index finger. The Arbitrator did not note any bulges as compared to the left index finger. Petitioner did not return to his job at Buy-N-Save; however, this was not due to any long term effects of his injury. Petitioner testified that when he completed his medical treatment he called Mr. Zayyad and Mr. Zayyad told Petitioner he had already filled Petitioner's position. Petitioner is currently employed as a steward at Prestwick Country Club. Petitioner's main duties in his current job are food preparation and washing dishes. Petitioner testified that he notices decreased strength when gripping and when preparing food. Petitioner also testified that he takes over the

counter aspirin several times a week. Petitioner is not taking any prescription medication for this injury and has not taken any prescription medication since March 30, 2009.

The Arbitrator notes that although Petitioner has a scar on his right index finger, the observed scar does not rise to the level of "serious and permanent disfigurement" as required by Section 8(c) of the Act. Furthermore, disfigurement is not awarded when compensation is awarded pursuant to Section 8(e) of the Act. Based on the foregoing, the Arbitrator finds Petitioner sustained a 20% loss of his right index finger pursuant to Section 8(e) of the Act.

Other: Insurance

The Arbitrator finds the Respondent Buy-N-Save did not have insurance based on proof of non-insurance as provided by NCCI.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sabino Vazquez Gonzales,
Petitioner,
vs.

NO: 11WC 24220

Most Valuable Personnel,
Respondent,

15IWCC0231

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 partial 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 April 22, 2014, is hereby affirmed and adopted.

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

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

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

DATED: MAR 27 2015
MJB/bm
o/3/23/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VAZQUEZ GONZALEZ, SABINO
Employee/Petitioner

Case# **11WC024220**

15IWCC0231

MOST VALUABLE PERSONNEL
Employer/Respondent

On 4/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1554 LAW OFFICES OF ALBERT R PINO LTD
3900 MERCY DR
McHENRY, IL 60050

4799 KOREY LAW LLC
NICOLAS TATRO
20 S CLARK ST SUITE 500
CHICAGO, IL 60603

15IWCC0231

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

Sabino Vazquez Gonzalez
Employee/Petitioner

v.

Most Valuable Personnel
Employer/Respondent

Case # **11** WC **024220**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **2/27/2014**. 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 _____

15IWCC0231

FINDINGS

On **06/03/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$2,225.44**; the average weekly wage was **$317.92**

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

Respondent shall be given a credit of **$2,566.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$8,518.43** for other benefits, for a total credit of **$11,084.57**.

No permanent partial disability 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 current condition is not causally connected to the accident.

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

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

#01 George V Andros
Signature of Arbitrator

April 17th, 2014
Date

APR 22 2014

Findings of Facts 11 WC 24220

On June 4, 2011, Petitioner was working at Visual Pak. Petitioner was a temporary labor employee of Most Valuable Personnel ("MVP") and had been working at Visual Pak on assignment from MVP for about a month and a half. Petitioner was walking through the warehouse when Valente, a forklift driver, backed out of a bay, honked his horn and accidentally bumped into Petitioner. Rx5. Petitioner was taken to Vista Medical Center (hereinafter "Vista") following the accident.

At Vista, Petitioner underwent a battery of diagnostic tests, which included x-rays to the chest, lumbar spine, thoracic spine, knee and pelvis. Px7. No acute findings were seen on any of these examinations. *Id.* Petitioner's lumbar spine x-ray did show that Petitioner suffers from osteoporosis and had mild to moderate degenerative joint disease. *Id.* Petitioner was diagnosed with contusions to the low back, left knee, abdominal wall and chest wall and was released from care. *Id.* Petitioner was seen by Vista again on June 6, 2011 and was given work restrictions of no lifting over ten pounds, limited bending and stooping, and alternating sitting and standing as needed. *Id.* and Rx5.

On June 6, 2011, Petitioner met with MVP representatives who together completed the "IR Package". Rx5. The IR Package consisted of accident investigation reports, along with a medical record release form and an offer of transitional duty, or light duty work.[1] *Id.* According to the testimony of Daniel Vargas, Respondents safety coordinator, Petitioner was offered a job at MVP's Waukegan office performing light janitorial and office work. According to the transitional duty form, Petitioner was to begin work on June 9, 2011 and was to work from 9 am to 12 pm, five days a week. *Id.* Mr. Vargas testified that Petitioner would be paid minimum wage for his light duty work.[2] Petitioner testified that he refused the light duty job. Petitioner never performed any light duty work.

According to Petitioner's testimony, Petitioner next spoke with Grupo MedLegal about what he should do next for his Workers' Compensation Claim. Petitioner was referred by Grupo MedLegal to see the chiropractors of Spine & Joint Institute of Lake County. Petitioner first saw Spine & Joint of Lake County on June 7, 2011 and it was noted that Petitioner had been experiencing low back and left knee pain. Px8. Petitioner was diagnosed with low back injury and left knee injury and was taken off of work for two weeks. *Id.* Additionally, Petitioner immediately was fitted for a back brace and was referred to see a pain management doctor. *Id.* Petitioner would undergo about five months of chiropractic treatments with Spine & Joint Institute. *Id.*

On June 8, 2011, Petitioner saw Dr. Suneela Harsoor, a pain management physician, to begin pain management treatment. Px9. Dr. Harsoor noted that Petitioner was suffering from low back pain and left knee pain. *Id.* Dr. Harsoor recommended that Petitioner undergo an MRI of his low back. *Id.* On June 28, 2011, Petitioner underwent an MRI of his lumbar spine at

[1] The medical record release form and offer of transitional duty are written in Spanish. A blank English version of the transitional duty form was provided and entered into evidence as Rx4.

[2] The Illinois minimum wage in 2011 was 8.25 / hour. *See* http://www.dol.gov/whd/state/stateMinWageHis.htm.

Lakeshore Open MRI and CT which revealed multilevel degenerative changes throughout Petitioner's lumbar spine. Px10. On July 20, 2011, Dr. Harsoor noted that Petitioner's MRI revealed degenerative disc disease and Dr. Harsoor released Petitioner to return to light work. Px9. At trial, Petitioner testified that Respondent did not accommodate this light duty work; however, on cross-examination, Petitioner admitted that he never attempted to return to light duty work and he never brought Respondent a copy of any light duty release slip or made Respondent aware of the light duty restrictions in any way. On August 9, 2011, Petitioner underwent a lumbar epidural injection at Rogers Park One Day Surgery Center. Px11. The injection was administered by Dr. Harsoor. *Id.* Dr. Harsoor noted that day that Petitioner's diagnosis was lumbar disc herniation, despite never having made such a diagnosis previously. *Id.*

At the request of Respondent, Petitioner saw Dr. Alexander Ghanayem of Loyola University Medical Center for a section 12 exam. (hereinafter "IME") on October 5, 2011. According to his report, Petitioner stood with normal posture and walked with a normal gait. Rx1. Petitioner complained solely of low back pain, as well as pain in his knee. *Id.*, Rx2 at 16. Dr. Ghanayem reviewed Petitioner's MRI report and noted that it showed multilevel lumbar disc degeneration which was consistent with a person Petitioner's age. Rx1. A small annular tear at the L4-5 which was consistent with one that had been present for a long time, given the hydration issues seen on the film, was also present. *Id.* Dr. Ghanayem noted that no true disc herniation or other traumatic lesion was present. *Id.* Dr. Ghanayem concluded that Petitioner had reached maximum medical improvement and believed that Petitioner could return to full duty work. *Id.* Dr. Ghanayem believed that, at most, Petitioner sustained a low back strain, aggravating his pre-existing degenerative disc problems. *Id.* Additionally, Dr. Ghanayem stated that the epidural that Petitioner underwent on August 9, 2011 was neither reasonable nor necessary, as Petitioner lacked both radicular pain and neurologic compression on his MRI scan. *Id.* Dr. Ghanayem believed that physical therapy of one or two months would have been appropriate care. Rx2 at 17. Dr. Ghanayem did not think that Petitioner was a candidate for surgery of any kind and was not in need of any epidural injections. *Id.* at 15-16.

Petitioner next saw Dr. Michel Malek on November 9, 2011. According to Dr. Malek's visit note, Petitioner complained of pain in his low back and "that pain *does not* radiate down the lower extremity, but is distinctly central in the spine," since the date of the accident. Px12, emphasis added. Dr. Malek diagnosed Petitioner with a lumbar musculoligamentous sprain and non-radicular low back pain and recommended that Petitioner undergo a second and third epidural steroid injection. *Id.*

In his next report dated November 17, 2011, Dr. Malek wrote in response to Dr. Ghanayem's IME report. *Id.* Dr. Malek wrote that "Dr. Ghanayem failed to take an adequate history from the patient stating that the patient has no radicular symptoms…" *Id.* Dr. Malek reiterated his opinion that Petitioner was in need of further epidural injections. *Id.* Amongst the list of items under the heading "Diagnosis," Dr. Malek listed "non-radicular low back pain." *Id.*

Conclusions of Law

In regards to disputed issue (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds in the following:

The Arbitrator concludes that Petitioner has failed to prove that his current condition of ill being is causally related to his injury. Therefore, Petitioner's claim for compensation is hereby denied. The Arbitrator adopts the opinions of Dr. Ghanayem.

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). "[C]laimant has the burden of showing by a preponderance of credible evidence that his injury arose out of and in the course of employment, which requires a showing of causal connection." *Id.*

In *Horath*, the claimant was "stripping forms" at work on top of his company building. *Id.* at 1346. Claimant and other workers were holding ropes attached to a steel form to stabilize said forms while they were lowered. *Id.* While claimant held a rope located across his back, a gust of wind caused the form to which this rope was attached to rotate, pulling claimant into a stack of steel bars. *Id.* Following this accident, claimant felt pain in his left leg, back, neck and left arm. *Id.* Later, claimant was accused of giving varying versions of his accident to different treating physicians. *Id.* Eventually, the arbitrator found that claimant failed to show his ill-being was causally connected to his workplace accident. *Id.* at 1347. On appeal, the Commission affirmed the arbitrator's decision that there was a lack of causal connection between claimant's state of ill-being and his workplace accident. *Id.* at 1348. Subsequently, the Supreme Court of Illinois affirmed the decision, as it was not against the manifest weight of the evidence. *Id.* at 1349. Special weight was given to claimant's inconsistent testimony and statements to treating medical professionals. *Id.* Because the Commission determined that claimant's testimony and statements lacked credibility, the judgment of the circuit court against claimant was affirmed. *Id.*

In the instant matter, Petitioner made several inconsistent statements to his treating doctors, leading to inaccurate causal connection opinions, which are ultimately unreliable and not sufficient to support a finding of causal connection. When seen initially at Vista on June 4, 2011, Petitioner stated that he was hit by a forklift at work on his left side and was thrown to the ground, which caused pain to his left knee and lower back. Px7. Petitioner was next seen on June 7, 2011 by Spine & Joint Institute of Lake County wherein he stated that he was run over by a forklift which caused him to fly a couple of feet away. Px8. Petitioner then revised his story again when he saw Dr. Harsoor on June 8, 2011 when he stated that a forklift "bumped him," and he fell forward on his left knee and onto his side. Petitioner's story underwent its final rewrite when he saw Dr. Malek on November 9, 2011 and stated that a forklift struck him causing him to fall on his left knee and back, and that a pallet hit him in the lower extremity as well. Px12. Petitioner further told Dr. Malek that as he fell, he felt a twisting sensation in his back. *Id.* Finally, Petitioner told Dr. Malek that initially, only his knee was in pain. *Id.*

"A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines*, 2012 WL 440353 at 13 (Ill. Indus. Com'n) interpreting *Horath v. Industrial Commission*, 96 Ill.2d 349 (Ill. 1983). It is unclear from the record which of Petitioner's many versions of events is the actual version of events and whether Petitioner's alleged accident resulted in both knee and back pain, or just knee pain is in doubt.

Based upon the totality of the evidence, the Arbitrator concludes that Petitioner failed to prove that his current condition of ill being is causally connected to his alleged work accident.

In regard to disputed 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 the following:

Having determined that Petitioner failed to prove that that his current condition of ill being is causally connected to his alleged work accident, the Arbitrator concludes that the medical services provided to Petitioner were not reasonable and necessary and Respondent is not required to pay for any charges of said medical services. Opinions of Dr. Ghanayem are adopted.

Should the Arbitrator have concluded differently in regards to disputed issue (F) above, the Respondent states the following:

Petitioner claims the following medical bills remain outstanding:

1) Spine & Joint Institute of Lake County: $19,765.49 (6/7/11 to 11/8/11)
2) Advanced Medical Supplies: $5,477.09 (6/7/11 to 11/8/11)
3) Transit Rehab Centers: $645.00 (6/9/11 to 6/23/11)
4) Steven's Mail Order Pharmacy: $950.05 (8/26/11 to 8/29/11)
5) Waukegan Pain Clinic: $8,771.00 (6/8/11 to 7/20/11)
6) Lakeshore Open MRI: $1,601.57 (6/28/11)
7) Rogers One Day Surgery: $9,456.56 (8/9/11)
8) Paulina Anesthesia Associates: $900.00 (8/9/11)
9) Dr. Michel Malek: $460.00 (11/9/11 to 11/17/11)

In regards to the medical bill from Steven's Mail Order Pharmacy, at hearing Respondent produced evidence that it paid in full for the billing provided by EQMD. Rx7. In reviewing the billing provided by Petitioner for Steven's Mail Order Pharmacy, the billing provider noted on that billing is noted to be "EQMD". Px2c. Therefore, Respondent has proven that the billing for Steven's Mail Order Pharmacy has been paid in full and no further payments need be made.

In regards to the balance of the medical bills that Petitioner claims remain outstanding, the IME report of Dr. Ghanayem is instructive as to which, if any, of the remaining medical bills are compensable pursuant to the Illinois Workers' Compensation Act. According to Dr. Ghanayem, if Petitioner sustained an injury at all as a result of his alleged work accident, Petitioner sustained a mere strain and aggravation of his pre-existing lumbar degenerative disc disease. Rx1.

According to Dr. Ghanayem, appropriate treatment for such an injury would include one or two months of physical therapy. Rx2 at 17. Dr. Ghanayem further stated that Petitioner did not suffer from a compressive lesion to his lumbar spine and he did not complain of radicular pain; therefore, Petitioner did not require an epidural steroid injection. Rx1.

Based on the opinions of Dr. Ghanayem, the Arbitrator concludes that the care provided by Advanced Medical Supplies, Waukegan Pain Clinic, Rogers One Day Surgery, Paulina Anesthesia Associates and Dr. Michel Malek were neither reasonable nor necessary and Respondent is not responsible for such charges. These bills relate entirely to the administration of the epidural steroid injection or post-date Dr. Ghanayem's IME report.

Additionally, in reviewing medical bills from Spine & Joint Institute of Lake County and Transit Rehab Centers, it appears as though Petitioner underwent physical therapy at both locations on June 9, 2011 and June 23, 2011. Px2 and Px2b. This is patently excessive and neither provider should be compensated for such overtreatment. Given that Dr. Ghanayem concluded that one month of physical therapy was appropriate for Petitioner's care, and Spine & Joint Institute of Lake County provided over five months of physical therapy to Petitioner, such care is clearly excessive and the Arbitrator declines to award payment of any of the bills. Therefore, the Arbitrator concludes that the care provided by Spine & Joint Institute of Lake County and Transit Rehab Centers was neither reasonable nor necessary and Respondent is not responsible for such charges.

The Arbitrator concludes that Respondent is liable for payment of the MRI bill of Lakeshore Open MRI. Payment will be made pursuant to the Medical Fee Schedule.

The Arbitrator finds the conclusions of Dr. Malek, that Dr. Ghanayem's opinions were based on faulty history of Petitioner's injury, to be without merit. Dr. Malek's own record, dated November 9, 2011, states that Petitioner's pain is entirely located in his lower back and does not radiate into his leg. Px12. Dr. Malek's contention that Petitioner suffered from radiating pain, requiring epidural steroid injections, is not even supported by his own records. Therefore, the opinions of Dr. Malek are found to be not credible.

In regard to disputed issue (K), what temporary benefits are due (TTD), the Arbitrator finds the following:

Having determined that Petitioner failed to prove that his current condition of ill being is causally connected to his alleged work accident, the Arbitrator finds that Petitioner's demand for TTD benefits is hereby denied.

In regard to disputed issue (L) What is the nature and extent of the injury, the Arbitrator finds the following:

Having determined that Petitioner failed to prove that his current condition of ill being is causally connected to his alleged work accident, the Arbitrator concludes that no permanent partial disability benefits are due and owing in the case at bar.

In regard to disputed issue (M) Should penalties or fees be imposed upon Respondent, the Arbitrator finds the following:

Having determined that Petitioner failed to prove that his current condition of ill being is causally connected to his alleged work accident, the Arbitrator concludes that the there are no penalties or fees imposed upon the Respondent.

In regard to disputed issue (N) Is Respondent due any credit, the Arbitrator finds the following:

Respondent shall be given a credit of $2,566.14 for temporary total disability payments, and $8,518.43 for other benefits, for a total credit of $11,084.57. Petitioner stipulated to the temporary total disability payment prior to trial and Respondent produced evidence of the $8,518.43 in other benefit payments at trial. *See* Rx6 – 7.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

☒ 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 BECK,

Petitioner,

vs.

NO: 13WC1858

KEMPER VALVE & FITTING Co.,,

15IWCC0232

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

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

15IWCC0232

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

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

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

DATED: MAR 2 7 2015
MJB/bm
o/03/24/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

BECK, KEVIN
Employee/Petitioner

Case# **13WC001858**

KEMPER VALVE AND FITTING CORP
Employer/Respondent

15IWCC0232

On 7/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
EDWARD L HENNESSY
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0232

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)

KEVIN BECK
Employee/Petitioner

v.

KEMPER VALVE AND FITTING CORP.,
Employer/Respondent

Case # 13 WC 01858

Consolidated cases: NONE .

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Woodstock**, on **May 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 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 **$24,305.42**; the average weekly wage was **$467.41**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $ **2,047.52** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **2,047.52**.

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

ORDER

Respondent shall pay to Petitioner temporary total disability benefits of **$311.60**/week for **69-1/7** weeks, commencing **January 10, 2013** through **May 9, 2014,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary total disability benefits that have accrued from **October 25, 2012** through **May 9, 2014,** and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay to Petitioner the cost of reasonable and necessary medical services, pursuant to the Medical Fee schedule, in the amount of **$128,961.42**, as provided in Section 8(a) and 8.2 of the Act.

Respondent is ordered to provide and pay for the physical therapy and continued rehabilitative care as prescribed by Dr. Theodore Fisher.

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

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

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

Signature of Arbitrator **JOANN M. FRATIANNI**

June 30, 2014
Date

ICArbDec19(b)

JUL 8 - 2014

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

Petitioner works for Respondent as a CNC lathe operator. His job duties included loading and unloading metal parts out of machines. The metal parts can weigh 50 pounds. On October 25, 2012, Petitioner was pulling a piece of metal out of a machine when the piece fell. Petitioner attempted to grab or catch the piece and stop it from falling with his right arm. As he did so, he experienced severe pain in his right shoulder and neck.

Following this episode, Petitioner continued working the remainder of his shift.

The next day, he reported to work and notified his supervisor of the accident. Respondent then sent him to Centegra Occupational Health where he was provided pain medication, prescribed light duty and was referred to see an orthopedic surgeon.

Following this visit, Petitioner worked light duty for Respondent. He then returned to Centegra Occupational Health on October 29, 2012 and was prescribed a right shoulder MRI. During this visit, Petitioner complained of tingling in his right fingers. The MRI was performed on October 30, 2012 and revealed likely bursitis and edema. Following the MRI, Petitioner remained under the care of this clinic through November 29, 2012.

Petitioner then sought treatment with Dr. Richard Caner, a pain specialist. Petitioner first saw Dr. Caner on December 4, 2012, as the pain in his right shoulder and neck did not subside. Dr. Caner prescribed physical therapy for Petitioner's preexisting lower back condition along with pain medication. (Px5)

Petitioner then sought treatment with Dr. Robert Nixon, an orthopedic surgeon. This was on referral from Centegra Occupational Health. Dr. Nixon diagnosed a rotator cuff strain but felt the symptoms may have a secondary source from his cervical spine. Dr. Nixon performed a subacromial injection to the right shoulder and prescribed physical therapy and light duty work.

Petitioner continued working light duty and underwent several therapy sessions from January 7, 2013 through January 11, 2013. (Px4)

On January 10, 2013, Respondent laid Petitioner off from work. Petitioner also saw Dr. Caner on January 10, 2013, who recommended he follow up with an orthopedic surgeon for his shoulder and neck conditions.

Petitioner then saw Dr. Nixon on January 16, 2013, who prescribed a cervical MRI. This MRI was performed on January 18, 2013 and revealed a disc protrusion at C6-C7 with central canal stenosis. Petitioner then returned to see Dr. Caner on January 28, 2013, who prescribed additional pain medication.

Petitioner then saw Dr. Jay Levin on February 25, 2013. This examination was at the request of Respondent. Dr. Levin was of the opinion that Petitioner sustained an injury to his right shoulder and required a review of the right shoulder MRI to finalize his opinion.

Petitioner then saw Dr. Caner on February 28, 2013, who considered an epidural steroid injection to the shoulder. Dr. Caner advised Petitioner to continue treatment with his orthopedic surgeon.

Dr. Levin then authored an addendum to his first report on March 5, 2013, repeating his opinion that a right shoulder sprain was sustained but no neck injury. Dr. Levin further was of the opinion that Petitioner had reached maximum medical improvement and could return to full duty work.

Petitioner then saw Dr. Caner on March 28, 2013 with complaints of increased neck pain. Dr. Caner noted the right shoulder pain was stable but the neck pain had increased. Dr. Caner noted that approval of his prior prescription for physical therapy was not given by Respondent. Dr. Caner instructed Petitioner to follow up with his orthopedic surgeon.

Petitioner then saw Dr. Nixon on April 4, 2013. Dr. Nixon prescribed a cervical MRI. On May 1, 2013, Dr. Nixon again diagnosed a herniated cervical disc and prescribed an evaluation with a spine specialist.

On June 10, 2013, Petitioner saw Dr. Theodore Fisher, an orthopedic surgeon. Dr. Fisher diagnosed a C6-C7 right paracentral herniated nucleus pulposus, right arm radiculopathy in the C7 nerve root distribution and C4-C5 central herniated nucleus pulposus. Dr. Fisher prescribed physical therapy and a course of cervical epidural steroid injections. Dr. Fisher also prescribed that Petitioner remain off work. Petitioner commenced physical therapy on June 18, 2013 and underwent two cervical epidural steroid injections with Dr. Caner, the first on June 25, 2013 and the second on July 16, 2013. Petitioner testified these injections failed to alleviate his neck symptoms.

Petitioner then returned to see Dr. Fisher on July 22, 2013. Dr. Fisher prescribed a C6-C7 cervical discectomy and fusion due to the failure of conservative medical care. Petitioner underwent this surgery with Dr. Fisher on August 27, 2013.

Post surgery, Petitioner has been visiting Dr. Fisher on a monthly basis, who has continued to prescribe that he remain off work. On February 28, 2014, physical therapy was prescribed along with a neck CT scan. Respondent has refused to authorize such testing and treatment.

Petitioner testified he wishes to complete his physical therapy as prescribed by Dr. Fisher. Petitioner further testified he has a history of low back pain that started in 2005. Petitioner testified he had previously treated with Dr. Caner for that condition and was diagnosed with degenerative disc disease. Petitioner testified he had no physical problems performing his job prior to October 25, 2012. He acknowledged he received a written warning from Respondent for excessive absenteeism with a notice of suspension dated October 18, 2012. He also had declared bankruptcy previously and had deductions from his paycheck for back child support payments.

Ms. Denise Gilbert testified on behalf of Respondent. Ms. Gilbert is Respondent's human resources supervisor. Ms. Gilbert testified that attendance warnings were sent to Petitioner for excessive absenteeism and that he was suspended for one day of work on October 24, 2012. Ms. Gilbert testified Petitioner reported a work injury to her on October 26, 2012, for which he was sent to Respondent's clinic. Ms. Gilbert also testified to company policy of physical and drug test screenings. Petitioner passed his physical and she received no complaints of his work during that time.

Mr. Alex White testified on behalf of Respondent. Mr. White is a field investigator hired to perform surveillance of Petitioner. Mr. White testified he performed surveillance on June 2, 2013 and recorded a video on DVD. The video reflects Petitioner carrying a grill with a woman and loading it into the back of his pick-up truck. The video also shows him speaking with two women for approximately 7 minutes, then later moving the grill off the truck. A video taken on May 29, 2013 revealed Petitioner running some personal errands to a grocery store and pawn shop. Mr. White testified he prepared written reports of his activities for Respondent but did not bring them to court. The reports contained a summary of his surveillance. He did not review the reports prior to his testimony and last saw them shortly after they were drafted. Mr. White testified he observed Petitioner on other occasions but did recall if additional video was taken or what those dates were.

Petitioner in rebuttal testified he was picking up his grill from his sister-in-law in order to pawn it. Petitioner testified he had pawned his computer, television and other items for money.

Based upon the above, the Arbitrator finds the right shoulder condition as described above to be causally related to this accidental injury. Based further upon the above, the Arbitrator also finds the neck condition as described above to be causally related to this accidental injury. Based further upon the above, the Arbitrator also finds the lower back condition as described above to be not causally related to this accidental injury.

The Arbitrator further finds the opinions of causation by Dr. Fisher are more credible than those of Dr. Levin. Dr. Fisher testified by evidence deposition that the underlying reason for his opinion to the neck and cervical area was that Petitioner did not have such symptoms prior to his work accident and they became symptomatic directly following. Dr. Fisher testified Petitioner had a constellation of complaints following his work injury consistent with a disc herniation and the radicular right arm symptoms are consistent with this type of injury.

Dr. Levin testified by evidence deposition that the neck injury was not related due to a lack of physical complaints by Petitioner directly following the injury. Dr. Levin testified to a positive Spurling's test, right arm numbness and tingling, cervical tenderness and diminished grip strength, conditions that can be associated with spinal stenosis. The Arbitrator notes with interest right finger tingling was noted on November 1, 2012 at Centegra Occupational Health. Dr. Levin testified the work injury was a competent mechanism of injury for a cervical condition. Dr. Levin testified that if Petitioner complained of pain in his neck or associated symptoms, then his opinion concerning causation would change.

The surveillance video testimony is deemed to be less than reliable based on Mr. White's testimony. The testimony that a report exists that was not produced or reviewed prior to trial makes his testimony more difficult to believe.

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

Petitioner incurred charges from the following medical providers after this accidental injury that she introduced into evidence:

Centegra Hospital McHenry	$ 2,570.00
McHenry County Orthopedics	$ 463.00
Prairie Shore Pain Center	$ 6,938.00
Illinois Bone & Joint Institute	$37,564.00
Illinois Physician's Network	$12,120.66
Saint Joseph Hospital	$67,348.59
Resurrection Healthcare	$ 314.00
Summit Pharmacy	$ 1,643.17

These charges total $128,961.42.

See findings of this Arbitrator in "F" above. Based upon said findings, the Arbitrator further finds the above medical charges to represent reasonable and necessary medical care and treatment designed to cure to relieve the conditions of ill-being caused by this accidental injury.

15IWCC0232

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "F" above.

Based upon the findings of Dr. Fisher, Respondent is ordered to authorize and pay for physical therapy and additional visits to Dr. Fisher, including all further treatment that may result or stem from such treatment.

L. What temporary benefits are in dispute?

See findings of this Arbitrator in "F" above.

Based upon the testimony and medical evidence presented, the Arbitrator finds that as a result of this accidental injury, Petitioner is entitled to receive temporary total disability benefits from Respondent commencing January 10, 2013 through May 9, 2014.

Petitioner was working light duty as a result of this accidental injury when he was part of a large lay off on January 10, 2013. No light duty accommodations were made at that time and he has yet to be released to return to work by his treating physicians.

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

MARIA GALLARDO,

Petitioner,

15IWCC0233

vs.

NO: 10 WC 042424

ALDEN VILLAGE NORTH,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator only as it pertains to medical expenses. In reviewing the awarded medical expenses, it is determined that the award for Petitioner's treatment at Michigan Avenue Medical Associates did not include the $508.00 charge for Petitioner's visit to Dr. Riera on April 3, 2012. The Commission finds Petitioner incurred not $758.00 in compensable medical services at Michigan Avenue Medical Associates but $1,266.00. Accordingly, the arbitration award is modified to reflect this.

The awarded medical expenses are further modified to vacate the $9,060.00 that was awarded as compensation for Petitioner's treatment at Premier Physical Therapy as Petitioner failed to prove that these charges were related to treatment of her compensable back injury. As recorded in the Decision of the Arbitrator, Petitioner was seen at Premier Physical Therapy for treatment of both her hand and her back and, as was also recorded, the accompanying bill did not delineate which charges were attributable for the treatment to Petitioner's back and which were attributable for treatment of her hand. The decision to divide the $18,120.00 bill in half fails to take into consideration that treatment to one body part might be more or less intensive than the treatment to the other body part and, consequently, billed differently.

15IWCC0233

While a practical solution, there can be no certainty that dividing the bill by two accurately reflects the compensable treatment costs. As it stands, the Commission finds Petitioner failed to prove that the sought after compensation was reasonable and necessary.

The Commission affirms and adopts the Decision of the Arbitrator on all other issues.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $245.33 per week for a period of 97-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,266.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the medical expenses awarded for treatment at Premier Physical Therapy 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 7 2015
KWL/mav
O: 02/03/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0233

GALLARDO, MARIA
Employee/Petitioner

Case# **10WC042424**

ALDEN VILLAGE NORTH
Employer/Respondent

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:

5015 LAW OFFICE OF EDWARD S RUEDA
33 N LASALLE ST
SUITE 3350
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
JOHN P O'GRADY
200 N LASALLE ST SUITE 2700
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)

15IWCC0233

Case # 10 WC 42424

Consolidated cases: 11 WC 47668
(voluntarily dismissed 3/21/14)

Maria Gallardo
Employee/Petitioner

v.

Alden Village North
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **3/21/2014** and **3/27/14.** 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, **10/1/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $17,420.00; the average weekly wage was **$335.00**.

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

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

Per the parties' stipulation, Respondent shall be given a credit of **$20,500.10** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$20,500.10. Arb Exh 1.**

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $245.33/week for 97 1/7 weeks, commencing 5/11/12 through 3/21/2014, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $20,500.10 in benefits paid prior to arbitration, per the parties' binding stipulation. Arb Exh 1.

Medical Expenses

See pages 17-18 of the attached conclusions of law for the Arbitrator's medical award.

Prospective Care

The Arbitrator awards prospective care in the form of a return visit to Dr. Erickson along with the minimally invasive decompression and intra-operative testing Dr. Erickson recommended on July 20, 2012, assuming the doctor continues to recommend those procedures.

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

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

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

Molly C Mason

APR 29 2014

4/29/14

Maria Gallardo v. Alden Village North
10 WC 42424

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter.

Petitioner testified she began working as a housekeeper for Respondent in 2008. T. 9. She was required to undergo a physical examination as part of the hiring process. T. 10.

Petitioner denied having any lower back problems before her undisputed work accident of October 1, 2010 other than a minor back strain in 2005 which resolved within one week. T. 10.

Petitioner testified her housekeeper duties included collecting garbage, using a spatula or scraper to clean dirt off floors, washing walls, lifting children's mattresses, sweeping, mopping and cleaning beds and bathrooms. T. 17-18. Petitioner testified she was responsible for cleaning an entire floor of Respondent's facility each shift. T. 18.

Petitioner testified that, on October 1, 2010, she was moving quickly while mopping a floor at work when the mop "jammed." She felt an immediate onset of lower back pain and numbness in both legs, right worse than left. T. 11-12.

Petitioner testified she reported the injury to her supervisor. T. 12. Notice is not in dispute. Arb Exh 1.

Petitioner sought treatment at Peterson Urgent Care Center/Occupational Health Services [hereafter "Peterson Occupational"] on the same day the accident occurred. Petitioner testified she went to this facility at Respondent's direction. T. 12-13.

The records from Peterson Occupational contain an Illness and Injury Report dated October 1, 2010. This report sets forth the following history:

> "Pt states that while mopping the carpet she began to have severe pain low back and abdominal pain. She also states that her right leg became numb (pain level #10)."

The history also reflects that Petitioner denied any prior back injuries. On examination, Dr. Del Mundo noted positive straight leg raising on the right. He administered an injection of Toradol for pain. He ordered lumbar spine X-rays which showed mild multi-level marginal osteophytes. He diagnosed an acute lumbar strain. He prescribed Vicodin, took Petitioner off work and instructed Petitioner to return in two weeks. PX 3.

Petitioner returned to Peterson Occupational on October 4, 2010 and again saw Dr. Del Mundo. The doctor noted that Petitioner complained of severe lower back pain, difficulty walking, right leg numbness and occasional left leg numbness. On examination, Dr. Del Mundo noted spasm on the paraspinal area in the mid-spine at the level of L1 to S1. He also noted positive straight leg raising bilaterally. He instructed Petitioner to stay off work and perform home exercises while waiting for Respondent to approve formal therapy. PX 3.

On October 12 and 18, 2010, physicians at Peterson Occupational again recommended therapy and directed Petitioner to stay off work. PX 3. On October 25, 2010, Dr. Bulatovic noted that Petitioner was still complaining of severe pain and having difficulty getting on and off his examination table. He diagnosed "low back pain with radiculopathy." He prescribed a lumbar spine MRI and placed therapy on hold. He prescribed Norco and Flexeril and instructed Petitioner to remain off work. PX 3.

On November 3, 2010, Petitioner filed an Application for Adjustment of Claim (through her previous counsel) alleging a back injury of October 1, 2010.

The MRI, performed on November 4, 2010, showed "multi-level disc pathology, with disc bulges most prominent at L2-3, L3-4 and L4-5 and a small midline protrusion at L4-5." PX 3.

On November 8, 2010, Dr. Del Mundo re-examined Petitioner and again noted positive straight leg raising bilaterally. After reviewing the MRI, he diagnosed an "acute lumbar strain with possible slipped disc." He indicated he was referring Petitioner to a back specialist "because of the severe degree of pain that is not relieved with medications." He instructed Petitioner to remain off work. PX 3.

Three days later, Petitioner saw Dr. Malek, a neurosurgeon. The doctor noted that Petitioner injured her back on October 1, 2010, while continuously bending and mopping. He indicated that Petitioner described her duties as involving picking up garbage, making sure soap and towels were in the residents' bathrooms and cleaning walls and floors.

Dr. Malek noted that Petitioner complained of upper and lower back pain and pain in both legs, with the left leg pain extending to the ankle and the right leg extending to about the knee. He also noted that Petitioner complained of numbness and weakness in both legs. He indicated that Petitioner denied any history of similar complaints.

Dr. Malek described Petitioner as having "signs and symptoms of lumbar radiculopathy consistent with neurogenic claudication." He recommended therapy, medication, a caudal epidural steroid injection and a left L4-5 transforaminal injection. He requested the MRI films. He instructed Petitioner to remain off work and indicated he would consider light duty after the first injection. PX 3.

On December 28, 2010, Petitioner underwent the recommended injections. On January 6, 2011, Dr. Malek noted that Petitioner reported about 60-70% improvement but still had pain.

He recommended that Petitioner continue therapy and undergo another round of injections. He continued to keep Petitioner off work. PX 3.

On January 26, 2011, following the second round of injections, Dr. Malek noted a "partial response." He recommended continued therapy and a third round of injections. He released Petitioner to light duty, four hours per day, with no lifting over 10 pounds. He indicated Petitioner should remain off work if light duty was not available. PX 3.

Petitioner did not testify that she resumed part-time light duty as of January 26, 2011.

On February 9, 2011, Petitioner underwent a third round of injections. On February 17, 2011, Dr. Malek noted significant improvement but indicated Petitioner still had "residual pain." He prescribed work conditioning, to be followed by a functional capacity evaluation. He indicated that "consideration of surgery would be the last and only remaining option" if Petitioner's symptoms worsened. He again released Petitioner to light duty four hours per day with no lifting over 10 pounds. PX 3.

On April 7, 2011, Dr. Malek described Petitioner's physical examination as "negative." He prescribed another four weeks of work conditioning. He continued the previous work restrictions. PX 3.

On May 5, 2011, Dr. Malek noted that Petitioner had undergone four weeks of conditioning but still had pain that worsened with walking or other activity. He recommended additional work conditioning and continued the previous work restrictions. PX 3.

On May 26, 2011, Petitioner underwent a functional capacity evaluation at Diversey Medical. The evaluator, Steven Sedlacek, P.T., noted he used an interpreter while performing the evaluation. He indicated that Petitioner complained of right-sided lower back pain, rated 1-2/10. He noted no limp.

Sedlacek addressed Petitioner's effort, job demands and work capacity as follows:

> "It should be noted that even though [Petitioner's] job description states 'housekeeper', the job of "janitorial, industrial or commercial' was chosen as her job description required her to lift, push and move equipment, supplies, etc. in excess of 50# throughout the day. Lifting and pinch tests were repeated at random and blindly. Each test demonstrated the same results. Since this would be near impossible to replicate without putting forth a sincere effort, I believe that [Petitioner] put forth a sincere effort. Also, her results are consistent with her injury and what she has been doing in work conditioning. Therefore, I would view this test as a valid indication of her function. Since the only

> areas she failed to be able to return to her previous job without restrictions is lifting and ROM, I would recommend that she receive P.T. 2x/week for 6 weeks to focus on these areas, then re-test. Since she passed the other areas, a full-blown work conditioning program would not be needed. Instead, I would recommend that she focus on the areas where there were deficits."

Elsewhere in his report, Sedlacek noted that "the Dictionary of Occupational Titles places [Petitioner's] occupation as a "cleaner, commercial or institutional" in the heavy strength category." He found Petitioner capable of working in a "medium strength category," meaning she could lift a maximum of 30 pounds and carry a maximum of 25 pounds. He indicated that "since [Petitioner] fell into a higher DOT category [heavy] for carrying than she did for lifting [medium], the lower DOT category [medium] is chosen to ensure patient safety." He went on to say that Petitioner would need to avoid stooping and any balancing activities that require crouching in order to successfully return to a medium strength job. PX 3. RX 8.

Petitioner returned to Dr. Malek on June 2, 2011. In his note of that date, the doctor indicated he reviewed the functional capacity evaluation, which showed that Petitioner "does not meet the criteria for cleaner commercial/industrial, which is in the heavy strength category, as required by her job." He also indicated that Petitioner was doing better and had reached maximum medical improvement. He imposed permanent medium duty restrictions "per FCE 5/26/11." PX 3.

Petitioner returned to Dr. Malek on June 30, 2011. The doctor's note of that date reflects that Petitioner "stated that her employer has not accommodated her restrictions." He characterized these restrictions as "permanent and based on a valid FCE." He refilled Petitioner's medication and noted she was likely to require medication for another year or two. He recommended that Petitioner follow up in three to four months. PX 3.

On July 21, 2011, Petitioner saw Dr. Malek again. The doctor described Petitioner as stating "her symptoms are under control" and she "would like to raise the 15-lb. push and pull." The doctor released Petitioner to work as of the following day with maximum lifting/carrying of 30 pounds, occasional pushing/pulling with maximum of 50 pounds, no mopping, sit/stand for comfort and medication. [See detailed work status report in PX 4.]

Petitioner testified she returned to work at Respondent's facility on the 21st or 22nd day of some month in 2011. She could not recall exactly which month. When she returned, she did not resume her regular housekeeper duties. Instead, she was assigned to work in Respondent's laundry. She had to take clothes out of a chute and put them in a large cart. She also had to remove laundry from a machine, fold the laundry, place the folded laundry in cubicles and a cart and then distribute the laundry to all the floors. She testified that another woman helped her for one day, while she performed these laundry duties, but that, after that one day, she was

no longer able to perform the job. She testified she never returned to work following the one day she spent in Respondent's laundry. T. 20, 27.

The Arbitrator finds it most probable that Petitioner returned to work in Respondent's laundry very shortly after seeing Dr. Malek on July 21, 2011, based on Petitioner's recollection of returning to work on the 21st or 22nd and the wording of Dr. Malek's next note of August 10, 2011. In that note, the doctor indicated that Petitioner returned to work but was "unable to complete it." He also noted a recurrence of back and leg symptoms. Given the failed return to work, he recommended a lumbar CT discogram at L3-4, L4-5, L5-S1 and a control level. He also recommended a repeat lumbar spine MRI and EMG/NCV testing in order to "reassess for surgery." He released Petitioner to light duty with no lifting over 10 pounds and no mopping. PX 3.

At the next visit, Dr. Malek made the same recommendations, noting Petitioner had "not been accepted back to work with the restrictions." PX 3.

On September 22, 2011, Dr. Malek noted that Petitioner's treatment had been delayed because the carrier had refused to authorize the discogram, EMG/NCV and repeat MRI. PX 3.

At Respondent's request, Petitioner saw Dr. Harel Deutsch for a Section 12 examination on October 2, 2011. Dr. Deutsch is associated with Rush University Medical Center.

In his report of October 2, 2011, Dr. Deutsch noted that Petitioner "speaks only Spanish." He also noted that Petitioner reported an injury on October 1, 2010 "while working and pulling something." He indicated Petitioner stated she experienced "mostly lower back pain" after this injury. He also noted that Petitioner rated her current pain level at 3/10. He described Petitioner as "working in a light duty capacity until one month ago." He noted that a functional capacity evaluation showed she could work at a medium duty level but that "her work requirements are reportedly for heavy lifting." He indicated he reviewed the MRI report and Dr. Malek's recent recommendations of a discogram, EMG/NCV and repeat MRI.

Dr. Deutsch described Petitioner's gait as normal. On spinal examination, he noted no tenderness to palpation along the lumbar and thoracic spine, normal musculature, forward flexion to 90 degrees with some mild increased back pain, extension to 20 degrees and negative straight leg raising bilaterally. He indicated that Petitioner was "able to squat and get up easily."

Dr. Deutsch described the MRI as showing "significant degenerative disc disease." He indicated that the increased pain Petitioner experienced after the reported work incident "is an exacerbation of her degenerative disc disease." He described the treatment to date as adequate. He found Petitioner to be at maximum medical improvement. He indicated Petitioner "does not want surgery" and "would not benefit from surgery for her diffuse degenerative disc disease." He described Petitioner as tolerating her current pain level. He indicated that a discogram was not needed because Petitioner was not a surgical candidate. He

indicated that the initial MRI was "sufficient" and that there had been no change in Petitioner's condition warranting a repeat MRI. He stated an EMG was unnecessary because Petitioner "has no radicular symptoms currently."

Dr. Deutsch commented on work status as follows: "Ms. Gallardo's permanent restrictions are as set forth in her functional capacity evaluation. She is able to work at the medium level of work which includes lifting up to 45 lbs." PX 3.

Petitioner testified that, at the October 2, 2011 examination, Dr. Deutsch communicated with her in English. No Spanish-speaking interpreter was present. She did not understand the doctor's questions. T. 31-32. She told the doctor she was experiencing pain in her lower back and numbness in both legs, worse on the right. The doctor did not respond to this. He simply told her the appointment was finished. T. 33.

Petitioner returned to Dr. Malek on October 20, 2011, with the doctor noting he had "not been able to obtain the IME report in spite of multiple requests." He described Petitioner's physical examination as unchanged. He again recommended a discogram, EMG/NCV testing and a repeat lumbar spine MRI. PX 3.

Petitioner saw Dr. Malek again on November 3, 2011. In his note of that date, Dr. Malek indicated he had reviewed Dr. Deutsch's report. He expressed concern as to whether Dr. Deutsch truly understood Petitioner. He noted that, per Petitioner, "the IME was carried out without an interpreter" and Petitioner described Dr. Deutsch's command of Spanish as "not perfect." He noted that, while speaking with Petitioner through an interpreter who was fluent in Spanish, Petitioner indicated her pain was <u>not</u> tolerable and she wanted to take the next steps to see if surgery was necessary. He again recommended a discogram, EMG/NCV testing and a repeat lumbar spine MRI. PX 3.

Under cross-examination, Petitioner identified RX 1 as a letter from Respondent. [RX 1 is a letter dated November 10, 2011 from Respondent's personnel director to Petitioner acknowledging receipt of a report from Diversey Medical indicating Petitioner could return to work with permanent restrictions and directing Petitioner to report to work on Monday, November 21, 2011 at 7:00 AM, at which time she would undergo an orientation.] Petitioner testified that, in November 2011, Respondent directed her, via telephone, to present to work on a certain date, indicating that light duty was available. She presented herself to work but Respondent would not accept her "with those restrictions." T. 51-52.

Petitioner returned to Dr. Malek on November 17, 2011. In his note of that date, the doctor described Petitioner's symptoms as unchanged. He also noted that Petitioner "received a letter dated November 10, 2011 from Maureen Dominguez, [Respondent's] personnel director, requesting her to report to work on November 21st at 7:00 a.m." According to the letter, Petitioner was to undergo "an orientation due to new equipment and procedures." Dr. Malek indicated he told Petitioner she could "go ahead and try and see how she does." He indicated that other options could be considered if the return to work failed. He continued the

previous restrictions, i.e., light duty with no lifting over 10 pounds and no mopping "per FCE 5/26/11." PX 3. [The Arbitrator notes that the evaluator who performed the first functional capacity evaluation did not recommend that Petitioner avoid mopping and lifting over 10 pounds.]

In his next note, dated December 1, 2011, Dr. Malek described Petitioner's report of her attempt to return to work as follows:

> "The patient attempted to return to work within the restrictions of the FCE. However, the patient stated that she was turned down and was told that she had to return to work full duty or else she could not have a job."

Dr. Malek again recommended a discogram, EMG/NCV testing and a repeat lumbar spine MRI. He continued the previous work restrictions. PX 3.

Dr. Malek's itemized bill (see bill near the end of PX 3) shows that Petitioner returned to him on December 27, 2011 but no records concerning this visit are in evidence.

Petitioner's current counsel substituted into the case on December 13, 2011.

On February 20, 2012, Respondent's counsel sent a letter via facsimile to Petitioner's current counsel, indicating that Petitioner failed to report to work per the letter of November 10, 2011 (RX 1) and stating that Respondent has been able to accommodate Petitioner's restrictions "per Dr. Deutsch's IME report" since the IME of October 2, 2011. RX 5.

On March 8, 2012, Respondent's counsel sent another letter via facsimile to Petitioner's current counsel directing that counsel to communicate only with him and reiterating that Respondent had had restricted duty available for Petitioner since October 2, 2011. Respondent's counsel did not further define "restricted duty." The letter ends as follows: "If your client wishes to report for work, she should do so immediately." RX 6.

On April 3, 2012, Petitioner saw Dr. Riera at Michigan Avenue Medical Associates. The doctor's note of that date sets forth a history of the work accident and subsequent treatment. The doctor indicated that Petitioner primarily complained of very sharp left-sided back pain, rated 7/10, radiating to the right leg, along with numbness and tingling in the right leg. He also noted that Petitioner had undergone three injections.

Dr. Riera described Petitioner's gait as antalgic. He described Petitioner's spine as "very rigid and painful on palpation of the paraspinal muscles with muscle spasm." He indicated that straight leg raising was limited to 15 degrees bilaterally. He recommended a repeat lumbar spine MRI. This MRI, performed without contrast on April 6, 2012, showed a 1.5 millimeter

posterocentral disc protrusion/early herniation at L4-L5 with mild narrowing of the central canal and a disc bulge at L3-L4 without significant central or foraminal compromise. PX 4.

On April 4, 2012, Petitioner underwent an initial therapy evaluation at Premier Physical Therapy. Petitioner attended therapy (for both her lower back and her hands) at this facility on a regular basis thereafter through August 3, 2012, with the therapist noting little sustained improvement along the way. PX 5.

On April 27, 2012, Petitioner saw Dr. Erickson at Michigan Avenue Medical Associates. The doctor recorded a history of the work accident and subsequent care. He indicated that Petitioner experienced "slight but definite improvement with epidural steroid injections on three occasions." He also indicated that Petitioner reported being able to stand for three to four minutes, walk briefly and sit for fifteen minutes before needing to stand up due to pain.

Dr. Erickson indicated he reviewed both of Petitioner's lumbar spine MRIs. He interpreted them as showing a "small central disc herniation at L4-L5." He indicated he "reassured [Petitioner] about her relatively good neurologic examination." He noted he saw no severe weakness, long tract signs or pathological reflexes. He described sensation as normal. He detected a "trace of dorsiflexion weakness on the right side." He recommended evoked potential testing of both lower extremities. He linked the need for this testing to the work accident. PX 4.

At Dr. Erickson's direction, Petitioner underwent a functional capacity evaluation at Premier Physical Therapy on May 3, 2012. The evaluator, Ahmed Hassan, P.T., rated the results as valid "due to the maximal effort demonstrated by Mrs. Gallardo in her performance of the functional activities throughout testing." Hassan addressed Petitioner's specific limitations as follows:

> "Mrs. Gallardo had limitations in her ability to sit, stand or walk for any extended period of time. These limitations affect her ability to maintain one position for over 10 minutes in any given work environment, which affects her ability to perform in a regular eight-hour day shift. Mrs. Gallardo was able to perform the non-material handling test with the following restrictions: she was unable to bend her trunk for over 40 degrees, the LBP increased while performing standing, walking, sitting and trunk activities. The pain radiates to the lower extremities worse at the right side. The patient was able to sit for only 15 minutes, stand for 10 minutes. She was unable to walk for 1 mile. She was unable to maintain or perform repetitive squatting. In the material-handling test Mrs. Gallardo was able to lift occasionally 12.5 lbs from floor to waist and 15 from 12" to waist, 15 lbs from waist to shoulder and 12.5 lbs from shoulder

> to overhead. She was able to carry 12.5 lbs for 20 feet – please note that the weight was handed to the patient at waist level. She was able to push 50 lbs and pull 50 lbs for 20 feet."

Hassan found that Petitioner was functioning at a light physical demand level. PX 4.

Petitioner returned to Dr. Erickson on May 11, 2012. On that date, the doctor described the evoked potentials as "correlative showing delay at L5 on the right side at 1.0 standard deviations and at S1 on the right side at 0.9 standard deviations." He noted Petitioner had undergone a functional capacity evaluation placing her at a light duty level. He found Petitioner to be an "excellent surgical candidate for minimally invasive surgery at L4-L5 on the right side." He indicated that L5-S1 on the right side was "likely also responsible for part of" Petitioner's pain. He planned to perform intra-operative testing at L5-S1 to determine whether to approach this level during surgery. He addressed causation as follows: "the surgical recommendation is a direct result of the injury of 10/1/10." PX 4.

At Respondent's request, Dr. Deutsch re-examined Petitioner on June 13, 2012. In his report of that date, Dr. Deutsch indicated that a Spanish-speaking interpreter was present on June 13, 2012. He stated that Petitioner reported an onset of abdominal pain and nausea on October 1, 2010 while pulling a wheeled mop bucket across a carpet. He outlined the treatment provided by the physicians at Peterson Occupational and Dr. Malek. He referenced only the original functional capacity evaluation and made no mention of Dr. Erickson's findings and recommendations. He indicated that Petitioner had worked only two to three days since the accident and mainly complained of low back pain.

On lumbar spine re-examination, Dr. Deutsch noted equivocal straight leg raising bilaterally, diffuse tenderness to palpation of the lumbar spine, normal paraspinal musculature, forward flexion to 90 degrees and extension to 20 degrees.

Dr. Deutsch stated that Petitioner described no mechanism of injury other than pulling a bucket on wheels. He indicated that physicians at Peterson Occupational diagnosed Petitioner with a lumbar strain and that he agreed with this diagnosis. He indicated symptoms from a lumbar strain "would resolve within 30 days." He related Petitioner's ongoing complaints to degenerative disc disease. He found Petitioner to be at maximum medical improvement and capable of full duty without restrictions. He restated his previous opinions that there was no need for a discogram, EMG/NCV or repeat MRI. RX 7.

Petitioner returned to Dr. Erickson on July 20, 2012. In his note of that date, Dr. Erickson indicated he reviewed Dr. Deutsch's June 13, 2012 report. He noted the following "significant problems with" the doctor's assessment:

> "First, he [Dr. Deutsch] minimizes the initial injury which is described as pulling a mop bucket on wheels across a carpet. While the injury itself was not a dramatic occurrence, she

was engaged in repetitive mopping activity during that day. Repetitive activities involved in housekeeping are a known competent cause of lumbar disc herniation.

She does have degenerative changes in the back but also has disc herniation. We are most concerned about the small disc herniation at L4-L5. I am in agreement that the volume of the disc herniation is small.

Based upon the amount of time that had passed, we recommended confirmation with somatosensory evoked potential testing before proceeding further. Indeed, the evoked potential testing showed a significant L5 nerve abnormality which correlates perfectly with the small disc herniation seen at L4-L5.

The diagnosis reached by Dr. Deutsch is that of lumbar strain. This would be a reasonable working diagnosis within the first four months of such an injury. This injury has caused problems that have remained since October 1, 2010. The working diagnosis of lumbar strain must be regarded as void.

I agree that there is no need for lumbar discography.

This situation of a small, symptomatic disc herniation is not uncommon.

I regard her as an excellent surgical candidate based upon the significant amount of time that has passed, the poor response to conservative treatments including injection therapy, and a perfect correlation between the MRI findings and the neurophysiological studies."

In separate notes, also dated July 20, 2012, Dr. Erickson indicated that Petitioner reported slight improvement. Petitioner was now rating her pain level at 5/10 when it was usually 7-8/10. He indicated he would await surgical authorization. He discontinued therapy and instructed Petitioner to remain off work. Petitioner was discharged from therapy on August 3, 2012 pending surgical authorization. PX 5.

On January 15, 2013, Petitioner filed a Section 19(b) petition along with a petition for penalties and fees. [Petitioner withdrew her claim for penalties and fees at the hearing.] The 19(b) petition alleges that Petitioner last received temporary total disability benefits on November 21, 2011.

On September 6, 2013, Dr. Deutsch gave a deposition on behalf of Respondent. Dr. Deutsch testified he achieved board certification in neurosurgery in 2008. He is an associate

professor of neurosurgery at Rush University. RX 7 at 5. He has authored a number of published articles relating to neurosurgical issues. RX 7 at 5-6. Deutsch Dep Exh 1.

Dr. Deutsch testified he examined Petitioner twice on behalf of Respondent. The first examination took place on October 2, 2011 and the second on June 13, 2012. RX 7 at 7. His report concerning the first examination reflects that Petitioner speaks only Spanish. He sees many patients who speak only Spanish. He is able to effectively communicate in that language. Spanish is not his native language but he studied Spanish in high school and college. RX 7 at 8. Petitioner was "somewhat of a poor historian" but he had no difficulty understanding her. RX 7 at 9. His first report sets forth detailed information provided by Petitioner. RX 7 at 9. Petitioner's examination on October 2, 2011 was essentially negative. RX 7 at 10. He noted no tenderness to palpation along the thoracic and lumbar spine. Straight leg raising was negative bilaterally. He expected this test would be negative because Petitioner primarily complained of back pain "and had no complaints of leg pain." RX 7 at 11. Petitioner could squat and easily get up from a squatting position. RX 7 at 11. He found Petitioner to be at maximum medical improvement and capable of working at a medium level with lifting up to 45 pounds. RX 7 at 12. An EMG was not warranted because an EMG plays no role when back pain is at issue. RX 7 at 13. A discogram was also not warranted. The purpose of a discogram is to determine the appropriate level for a fusion and Petitioner would not benefit from a fusion. RX 7 at 13. Petitioner told him her pain was well-controlled and she did not want surgery. RX 7 at 13-14. Petitioner's lumbar spine MRI of November 4, 2010 was "essentially normal for someone who is in his 50s." The MRI showed "bulging at all levels." This is to be expected based on Petitioner's age. The MRI showed no evidence of acute trauma, disc herniation, stenosis or anything else that surgery could correct. RX 7 at 14. He believes he reviewed the scan of the November 4, 2010 MRI. RX 7 at 15. The MRI showed degenerative changes at every level. Surgery would be worse than this condition. RX 7 at 15.

Dr. Deutsch testified he understands Petitioner worked as a housekeeper for Respondent. He did not get into details insofar as her daily activities were concerned. He understood that Petitioner was "basically mopping and vacuuming." RX 7 at 16. Petitioner never told him her housekeeper job involved industrial janitorial work or heavy duty level work. RX 7 at 16. He reviewed Dr. Malek's notes. Dr. Malek did not refer to Petitioner's job as heavy. RX 7 at 17. He reviewed a functional capacity report that described Petitioner's job as heavy. He is not sure whether this is accurate. The extent of his knowledge concerning Petitioner's job is that she was required to mop and vacuum. The functional capacity evaluation showed she could lift up to 45 pounds. That is a "reasonable evaluation" for anyone who is in his or her 50s. RX 7 at 18-19.

Dr. Deutsch testified he re-examined Petitioner on June 13, 2012. On this occasion, Petitioner was accompanied by a Spanish-speaking interpreter. RX 7 at 19. Petitioner "basically had the same story as before." Her examination was "somewhat unchanged" although he described straight leg raising as "equivocal" and noted tenderness to palpation in the back. RX 7 at 19-20. Petitioner told him she was injured while pulling a mop bucket across a carpeted floor. Petitioner also told him that most of her pain was abdominal and she felt like vomiting.

Those symptoms are not typical for a lumbar injury. RX 7 at 20. Dr. Deutsch acknowledged he did not have access to the repeat lumbar spine MRI of April 6, 2012 when he re-examined Petitioner. RX 7 at 20-21. He saw the report concerning this repeat MRI on the day of the deposition. RX 7 at 21. He did not believe she required a repeat MRI. The repeat MRI is "basically no different from the previous MRI." It again shows "degenerative changes in the spine and mild bulging at multiple levels." RX 7 at 21. The radiologist who interpreted the repeat MRI noted no nerve root impingement or thecal sac involvement. He did, however, note some mild narrowing the central canal at L4-L5 but this is not a significant finding for a person who is in his 50s. The repeat MRI was "consistent with [Petitioner] not having lower extremity complaints." RX 7 at 22. Petitioner would not benefit from lumbar spine surgery because her MRI is essentially normal. There is "no one level that is terrible that could be fixed with surgery." Petitioner has back pain but no radicular symptoms. RX 7 at 23.

Dr. Deutsch testified that, in his first report, he described Petitioner as having a lumbar strain and an exacerbation of her degenerative disc disease. The exacerbation was temporary in nature. RX 7 at 24. A lumbar strain should resolve within thirty days. RX 7 at 25.

Dr. Deutsch testified that Petitioner could return to unrestricted duty "or, per the functional capacity evaluation, work at a medium level." He acknowledged that a woman like Petitioner, who is almost 60, "is not going to be able to work at a heavy level, lifting 75 or 100 pounds." That would not be reasonable. RX 7 at 25. Petitioner did not tell him that she was required to perform any heavy lifting when she worked for Respondent. RX 7 at 25.

Dr. Deutsch testified that Petitioner got hurt while mopping, as far as he knows. He does not know the exact details of her injury. RX 7 at 26. It is reasonable for mopping to cause a lumbar sprain. RX 7 at 26.

Dr. Deutsch testified that his website describes him as being able to speak Spanish. He also speaks Hebrew. RX 7 at 27.

Under cross-examination, Dr. Deutsch testified he reviewed the MRI reports, not the scans, in preparation for the deposition. RX 7 at 28. He does not perceive any real difference between the findings set forth in the two reports. The radiologists' descriptions read differently but the differences are not significant. RX 7 at 29-30. He does not believe that an EMG is ever helpful for people who have back pain. RX 7 at 30. An EMG is a test doctors like to perform and charge for but it would not change Petitioner's management. RX 7 at 31. If a patient has leg pain, and a doctor is worried about a particular nerve root, an EMG could help but an EMG would not benefit a patient who only has back pain. RX 7 at 31. Petitioner's complaints varied but were never suggestive of radiculopathy. RX 7 at 32. Petitioner's complaint was "consistently just lower back pain." RX 7 at 32. "Doctors order EMGs all the time but it's mainly a billing phenomenon." RX 7 at 33.

On redirect, Dr. Deutsch testified he is aware that the treating neurosurgeon in this case is Dr. Malek. He is familiar with Dr. Malek. RX 7 at 34. Dr. Deutsch testified he has been

affiliated with Rush University Medical Center for ten years. Rush University Medical Center is well-regarded in the field of medicine. RX 7 at 34. He did review the scan of the original MRI, performed on November 4, 2010. RX 7 at 35.

Petitioner filed another 19(b) petition on December 2, 2013. In the early part of 2014, the Arbitrator specially set the case for hearing on March 21, 2014, at the request of both parties.

Petitioner testified she wants to undergo the surgery that Dr. Erickson of Michigan Avenue Medical Associates recommended. T. 29. After sitting and testifying for about forty minutes, she feels lower back pain and numbness in both legs. T. 30-31. She has not worked in any capacity since the one day she attempted to work in Respondent's laundry. T. 37-38.

Under cross-examination, Petitioner testified she worked as a housekeeper or cleaner for Respondent between the time she was hired in 2008 and the accident. T. 38. When she worked in this capacity, she had to move beds and a very heavy cart. T. 40. The cart was loaded with bags and cleaning materials. T. 40. The cart had wheels. T. 41. She did not have to trim grass, shovel snow or use power equipment. T. 41. She had to set up the dining room twice daily. She had to stack dining room chairs. She also had to move children's mattresses. T. 42. She told her doctors about the lumbar strain she sustained in 2005. T. 48. She is currently taking pain medication. T. 49. She was in pain while testifying but tolerates the pain. T. 49. She does not know what her current work restrictions are. T. 50. She has not looked for restricted duty. T. 50. No physician is currently prescribing pain medication for her. T. 50-51. Her supervisor at Respondent told her that her housekeeper job was heavy because she had to mop, sweep and clean bathrooms. T. 52. She does not have any document that describes her housekeeper job as heavy but she knows the job was heavy because she performed the job. She views sweeping and mopping as heavy duty. T. 53.

Christy Czajka testified on behalf of Respondent. Czajka testified she works as an administrator for Respondent. She handles personnel and other administrative issues. T. 55. She knows Petitioner. Petitioner is still technically an employee of Respondent but she is not currently drawing paychecks. Petitioner was hired as a housekeeper on September 23, 2008. T. 56. RX 2. Petitioner's housekeeper job was a medium duty position. T. 57.

Czajka testified she has heard of the Dictionary of Occupational Titles. She is aware that the Dictionary of Occupational Titles categorizes a housekeeper job as a medium duty job and a commercial or industrial cleaner job as a heavy duty job. T. 57-58. RX 3. At all times, Respondent has had work available that would accommodate light or medium duty restrictions. T. 58. On November 10, 2011, Respondent's then personnel director sent Petitioner a letter indicating Respondent could accommodate Petitioner's existing restrictions. RX 1.

Czajka identified RX 4 as a schedule of a housekeeper's duties at Respondent. T. 60. Those duties included spot cleaning, replacing supplies and pulling trash. T. 61. Petitioner typically worked from 7 AM to 3 PM. She had a morning break from 9 AM to 9:30 AM and a

lunch break from 1 PM to 1:30 PM. T. 61-62. At no time was Petitioner required to clean 50 rooms twice a day. At no time were Petitioner's duties even close to that. T. 62. On arrival at work, Petitioner was required to perform a walk-through to check for spills. She had to clean such spills, pick up paper or debris from the floor, clean out the garbage cans, clean the dining room after meals and deep clean one patient room per shift. RX 4 sets forth a schedule for the deep cleaning. T. 63-64.

Under cross-examination, Czajka testified she is not personally acquainted with Petitioner. She works at the same facility where Petitioner worked. T. 64-65. She has never observed Petitioner performing her work duties. T. 66. She was hired by Respondent on June 28, 2010. As a housekeeper, Petitioner was responsible for cleaning the entire third floor of Respondent's facility on North Sheridan Road. T. 66. That floor consisted of one office, two nursing stations and twenty bedrooms. T. 67. Each bedroom has an attached bathroom. T. 69. The patients who reside at the facility are developmentally disabled. Many of them are wheelchair bound. T. 67. There was the potential for the wheelchair bound patients to leave skid marks on the walls and floors. T. 68. Petitioner was not responsible for removing these marks. Typically, a construction company would come out to perform repairs if a wall was damaged. T. 69. She did not witness Petitioner's accident. T. 70. She does not know whether Petitioner presented to work after receiving the November 10, 2011 letter but was refused employment based on her restrictions. T. 73.

Arbitrator's Credibility Assessment

The treatment records contain somewhat varying accounts of the exact mechanism of injury but most reference mopping as the triggering event. Respondent stipulated to both notice and accident. Arb Exh 1.

The treatment records reflect that Petitioner denied prior back injuries and complaints. At the hearing, Petitioner acknowledged injuring her back in 2005. She described this injury as a minor strain that resolved within one week. The Arbitrator does not view this slight variance as undermining Petitioner's credibility.

The Arbitrator finds credible Petitioner's testimony that she had some difficulty understanding Respondent's examiner, Dr. Deutsch, at the first examination and that she complained to the doctor of symptoms in her legs as well as her back. Why would Petitioner have told Dr. Deutsch she had no leg symptoms when she complained of such symptoms to all of her treating physicians and therapists? The Arbitrator also notes that Dr. Deutsch described Petitioner as having "mainly" back symptoms. He did not specifically state that Petitioner denied leg symptoms.

None of Petitioner's treating physicians documented positive Waddell signs or symptom magnification. Both of Petitioner's functional capacity evaluations were found to be valid.

The Arbitrator found Petitioner credible overall.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between her undisputed work accident of October 1, 2010 and her current lumbar spine condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection between her undisputed work accident of October 1, 2010 and her current lumbar spine condition of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any significant pre-accident lumbar spine problems; 2) the fact that Petitioner performed the physical duties of a housekeeper for two years before the accident; 3) Petitioner's credible testimony that she experienced the immediate onset of low back and leg complaints following the accident [see Dr. Del Mundo's notes of October 1, 4 and 18, 2010 – the doctor documented a complaint of right leg numbness on the date of the accident and bilateral leg complaints thereafter]; and 4) the notes of Dr. Malek, the functional capacity evaluators and Dr. Erickson, all of which document radicular complaints.

The Arbitrator assigns virtually no weight to the opinions expressed by Respondent's Section 12 examiner, Dr. Deutsch. Dr. Deutsch based most of those opinions on what he perceived as the absence of radicular complaints. He failed to acknowledge that the physicians at Peterson Occupational, a medical facility of Respondent's selection, documented radicular complaints from the outset. At his September 6, 2013 deposition, he described Dr. Malek as Petitioner's current treating neurosurgeon. It is not clear whether he knew Petitioner began seeing a different neurosurgeon, Dr. Erickson, in 2012. He expressed no awareness of the correlative evoked potential test results or Dr. Erickson's treatment recommendations. He did not see the film of the repeat lumbar spine MRI. He dismissed the need for a discogram and a fusion, not realizing that Dr. Erickson shared his view on these issues. In his first report, he found Petitioner to be subject to permanent medium duty restrictions per the first functional capacity evaluation. In his second report, dated June 13, 2012, he found Petitioner capable of unrestricted work. At his deposition, he hedged, indicating Petitioner was capable of either medium or unrestricted duty. It appears he never reviewed the second functional capacity evaluation, performed on May 5, 2012, which showed Petitioner to be capable of only light duty. PX 4. He readily acknowledged that he lacked details concerning Petitioner's housekeeping duties.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from September 16, 2011 through the initial hearing of March 21, 2014. Petitioner raised no objection to RX 9, Respondent's payment print-out. Petitioner agreed that Respondent paid her temporary total disability benefits totaling $20,500.10. Arb Exh 1.

It is not clear why Petitioner claims a temporary totally disability "start date" of September 16, 2011. Petitioner did not see any physician on September 16, 2011. In fact, she was off work, receiving benefits, as of that date. PX 3. RX 9.

Petitioner acknowledged that, on the 21st or 22nd day of some month in 2011, she returned to Respondent and, for one day, performed a job that was different from her regular housekeeper job. Petitioner testified that this job involved working in Respondent's laundry, handling and folding linen and distributing clean laundry items throughout Respondent's facility. Neither Petitioner nor Respondent's witness, Christy Cjaka, provided any estimates as to the weights Petitioner had to lift or carry while performing this job. Petitioner simply testified she could not handle the job and lasted only one day, after which she never worked again. As indicated above, the Arbitrator finds it likely that Petitioner worked in the laundry on July 22, 2011, based on Dr. Malek's new, more liberal lifting/pushing/pulling restrictions of July 21, 2011 and his subsequent note and much stricter restrictions of August 10, 2011. The Arbitrator also finds it likely that Petitioner returned to Respondent after receiving Dominguez's note of November 10, 2011 and that Respondent did not put her to work that day based on the variance between Dr. Malek's August 10, 2011 restrictions (including no lifting over 10 pounds and no mopping), which were considerably stricter than those recommended by the first functional capacity evaluator, and Dr. Deutsch's October 2, 2011 opinion that Petitioner could perform medium duty.

The parties' attorneys focused a great deal of attention on whether Petitioner's housekeeper job fell into a medium or heavy work category. The Arbitrator's focus lies elsewhere. The therapist who performed the first functional capacity evaluation did not place Petitioner at medium duty per se. Instead, he found that, from a physical safety standpoint, Petitioner would be capable of medium duty only if she avoided stooping and any activities that involved balancing while crouching. He also recommended that Petitioner undergo six more weeks of physical therapy. At the hearing, neither attorney expressed any awareness of, or asked any questions about, the second functional capacity evaluation of May 3, 2012, which placed Petitioner at a light demand level, thus potentially eliminating the medium versus heavy debate. Respondent's examiner was aware of the repeat lumbar spine MRI but made no mention of the second functional capacity evaluation. Dr. Erickson continued to keep Petitioner off work following this evaluation, pending surgical authorization, but even if he had released Petitioner to work per the second evaluation, there is no evidence that Petitioner refused an offer of light demand level work at any time after May 3, 2012. Interstate Scaffolding, Inc. v. IWCC, 236 Ill.2d 132, 146 (2010).

Based on the foregoing, the Arbitrator views Petitioner's lumbar spine condition as unstable as of May 11, 2012, the date on which Dr. Erickson acknowledged the second functional capacity evaluation and recommended surgery. The Arbitrator awards Petitioner temporary total disability benefits at the rate of $245.33 per week (based on the stipulated average weekly wage and the applicable minimum rate) from May 11, 2012 through the first hearing of March 21, 2014, a period of 97 1/7 weeks, with Respondent receiving credit for the $20,500.10 in benefits it paid prior to trial, per the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of the expenses associated with the care rendered by Peterson Occupational, Dr. Malek, Michigan Avenue Medical Associates (Dr. Erickson) and Premier Physical Therapy. Respondent claims payment of numerous medical expenses. Respondent submitted a payment print-out (RX 9) into evidence when the Arbitrator closed proofs on March 27, 2014. Petitioner did not object to RX 9. Respondent indicated that the medical payments listed in RX 9 represent payments made in accordance with the fee schedule.

The Arbitrator notes that some of the claimed bills, along with the payment print-out, refer to expenses associated with treatment not at issue in this case, i.e., treatment of carpal tunnel syndrome. [At the first hearing, held on March 21, 2014, Petitioner voluntarily dismissed the companion claim numbered 11 WC 47668, which alleged carpal tunnel syndrome.]

The itemized bill from Peterson Occupational (see last two pages in PX 3) sets forth charges of $1,083.00 (for lumbar spine treatment rendered from October 1, 2010 through November 8, 2010), payments and adjustments totaling $1,016.00 and an unpaid balance of $67.00. RX 9 shows various payments to Peterson Occupational for treatment rendered from October 1, 2010 through November 4, 2010. The Arbitrator awards no expenses relating to treatment rendered by Peterson Occupational based on Respondent's representation that the payments shown in RX 9 reflect payments per the fee schedule.

The itemized bill of Dr. Malek (see bill near the end of PX 3) shows total charges of $14,475.00 for lumbar spine treatment rendered from November 11, 2010 through December 27, 2011. The bill also shows various payments and write-offs and an unpaid balance of $650.00, with that figure representing five $130.00 charges for office visits on October 20, November 3, November 17, December 1 and December 27, 2011. RX 9 shows various payments to Dr. Malek for treatment rendered from November 11, 2010 through August 24, 2011. The Arbitrator awards Petitioner unpaid medical expenses totaling $520.00 for the visits she made to Dr. Malek from October 20, 2011 through December 1, 2011, subject to the fee schedule. The Arbitrator declines to award any expenses associated with the office visit of December 27, 2011 since no records concerning that visit are in evidence.

The itemized bill of Michigan Avenue Medical Associates (see last page of PX 4) shows charges for both carpal tunnel and lumbar spine treatment, with the latter (representing Dr. Erickson's office visits of April 27, May 11 and July 20, 2012) totaling $758.00. RX 9 shows no payments to Michigan Avenue Medical Associates. The Arbitrator, having elected to rely on Dr. Erickson's opinions and treatment recommendations, awards Petitioner Dr. Erickson's charges totaling $758.00, subject to the fee schedule.

The itemized bill of Premier Physical Therapy (see last pages of PX 5) shows unpaid charges of $18,120.00 for therapy rendered from April 4, 2012 through July 19, 2012. The accompanying physical therapy records (PX 5) show two diagnoses: "pain in joint, hand" and

"lumbago." The bill does not designate which of the charges relate to the hand/carpal tunnel condition and which relate to the back. Records in PX 4 show that Drs. Riera and Schafer, who treated Petitioner's carpal tunnel condition, as well as Dr. Erickson, prescribed therapy during the relevant period. On this record, the Arbitrator elects to award Petitioner one half of the therapy charges set forth in PX 5, or $9,060.00, subject to the fee schedule. RX 9 does not show any payments to Premier Physical Therapy.

Is Petitioner entitled to prospective care?

Petitioner seeks an award of the surgery that Dr. Erickson recommended, i.e., a minimally invasive decompression at L4-L5 on the right side and possibly also at L5-S1, depending on the results of intra-operative nerve testing. [See Dr. Erickson's treatment notes of May 11, 2012 and July 20, 2012 in PX 4.] Petitioner testified she wants to undergo surgery but it appears she has not seen Dr. Erickson since July 20, 2012. More than twenty months have passed since that visit.

The Arbitrator awards prospective care in the form of a return visit to Dr. Erickson along with the minimally invasive decompression and intra-operative testing Dr. Erickson recommended on July 20, 2012, assuming the doctor continues to recommend those procedures.

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

Drew Henderickson,

Petitioner,

vs.

NO: 12 WC 41071

Packaging Corp. of Illinois,

15IWCC0234

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 10, 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: MAR 2 7 2015

MB/mam
o:2/5/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENDERICKSON, DREW
Employee/Petitioner

Case# **12WC041071**

PACKAGING CORP OF ILLINOIS
Employer/Respondent

15IWCC0234

On 3/10/2014, 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 0.08% 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:

2208 CAPRON & AVGERINOS PC
NICK J AVGERINOS
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0532 HOLECEK & ASSOCIATES
BARNALDI ROY-MOHANTY
161 N CLARK ST SUITE 800
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

DREW HENDERICKSON
Employee/Petitioner

Case #12 WC 41071

v.

15IWCC0234

PACKAGING CORP. OF ILLINOIS
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 26, 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 August 28, 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.

- In the year preceding the injury, the petitioner earned $85,800.00; the average weekly wage was $1,650.00.

- At the time of injury, the petitioner was 51 years of age, married with no children under 18.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

March 10, 2014

Date

MAR 10 2014

FINDINGS OF FACTS:

On September 5, 2012, the petitioner, a carpenter, sought medical care with Dr. Niemeyer at Lincolnway Medical Associates and reported that both knees hurt and he had a very physical job. The physical examination was consistent with bilateral osteoarthritis, for which the plan was to aspirate/inject the major joint or bursa. X-rays of his knees on October 2nd revealed intact bony structure and osteoarthritic changes and medial joint compartment changes, left greater than the right with no evidence of an acute injury or joint effusion. The petitioner reported that the pain in his knees began at work while lifting heavy objects.

On October 9th, Dr. Robert Semba at Parkview Orthopaedic Group evaluated the petitioner and assessed tricompartmental degenerative joint disease, right greater than the left. An MRI of the right knee on October 17th revealed a complex tear of the medial meniscus body with meniscal substance and a small volume joint effusion. The petitioner told Dr. Semba on October 24th that the only thing he could relate to his meniscal tear was climbing up and down a ladder at work and feeling a pop in his knee. On December 14th, the petitioner had a trans-arthroscopic partial right knee medial meniscectomy. He started a home exercise program on December 20th. The petitioner followed up and on March 14, 2013, was released to work full duty.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on August 28, 2012, arising out of and in the course of his employment with the respondent. The petitioner never reported a trauma or knee

injury prior to October 24, 2012, and at his initial medical care on September 5, 2012, he attributed his bilateral knee pain to heavy work. Also, there was no evidence of an acute injury or joint effusion in the x-rays of his knees on October 2, 2012. It was only after the petitioner's visit with Dr. Semba on October 24, 2012, that he speculated that climbing up and down ladders caused his meniscus tear and notified the project supervisor of an injury the next day. The petitioner's request for benefits is denied and the claim is dismissed.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The petitioner's project supervisor, Brad Sefcik, was notified on October 25, 2012. The petitioner failed to provide timely notice to the respondent. Sefcik denied that the petitioner advised him of an injury prior to October 25, 2008. Sefcik's testimony is consistent with the petitioner's first report on October 24th of a work injury climbing up and down a ladder. The petitioner's request for benefits is denied and the claim is dismissed.

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

Jimmy Wiley,
Petitioner,

vs.

Pace Surburban Bus Service,
Respondent,

NO: 07 WC 38810

15IWCC0235

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, 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 August 13, 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 $22,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 7 2015

MB/mam
o:2/26/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILEY, JIMMY
Employee/Petitioner

Case# **07WC038810**

15IWCC0235

PACE SURBURBAN BUS SERVICE
Employer/Respondent

On 8/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONOVICH
101 N WACKER DR SUITE 101
CHICAGO, IL 60606

1505 SLAVIN & SLAVIN
NICOLE NELSON
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

15IWCC0235

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

Jimmy Wiley
Employee/Petitioner

v.

Pace Suburban Bus Service
Employer/Respondent

Case # 07WC 38810

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 **Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **June 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 3/30/2007, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $37,043.24; the average weekly wage was $712.37.

On the date of accident, Petitioner was 54 years of age, *married* with 0 children under 18.

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

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

Respondent shall be given a credit of $13,230.13 for TTD, $n/a for TPD, $n/a for maintenance, and $n/a for other benefits, for a total credit of $13,230.13.

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

ORDER

Respondent owes and has paid Petitioner temporary partial disability benefits of $474.91/week for 30 5/7 weeks for period commencing March 31, 2007 through October 31, 2007 as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $13,230.13 for temporary total disability benefits that have been paid.

Respondent shall pay to Petitioner reasonable and necessary medical services, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act for medical services relating to the right hip and low back for period commencing March 31, 2007 through October 31, 2007.

Respondent shall pay Petitioner permanent partial disability benefits of $427.42/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Kelli Stetten
Signature of Arbitrator

8/13/14
Date

Factual History

Petitioner, Jimmy Wiley was 54 years old at the time of his work accident of March 30, 2007. He began working as a Bus Mechanic for Pace Bus in 2004. He was later transferred from the Joliet location to the Markham garage. Employment as a bus mechanic requires special training and certification, as well as a Commercial Driver's License (CDL).

As a Bus Mechanic, Mr. Wiley would perform preventative maintenance, as well as interior and exterior repairs. This work would require him to change out heavy parts, including tires, alternators, radiators, or batteries. When performing preventative maintenance he would have to crouch in a pit under the bus. If a bus broke down on a route, Mr. Wiley would be sent on a "road call" to repair it. This would take him away from the garage approximately two (2) to three (3) days per week. Mr. Wiley worked five (5) to six (6) days per week in this heavy duty capacity. Mr. Wiley was 54-years-old and considered himself physically fit with the strength and stamina to complete the above-listed physical duties without issue.

On March 30, 2007, Mr. Wiley was sent on a road call to repair Bus Number 2416. Mr. Wiley arrived on scene with two (2) batteries on a lift truck approximately four (4) feet off the ground. Each battery weighed approximately 90 pounds. He removed the two (2) dead batteries from the bus to the curb. He was in immediate pain and could not get them back to his truck. He then slid them onto the bus. When he was carrying the first replacement battery, he side stepped and felt pain. When carrying the second replacement battery, he felt a tear and pop in his right groin, as well as low back pain.

Mr. Wiley reported his injury to his foreman on the same date. A written report was completed the following day. Respondent does not dispute this accident.

Prior to this injury Mr. Wiley never had complaints of pain in his right hip/groin or lower back. He never had medical treatment to either of these areas.

Respondent directed Mr. Wiley to Ingalls Occupational Health on April 2, 2007. (P.E. 1) He was diagnosed with a right groin strain and low back pain. He was prescribed physical therapy. Mr. Wiley was also evaluated by his primary care physician, Dr. Manzoor Hussain Shah on April 5, 2007. (P.E.3). A CT Scan was obtained on April 20, 2007. Mr. Wiley participated in physical therapy at Accelerated Rehabilitation from April 25, 2007 through July 27, 2007.

A Lumbar Spine MRI obtained on June 18, 2007 revealed multilevel disc bulges with moderate foraminal stenosis at L4-L5. An EMG was reported to be normal on June 22, 2007.

On July 25, 2007, Mr. Wiley submitted to a Functional Capacity Evaluation (FCE). A valid evaluation found Mr. Wiley capable of performing at the medium physical demand level. On August 2, 2007, Ingalls authorized Mr. Wiley to return to work at the medium physical demand level. However, Respondent did not accommodate these restrictions and Mr. Wiley stayed off of work. On August 14, 2007, Dr. Shah authorized Mr. Wiley to stay off work and try work conditioning.

Mr. Wiley submitted to a Section 12 examination with Dr. Gunnar Andersson on September 25, 2007. (R.E.1). Dr. Andersson is a Board Certified orthopedic surgeon with subspecialties in back and neck disorders. (R.E.6, p.6). Twenty percent of his practice is devoted to Section 12 examinations. (R.E. 6, p.12). This is almost always on behalf of the defense. *Id.*

Mr. Wiley reported to Dr. Andersson that he was working as a mechanic and had been lifting four (4) 90-pound batteries on March 30, 2007, when he developed pain in the right groin and lower back. (R.E. 6, p.7). Mr. Wiley denied any history of back or groin pain prior to the accident of March 30, 2007 (R.E. 6, p.12-13). None of the medical records revealed the contrary. (R.E. 6, p. 13) Dr. Andersson testified he observed Mr. Wiley to walk with an antalgic gait indicating hip abnormality, normal back posture, normal range of motion of the lower back, negative straight leg raising, normal lower extremity reflexes, motor and sensory function and decreased hip range of motion in all directions. (R.E. 6, p.8) His report indicates the reflexes were weak. (R.E. 1)

Dr. Andersson reviewed medical records following the accident and found the focus of the evaluations and treatment to have been the lumbar spine. *Id.* Dr. Andersson felt that Mr. Wiley's primary problem was hip osteoarthritis. *Id.* However, Dr. Andersson opined that Mr. Wiley's hip osteoarthritis was not related to his described injury on March 30, 2007. (R.E. 6, p.9). Dr. Andersson opined that Mr. Wiley's work incident did not aggravate or accelerate his hip osteoarthritis. *Id.* At the time of his exam on September 25, 2007, Dr. Andersson felt Mr. Wiley had reached maximum medical improvement in regards to his March 30, 2007 work accident. *Id.* At the time of the examination Mr. Wiley was still complaining of low back pain, as well as numbness in his buttocks and thigh on the right side (R.E. 6, p. 19-20).

Dr. Andersson opined that once Mr. Wiley had a hip replacement, his lower back would no longer be an issue (R.E. 6, p.14). Dr. Andersson explained that Mr. Wiley's hip arthritis was causing a loss of motion affecting the pelvis and the lower back. *Id.* He claimed that if one corrects the hip problem the back problem almost always gets better. *Id.*

Dr. Andersson opined that certain work activities such as lifting and walking can cause a temporary aggravation of the underlying condition (R.E. 1). Dr. Andersson issued an addendum report on May 28, 2009, explaining that one can have an increase in symptoms from any type of activity in which the hip is involved, including walking, lifting, rising, sitting down, stair climbing, etc. (R.E. 2). Dr. Andersson opined that while this may have occurred on March 30, 2007, it does not mean this is why the patient continues to have hip symptoms or needed surgery. *Id.*

On cross-examination, Dr. Andersson was asked how he can determine when the temporary exacerbation or aggravation ends (R.E. 6, p.15). Dr. Andersson testified that the symptoms may continue, but the symptoms caused by the lifting incident, which seems to have involved primarily the back, really are only an initiating event and not a continuing problem. *Id.* Dr. Andersson testified this remains true even though the symptoms and treatment start and continue after the initiating event.

(R.E. 6, p.16). While Dr. Andersson testified Mr. Wiley's accident involved primarily a lifting injury to the back, he admitted that Mr. Wiley complained of right groin pain in his initial presentation in addition to low back pain. (R.E. 6, p.18–19). Dr. Andersson also stated that the right hip was worse than the left at the time of his examination. (R.E. 6, p.18) Further, Mr. Wiley's symptoms did not develop with everyday activities such as walking. *Id.*

Dr. Andersson also stated in his report of September 25, 2007 that Mr. Wiley needs a sedentary job due to the severity of his hip osteoarthritis. (R.E. 6, p.16) Dr. Andersson testified that even though the FCE showed that Mr. Wiley was capable of work at a medium level, this would just irritate his hip more; he needed to be at a job where his hip is not affected. *Id.* Dr. Andersson acknowledged that Mr. Wiley was working in a heavy physical demand capacity prior to his lifting accident and he could not be certain how long Mr. Wiley could have continued in this capacity absent the work injury. (R.E. 6, p.16-17).

Following Dr. Andersson's exam, Mr. Wiley's temporary total disability benefits were terminated on October 13, 2007. On October 22, 2007, Dr. Shah authorized Mr. Wiley to remain off work for his hip and back pain. However, on October 29, 2007, Dr. Shah authorized Mr. Wiley to return to work on November 1, 2007, due to financial hardship. Mr. Wiley did in fact return to work on November 1, 2007. He worked in his normal heavy duties, but his low back pain was "bad" during this time. He was taking Vicodin for his pain.

Mr. Wiley presented to Dr. Moran at Midland Orthopaedic Associates on November 29, 2007. (P.E. 4). Mr. Wiley completed a Medical History form for this appointment wherein he listed low back and right groin pain with an onset of March 30, 2007, lifting four (4), 90-pound batteries. Mr. Wiley also checked the work-related box. However, Dr. Moran's visit note for this date indicates that Mr. Wiley's complaints, examination, diagnosis, and treatment plan was to the left hip. Mr. Wiley testified this is a clerical error on Dr. Moran's part. All of their discussions were regarding the right hip. Mr.

Wiley was not experiencing symptoms in his left hip at this time. This is supported by the intake form and prior exam by Dr. Andersson. Dr. Moran recommended a total hip arthroplasty, but noted that Mr. Wiley had insurance issues and prescribed Diclofenac. (P.E. 4).

Mr. Wiley returned to Dr. Moran on February 7, 2008. (P.E. 4). Dr. Moran noted the left hip to have bone on bone grinding, but this was again typographical error as it relates to the left hip. Dr. Moran observed coxalgic gait and explained that Mr. Wiley's lumbar spondylosis was being aggravated by his hip problem. Dr. Moran issued an addendum to this visit note stating that Mr. Wiley's pain really started when he slipped and injured himself at work on March 30, 2007; his hip was fine prior to that time. Mr. Wiley testified that Dr. Moran's indication that he slipped at work was an error, as he already indicated the lifting incident on the form to Dr. Moran on November 29, 2007. Dr. Moran also authorized Mr. Wiley to return to work February 8, 2008.

On May 28, 2008, Dr. Shah took Mr. Wiley back off work due to his back pain. (P.E. 3). On June 3, 2008, Dr. Shah indicated that Mr. Wiley was still being treated for hip pain. *Id.* Dr. Moran subsequently left the practice and Mr. Wiley was seen by his associate, Dr. Jay M. Brooker on July 16, 2008. Dr. Brooker performed bilateral injections at this time. (P.E. 4). When he followed up on August 11, 2008, Mr. Wiley reported significant improvement with the injections. *Id.* Dr. Brooker authorized Mr. Wiley to return to work on Wednesday. *Id.* Mr. Wiley returned to work for Respondent on August 13, 2008. His employment was later terminated on August 18, 2008. Dr. Brooker repeated the bilateral injections on October 6, 2008. (P.E. 4).

Dr. Brooker issued a Narrative Report on November 18, 2008. (P.E. 5, E. 2). Dr. Brooker is a Board-Certified orthopedic surgeon who treats both lumbar spine and hip injuries in the course of his practice. (P.E. 5, p. 5-6). Dr. Brooker opined that if Mr. Wiley never had symptoms prior to March 30, 2007 than his pain and condition was exacerbated by the incident. (P.E. 5, E. 2). Dr. Brooker acknowledged the pre-existing nature of Mr. Wiley's arthritis, but explained that it was certainly

worsened and aggravated by the work accident. *Id.* According to Dr. Brooker the incident most likely sped up the process of when Mr. Wiley would require such a surgery, even though he would have required surgery at some point in his life. *Id.* The incident significantly aggravated his pre-existing condition and made him unable to work until August 2008. *Id.*

Dr. Brooker testified that certain activities, such as heaving lifting, can cause an aggravation of osteoarthritis. (P.E. 5, p.12). Dr. Brooker testified to reasonable degree of medical and surgical certainty that the incident of lifting the batteries exacerbated Mr. Wiley's hip condition. (P.E. 5, p 13). This exacerbation aggravated his condition sufficiently to make it necessary to receive treatment for the arthritis (P.E. 5, p 13-14). The treatment and injections performed were reasonably required to alleviate Mr. Wiley of the effects of his injury. (P.E. 5, p.14). Dr. Brooker testified that if it was not bothering him before, this was the "straw that broke the camel's back." (P.E. 5, p.16).

Respondent obtained a second Section 12 examination by Dr. Joshua Jacobs on July 20, 2009. (R.E. 4). Dr. Jacobs is a Board-Certified orthopedic surgeon. (R.E. 7, p. 5). Mr. Wiley reported to Dr. Jacobs that he lifted a battery from the tray and felt a sharp, intense pain in the right groin and felt it pop. (R.E. 7, p. 7). He had increasing back pain the next day. (R. E. 4). Mr. Wiley reported not having worked since August 2008. *Id.*

Dr. Jacobs observed a severe coxalgic gait on the right side, less severe on the left side, severe pain with right straight leg raise, and quite painful range of motion. (R.E. 7, p. 8). Dr. Jacobs explained that Mr. Wiley's hip osteoarthritis has progressed since the x-rays of September 25, 2007 and he was now bone-on-bone. (R.E. 4).

Dr. Jacobs opined that Mr. Wiley's bilateral hip osteoarthritis pre-dated March 30, 2007. (R.E. 4). Dr. Jacobs testified that the accident did not accelerate the arthritis in the hips. (R.E. 7, p. 9). Dr. Jacobs testified Mr. Wiley's work related injury temporarily exacerbated the osteoarthritis in the right hip. (R.E. 7, p. 13). Dr. Jacobs explained that heavy lifting is one of the many activities that can

make osteoarthritis painful. (R.E. 7, p. 16). Dr. Jacobs opined that the medical treatment to date was reasonable and necessary, but that future bilateral hip arthroplasties would be required but not related. (R.E. 7, p. 10, 15).

Finally, Dr. Jacobs opined that Mr. Wiley required sedentary work restrictions due to the end-stage severity of the bilateral hip osteoarthritis. (R.E. 7, p. 9). Dr. Jacobs explained that sedentary restrictions are imposed because it's painful when you have arthritis and such activities can lead to progression. (R.E. 7, p. 13). These restrictions would still be necessary after replacements. (R.E. 4). Dr. Jacobs went on to state that these permanent restrictions would have been necessary absent the incident because severe bilateral osteoarthritis pre-dated the work-related injury. (R.E. 4). Dr. Jacobs was unable to state how long Mr. Wiley could have continued in his full-duty job absent the injury. (R.E. 7, p. 15).

Mr. Wiley went on to treat with Dr. Jacobs on September 14, 2009. (P.E. 6). Dr. Jacobs obtained x-rays showing near complete loss of joint space bilaterally, although the right hip was somewhat worse than the left. Dr. Jacobs diagnosed severe disabling osteoarthritis of the right hip, osteoarthritis of the left hip, and low back pain. He recommended that Mr. Wiley pursue hip replacement with Dr. Levine, who would have a quicker schedule.

Mr. Wiley was evaluated by Dr. Levine on September 18, 2009. (P.E. 6). Dr. Levine noted that the left hip also has very poor range of motion but no significant pain. Dr. Levine planned to proceed with right hip arthroplasty. Mr. Wiley underwent an additional pre-operative visit on October 23, 2009. His pre-operative lab work, chest x-rays and electrocardiogram (EKG) was performed at Advocate Trinity Hospital on October 26, 2009 and November 2, 2009. (P.E. 2). Right hip arthroplasty was performed by Dr. Levine at Rush University Medical Center on November 11, 2009.

Mr. Wiley attended post-operative therapy at Advocate Trinity Hospital beginning on November 24, 2009. The initial evaluation listed lifting four (4), 90-pound batteries at work with twisting when

pain began in the right groin area, as the mechanism of injury. Mr. Wiley attended this therapy through January 5, 2010. Mr. Wiley also underwent post-operative labs for monitoring his Coumadin blood thinner to prevent a deep vein thrombosis (DVT) at Advocate Trinity Hospital through December 7, 2009.

Mr. Wiley attended his three-week follow-up with Dr. Levine on December 4, 2009. At his six week follow-up status post right hip replacement on January 8, 2010, Dr. Levine noted that the left hip was now bothering him worse than the right. Mr. Wiley testified that it was not until now that he first had a problem with the left hip. He denied injuring his left hip in the original accident on March 30, 2007. This is confirmed in Dr. Levine's visit note on November 8, 2011.

Mr. Wiley attended his six month follow-up with Dr. Levine's Physician Assistant on May 18, 2010. He was noted to have severe limitations on the left side and some back pain. Mr. Wiley wanted to delay left hip replacement. Mr. Wiley continued to treat his left hip pain with injections by Dr. Levine on August 17, 2010, February 1, 2011, and May 3, 2011.

Mr. Wiley presented to Dr. Levine with new complaint of low back pain following a fishing trip on June 24, 2011. Dr. Levine diagnosed low back spasm and prescribed Flexeril and Flector patch samples. Mr. Wiley testified that his low back pain continued after his right total hip arthroplasty. The fishing trip made his ongoing low back pain temporarily worse. It then returned to the baseline low back pain that he experienced without relief since the accident.

On November 8, 2011, Mr. Wiley requested to proceed with scheduling his left hip surgery. He complained of numbness and tingling in his feet and some back pain. Dr. Levine referred Mr. Wiley to his associate, Dr. Phillips. Mr. Wiley was evaluated by Dr. Phillips on December 6, 2011 for low back pain. Dr. Phillips noted the onset was in 2007 while working as a mechanic for Pace, lifting 90-pound bus batteries with immediate pain with radiation into the leg. The back pain was not as

significant as the lower extremity symptoms. Dr. Phillips ordered a lumbar spine MRI to determine whether left lower extremity symptoms were originating in the hip or the back.

An MRI of the lumbar spine obtained on December 13, 2011 revealed:

(1) minimal anterolisthesis L4 on L5;
(2) degenerative disc disease throughout, most pronounced at L4-L5;
(3) severe bilateral facet arthropathy L4-L5 and L5-S1; and
(4) L4-L5 posterior disk extrusion with mild superior migration causing moderate to severe spinal canal stenosis and mild bilateral foraminal stenosis.

Mr. Wiley underwent left total hip arthroplasty by Dr. Levine on January 19, 2012. He attended his post-operative therapy and labs at Advocate Trinity Hospital. On February 3, 2012, Dr. Levine noted Mr. Wiley would see Dr. Phillips due to continued back problems. On March 6, 2012, Dr. Phillips referred Mr. Wiley to the pain clinic.

Mr. Wiley was seen by Dr. Zhang in the pain clinic on March 22, 2012. (P.E. 6). It was noted that he was initially injured at work in 2007 while lifting a heavy object, with persistent low back pain radiating to the back of both thighs. Dr. Zhang administered a bilateral L4 transforaminal selective nerve root injection. This was repeated on April 20, 2012. Mr. Wiley reported improvement after the first injection, with low back pain only when walking on certain days. The third injection was administered on June 7, 2012. Mr. Wiley reported being pain-free for two-weeks after the second injection. At his six-month follow-up with Dr. Levine status post left total hip arthroplasty on July 3, 2012, Mr. Wiley reported no pain in the hips but difficulty walking due to low back pain. Dr. Levine cautioned Mr. Wiley to avoid high impact activities due to the bilateral total hip arthroplasties.

Mr. Wiley presented for his fourth injection with Dr. Zhang on July 19, 2012. He reported another pain flare after a three day fishing trip with uneven terrain.

Mr. Wiley followed-up with Dr. Phillips for spondylolisthesis and spinal stenosis on July 26, 2012. The injections provided temporary relief, but since his function was reasonable Mr. Wiley did not want

to pursue surgery at this time. Mr. Wiley went on to have additional visits with Dr. Zhang on December 18, 2012, November 15, 2012, December 17, 2012, and January 3, 2013.

Mr. Wiley testified that he continues to experience low back pain. He described it as excruciating. He experiences it day-in and day-out. He continues to treat his pain with medications prescribed by Dr. Shah. He reported seeing Dr. Shah just Monday last week before trial. His pain wakes him up and makes him want to cry. He rates it as eight (8) out of ten (10). He cannot cut the grass, do prolonged walking, or stand more than fifteen to twenty minutes.

Mr. Wiley has had good relief of his hip pain following right total hip arthroplasty. However, he has never been cleared to return to the heavy physical demand level and was specifically cautioned by Dr. Levine to avoid high impact activities. He has not worked for any other employer since his employment with Respondent terminated in August 2008.

Analysis/Findings

F. In support of the Arbitrator's Decision with regards to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

To recover in a preexisting condition case, a claimant need only establish a causal connection between her work-related injury and claimed current condition of ill-being by showing that her injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, 797 N.E.2d 665, 278 Ill.Dec. 70, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199, 775 N.E.2d 908 (2003)). As in this case, even where an employee has a pre-existing condition that renders her more vulnerable to an injury, "recovery for an accidental injury will not be denied as long as it can be shown that the

employment was also a causative factor." *See Sisbro*, 207 Ill. 2d at 205 (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122, 51 Ill. Dec. 685, 421 N.E.2d 193 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18, 12 Ill. Dec. 716, 370 N.E.2d 520 (1977)).

Whether a claimant's disability is attributable solely to a degenerative process of the preexisting condition or to an aggravation or acceleration of a preexisting condition because of an accident is a factual determination to be decided by the Industrial Commission. Roberts v. Indus. Comm'n, 93 Ill. 2d 532, 538, 67 Ill. Dec. 836, 445 N.E.2d 316 (1983); Caterpillar Tractor Co. v. Indus. Comm'n, 92 Ill. 2d at 36-37; Caradco Window & Door v. Indus. Comm'n, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981).

In the case of Crader v. Frito Lay, 3 IIC 599 (2003), the Commission relied on Sisbro and held that the claimant's work related injury hastened his need for surgery and set off the chain of events leading to his current condition. The Commission found that the petitioner's work injury "hastened" the need for his knee replacement even though the petitioner had severe pre-existing arthritis. In Crader, the petitioner's treating physician testified that although the petitioner had several years of extensive treatment to his knee and pre-existing arthritis, the work accident was, "the straw that broke the camel's back and put petitioner in a situation where he felt like he was not able to function without going ahead with the joint replacement." *Id.* The Commission relied on the petitioner's treating physician and found that even though the petitioner had pre-existing arthritis, his work injury necessitated the need for surgery, and thus it was a compensable case.

In the case at bar, Mr. Wiley had pre-existing right hip arthritis. He had documented significant pre-existing bilateral hip osteoarthritis. He worked without issue until his injury on March 30, 2007. While his right hip arthritis could warrant a total hip arthroplasty at some indeterminable point in the future, Petitioner had no imminent medical directives for the same. The issue is whether the accident

at work on March 30, 2007 caused the need the total hip replacement surgery through an aggravated or accelerated the pre-existing condition or if the work accident caused a temporary exacerbation of Mr. Wiley's pre-existing condition which subsided.

The treating physician, Dr. Brooker and the IMEs, Drs. Andersson and Jacobs give differing medical opinions as to this causation issue. Drs. Anderson and Jacobs opine that the accident of March 30, 2007 caused a temporary exacerbation of Mr. Wiley's pre-existing condition. Dr. Brooker opines that Mr. Wiley's pre-existing arthritis was worsened and aggravated by the work accident which hastened the need for the hip replacement. (P.E. 5).

Upon a review of the differing medical opinions, the comprehensive medical records and witness testimony, the Arbitrator finds that the Petitioner experienced a temporary exacerbation of pain as a result of picking up the 90lbs batteries but that his condition returned back to the baseline by October, 2007.

Initially, it is worth noting that Petitioner is a likeable, hardworking and honest individual. His testimony and demeanor in court were noteworthy. He did not exaggerate his condition and he appeared to take his work duties seriously. The Arbitrator gives weight to his testimony regarding his symptoms and his pain. However, Petitioner credible testimony does not overcome the medical question regarding the cause of Petitioner's continued and extensive hip and back pain. The burden is upon the Petitioner and he had failed to prove by a preponderance of credible evidence that his current condition of ill-being is related to the March 30, 2007, incident. The Arbitrator finds that Petitioner experienced a temporary exacerbation of pain as a result of picking up the 90lbs batteries. His current condition of ill-being is related to his severe degenerative condition of his hips and back rather than his work related accident.

Right Hip

Petitioner claims his work related accident on March 30, 2007, aggravated and accelerated his right hip degeneration. He testified credibly to never having any prior hip pain or treatment for either hip. Dr. Brooker opines that the work related accident accelerated Petitioner's need for right hip replacement. Pet. Ex. 5. The two IME's disagree. The Arbitrator finds the opinions of Dr. Andersson and Dr. Jocobs to be more persuasive on the issue. Dr. Jacob testified that, "The problem here is that the accident really is not an accident to the hip joint, it is a lifting activity." Res. Ex. 6, p. 17. The mechanism of Petitioner's injury does not correlate to an injury to the hip joint. It can cause a temporary period of pain, not permanent damage to the hip. Dr. Jacobs and Dr. Andersson stated that these flare-ups of pain can happen with any activity of daily living. Res. Ex. 6 and 7.

The Arbitrator is persuaded by this point along with clear evidence that Petitioner's left hip was just as bad, if not worse and in need of treatment. Dr. Brooker simultaneously treated both of Petitioner's hips including injections and recommendation for replacement. Further, on October 25, 2007, bilateral hip x-rays were taken that showed degeneration was more severe in the left hip. Dr. Jacobs recommended bilateral total hip replacement at the time of his IME examination on July 20, 2009. Petitioner's right hip treatment was not accelerated by the March 30, 2007 accident as he was simultaneously receiving left hip treatment for his severe degeneration.

Lastly, Petitioner's hip condition healed and returned to baseline to a degree that allowed him to resume and perform full time work duties starting November 1, 2007. The Petitioner continued to do a heavy demanding job until when he was taken off work in Mary, 2008. The Arbitrator finds this six month period where Petitioner continued in his labor-heavy employment to be a significant factor in determining whether the Petitioner's accident caused a temporary exacerbation or a permanent shift of his baseline relating to the hip condition.

Based on these factors, the Arbitrator concluded that Petitioner suffered a temporary exacerbation of his right hip condition but that the condition subsided and Petitioner returned to work on November 1, 2007.

Left Hip

The Arbitrator finds that Petitioner did not sustain any injury to his left hip on March 30, 2007. The Arbitrator infers that any indication to the contrary by Midland Orthopedic Associates was typographical error, as evidenced by the Medical History completed by Petitioner at his first visit on November 29, 2007. The medical evidence as a whole shows that all of Petitioner's complaints were to the right hip. Petitioner himself testified that he did not injure his left hip as a result of the lifting accident on March 30, 2007. He did not experience symptoms in his left hip that required treatment until after he had the right total hip replacement in 2009. His first complaint of left hip symptoms was to Dr. Levine on January 8, 2010. As such, the Arbitrator finds that Petitioner's condition of ill-being as it relates to the left hip is not causally-related to the accident at work on March 30, 2007.

Lower Back

Petitioner claims injury to his lower back as a result of the accident of March 30, 2007. There is a notation of low back pain at the company clinic on April 2, 2007. Petitioner has consistently complained of right groin and low back pain to all providers. A lumbar spine MRI on June 18, 2007 revealed multi-level disc bulges with moderate foraminal stenosis at L4-5. Drs. Andersson and Brooker had opined that Petitioner's low back pain would improve once his right hip condition was no longer aggravating it. However, Mr. Wiley continued to complain of back pain post surgery. There is testimony that Mr. Wiley aggravated his low back pain due to increased activity and/or fishing trips.

All three physicians, Dr. Brooker, Dr. Anderson and Dr. Jacobs have opined that that Petitioner's low back pain was a result of his poor ambulation from his hip pain, not as a result of the March 30, 2007, accident. Pet Ex. 5, Res. Ex. 6 and 7. Multiple MRIs of his lumbar spine reveal

degenerative findings in the back. However, Petitioner was able to work in his full duty capacity until the accident. The Arbitrator finds that the accident on March 30, 2007 did caused a temporary exacerbation of Petitioner's pre-existing degenerative condition but that said condition subsided by October 13, 2007. Dr. Anderson's medical records clearly indicate that on the September 25, 2007, visit, the Petitioner's low back pain symptoms were not that intense and he had reached MMI with regards to his back. Res. Ex. 6, p. 19.

Petitioner returned to work on October 31, 2007, and was able to work full duty with no low back complaints until May 28, 2008, when he was taken off work for his hip pain. Therefore, the Arbitrator finds that the Petitioners current condition of ill-being relating to his back is not related to the accident on March 30, 2007.

J. In support of the Arbitrator's Decision with regards to 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 as follows:

Right Hip

Dr. Brooker and Dr. Jacobs have opined that all of the medical treatment to date was reasonable and necessary. (R.E. 7, p. 15) (P.E. 5, p. 14). Therefore the issue regarding the medical bills stems on whether the right hip medical condition was causally connected. The Arbitrator awards medical bill for treatment regarding the right hip and low back until medical service date from date of accident till November 1, 2007 based on the causal connection finding that the right hip was a temporary exacerbation..

Petitioner's Fee Schedule Analysis of the outstanding medical bills is attached and has been made a part of Arbitrator's Exhibit No. 1.

Specifically, the Arbitrator awards the following charges:

- Advocate Trinity Hospital services August 16, 2007 through November 1, 2007.
- Chicago Imaging, Ltd., services August 16, 2007 through October 26, 2007.
- University Pathologists, P.C., bills from March 31, 2007 through November 1, 2007.

The Arbitrator awards these bills subject to the fee schedule and allows Respondent credit for payment of the same.

Left Hip

Based upon the Arbitrator's conclusions on causal connection above, and the record as a whole, the Arbitrator denies any medical charges related to the left hip. The evidence shows that Petitioner did not injure his left hip in the accident of March 30, 2007. Any expenses listed in Petitioner's Fee Schedule Analysis to be for the left hip is denied. Specifically, the Arbitrator denies the following charges:

- Advocate Trinity Hospital from August 4, 2010 to present.
- Affiliated Radiologists, S.C. on January 3, 2012 and January 19, 2012.
- Chicago Imaging, Ltd. From December 31, 2010 to present.
- Midland Orthopedic Associates for left hip injections on July 16, 2008 and October 6, 2008.
- Midwest Diagnostic Pathology for services on August 4, 2010.
- Midwest Orthopedics at Rush, LLC, for services on August 17, 2010, February 1, 2011, March 3, 2011, January 3, 2012, January 19, 2012, February 3, 2012, and March 6, 2012 with Dr. Levine.
- Provident Hospital all services. No medical records were introduced to support these charges.
- Dr. Shah for services on April 24, 2007, May 29, 2007, May 31, 2007, December 22, 2007, May 20, 2008, May 29, 2008, May 31, 2008, June 3, 2008, June 7, 2008, June 30, 2008, August 21, 2008, August 28, 2008, September 2, 2008, March 9, 2010, August 5, 2010, September 25, 2010, February 7, 2011, February 19, 2011, August 2, 2011, August 16, 2011, December 1, 2011, January 2, 2012, January 12, 2012, February 20, 2012, May 1, 2012, July 9, 2012, August 2, 2012, August 7, 2012, October 2, 2012, October 4, 2012, November 15, 2012, and December 4, 2012.
- University Anesthesiologists, S.C. for services on January 19, 2012.

The Arbitrator notes that Medicare is claiming Conditional Payments for some of the above-listed dates. Specifically, the payment to Rush University Medical Center on January 3, 2012 is not causally-related. The Arbitrator also notes that First Recovery Group is requesting reimbursement on behalf of Advocate Health Partners for services of Dr. Brooker for the left hip injection on July 16, 2008 that is not causally-related. Only the right hip injection on this date is related. Further, the cervical services on January 29, 2008 are not causally-related.

Lower Back

Based on the above findings and the record as a whole, the Arbitrator awards medical bill for treatment to the lower back up to the return to work date of November 1, 2007. The arbitrator notes the MMI date of September 25, 2007 based on the records and opinion of Dr. Anderson. Res. Ex. 6, p. 19.

Specifically, the Arbitrator awards the following:

- Advocate Trinity Hospital services on April 6 and April 19, 2007.
- Chicago Imaging, Ltd. Services on April 6 and April 19, 2007.
- Dr. Shah's services on April 6, 2007, April 12, 2007, April 16, 2007, August 14, 2007, August 17, 2007, August 20, 2007, October 22, 2007, October 25, 2007, October 29, 2007, November 1, 2007.

In conclusion, the Arbitrator awards medical for the back till the return to work date of November 1, 2007. The Arbitrator has specifically allowed for the follow-up visit bill with Dr. Shah on November 1, 2007 which is past Dr. Anderson's MMI note.

K. In support of the Arbitrator's Decision with regards to what temporary total disability benefits Petitioner is entitled to, the Arbitrator finds the following:

Petitioner claimed entitlement to TTD benefits from March 31, 2007 through October 31, 2007, May 29, 2008 through August 12, 2008, and November 19, 2009 through May 18, 2010. Respondent claimed Petitioner was only entitled to TTD benefits from March 31, 2007 through October 31, 2007. Respondent paid Petitioner $13,230.13 for this TTD period. Petitioner returned to work for Respondent on November 1, 2007.

Dr. Shah then took Petitioner back off work for his low back and right hip pain on May 28, 2008. Petitioner was improved enough following right hip injection by Dr. Brooker to return to work on August 13, 2008. He worked full duty when he was terminated on August 18, 2008. He underwent his right total hip arthroplasty on November 19, 2009. Based on the above findings and the record as a whole, the Arbitrator finds that was entitled to and did receive TTD for the period of March 31, 2007 through October 31, 2007. Additional TTD benefits are denied.

L. In support of the Arbitrator's Decision with regards to the nature and extent of Petitioner's injury, the Arbitrator finds the following:

The lifting accident on March 30, 2007 caused temporary exacerbation to Mr. Wiley's right hip and lower back. Petitioner returned to full duty work on November 1, 2007 and continued in this capacity until May 28, 2008. Dr. Shah then took Petitioner back off work for his low back and right hip pain on May 28, 2008. Petitioner was improved enough following right hip injection by Dr. Brooker to return to work on August 13, 2008. He worked full duty when he was terminated on August 18, 2008. He underwent his right total hip arthroplasty on November 19, 2009.

A valid FCE on July 25, 2007 had found Mr. Wiley capable of performing at the medium physical demand level. Respondent's two Section 12 examiners opined that even with right hip replacement, Mr. Wiley should be restricted to sedentary work. Petitioner's treating physician, Dr. Levine, advised against high-impact activities.

Petitioner has undergone post-operative therapy, labs and injection for low back pain. He has had good relief of his hip pain but suffers from extensive back pain. He has never been cleared to return to the heavy physical work and has not worked for any other employer since August 2008.

The Arbitrator has found that the Petitioner's injury to his low back was a temporary aggravation of his degenerative condition. He reached MMI six months following his work related accident on or about September 25, 2007. Petitioner successful returned to full time work after this date and continued in this capacity until May 28, 2009. Therefore, the Arbitrator finds permanency at 5% loss of man as a whole for the right hip injury and 5% loss of man as a whole for the low back injury. Arbitrator awards a total of 50 weeks at the rate of $427.24/week.

Kethi Steffen
Signature of Arbitrator

8/13/14
Date

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra Wulf,

Petitioner,

vs.

NO: 11 WC 19789

Red Lobster,

15IWCC0236

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the Decision of Arbitrator Zanotti in a §19(b) proceeding finding that as a result of accidental injuries arising out of and in the course of her employment on February 18, 2011, Petitioner was entitled to medical expenses of $19,706.02, that Respondent was entitled to credit under §8(j) of the Act for medical expenses paid by group health insurance, that Petitioner was entitled to prospective medical care and ordered Respondent to authorize and pay for medical treatment recommended by Dr. Gornet and that Respondent was entitled to credit of $1,571.70 for TTD benefits paid and $3,587.44 for TPD benefits paid, a total credit of $5,159.14. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of her employment on February 18, 2011, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the amount of medical expenses and whether she is entitled to prospective medical care. The Commission, after reviewing the entire record, reverses 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 February 18, 2011 and denies Petitioner's claim for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On May 24, 2011, Petitioner filed an Application for Adjustment of Claim which listed a date of accident of February 18, 2011 and alleged that she sustained right shoulder and upper back injuries while pulling a box of crab off of a stack of boxes.

At the arbitration hearing, Petitioner's attorney made an oral motion to amend the Application for Adjustment of Claim to include injuries to the cervical spine (Tr 4). Respondent's attorney objected, arguing that Petitioner could have amended the Application long before this point in time (Tr 5). Petitioner's attorney argued that amendments to Applications are allowed at any time prior to closing of proofs to conform with the evidence and there was no prejudice to Respondent by this amendment (Tr 6). The arbitrator overruled Respondent's objection and allowed Petitioner's oral motion to amend the Application to include the cervical spine for claimed injuries (Tr 6). The parties stipulated that in the event that the medical bills were awarded that those bills could be paid directly to the providers pursuant to the fee schedule and that Respondent would get credit for any medical bills that were previously paid (Tr 6). Petitioner's attorney informed that Petitioner was not claiming any TTD or TPD benefits because all of those benefits had been paid by Respondent (Tr 7).

2. Petitioner, a 54 year old production worker, testified she has worked at Respondent for 31 years (Tr 14-15). She prepares food that has to be cooked (Tr 15). Petitioner testified she was injured on February 18, 2011 and on that date, "I went into the freezer to get crab legs to do that day, prepare for that day; and they were kind of stuck to the wall, stuck to the freezer wall because sometimes it condensates; and it gets wet; and then after it refreezes, it kind of sticks to the wall; and I went in; and they were above my head; so it was like maybe six foot above my – because I had to stretch to get to them; and when I pulled them down, they fell on top of me; and then I fell back and hit my back on some more product that was in the freezer because our freezer all four walls are product in there. So when I brought the crab legs down, they just kind of fell on top of me." (Tr 15-16). The crab legs were in boxes weighing 40 pounds each. The boxes were stacked on top of each other. She had to get a 40 pound box down, deglaze the crab legs and weigh them out (Tr 16). Petitioner is about 5'4" tall (Tr 16). She was standing on her tippytoes and reaching up with both arms (Tr 17). Petitioner had grabbed the 40 pound box of crab legs (Tr 17). She fell backwards against product that was in boxes (Tr 18). Petitioner reported what happened to general manager Michael Tomms the same day that it happened (Tr 18). Immediately after the accident, Petitioner hurt but felt she could finish the day and did so (Tr 19). The 40 pound box fell on her chest (Tr 19). Her chest hurt, her back hurt and her arms were a little sore because she tried to catch the boxes that came down when she fell against them (Tr 19).

Petitioner testified that on February 22, 2011, she went to the emergency room at St. Anthony's (Tr 19). After that, she followed up with her primary care physician, Dr. Patel (Tr 19). Dr. Patel ordered physical therapy, which Petitioner attended (Tr 20). At Respondent's request, Petitioner saw Dr. Petkovich and he recommended additional physical therapy, which she attended (Tr 20). Ultimately, Petitioner's attorney gave her a list of 3 or 4 doctor's names and she picked Dr. Gornet (Tr 20). Petitioner saw Dr. Gornet and he ordered MRIs of her neck

and back. Dr. Gornet then referred her to Dr. Boutwell, who gave her two injections between her shoulder blades (Tr 21). The injections did help, but wore off (Tr 21). It is Petitioner's understanding that Dr. Gornet has recommended surgery for her consisting of replacing C6-7 (Tr 21-22). Dr. Gornet told Petitioner he would have to go through her neck to get to it (Tr 22).

Petitioner testified she is currently working full duty. She is currently having neck pain all the time, which is not so bad that she cannot stand it (Tr 22). After working a few hours, her pain gets worse and by the end of the day it is really bad (Tr 22). Her pain starts between her shoulder blades, around her neck area down toward her shoulder blades. By the end of the day the pain is in her hips (Tr 22). Petitioner wants to have the recommended surgery done (Tr 23). Prior to the work injury, Petitioner had never had neck or back treatment. Prior to the work injury, Petitioner never had a MRI or injections in her neck or back or x-rays of her neck or back (Tr 23). Petitioner was handed Rx2 and acknowledged that the document says "accident report" on the top (Tr 23-24). Petitioner was pretty sure she filled out Rx2 at Dr. Patel's office on August 30, 2011 (Tr 24). Petitioner acknowledged that under accident date she wrote down "3-28-11" (Tr 24). Petitioner explained that she wrote that date down because it had been so many months in between and she had so many doctor appointments and different things had gone on. Petitioner then stated she could not explain it and did not know why she wrote that down (Tr 24). It is fair to say that it is a mistake and all the other things filled out in Rx2 are correct (Tr 25). Rx2 was later admitted into evidence.

On cross-examination, Petitioner testified that the first treatment she had was when she went to the emergency room on February 22, 2011 (Tr 25). Her claimed injury was on February 18, 2011 (Tr 26). Petitioner worked the rest of her shift on February 18, 2011 (Tr 26). She was not sure if she worked on February 19, 2011. Her schedule was not a set schedule and if she was scheduled to work, she worked (Tr 26). She was not under any restrictions from any doctor at that time (Tr 26). Petitioner did not seek any treatment before going to the emergency room on February 22, 2011 (Tr 26-27). When she went to the emergency room on February 22, 2011, Petitioner was asked how she was injured, her complaints and what was hurting her (Tr 27). She was truthful and honest with the physicians at St. Anthony's Hospital on February 22, 2011(Tr 27). It is fair to say that it was likely that the events and her complaints were more fresh in her mind on February 22, 2011 than they are on the day of this hearing (Tr 27). Petitioner stated that she did tell the emergency room doctors about her specific accident of February 18, 2011 (Tr 28). If the emergency room records reflect there was no specific history, Petitioner is not saying those records are wrong (Tr 28). When she went to the emergency room, Petitioner told them she was having chest pains because that was what it felt like (Tr 28). Petitioner had told Respondent earlier that week that she got hurt in the freezer and if Respondent did not document that, she did not know about that (Tr 29). Petitioner remembered him telling her that the back spasms she was having could have been from the box falling on her; Petitioner did not say who she was referring to (Tr 29). Petitioner complained of chest pain, but it really was not chest pain; it was like in her upper shoulder and down her arm (Tr 30). She was also complaining of her shoulders hurting (Tr 30). She also complained that her back and neck hurt that day (Tr 30). Petitioner was asked, "Q. Would it be accurate to say that you never

specifically complained about your neck that day on February 22, 2011? She answered, "A. I can't recall that I told them that or not, but I told them what I hurt, and at that time I was hurting all the way across, which to me from here down (indicating) is part of my neck and across my back. That's what I call my shoulder blades so –." She was asked, "Q. But if the records would reflect there were no specific complaints that say your neck was hurting, would you say that might or could be true?" She answered, "A. It might be, yeah." (Tr 30-31).

Petitioner was shown Rx3, Page 9 of the St. Anthony's Health Center records and agreed that there is a section that is titled "neck." (Tr 33). Next to that it says "painless ROM" and that box was checked (Tr 33-34). Rx3 was later admitted into evidence. Petitioner saw Dr. Patel a few days after being seen in the emergency room (Tr 35). She was also seeing Dr. Patel for carpal tunnel syndrome (Tr 35). The records indicate Petitioner saw Dr. Patel on March 22, 2011 (Tr 35). Petitioner was sure she gave Dr. Patel a history of her February 18, 2011 accident (Tr 36). Petitioner was not saying Dr. Patel's records were wrong if his records do not contain a statement of specific accident on February 18, 2011 (Tr 36). Petitioner saw Dr. Patel again on May 4, 2011 and complained of pain in her back below her shoulders; she might not have mentioned any complaints of her neck (Tr 37). Petitioner would tell Dr. Patel every area where she was having pain (Tr 38). Petitioner was sure she gave Dr. Patel a history of what happened regarding the box of crab legs (Tr 39).

Petitioner filled out an accident report on August 30, 2011. She had kept telling Dr. Patel that she was hurt and he finally decided to have her fill out an accident report, but she was just speculating (Tr 40). Petitioner was shown Rx2, the accident report dated August 30, 2011, and acknowledged it states "3-28-11" as the accident date (Tr 40). Petitioner did not recall what date she gave as the date of accident on the Application for Adjustment of Claim for her claim for right and left carpal tunnel syndrome; she then stated that was probably that date (Tr 41). She then stated that might be why she put a date of accident of March 28, 2011 on Rx2 in Donna Hale's office; she acknowledged she signed Rx2 (Tr 42). Petitioner acknowledged that Rx2 states that the crab leg box was frozen to the wall and when she pulled it out, she hurt her back; she acknowledged it did not say neck; she stated she did not always put back and neck in everything (Tr 42-43). Rx2 was later admitted into evidence. Petitioner stated she hurt from her neck down to her shoulder blades (Tr 43). Petitioner testified she asked Dr. Patel for a back brace for her whole torso on September 27, 2011 (Tr 43-44). She recalled that Dr. Patel x-rayed her thoracic spine.

Petitioner testified she then began treating with Dr. Gornet (Tr 45). She picked Dr. Gornet's name from the 2 or 3 names her attorney gave her (Tr 45). She first saw Dr. Gornet in October 2011 (Tr 45). Dr. Gornet discussed surgery after she underwent a MRI (Tr 46). Injections only gave her temporary relief for maybe 3 weeks (Tr 46). Dr. Gornet did not recommend physical therapy (Tr 47). She last saw Dr. Gornet on April 14, 2014 (Tr 47). Prior to that she last saw Dr. Gornet in November 2013 (Tr 47). She had no other treatment from November 2013 to April 2014 (Tr 47). Petitioner has been working regular duty the last 6

months (Tr 47). She is currently working full time, 35 to 40 hours per week. Dr. Gornet has not placed any specific restrictions on her work (Tr 48). At Respondent's request, Petitioner saw Dr. Petkovich on December 29, 2011 for an independent medical evaluation. Dr. Petkovich asked Petitioner how she was injured and she was honest and truthful in answering his questions (Tr 48). Petitioner was almost certain she told Dr. Petkovich that her neck and back were hurting at that time (Tr 48). She was not going to call Dr. Petkovich a liar if his report stated that she told him she was not having any neck pain the day she saw him (Tr 48-49). She could not fully turn her neck at that time (Tr 49). She also saw Dr. Petkovich on December 30, 2013 (Tr 49). Petitioner brought her MRI films and gave them to Dr. Petkovich (Tr 49).

Petitioner was shown Rx4, the Application for Adjustment of Claim for this case (Tr 50). The Application is dated May 10, 2011 and Petitioner acknowledged she signed it. Her attorney had asked her questions at that time and she answered them. Petitioner acknowledged she had an opportunity to review the Application before she signed it (Tr 51). The Application stated the part of her body affected were her right shoulder and upper back (Tr 52). The events of February 22, 2011 were more fresh in her mind on May 10, 2011 than they are at the time of this hearing (Tr 52). Rx4 was later admitted into evidence. Petitioner testified she works her job at Respondent as a production worker. She prepares food, reaches overhead, lifts and carries pots and pans and carries trays (Tr 52-53). Petitioner did tell Dr. Gornet that she is a production worker at Respondent (Tr 53). Dr. Gornet did have her on a lifting restriction of 10 to 15 pounds for a few months (Tr 53). Currently, Dr. Gornet has her under no restrictions because he was going by what Dr. Petkovich had put in his records and told Petitioner that they should go by what Dr. Petkovich said (Tr 53).

The box of crab legs fell and hit her in the chest. She was facing the box (Tr 54). She fell backwards and hit another box (Tr 54). The boxes are stacked to the ceiling along all 4 walls in the freezer most of the time (Tr 54). Her manager has the guys lift the 40-pound boxes of crab legs now for her (Tr 55). Petitioner takes Ibuprofen for pain throughout the day. She does not take prescribed medication (Tr 55).

On re-direct examination, Petitioner pointed to where she currently hurt. She did not clarify for the record where she was pointing to (Tr 56-57). Her pain starts up in her neck and goes down and across her shoulders (Tr 57). She has headaches almost every day (Tr 58). When she used the term "upper back" on the Application for Adjustment of Claim, she was referring to her neck down to her ribs (Tr 58). Petitioner was shown Rx3, Page 5, a pain diagram (Tr 58). The emergency room personnel asked her to indicate on the pain diagram where her pain was at that time. She acknowledged that maybe she did not put it exactly where she was supposed to. The picture is pretty accurate, but she should have drawn a little bit higher. She is pretty sure she scribbled it and not the doctor, but then stated she did not know (Tr 59). All the way across her chest was sore because the box hit her in the chest (Tr 60). She kind of caught the box when it came to her chest (Tr 60).

3. St. Anthony's Health Center records, Px1 and Rx3, indicate Petitioner was seen in the emergency room on February 22, 2011 for complaints of back pain and chest pain. The following was noted in the Nursing Assessment: "Pt reports back pain that started 3 days ago and is now radiating around into her chest. Reports her chest feels "sore" and hard for her to take a deep breath." The Emergency Department Flowsheet included a diagram of Petitioner's complaints which showed the word "sore" with lines to below the shoulders on each side was drawn. On the back of the diagram the word "pain" with squiggly lines between the shoulder blades and just below is drawn. The following is noted in the Emergency Services Patient Care Notes: "54 y/o female to ER, 10. Pt A & O x 3. Resp even-not labored. Pt comes in with c/o back pain x 3 days that is now radiating around to the front making her chest sore. Pt tender to touch on chest/shoulders & back. Reports hurts to take a deep breath. Pt has no complaint of radiating "chest pain"." Petitioner was given discharge instructions and two prescriptions. She was to follow-up with her primary care physician.

The Emergency Physician Record Low Back Pain/Injury dated February 22, 2011 noted the following: "Chief complaint: pain to back. Onset 3 days. Feel soreness at left chest wall over left pectoral muscle arc with ache to muscles at scapular tip bilaterally for past 3 days. Does a lot of lifting frequently." A pain diagram was included which showed the same as the Flowsheet diagram. It was noted there was supraclavicle pain only with active movements of the upper extremity. An examination of the neck was noted as a normal inspection, non-tender with painless range of motion. An EKG was performed and the results were within normal limits. The clinical impression was noted as musculoskeletal back pain. Petitioner was prescribed Flexeril and Tylenol #3. She could perform activity as tolerated. Petitioner was to follow-up with her primary care physician Dr. Patel as needed. The Commission notes that there was no mention of a February 18, 2011 accident or neck pain in any of the emergency room records.

4. Patel Internal Medicine records, Px2, indicate Petitioner contacted Dr. Patel's office by telephone on March 1, 2011 and left a message that she was in severe pain from possible carpal tunnel syndrome. It was noted that she had been given Mobic, but it was not helping. Petitioner requested something stronger. In a Progress Note dated March 22, 2011, it was noted that Petitioner reported her chief complaint was right hand tingling, it was painful to her elbow and she felt a pinch in her right shoulder. Petitioner reported numbness of the right 2nd and 3rd fingers and at times radiated to her right elbow. She was unable to hold a cup. On examination, Dr. Patel found Petitioner's neck to be within normal limits and mild tenderness of the left scapular. Dr. Patel's assessment was numbness to the right hand and left scapular pain with questionable bursitis. Dr. Patel prescribed medications and an EMG. The Commission notes that there was no mention of a February 18, 2011 accident and no mention of neck pain in this Progress Note.

Petitioner underwent an EMG performed by Dr. Yu on March 28, 2011. Dr. Yu's impression was: 1) right ulnar neuropathy across the elbow; 2) entrapment neuropathy of the right median nerve at the flexor retinaculum, i.e. carpal tunnel syndrome. (Px1).

5. In a slip dated May 4, 2011, Dr. Patel wrote: "Ms. Wulf is under my care for carpal tunnel syndrome of right upper extremity and tendinitis of right shoulder." In his Progress Note dated May 4, 2011, Dr. Patel noted that Petitioner's chief complaint was back pain under her shoulders. Petitioner reported she was dizzy when getting out of bed and when bending over. She reported she continued to have pain and numbness of her right forearm radiating to her right shoulder area. Petitioner reported she also now had pain in her right upper back. Petitioner reported she frequently lifted heavy stuff at work and frequently worked above the shoulder level. On examination, Dr. Patel found Petitioner's neck was within normal limits. Dr. Patel noted that they discussed carpal tunnel syndrome. It was Dr. Patel's assessment that Petitioner had right carpal tunnel syndrome, right shoulder pain and tendinitis. The Commission notes that there was no mention of a February 18, 2011 accident and no mention of neck pain in this Progress Note. (Px2).

6. In his August 30, 2011 Progress Note, Dr. Patel noted Petitioner's chief complaint was "injured back at work." Petitioner complained of hand tenderness and bilateral scapular pain. Dr. Patel prescribed medications and physical therapy. He restricted Petitioner to light duty work for 2 weeks. In an Accident Report dated August 30, 2011, a date of accident of March 28, 2011 was noted. The following was noted as what happened: "Was getting crab legs out of freezer. Box was frozen to wall. When I pulled it, it hurt my back." Injury was listed as "pulled muscle." It was noted that Petitioner now complained of back pain between both shoulder blades. The Commission notes that there was no mention of the neck. In a slip dated August 30, 2011, Dr. Patel wrote: "Ms Wulf was seen in office today for upper back pain." Dr. Patel noted he authorized light duty work and Petitioner was to avoid repetitive bilateral shoulder movements, avoid frequent bending and lifting not more than 10 pounds. (Rx2).

7. Petitioner underwent an initial Physical Therapy Evaluation on September 7, 2011. In the report, the physical therapist noted the following: "Patient reports she was working at Red Lobster and in the middle of February 2011, a 40 pound box landed on her chest. Patient reported pain started shortly afterwards and that night went to ER." Petitioner complained of pain in her lower neck and shoulder blade area. (Px2). The Commission notes that this is the first mention of neck pain in the medical records. In a letter To Whom It May Concern dated September 7, 2011, the physical therapist noted Petitioner was seen for a physical therapy evaluation on this date for cervical and scapular muscle strain. It was noted that Petitioner was to be seen three times a week for eight weeks. (Px1).

8. In his September 13, 2011 Progress Note, Dr. Patel noted Petitioner reported the same complaints. Dr. Patel noted Petitioner was off work as there was no light duty work available. Dr. Patel continued physical therapy, prescribed medications and continued light duty work. Dr. Patel noted on September 27, 2011 that Petitioner was the same. It was Dr. Patel assessment that Petitioner had dorsal pain and left shoulder pain. In a telephone call to Dr. Patel on September 29, 2011, Petitioner requested a back brace. In his October 12, 2011 Progress Note, Dr. Patel noted that Petitioner continued to complain of bilateral scapular pain, worse on the left side. Dr. Patel continued physical therapy, prescribed medications and continued light duty work.

In his October 26, 2011 Progress Note, Dr. Patel noted his assessment of persistent upper back pain. Dr. Patel referred Petitioner to the Pain Clinic. Dr. Patel noted on November 9, 2011 that Petitioner continued to have mid back pain which radiated to the front at times. Petitioner reported working 4-5 hours a day and she was not lifting heavy stuff. Dr. Patel's assessment was dorsal pain. He continued physical therapy and prescribed medications. Petitioner reported the same complaints on November 23, 2011 and that she was unable to go to the Pain Clinic yet due to an insurance issue. Dr. Patel noted Petitioner had her accident on February 28, 2011. Dr. Patel's assessment was dorsal pain and bilateral shoulder pain. Dr. Patel continued physical therapy, prescribed medications and continued light duty work.

On November 26, 2011, Petitioner underwent thoracic x-rays that had been ordered by Dr. Patel. The radiologist's impression was mild to moderate degenerative changes of the thoracic spine. On December 5, 2011, Petitioner underwent a thoracic MRI that had been ordered by Dr. Patel. The radiologist's impression was mild multilevel degenerative disc disease, but no significant stenosis and no evidence of acute compression fracture. In his December 14, 2011 Progress Note, Dr. Patel noted Petitioner reported upper back pain between her shoulder blades, especially after working 4-5 hours. Dr. Patel continued physical therapy, prescribed medications and continued light duty work. (Px2).

9. At Respondent's request, Petitioner saw Dr. Petkovich on December 29, 2011 for a §12 evaluation. In his report of that day, Rx1, DepEx2, Dr. Petkovich noted the following: "Ms. Wulf told me that she injured herself while at work on February 18, 2011 when she was in a freezer trying to grab a 40-pound box of crab legs that was on a shelf above her. She stated that she grabbed the box of frozen crab legs, which fell forward onto her and hit her in the upper chest area and her shoulder areas, and she told me that she hit her upper back against the wall behind her." Petitioner told him she had reported this to her manager and continued working. Dr. Petkovich noted Petitioner's ER visit, her treatment with Dr. Patel and her discharge from physical therapy. He noted her light duty restrictions of a 15 pound lifting limit and working only 6 hours per day. Dr. Petkovich noted Petitioner informed him that she was having no further pain in her neck or cervical spine area and that she had no pain in her right shoulder and essentially no pain in her left shoulder, other than occasionally hearing some mild grinding with range of motion. Petitioner's only complaint to Dr. Petkovich was persistent intermittent aching pain in her upper back. He pain increased during the work day and can become quite intense in the last 2 hours of work.

On examination of the cervical spine, Dr. Petkovich found full range of motion and no tenderness or muscle spasm. On examination of the thoracic spine, Dr. Petkovich found some tenderness to palpation in the mid and lower thoracic area from approximately T8 to T12. On examination of the lumbar spine, Dr. Petkovich found tenderness in the paraspinal lumbar area and full range of motion. The examination findings of the right and left shoulders were normal with full active and passive range of motion. Petitioner did not bring x-rays or the MRI scan with her. Dr. Petkovich diagnosed: 1) thoracic strain with persistent discomfort in the midthoracic area; 2) cervical strain, now resolved; 3) contusion right shoulder, now resolved;

4) contusion left shoulder, now resolved. Dr. Petkovich opined Petitioner's subjective complaints of pain in the upper portion of her spine in the thoracic area were consistent with the objective physical findings. Dr. Petkovich opined causal connection to the February 18, 2011 accident. Dr. Petkovich opined that getting hit by a falling object weighing approximately 40 pounds was consistent with a mechanism to cause soft tissue injuries. Dr. Petkovich opined that soft tissue injuries can have late effects if appropriate active rehabilitation is not initiated. Dr. Petkovich opined Petitioner's treatment to date had been reasonable and necessary, but that she had not had the appropriate type of physical therapy. He opined she should continue light duty for 6 weeks, then return to work at full duty. Dr. Petkovich opined that during that time, Petitioner should attend more aggressive physical therapy. Dr. Petkovich opined he did not anticipate she would have any permanent disability. He opined that Petitioner's injury is temporary and will resolve with the appropriate care outlined above. Dr. Petkovich opined that the injuries to her cervical spine and shoulders had completely resolved and there was no permanent disability for her cervical spine or shoulders. He opined that there would be no permanent disability for her thoracic spine after she completed the recommended physical therapy. Dr. Petkovich recommended aggressive physical therapy for 2 to 3 times a week for 6 weeks. Dr. Petkovich opined Petitioner would reach maximum medical improvement after attending this aggressive physical therapy. He opined no prescribed medications were needed.

10. Dr. Patel's Progress Notes for January 3, 2012 and February 3, 2012 were the same as on December 14, 2011. Petitioner was discharged from physical therapy on February 22, 2012. On February 29, 2012, Petitioner underwent a physical therapy evaluation at a different provider for more aggressive physical therapy, as recommended by Dr. Petkovich. In his March 2, 2012 Progress Note, Dr. Patel noted Petitioner reported an increase in pain and stiffness after working 4 hours. Dr. Patel ordered a TENS Unit and Petitioner was to continue therapy at home. Petitioner saw Dr. Patel on March 9, 2012 for bronchitis. Dr. Patel took Petitioner off work and she was to return to work on March 12, 2012. In his April 2, 2012 Progress Note, Dr. Patel noted Petitioner reported she was unable to work more than 6 hours due to pain. Dr. Patel's assessment was dorsal pain and insomnia. Dr. Patel continued physical therapy, prescribed medications and restricted Petitioner to light duty work. Dr. Patel noted the same in his May 1, 2012 Progress Note. (Px2).

11. In his May 10, 2012 report, Rx1, DepEx3, Dr. Petkovich noted that Liberty Mutual sent him physical therapy records and EMG reports of March 28, 2011 and September 13, 2011 for his review. Dr. Petkovich noted that Petitioner had completed a course of aggressive physical therapy that was previously recommended by him. Dr. Petkovich opined that no further treatment was indicated. He noted that home exercises were recommended by the physical therapist and opined these were sufficient. Dr. Petkovich opined that no TENS Unit or home traction unit were necessary. Dr. Petkovich opined Petitioner had reached maximum medical improvement and she was able to work full duty.

12. Dr. Patel records indicate Petitioner called his office on May 16, 2012 and requested a referral to an orthopedic surgeon. She informed that the workers' compensation insurer was not paying for pain medications. She also informed that her attorney told her to try Drs. Robson, Gornet or Raskas. It was noted that the call was returned and it was okay with Dr. Patel whomever she wanted to go see. In his June 4, 2012 Progress Note, Dr. Patel noted that Petitioner reported an increase in mid/upper back pain since she had to lift heavy stuff at work. She reported receiving the TENS Unit. Dr. Patel's assessment was dorsal pain and he prescribed medications. (Px2).

13. In his September 13, 2012 deposition, Rx1, Dr. Petkovich testified he is a board certified orthopedic surgeon. Dr. Petkovich recited from his reports, already noted above. On cross-examination, Dr. Petkovich testified he was not provided the MRI films (Dp 34). Dr. Petkovich did not know if Petitioner had any prior history of back or neck pain (Dp 35). Dr. Petkovich opined that Petitioner appeared to be credible to him (Dp 35).

14. According to Dr. Gornet's records, Px3, Petitioner was seen on October 18, 2012 for complaints of neck pain, headaches, pain into her upper back, shoulder blades to both shoulders, tingling in her arms, right greater than left, low back pain and bilateral leg pain. Dr. Gornet noted the following history: "She states her current problem began approximately 02/18/11. She was working at Red Lobster. She went to the walk-in freezer to get a case of crab legs. She estimates the weight of 40 pounds. She stated in lifting up the box, which was overhead, it fell forward striking her in arms and chest. She slipped and fell backwards. During this process, she feels she has injured her back." Petitioner stated she told her manager immediately and it was formally reported several weeks later. Dr. Gornet reviewed the ER records and Dr. Petkovich's report. Dr. Gornet noted that Petitioner had undergone a right elbow ulnar nerve transposition and bilateral carpal tunnel releases. Dr. Gornet reviewed the December 5, 2011 thoracic MRI scan and noted it did not show significant disc herniation, but a noticeable thoracic kyphosis and disc degeneration in the mid-thorcic spine.

Dr. Gornet's impression was that he agreed with Dr. Petkovich that Petitioner's symptoms were causally related to the work related injury of February 18, 2011. Dr. Gornet opined that her symptoms of supraclavicular pain and even chest pain are often referral of an acute cervical radiculopathy or irritation. Dr. Gornet recommended cervical and lumbar MRIs. Dr. Gornet gave Petitioner work restrictions of light duty with a 15 pound limit and 6 hour days. Dr. Gornet opined Petitioner was not at maximum medical improvement.

On December 13, 2012, Dr. Gornet noted he had reviewed the cervical MRI scan, which clearly revealed a disc herniation at C6-7, which correlated with her symptoms. Dr. Gornet reviewed the lumbar MRI scan, which revealed a small central disc protrusion at L5-S1, possibly consistent with an annular injury. Dr. Gornet recommended Petitioner continue light duty, but she stated that her current work had retaliated against her by limiting her hours. Dr. Gornet released Petitioner to full duty, but noted she was still miserable. Dr. Gornet recommended a C6-7 disc replacement. He also recommended cervical epidural steroid injections. Dr. Gornet

noted Petitioner had a significant amount of axial neck pain and headaches. Dr. Gornet opined that a causal relationship existed to the work related injury of February 18, 2011.

15. The records of MRI Partners of Chesterfield, Px5, indicate that Petitioner underwent a cervical MRI on December 13, 2012 and the radiologist's report was done on December 14, 2012. The radiologist's impression was: 1) C6-7 central 3.5mm herniation with superior extrusion of disc material, resulting in ventral cord contact but no cord deformity, central canal or foraminal stenosis; 2) circumferential disc bulges with facet arthropathy at the C3-4, C4-5 and C5-6 levels; there were foraminal stenoses at each of these levels but no central canal stenosis. Petitioner also underwent a lumbar MRI on December 13, 2012. In his December 14, 2012 report, the radiologist noted his impression of: 1) facet arthropathy bilaterally at each of the L3-4, L4-5 and L5-S1 levels without significant central canal or foraminal stenosis; 2) disc desiccation at all levels without focal disc bulge or herniation.

The records of MRI Partners of Chesterfield indicate Petitioner underwent a repeat cervical MRI on January 17, 2013. In his January 18, 2013 report, the radiologist noted his impression of: 1) at the C6/7 level, there was a broad based central disc protrusion which contributed to mild to moderate central canal stenosis and was not a significant change from the prior study; 2) at the C3/4 level, there was mild disc desiccation with diffuse annular disc bulge without central canal stenosis and bilateral uncovertebral joint spurring and bilateral facet arthropathy contributing to mild bilateral neural foraminal exit stenosis; 3) at the C4/5 level, there was mild disc desiccation with diffuse annular disc bulge, no central canal stenosis and bilateral uncovertebral joint spurring and bilateral facet arthropathy contributing to mild bilateral neural foraminal exit stenosis; 4) at the C5/6 level, there was mild asymmetric left uncovertebral joint spurring contributing to mild left neural foraminal exit stenosis and there was no significant central canal stenosis or right neural foraminal exit stenosis.

16. In his April 11, 2013 deposition, Px4, Dr. Gornet testified he is a board certified orthopedic surgeon specializing in spinal surgery. Dr. Gornet recited from his records, already noted above. On cross-examination, Dr. Gornet testified he had only seen Petitioner twice by the time of this deposition. Dr. Gornet did not know who referred Petitioner to him (Dp 15). Petitioner had brought in medical records. Dr. Gornet reviewed the December 5, 2011 thoracic MRI films, which Petitioner had brought (Dp 17). Dr. Gornet would agree that the MRI radiologist's report makes no reference to any cervical disc herniation (Dp 18). The radiologist would have only evaluated the thoracic spine, not the cervical spine (Dp 19). Dr. Gornet believed he had reviewed the ER records (Dp 22). Dr. Gornet opined that Petitioner's initial presentation is not as important because it is the inflammatory responses that build up over time that causes more of the symptoms. Dr. Gornet testified he is dealing with a smaller disc herniation and a mechanical problem (Dp 24). Dr. Gornet reviewed Dr. Petkovich's December 29, 2011 report (Dp 25). Dr. Gornet noted that Petitioner reported to Dr. Petkovich that she had no further pain in her neck or cervical spine, no pain in her right shoulder and essentially no pain in her left shoulder (Dp 26). Dr. Gornet did not believe Petitioner had a

significant amount of radicular pain (Dp 27). Dr. Gornet opined that Petitioner having bilateral carpal tunnel syndrome would not change his opinions, but it could be a contributing cause to some of the tingling she gets in her hands (Dp 31).

17. According to Dr. Boutwell's records, Px7, Petitioner was seen on July 8, 2013 and was given a right C6/7 epidural steroid injection. Dr. Boutwell also saw Petitioner on July 22, 2013 and gave her a C6/7 epidural steroid injection.

18. Petitioner saw Dr. Gornet on September 16, 2013. Dr. Gornet noted that Petitioner had undergone two epidural steroid injections in July 2013 which gave her temporary relief, but her symptoms returned. Petitioner reported she continued to have neck pain with fairly significant headaches with pain into her upper back, shoulder blades and tingling in her arms, right greater than left. Dr. Gornet noted Petitioner's low back issues were on hold. Dr. Gornet recommended a new cervical MRI, a CT myelogram of cervical spine and disc replacement of C6-7. He noted that Petitioner wanted the C6-7 disc replacement surgery. (Px3).

19. According to the records of CT Partners of Chesterfield, Px6, on November 7, 2013, Petitioner underwent a cervical CT post myelogram. That same day, Petitioner saw Dr. Gornet, who noted that he reviewed the cervical MRI and CT myelogram and both clearly showed a large disc herniation at C6-7, which correlated with her symptoms. There was a smaller protrusion centrally at the C3-4 level. Dr. Gornet opined causal connection and again recommended the C6-7 disc replacement surgery. (Px3).

20. At Respondent's request, Petitioner saw Dr. Petkovich on December 18, 2013 for a §12 evaluation. In his December 30, 2013 report, Rx5, Dr. Petkovich noted Petitioner's complaints of pain in her neck and upper back. He noted her treatment since he last saw her. Petitioner brought compact discs of her MRI scans, which he reviewed. Dr. Petkovich noted Dr. Gornet's recommendation. Dr. Petkovich diagnosed: 1) cervical strain, now resolved; 2) degenerative cervical disc condition, C6-7; 3) thoracic strain, now resolved; 4) degenerative thoracic disc condition. On examination, Dr. Petkovich found full cervical spine range of motion and no tenderness to palpation. Dr. Petkovich noted that his prior opinions remained unchanged. Dr. Petkovich opined the recommended cervical surgery was not the result of the February 18, 2011 incident. Dr. Petkovich opined that any surgery for her cervical spine would be due to the underlying degenerative disc condition that is unrelated to the February 18, 2011 incident. Dr. Petkovich opined that Petitioner's injury was muscular in nature and had long since resolved. Dr. Petkovich opined that there was no radiographic evidence by which to conclude that her preexisting degenerative disc condition at C6-7 was exacerbated, aggravated or accelerated as a result of the February 18, 2011 incident. Dr. Petkovich opined Petitioner was not in need of further treatment after maximum medical improvement.

21. Petitioner saw Dr. Gornet on April 14, 2014 and reported she continued to have neck pain and headaches with pain into her upper back and shoulder blades and low back pain. She continued to work full duty. Dr. Gornet recommended same disc replacement surgery at C6-7. Dr. Gornet opined that disc degeneration had very little to do with why Petitioner was symptomatic. He would await approval for treatment. (Px3).

22. Petitioner's attorney submitted the medical bills and a summary of same into evidence and these were admitted as Px8. Respondent's attorney submitted the St. Anthony's Health Center records and these were admitted into evidence as Rx3. Respondent's attorney submitted the Application for Adjustment of Claim and this was admitted into evidence as Rx4. Respondent's attorney also submitted medical payments made by Respondent and these were admitted into evidence as Rx6.

Based on the record as a whole, the Commission reverses 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 February 18, 2011 and denies Petitioner's claim.

Petitioner claimed an injury on February 18, 2011. She did not seek treatment until February 22, 2011, when she was seen at St. Anthony's Health Center emergency room. The ER records indicate that Petitioner complained of back pain and chest soreness. The ER records show Petitioner did not mention the February 18, 2011 accident and did not mention any neck pain or injury. Petitioner testified she did tell the ER doctors about her specific accident of February 18, 2011. Petitioner testified that if the ER records reflect there is no specific history, she is not saying those records are wrong. Petitioner then saw Dr. Patel on March 22, 2011. According to Dr. Patel's records, Petitioner did not mention the February 18, 2011 accident and did not mention any neck pain or injury. She also did not mention the February 18, 2011 accident and did not mention any neck pain or injury to Dr. Patel on May 4, 2011. On August 30, 2011, Petitioner filled out an Accident Report at Dr. Patel's office. In this Accident Report, Petitioner gave a Date of Accident of March 28, 2011 and described what she testified to occurring on February 18, 2011. In her testimony, Petitioner attempted to equate her shoulder blades with her neck. The Commission finds that Petitioner's testimony is rebutted by the contemporaneous medical records.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment on February 18, 2011, her claim for compensation and medical expenses is hereby denied.

15IWCC0236

There is no bond as there is no award. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 7 2015
MB/maw
o01/29/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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 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 THAYER,

15IWCC0237

Petitioner,

vs.

NO: 97 WC 1514

CHRYSLER GROUP LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of "accident," causation, exposure to hazardous substance, date of last exposure, temporary total disability, and permanent partial disability, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner claimed that his condition of ill being, laryngeal cancer was caused by exposure at his place of employment. Petitioner worked in a facility where automobiles were painted. The Arbitrator found that Petitioner did not sustain his burden of proving that his exposure to chemicals used in the painting process caused his condition of ill being. The Commission agrees with that finding and affirms and adopts that portion of the Decision of the Arbitrator.

Petitioner argues that the Arbitrator erred not only in the finding that chemical exposure did not cause his condition of ill being but also that the Arbitrator did not find that voice abuse required at the place of employment was a causal factor in developing an occupational disease. The Commission agrees that the Arbitrator did not specifically address the issue of voice abuse as a possible causal factor. Therefore, for the purpose of completeness the Commission hereby addresses that issue.

15IWCC0237

Petitioner testified that the workers at his facility had to talk "at the top of their lungs" because they all wore ear plugs due to ambient noise in the factory. There was no evidence adduced at hearing specifying how much the workers at the factory conversed with each other during the working day. A medical treatment note indicated that Petitioner had moderate but not excessive voice usage. An article reviewed by Respondent's Section 12 medical examiner, Dr. Greave, prior to his deposition, (Respondent's Exhibit 4), indicated that voice abuse was a risk factor for development of laryngeal cancer. However, Dr. Greave testified at his deposition that in his opinion there was no causal link between voice abuse and laryngeal cancer. Looking at the entire record before us the Commission finds that Petitioner did not sustain his burden of proving that occupational voice abuse was a causal factor in his development of laryngeal cancer. Therefore, the Decision of the Arbitrator is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that because Petitioner has failed to prove his condition of ill being (laryngeal cancer) is causally related to occupational exposure, all benefits are denied.

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: MAR 2 7 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-3/17/15
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0237

THAYER, MICHAEL
Employee/Petitioner

Case# **97WC001514**

CHRYSLER GROUP LLC
Employer/Respondent

On 8/14/2013, 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:

0728 DUDA, THOMAS W
3125 N WILKE RD
SUITE A
ARLINGTON HTS, IL 60004

2027 WIEDNER & MCAULIFFE LTD
JEFF SALISBURY
1639 N ALPINE RD SUITE 300
ROCKFORD, IL 61107

15IWCC0237

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

Michael Thayer
Employee/Petitioner

v.

Chrysler Group LLC
Employer/Respondent

Case # **97 WC 01514**

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 **April 15, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Was Petitioner exposed to the hazards of an occupational disease that arose out of and in the course of 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 occupational exposure?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **5/1/96**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***was*** exposed to the hazards of an occupational disease that arose out of and in the course of employment. **See attached.**

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

Petitioner's current condition of ill-being ***is not*** causally related to the occupational exposure. **See attached.**

In the year preceding the injury, Petitioner earned $39,977.60; the average weekly wage was $768.80.

On the date of last exposure, Petitioner was 52 years of age, ***married*** with no dependent children.

ORDER

Having found that Petitioner failed to prove that his condition of ill-being (laryngeal cancer) is causally related to occupational exposure, all benefits are denied.

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

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

Edward Lee — Signature of Arbitrator

8/14/13 — Date

AUG 14 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Thayer,
Employee/Petitioner

v. Case No: 97 WC 01514

Chrysler Group LLC,
Employer/Respondent

FINDINGS OF FACT

Michael Thayer testified that he was an employee of Chrysler Corporation from October 13, 1967 until he retired in August of 1997. His first job was working on the sealer line, located on the second floor of the Belvidere Assembly Plant. The second floor contains the paint shop.

Petitioner described his job on the sealer line using VMP and a rag, wiping off excess sealer on the joints of the metal. He had rubber gloves and a rubber apron. Petitioner verified working from 1967 until 1970 in that position, referencing Respondent's Exhibit 1, an Hourly Human Resource System Inquiry History. On one side of the sealer line was the phosphate line, which he described as enclosed where they dipped the cars in phosphate. On the other side was the prime booth for painting. He described a paint smell in the shop.

Petitioner described a process where a body of a car goes through an oven after the phosphate line. It then goes to the sealer line, the prime booth, another oven, the sanding area, a second prime booth, through another oven, the first color, through ovens, gets sanded again, goes through a second spray booth and oven, then goes to the polish line or repair line. From either the polish line or the repair line, the body then goes downstairs. All of the activity described occurs on the second floor.

Petitioner described being within 20 feet of the prime booth while working on the sealer line, and three feet of the phosphate booth. He described a noxious odor like rotten eggs emanating from the phosphate line.

After the sealer line, his next job was spraying paint. Petitioner described working in "small parts" on the second floor doing assembly and painting for four or five years. Petitioner stated he did not recall exactly how long he worked as a sprayer, and acknowledged that if respondent had a "paper" that says he was at a certain place at a certain time, he would have no way to dispute that.

In the prime booth, he sprayed either the side or roof and the deck and the hood or in the doors of the car body. There would be 12 people spraying simultaneously in the booth. There was a system of water flowing below and air coming down from above to take the paint away, but the paint spray got all over the clothing. Petitioner described the sprayers wearing coveralls, a hat and gloves, and putting Vaseline on faces so they could wipe their faces off with rags on

break. He did not use a mask. At some point, a mask was provided, but he did not wear it, finding it inhibiting and inconvenient.

At some point, petitioner was transferred to the labor pool, a different classification at a higher rate of pay. At that point, he only worked part time in the spray booth, substituting for absent workers.

Petitioner also described working as a sander, using a sanding disc on a wheel that was on a grinder. Sanding pads would be stuck on to it just to sand flaws off the car.

Petitioner testified the paint booth was enclosed, but other areas were open, including lunch areas. While sanding, he wore a mask at first, then a face shield. The face shield was like a welder's mask.

Petitioner described working as a sealer operator, applying sealer to cracks where two pieces of metal overlapped. This also gave off a strong odor.

When petitioner retired, he was a polisher. He agreed with the company records showing that he started polishing in 1993. That job involved identifying minor flaws in the paint, sanding them off and applying new paint. He would then buff the area with a final finish polish on a polishing wheel. While polishing, polish could fly off the polishing pad if he hit a bare piece of metal.

Petitioner took photographs of the polishing booth. The Arbitrator observed the photographs. Photographs were taken in 1997, shortly after he returned to work from surgery. In the polish booth, the floor consisted of a grate with a filter underneath it. Air flow from above causes the polishing compound to collect on the floor grates and filters.

In May of 1996, petitioner began experiencing problems with hoarseness and a sore throat. He was referred to Dr. Sachs, an ENT specialist. Petitioner thought his hoarseness was due to the loud environment and having to yell at coworkers to be heard.

Dr. Sachs discovered nodules on the vocal cord. A biopsy was done and the nodule was found to be malignant. Petitioner testified he saw Dr. Charles Ford at the UW Madison Hospital, who performed surgery for removal of the nodules on December 5, 1996. He was in the hospital for seven days and was not released until he could perform a swallowing test. Petitioner was off work from December 5, 1996 through January 14, 1997.

After surgery, he had speech therapy. Dr. Ford also injected collagen into the vocal cord to build up the area and improve petitioner's speech.

Petitioner described improvement in his ability to speak, but he still experiences difficulty being understood in noisy environments.

Petitioner described 19 visits with Dr. Ford from 1998 through 2003, at which point he was told he no longer needed to come back, because the cancer was cured.

Petitioner described obtaining Hazard Communication Sheets in the paint department. He specifically identified a hazardous warning label marked Petitioner's Exhibit 21, for enamel paint used in the polish deck.

Petitioner provided some Hazard Communication Sheets to Dr. Steven Hessl at Cook County Hospital, and also signed a form to allow Cook County Hospital to obtain records directly from Chrysler.

Petitioner's classification affected his pay, so it was important for the company to keep updated records with regard to the correct classification. Prior to testifying, petitioner reviewed documents from the company showing his classifications during his employment. He agreed the record showed he was classified as a sprayer from November 29, 1970 through January 6, 1975.

Petitioner clarified that in the polishing department, he used a small touch-up container of paint somewhat bigger than a lipstick container. It was liquid paint, not sprayed on. He denied using any spray cans of paint on the polish line, in sealing, tack-off or sanding. He did not have any responsibility for maintenance in the paint department.

On the polish line, petitioner worked with white and gray polish called Finesse-It 1 & 2. The only other product worked with in that department was the touch-up paint applicator.

With regard to the paint spray job, petitioner testified that a spray gun had to be cleared of one color of paint before another could be used. Different colors were in different lines and solvent was used to clean off the connections between the paint lines and the spray gun. He did not know what particular solvent was used. Mixing of paints was done on the first floor. He did not have any responsibility for mixing paints. Paint lines were run from the first floor into the paint booth area on the second floor. At no time was he responsible for cleaning the paint booth.

Petitioner was asked a number of questions with regard to specific Hazard Communication Sheets, the product involved and whether he used that specific product. Other than paint products used in the spray operation, the touch-up paint applicator used in the polishing department, the Finesse-It finishing material used in the polishing department and VMP naphtha used in the sealer operation, he generally denied knowledge of the use or actually using most other products. Petitioner acknowledged not having ever sat down with either Dr. Hessl or Dr. Orris to review Hazard Communication Sheets or the products he used in the course of his employment.

Petitioner acknowledged having given a history of reflux to Dr. Ford and his nurse and having been diagnosed with a condition of reflux esophagitis as far back as October, 1980. He had a long course of treatment for reflux with Dr. Keller at Mercy Clinic. During that time, he took Prilosec for recurrent bouts of abdominal pain.

George Bertone testified on behalf of respondent. He started working for respondent in 1978. He was an employee for 34 years. At the time he testified in October, 2012, he had retired, but was still working at Chrysler on a contract basis for a six-month term. For 25 years

of his employment, he worked in the paint department, starting as a supervisor and then working as an area manager. He went to the paint department in 1979. He worked at the Belvidere Assembly Plant from 1978 until 1995, when he left for two years, then returned in 1997 until he retired in 2011. As area manager in the paint department, he was familiar with the nature of the jobs.

Mr. Bertone was familiar with the classification of various positions within the paint department. With regard to Respondent's Exhibit 1, Mr. Bertone testified as to the various classifications held by petitioner over the course of petitioner's employment. One of the first classifications held by petitioner was 0424, referring to the sealer deck where petitioner would use VMP to wipe off the car. On November 2, 1970, the classification was changed to 4369, correlating with a paint sprayer working in the paint booth. Mr. Bertone described environmental controls in the spray booth including a filtration system starting at the top with a fan house. Filters above the fan house filter particles out of the downdraft going through the paint booth. At the bottom of the paint booth there is a grate, with water and an exhaust system that takes the paint and residuals out. The paint booth is enclosed except for each end, where car bodies enter and leave. Every two hours measurements are taken of the downdraft through the booth. In the sprayer zones, the downdraft must be 100 feet per minute per OSHA requirement.

Mr. Bertone also testified with regard to the phosphate system, which causes the auto body to become etched and allowing paint to stick to the body. The booth is enclosed. No personnel are in the phosphate booth.

Mr. Bertone described the sealer line, where Cemidine sealer was applied to seams from the welding of the body. Cemidine was applied using a flow gun resulting in a bead of sealer rather than a spray.

With regard to the classifications, Mr. Bertone testified that petitioner's classification on January 6, 1975 changed to 3366 to a trucker class or conveyor loader. On November 14, 1977, the classification changed to 4348, sanding. On January 12, 1981, the classification changed to 0242, an assembler. On September 13, 1982, the classification changed to 4369, a paint sprayer. Then on December 12, 1983, the classification changed to 0468, tack-off. In that job, petitioner used a tacky cloth to wipe the car off before it went into the spray booth. As of August 8, 1984, petitioner's classification was 4348, a sander. As of May 19, 1986, the classification changed to 4363, miscellaneous spray and flow, which would be applying sealer to the car. Then on November 1, 1993, the classification changed to 4565, polish in the polish department.

With regard to the polish department and the photos identified by petitioner, Mr. Bertone testified to a system involving pressure gauges to monitor the filters. The pressure gauges determine whether the filters need replacing, and not appearance or visual inspection. Those gauges were monitored by the skilled trades people on a daily basis. The change in color indicates debris is getting on the filter, but the change in pressure identifies when the filter must be changed.

Craig Anderson testified on behalf of Chrysler. He was employed by Chrysler in September, 1993, but first started working in the Belvidere Assembly Plant for Behr Systems in

1985. His then current employer, Behr, had won the contract to install new spray equipment and a new spray booth at the Belvidere Assembly Plant. At the time of his testimony, Mr. Anderson was the process reliability manager and the Plant "champion" for total chemical management. He was responsible for quality standards and environmental standards in the paint shop. He held this position since 2004, but had worked in the paint department since 1993 as an employee.

Mr. Anderson testified that in 1987 the second floor was completely gutted and changed with new spray booths. There was a new building added for the phosphate line.

Mr. Anderson testified to the photographs of the polish booth. He was familiar with the maintenance of the supply filters that kept the air moving through the booth. He also testified to gauges to measure any pressure drop across the bank of filters in the polish department. Those gauges determine when the filters need to be changed. There is exhaust at the bottom of the booth to pull air through. This process creates a downdraft. Simply looking at the filter does not determine if it is functional or non-functional. The filters get debris on the top of them, but that is only the top layer and air can still flow through.

Jean Melvin testified on behalf of respondent. She is a certified industrial hygienist. She became certified in 1988 and began working for Chrysler after they took over the American Motors facility in 1987 in Kenosha. Ms. Melvin started at the Belvidere Assembly Plant about 1989. She worked between the Kenosha Plant and the Belvidere Assembly Plant until 2004, when she became a safety supervisor at the Kenosha Plant. She returned to the Belvidere Assembly Plant in January of 2009. She had occasion to conduct various industrial hygiene surveys in the paint department.

On November 7, 1996, Ms. Melvin performed personal air monitoring on petitioner relating to work in the polish deck. Testing consisted of analysis of total particulate, oil mist and hydrocarbons. Testing for hydrocarbons would indicate some kind of organic solvent exposure. Particulate is nuisance dust, categorized as non-hazardous dust particles. The testing was done at the breathing zone, near the shoulder. Results indicated there was nothing detected above the limits of detection with regard to all three categories tested.

With regard to use of a mask or respirator, Ms. Melvin testified that during her period of employment at Chrysler, neither masks nor respirators were required because air sampling showed over time there was no overexposure.

Jean Melvin testified to various exhibits regarding testing for various chemicals at the Belvidere Assembly Plant. On March 1, 1989, she tested for Benzene, Methyl Isobutyl Ketone, Xylene and total hydrocarbons and formaldehyde. Testing was done in the paint booths. All samples taken were below the limits of detection or very low detectible limits. None of the samples were above OSHA's standards. All of the testing done for formaldehyde revealed levels below permissible exposure limits.

Medical records reveal that petitioner was referred to Dr. Sachs at Mercy Clinic East for evaluation of hoarseness and occasional sore throats. Dr. Sachs first evaluated claimant on 8/1/96. On examination, claimant was noted to have small nodules present at the anterior one-

third and posterior two-thirds of the vocal cords. He was diagnosed with vocal nodules and recommended for speech therapy. His condition did not improve and Dr. Sachs recommended laryngoscopy. The records of Dr. Sachs show that on 11/29/96 petitioner was called and advised that the laryngoscopy revealed squamous cell carcinoma of the larynx. Petitioner was seen by Dr. Charles Ford on 12/4/96. Dr. Ford confirmed the diagnosis of a cancerous lesion of the right true vocal cord. Surgery was performed the following day. The preoperative history and physical records a history of hypertension, peptic ulcer disease and GERD. Among other medications, petitioner was currently taking Prilosec. Medical records confirm the testimony of petitioner that he engaged in swallowing therapy, speech therapy and injections for augmentation of the right vocal cord. Petitioner had no recurrence of the carcinoma. Petitioner was seen by Dr. Ford on 11/26/03 with various complaints, including indigestion and reflux symptoms. He had complaints of nasal congestion and drainage thought to be low-grade rhinitis/rhinosinusitis. Dr. Ford recommended medication, including returning to use of Prilosec.

Petitioner offered records from Dr. Keller and from Mercy Clinic East dating back to treatment as early as 1978. Petitioner had an endoscopy on 10/18/80 revealing reflux esophagitis and a healed peptic ulcer. Petitioner sought additional treatment on 8/8/92 for severe problems with abdominal pain in the epigastric area. He was placed on Prilosec. On 9/23/92 he continued to have problems with esophagitis. He was doing better as of 10/27/92, but continued on Prilosec. On 8/28/95 it was again noted that he had reflux esophagitis for which he was on Prilosec.

Petitioner offered records of evaluation by Dr. Steven Hessl and by Dr. Peter Orris from the Division of Occupational Medicine at Cook County Hospital. Initial evaluation was performed by Dr. Steven Hessl and a resident physician, Dr. Sahar Ahmad, on November 21, 1996. The primary complaint was hoarseness of voice for seven months and development of a nodule on the vocal cord. It should be noted the occupational history recorded by Dr. Hessl differs significantly from petitioner's testimony. Petitioner offered no testimony regarding spills of paint or hazardous spills nor fires at work. It is noted that petitioner started working as a painter/sander, but since 1994 was a polisher. There is no specific indication how long petitioner worked as a painter. The testimony of petitioner establishes several different classifications during his employment with Chrysler, and petitioner did not disagree with the timeframes indicated in Respondent's Exhibit 1. Dr. Hessl issued a report dated November 29, 1996 indicating he carried out a literature search to determine if there is any possible relationship between petitioner's work at Chrysler and vocal cord cancer. "We have been unable to find any evidence for a connection." Another letter was issued on December 12, 1996 stating that Dr. Hessl located several medical studies of laryngeal cancer which demonstrate an association between painting and laryngeal cancer.

Petitioner was first evaluated by Dr. Orris on 7/13/2000. Handwritten notes of Dr. Orris on 7/12/2000 indicate that petitioner worked as a painter and polisher at Chrysler for 30 years. He had previously been seen in the occupational medicine department in 1996 for evaluation of hoarseness. The condition turned out to be secondary to a cancerous laryngeal nodule. A literature review showed an association between laryngeal cancer and painting. It was noted the patient was informed by his ENT M.D., Dr. Ford, that the nodule was secondary to GERD. The patient wanted to know if there was such an association, even though he denied GERD

symptoms. The narrative report prepared by Dr. Orris dated 7/13/2000 indicates petitioner had ambulatory PH monitoring in 1998 that was normal and a barium swallow done at the University of Medicine (Madison) showing questionable GERD. Dr. Orris indicated he would obtain the records of the University of Madison.

The evidence deposition of Dr. Peter Orris was taken on July 5, 2007. Dr. Orris stated he first saw the patient on July 13, 2000, when petitioner returned to the clinic for a status report. Dr. Orris did not reach any opinion with regard to the cause of the squamous cell cancer of the larynx at the evaluation in July 2000. Dr. Orris next saw the petitioner on February 22, 2006, at which time he took a more detailed history according to the narrative report issued to petitioner's counsel. The report is undated. Among other things, the occupational history indicates that the petitioner began working in assembly in 1981 and had no further exposure to paint.

In the narrative report, Dr. Orris discussed the results of PH monitoring, which he thought eliminated the possibility of a diagnosis of GERD. Dr. Orris concluded in his report that it was possible the exposures to paint and solvents contributed to the development of vocal cord cancer.

Dr. Orris testified that petitioner's diagnosis as of February 22, 2006 was vocal cord squamous cancer status post resection in 1996 and that now ten years postoperative, the petitioner was cured of his cancer. He thought the history of hyperacidity could have indicated reflux disease, but the PH monitor eliminated that as a diagnosis (and this was of significance since that is, as well, a cause of vocal cord cancer). In his deposition testimony Dr. Orris reiterated his opinion that exposure to paint and paint products may have caused vocal cord cancer.

Dr. Orris further testified that he never discussed the case with Dr. Hessl, that he could recall. Dr. Hessl had left the clinic.

Dr. Hessl testified to reviewing a number of Hazard Communication Sheets obtained from Chrysler. Dr. Orris acknowledged having reviewed the two narrative reports authored by Dr. Hessl dated November 29, 1996 and December 12, 1996. He acknowledged he did not know specifically what medical literature Dr. Hessl reviewed on either occasion.

Dr. Orris testified that certain carcinogens were identified in the Hazard Communication Sheets he reviewed, including Benzene and Formaldehyde. However, he also stated that based on his review of medical literature, he found no connection between Benzene specifically and vocal cord cancer. He further noted the literature was not specific for vocal cord cancer and exposure to Formaldehyde. He acknowledged a case control study in France (Dr. LaForest) found no association between Formaldehyde and laryngeal cancer. He acknowledged a Turkish study of the risk of laryngeal cancer by occupational chemical exposure observed no association between Formaldehyde or solvent exposure and laryngeal cancer risk. In response to a question about a "debate" in the medical community regarding the association between Formaldehyde or solvent exposure and laryngeal cancer, Dr. Orris testified as follows: "We have some data. We have data to implicate and make suspicious that entire area of the upper respiratory tract with these exposures for a variety of reasons." He further testified that he thought all of these studies

support the suspicion that there is a relationship between these types of exposures and laryngeal cancer and vocal cord cancer. He further testified that he did not have an opinion as to the potential cause of this man's (petitioner's) cancer and did not agree with Dr. Hessl's expressed opinion in his letter, specifically referring to the December letter. He disagreed with the opinion expressed by Dr. Hessl, by stating he thought it was possible the exposures played a role, "but I do not have a causative opinion on more likely than not the basis." "But I do not have any opinion as to causation with respect to these chemicals to a reasonable degree or 51%, if you will, more likely than not basis."

Dr. Steven Hessl testified by evidence deposition on July 13, 2011. He testified that within a reasonable degree of medical certainty, he thought there was a relationship between work exposure at Chrysler and the subsequent laryngeal cancer. The cancer was unusual in a non-smoking, non-heavy-alcohol-using patient. Petitioner had a negligible smoking history, and he thought the alcohol history was far below the four drinks per day that he considered a threshold for heavy drinking. Laryngeal cancer has been associated with several known carcinogens, in addition to tobacco smoke, such as asbestos, polycyclic aromatic hydrocarbons, nitrogen mustard, chromic acid, wood dust and possibly Formaldehyde. Dr. Hessl testified that laryngeal cancer has been associated with exposure to solvents in the workplace and with painting, in several studies. He testified that many occupational cancers are associated with a long history of exposure. He concluded another risk factor that was considered was gastroesophageal reflux disease, which has been associated with laryngeal cancer, although he thought the association was not very strong and controversial. He also thought petitioner did not have significant GERD, even though it had been entered as a clinical diagnosis several times in the medical records.

Dr. Hessl had issued a narrative report dated December 4, 2010, citing a number of scientific papers he used to render his opinion.

Dr. Hessl further testified that he has known Dr. Orris since 1975, and considers him a very honest, hard-working, well-educated occupational medicine physician. With regard to the Hazard Communication Sheets, Dr. Hessl had no way of knowing for certain whether he had those available at the time of his original evaluation of Mr. Thayer in November 1996. He acknowledged the reports generated in 1996 did not specifically reference any chemical compounds, other than solvents. He had no discussion with the industrial hygienist at Chrysler doing the evaluation of Mr. Thayer before generating reports in 1996. When questioned with regard to the report dated November 29, 1996 and the subsequent letter dated December 12, 1996, Dr. Hessl testified he could only speculate that he found additional papers that changed his opinion.

With regard to an association between Formaldehyde and laryngeal cancer, Dr. Hessl acknowledged the literature shows it is suspected, "but not proven." He agreed that he would not relate the laryngeal cancer to Formaldehyde exposure, "not in and of itself." With regard to the various studies Dr. Hessl cited in his narrative report, he acknowledged that he did not have those studies available to him at the time of the deposition, nor did he remember the details. He acknowledged that at least some of the studies showed no association between Formaldehyde or solvent exposure and laryngeal cancer. With regard to reference No. 18, in response to a

question regarding the odds ratio of 1.04 and how to interpret that, Dr. Hessl responded: "Well, it would mean basically that that study doesn't confirm any relationship for solvents."

Dr. William Greaves testified on behalf of respondent. Dr. Greaves held a full-time faculty appointment at the Medical College of Wisconsin from 1981 through June of 2007. He is Board certified in occupational medicine and public health and general preventive medicine.

Dr. Greaves initially identified a report he prepared on April 20, 2004 after reviewing medical records relating to Mr. Thayer and his condition, including records of Dr. Hessl, Dr. Sachs and Dr. Ford. He also has certain Hazard Communication Sheets to review, including Clear Coat Paints, 3M Finesse-It, and Hazard Communication Sheets relating to sealers. Dr. Greaves testified that he performed a medical literature research trying to find a linkage between petitioner's medical condition of vocal cord squamous cell carcinoma and work exposure. He consulted a number of databases and textbooks with regard to toxicology, principles of internal medicine and otolaryngology. He did not examine petitioner, but acknowledged that he agreed with the medical diagnoses contained in the treatment records. He thought an actual evaluation of Mr. Thayer would not have added anything to his opinions. In response to a hypothetical question with regard to petitioner's work history, the medical records he reviewed and the Hazard Communication Sheets he reviewed, as well as his medical literature research, Dr. Greaves testified there was no relationship between the condition of laryngeal cancer and claimant's exposure to various chemicals at work. He could not come up with a linkage (based on the medical research) between the chemicals used at work and the laryngeal cancer. He also testified that petitioner has a medical condition, gastroesophageal reflux disease, linked to laryngeal cancer. He noted the report from Dr. Hessl dated November 21, 1996 where it was indicated petitioner used Prilosec. This medication is used to reduce acid production in the stomach, to reduce gastroesophageal reflux, which can impact the vocal cords.

Dr. Greaves concluded any Formaldehyde exposure was not causative of the laryngeal cancer. He acknowledged Formaldehyde is a probable human carcinogen under conditions of unusually high or prolonged exposure, but the condition most likely related would be hematopoietic, relating to the blood forming elements of the body.

Dr. Greaves received additional records for review resulting in preparation of a letter dated January 28, 2010. Those included a number of Hazard Communication Sheets relied on by Dr. Orris and by Dr. Hessl. His opinion remained the same; that petitioner's condition was not related to workplace exposure.

CONCLUSIONS OF LAW

On the disputed Issue C, whether Petitioner was last exposed to an occupational disease arising out of and in the course of his employment by Respondent on May 1, 1996, the Arbitrator finds as follows:

The Occupational Diseases Act requires that Petitioner establish a date of last exposure. In this case Petitioner alleges that date is May 1, 1996. Petitioner's testimony does not directly establish when he was last exposed to the hazards of an occupational disease. Petitioner's

testimony establishes that he was working for Chrysler in the polishing department during 1996, until he was off for surgery on December 5, 1996. Products used in the polishing department, based on Petitioner's testimony, included Finesse-It finishing material, identified on the hazard communication sheet as a mixture of solvents and other chemicals. Petitioner also testified to using paint touch-up applicators in the polishing department. Numerous Hazard Communication Sheets identify those products as a mixture of solvents, resins and pigments.

Petitioner began working in the polish department in November 1993 and held that classification only according to Respondent's Exhibit 1 until he retired. By Petitioner's testimony, he had no further exposure to the spray paint operation from the early 1980's. Having carefully reviewed the Hazard Communication Sheets, the Arbitrator notes that the touch-up applicators do not contain Formaldehyde, while paints used in the spray operation may contain small amounts of Formaldehyde, typically indicated as between 0.1% to 1% by weight. Based on the Petitioner's testimony and Respondent's Exhibit 1, Petitioner would have last been exposed to the hazards of any disease from Formaldehyde in the early 1980's.

Leaving aside the issue of causation, which will be addressed below, the Arbitrator finds that Petitioner failed to prove he was last exposed to the hazards of any occupational disease arising from exposure to Formaldehyde on May 1, 1996, or on any later date until his surgery on December 5, 1996. Furthermore, the Arbitrator finds that Petitioner failed to prove he suffered from any disablement as a result of exposure to Formaldehyde within two years after his last exposure in the early 1980's. There was no medical evidence offered to establish he was diagnosed with or disabled from any condition associated with exposure to Formaldehyde at any point in time during the 1980's. Section 1(f) of the Occupational Diseases Act requires that disablement occur within two years after the last date of the last exposure to the hazards of the disease. To recover any benefits for exposure to Formaldehyde, Petitioner would have had to establish disablement at some point in the mid-1980's. No such evidence was offered.

As noted above, the Arbitrator does find that Petitioner worked with products containing solvents and may have been exposed to hazards of an occupational disease in the course of his employment as a polisher with a date of last exposure on December 4, 1996. That date is based on the parties' stipulation that Petitioner was first off work for the alleged condition on December 5, 1996. Whether Petitioner suffers from any condition of ill-being causally related to said exposure is discussed below.

On the disputed Issue F, whether Petitioner's current condition of ill-being is causally related to occupational exposure, the Arbitrator finds as follows:

The Arbitrator notes that personal air monitoring performed on Petitioner on November 7, 1996 failed to identify exposure above the limits of detection for organic solvents, particulate and oil mist. Jean Melvin testified the testing was performed in conditions typical of the work environment. While the compounds used in the polish operation contained solvents, testing on that day confirmed that the environmental protections in place, a down draft and filters, were effective in preventing solvent exposure in the breathing zone. Furthermore, it should be noted that there was nothing sprayed in the environment in the polishing area. Petitioner testified to repairing minor defects in the paint on the auto body using a small touch-up applicator, when

necessary, and polishing compound applied to a buffer. It is apparent the process did produce particulate, from the photos offered into evidence, but the engineering controls cleared that from the breathing zone.

A number of Hazard Communication Sheets were offered into evidence. As noted above, Petitioner acknowledges never having spoken directly with Dr. Orris or Dr. Hessl regarding what specific materials he worked with in the course of his employment. It is difficult to tell from the testimony of Dr. Orris or the testimony of Dr. Hessl whether they relied on any particular Hazard Communication Sheets with regard to their respective opinions. It is impossible to tell whether they may have relied on chemicals identified in the various Hazard Communication Sheets, which Petitioner did not even use.

Both Dr. Orris and Dr. Hessl acknowledged that the peer review literature on which they relied was conflicting as to causation between exposure to paint, solvents and Formaldehyde and development of laryngeal cancer. At least some of those studies showed no association between those chemicals and laryngeal cancer. Dr. Orris testified that he found no connection between Benzene exposure and vocal cord cancer. The literature was not specific for vocal cord cancer and exposure to Formaldehyde.

The most telling reason to reject the opinion of Dr. Orris is that he admitted he could not offer an opinion to a reasonable degree of medical certainty. He clearly stated his disagreement with the opinion of Dr. Steven Hessl contained in the December 12, 1996 letter. That letter by Dr. Hessl stated that the laryngeal cancer was probably associated with Petitioner's prolonged work as a painter. Dr. Orris stated that he thought it was possible, but he did not have a causative opinion to a reasonable degree of medical certainty. Medical expert opinion evidence must rise to the level of a reasonable degree of medical certainty, not suspicion. Dr. Orris' testimony as to that standard further detracts from the opinion of Dr. Steven Hessl. Although Dr. Hessl expressed his opinion to a reasonable degree of medical certainty, the opinion of Dr. Orris clearly casts doubt on the validity or certainty of Dr. Hessl's opinion.

The Petitioner testified to giving a long history of reflux disease to Dr. Ford and other physicians. The records of Dr. Keller established convincingly that Petitioner had a long history of peptic acid disease, also referred to as reflux or reflux esophagitis. The records of Dr. Ford at the time of surgery clearly show a history of GERD, gastroesophageal disease. As late as November 26, 2003 when seen by Dr. Ford, Petitioner had complaints of indigestion and reflux symptoms. While a PH monitoring test may have cast doubt on the diagnosis, the weight of medical evidence shows Petitioner had problems with reflux for years and years before his diagnosis of vocal cord cancer. All of the medical experts who testified agreed there was at least some recognized association between gastroesophageal reflux disease and laryngeal cancer.

It is not the Respondent's burden of proving that Petitioner's condition of ill-being is causally related to some other health condition or exposure. It is the Petitioner's burden of proving by a preponderance of competent evidence and to a reasonable degree of medical certainty, that his condition of ill-being may be related to work-place exposure. The Arbitrator concludes that Petitioner has failed to meet that burden. Dr. Orris and Dr. Hessl acknowledge that medical studies are conflicting and/or equivocal on the association between exposure to

paints and solvents and laryngeal cancer. Although Dr. Hessl may have stated that his opinion was to a reasonable degree of medical certainty, Dr. Orris clearly admitted his opinion was not to that degree, but merely one of suspicion. Dr. Greaves clearly testified that he found no relationship between the condition of laryngeal cancer and Claimant's exposure to various chemicals at work. The Arbitrator relies on the opinions of Dr. Greaves finding that Petitioner failed to prove his condition of laryngeal cancer was causally related to any chemical exposure at work.

Having found that Petitioner failed to prove his condition of ill-being is causally related to occupational exposure, the Arbitrator need not address the other disputed Issues J, Medical Expenses, K, Temporary Total Disability Benefits and L, Nature and Extent of the Alleged Injury. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANCES SOMENEK,
Petitioner,

15IWCC0238

v.

02 WC 39539

DOMINICKS,
Respondent.

DECISION AND OPINION ON PETITION UNDER §§19(h) & 8(a)

This matter comes before the Commission on Petitioner's Petition under §§19(h) and 8(a). A hearing was held on Petitioner's Petition on September 9, 2014 in Chicago before Commission White. Both parties were represented by counsel and a record was taken.

In the underlying cases, the Arbitrator issued a decision pursuant to §§19(b) and 8(a) on October 8, 2008, in which he found Petitioner suffered a work-related accident on March 25, 2002 and awarded her 8&4/7 weeks temporary total disability benefits, and $262.41 in medical expenses. He also denied certain un-itemized medical expenses and denied prospective surgery. Petitioner sought review of that decision and the Commission modified the Decision of the Arbitrator, ordered Respondent to authorize and pay for a second prospective meniscal surgery recommended by Dr. Schroeder, and remanded the matter for determination of which un-itemized medical expenses were compensable.

On remand, the Arbitrator issued another decision pursuant to §§19(b) and 8(a) on September 12, 2011. In that decision he noted that Respondent had authorized surgery pursuant to the Decision of the Commission. However, Petitioner returned to Dr. Schroeder for treatment, who after another MRI no longer affirmatively recommended surgery, and apparently Petitioner declined surgical intervention as well.

In the second §19(b) decision, the Arbitrator awarded Petitioner prospective treatment then recommended by Dr. Schroeder, which included the use of an unloader brace, "treatment of a Baker's cyst and [viscal supplement therapy for] degeneration of the medial compartment possibly obviating the need for a future knee replacement." Thereafter, the case was heard by another Arbitrator who issued a final arbitration decision on February 20, 2013. She awarded Petitioner $2,442.24 in medical expenses and 70 weeks of PPD representing 35% loss of the use of the right leg.

Findings of Fact and Conclusions of Law

1. Petitioner testified by deposition on July 10, 2014, that she was currently unemployed. Her last day of employment was on September 27, 2013 with Respondent as an inventory control clerk. She was also working in that capacity when she last testified at an arbitration hearing.

2. Since the time of her arbitration testimony she fractured her "knee going up the stairs" in March of 2013. She could not remember the exact date or the day of the week. Her knee gave out and her kneecap slammed into the stair at home. She was not carrying anything and was not in a hurry. She had a lot of pain but did not seek medical treatment immediately. She used ice and an Ace bandage and did not lose any time at work.

3. At work, Petitioner noticed she could not bend or kneel or "do much of anything because of pain." She returned to Dr. Schroeder on March 25, 2013, about two weeks after the injury, because the pain was not going away. She did not recall whether she had an appointment scheduled prior to her latest accident. He took x-rays which showed the fracture. He then applied a brace on her right leg. Dr. Schroeder did not take her off work but Respondent would not let her work because she was hurt at home and not on the job. Petitioner then testified that she tried to work with the brace for three days but then her manager told her she had to stay off work until she was better.

4. Petitioner testified she was off work from March 28, 2013 to after Labor Day, so around May 30, 2013. During that time she had about four weeks of physical therapy. Petitioner had continued to perform her home exercise program after her arbitration testimony. Petitioner also continued to have problems with cramping, about which she testified in 2012. She also testified she had problems with her knee "locking" which she continued to experience occasionally after her testimony. When her knee gives out she loses balance and could fall. Currently, Petitioner has pain "very mildly every day," for which she takes 800 milligrams of Advil twice a day.

5. Petitioner had 2 Synvisc injections for her knee symptoms in the past and "they were wonderful." She wanted to return to get more of those injections, but they were not approved by the workers' compensation carrier. She can only drive limited distance because of soreness in her knee. Petitioner has not had any other incidents or traumas to her right knee other than her fall on the stairs at home.

6. On cross examination, Petitioner agreed she did not immediately make an appointment with Dr. Schroeder even though she felt immediate pain after the accident. She agreed that Dr. Schroeder's notes that the accident date was around March 4, 2013. She did not report an accident to Respondent from the day of the accident to the day she was taken off work by Respondent. She did not recall whether she testified as to her knee giving out at arbitration.

7. Petitioner agreed that she probably last saw Dr. Schroeder on September 20, 2012 prior to the December 2012 arbitration. At that time she complained of medial discomfort associated with weather changes, and prolonged standing, walking, and squatting. She did not complain of her knee giving out at that time. She also did not recall whether she complained to Dr. Schroeder of her knee giving out at her previous appointments. She also did not recall reporting her knee giving out at a functional capacity evaluation.

8. Petitioner agreed that she did not see any doctor for her knee between September 20, 2012 and March 25, 2013. Petitioner's manager came to her about not working while wearing the brace because the manager did not consider her injury work related. Petitioner did not talk to anybody from Respondent since that conversation, which was around March 27, 2013. She filled out medical leave documents. She then testified she told her manager that she just could not work on her knee.

9. Petitioner agreed that she previously testified that her job as inventory control clerk involved regular lifting, stooping, and bending. She was able to "basically" perform those activities from December of 2012 to march of 2013 and then again between May of 2013 and September of 2013 throughout her 8½ hour workday. She could not remember whether Dr. Schroeder ever told her the knee was unstable. She agreed that Dr. Schroeder recommended additional Synvisc injections prior to her March 2013 accident. Her current complaints about her knee were "pretty much" the same as they were prior to her accident at home.

10. On redirect examination, Petitioner testified that in her previous testimony she stated she did not wear the unloader brace while at work. After the March 2013 accident she had to use a brace from her ankle to her thigh for the entire day, except for showering. On re-cross examination, Petitioner testified she received some short-term disability benefits from her union after the March 2013 accident. She believed she received $800 a month for the period she was off work.

11. Dr. Schroeder's medical records indicate that on January 19, 2013, Petitioner reported good improvement after Synvisc injection on September 20, 2012. She had intermittent right knee pain which was improving. Her pain was aggravated by climbing stairs. Petitioner was negative for joint instability and should follow up in three months.

12. On March 25, 2013, Petitioner reported about three weeks previously her knee gave out while ascending stairs and she felt increased pain. Knee instability and tenderness was noted. Her pain was intermittent and worsening and aggravated by climbing stairs and walking. X-rays showed a fracture of the inferior pole of the patella, which was in good position. Dr. Schroeder provided a brace and took Petitioner off work indefinitely from March 28, 2013.

13. On April 18, 3013, Petitioner reported her pain was improving and had worn the knee brace as instructed. She was stiff from wearing the brace but was not taking pain medication. She had been off work due to the fracture since March 28, 2013. X-rays showed the fracture was healing well. Dr. Schroeder prescribed physical therapy.

14. On May 16, 2013, Petitioner reported her pain was still aggravated by climbing stairs and walking, but her tolerance with stairs and ambulation had improved. She was still off work. Dr. Schroeder declared the fracture healed, prescribed another week of physical therapy, and released her to full duty as of May 27, 2013. He recommended another Synvisc injection for osteoarthritis pending approval by the workers' compensation carrier.

It appears that Petitioner's work injury was a meniscal tear and associated Baker's cyst. Even accepting Petitioner's testimony at face value, it is clearly not certain whether the knee giving out was associated with the work injury involving the meniscus or the underlying osteoarthritis. The Commission notes that there was no medical record or opinion indicating any causal connection between the original work-related injury and the March 2013 accident. Therefore, the Commission finds that Petitioner failed to sustain her burden of proving that her fall was directly related to her 2002 work injury. Accordingly, the Commission denies temporary total disability benefits. Nevertheless, after the second remand from the Commission the Arbitrator did award prospective treatment for the arthritis in order to possibly obviate the need for knee replacement in the future. Therefore, it appears that the law of the case requires a finding that treatment for the osteoarthritis is compensable. Accordingly, the Commission orders Respondent to authorize and pay for Synvisc injections recommended by Dr. Schroeder.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition pursuant to §19(h) is hereby denied.

IT IS FURTHERORDERED BY THE COMMISSION that Petitioner's petitioner pursuant to §8(a) is hereby grants and Respondent shall authorize and pay for Synvisc injections recommended by Dr. Schroeder.

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: MAR 2 7 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-3/18/15
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STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua Moore,

Petitioner,

vs.

NO: 01 WC 46145

15IWCC0239

B & B Electric,

Respondent.

DECISION AND OPINION ON §8(a) PETITION

This matter comes before the Commission for consideration of Petitioner's §8(a) Petition. The issues on Review are whether Petitioner incurred additional medical expenses since the prior §8(a) Decision of the Commission dated February 17, 2011 and whether that treatment was causally related, reasonable and necessary to Petitioner's Complex Regional Pain Syndrome, whether Petitioner is entitled to prospective medical care and whether Petitioner is entitled to reimbursement for his out-of-pocket mileage expenses. After due consideration, the Commission grants Petitioner's §8(a) Petition to the extent of the costs of the prescribed medications listed and circled in Px8, finds that Petitioner is entitled to prospective medical care of Ketamine infusions prescribed by Dr. Lubenow, but denies Petitioner's request for mileage reimbursement for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed an Application for Adjustment of Claim on August 20, 2001 alleging a date of accident of May 8, 2000, a fall sustaining whole body injury.

2. The claim was settled by lump sum settlement contract approved on October 6, 2006. The settlement contract noted the TTD benefits paid prior to settlement was 287 weeks at $733.33 per week. The settlement amount was $200,000.00. Respondent agreed to pay the following medical providers directly:

Lifestar Ambulance: $668.15; Clinical Pathologists: $671.00; Vine Street Clinic: $355.00; Springfield Clinic: $5,004.00; Memorial Medical Center: $79.31, $660.60 and $106.30; Clinical Radiologists: $344.00, $588.50 and $337.00; University Anesthesiologists, Dr. Lubenow: $3,081.00 and $237.00. The settlement contract contained a provision that Petitioner's right to future medical care would remain open.

3. On October 27, 2009, Petitioner filed a §8(a) Petition. In its Decision and Opinion on §8(a) Petition dated February 17, 2011, the Commission granted the §8(a) Petition and ordered Respondent to pay the medical expenses contained in Px15 and the cost of one stellate ganglion block to be followed by radio frequency thermocoagulation, subject to §8.2 Medical Fee Schedule.

4. On October 31, 2013, Petitioner filed this §8(a) Petition. The matter was continued by the parties at various times. On June 26, 2014, a hearing on the §8(a) Petition was held before Commissioner Basurto.

At the June 26, 2014 hearing, Petitioner testified that before being injured, he was employed as an inside wireman for Respondent. His job duties included wiring commercial buildings (Tr 9). While working on May 8, 2000 at the Baylis Building, Petitioner was shocked and fell backwards off a ladder, tripping over debris behind the ladder and ultimately landed on a steel studded wall on his right elbow (Tr 10). Petitioner subsequently developed Complex Regional Pain Syndrome (CRPS) (Tr 10).

At Respondent's request, Petitioner saw Dr. Lubenow, a pain specialist, for a §12 evaluation (Tr 10). Ultimately, Petitioner's case was settled with the provision that his right to future medical care would be left open (Tr 10-11). Ever since his case has been settled, Petitioner has been seeing Dr. Lubenow (Tr 11). Dr. Lubenow is the person in charge of his care for CRPS (Tr 11). There have been medications prescribed by Dr. Lubenow that have not been approved by Respondent (Tr 11). For those, Petitioner had to use the Illinois Department of Public Aid For Health and Human Services under a Medicaid card to get many of his prescriptions paid (Tr 11-12). Respondent's insurer, Cincinnati Insurance Company, paid for his last doctor's visit, but have not paid for any of his medications for a long time (Tr 12). Petitioner stated that Cincinnati Insurance Company agreed to pay for Topamax, but have not paid for it in a long time and Petitioner did not know whose fault it was that they have not paid for it in a long time (Tr 12). Petitioner could not remember when Topamax was paid for by Cincinnati Insurance Company (Tr 12). Topamax had not been paid in 2013 or 2014 by Cincinnati Insurance Company (Tr 13). Medicaid has paid for his prescribed Topamax (Tr 13). Even though Topamax has been approved by Utilization Review, Petitioner has not been able to get his prescribed Topamax paid for through Cincinnati Insurance Company (Tr 13).

Petitioner was shown Px8 and identified it as a document he prepared (Tr 13). The medications that Petitioner circled on Px8 are those he has been taking for his CRPS (Tr 14). Dr. Lubenow's office has a program set up where at a visit he is given medication (Tr 14). Petitioner went through the circled medications on Px8 (Tr 14). Petitioner takes Baclofen, a muscle relaxer, for his nerve pain (Tr 14). He takes Amitriptyline, an antidepressant, for his nerve pain (Tr 15). Petitioner takes Morphine for his pain (Tr 15). He takes Olanzapine, an antipsychotic,

because he has problems with the Morphine (Tr 15). Topiramate is an anticonvulsant that he takes for nerve pain; it is like Lyrica (Tr 15). Duloxetine is Cymbalta that he takes for nerve pain as well (Tr 15). None of those are prescribed by Dr. Lanzotti, his primary care physician (Tr 15). Dr. Lanzotti used to prescribe Morphine for him, but he does not do anything for Petitioner right now. Dr. Lanzotti prescribes some generics like Hydrochlorothiazide, Magnesium Oxide, Hydroxyzine and Famotidine and Petitioner sees Dr. Lanzotti when he runs out of those medications (Tr 16). Dr. Lanzotti also prescribes eyedrops and inhalers (Tr 16). Dr. Lubenow has coordinated with Dr. Lanzotti as far as writing some of these pain medication prescriptions because for a long time Petitioner was not able to see Dr. Lubenow (Tr 16). For 10 months, the insurance company would not let him see Dr. Lubenow, so Dr. Lanzotti was writing all the prescriptions, including pain medications (Tr 16).

Petitioner testified that he was supposed to see Dr. Lubenow every 3 months because he would be given a 3 month prescription. The type of medications could not be re-filled and Petitioner would need a new prescription (Tr 17). Petitioner has had problems with Cincinnati Insurance Company pre-approving his trips to see Dr. Lubenow (Tr 17). Before a new adjuster was assigned to him, it was horrible (Tr 17). For his last visit he got an appointment immediately. Before the new adjuster, Petitioner would make an appointment and he would give them a month or two to let them know; then it would be the day of the appointment, he would call and they still had not done it (approved the appointment). Petitioner testified that Cincinnati Insurance Company should not wait until the day of the appointment to approve it and Petitioner should know a week ahead of time because he had to arrange transportation and stuff and it is just crazy that it takes so long for them to arrange the approval (Tr 18). Kelly Ward was the adjuster Petitioner was having issues with (Tr 18). Petitioner gave her plenty of time ahead and she would wait until the last minute to tell him whether it is a yes or no; if it was no, then Petitioner had to cancel everything and try to get his money back on his train tickets; Petitioner did not wait until 30 minutes before the train was supposed to take off to get a ticket (Tr 18).

In the summer of 2013, Dr. Lubenow requested both epidural steroid injections. Respondent's attorney stated that there was no issue regarding the epidural steroid injections (Tr 19). Approximately 2 to 3 months from July 2013, Dr. Lubenow wanted to do Ketamine Infusion, which has not been approved at all (Tr 19). Other than Petitioner's last office visit with Dr. Lubenow, no other treatment has been approved by Respondent (Tr 19). Petitioner has made trips to Dr. Lubenow in which he is asking reimbursement for mileage expenses, as set forth in Px6 (Tr 19). Petitioner has not been paid any mileage for any of his trips to Dr. Lubenow since 2002 (Tr 20). Petitioner is not currently working (Tr 20). He has an injection scheduled for the day after this hearing into his back and if it starts feeling better, Petitioner wants to start trying to go back to work. It is just his arm that kills him right now and he has not had anything done to it (Tr 20). The radiofrequencies made him feel better for a while (Tr 21). The stellate ganglion blocks helped if he had droop and he has not had anything like that since 2010 (Tr 21). Petitioner currently noticed his right arm hurts because he is freezing. His arm is drawn up and his elbow hurts; it is pulling to his elbow, pulling them together (Tr 21). One of the procedures that Dr. Lubenow did was radiofrequency, which made his mobility a lot better and made the burning go away (Tr 21). However, Dr. Lubenow told Petitioner that radiofrequency would not work anymore and that is why he wants to do Ketamine Infusion (Tr 21-22). Petitioner did not respond very well to the stellate ganglion blocks, which is why Dr. Lubenow started doing the

radiofrequencies (Tr 22). The only prospective procedure that Dr. Lubenow has for him is Ketamine Infusion (Tr 22). Petitioner requested that the Commission enter an order in his favor ordering Respondent's insurer, Cincinnati Insurance Company, to pay for Ketamine Infusion (Tr 22). He is also requesting his prescription bills be paid (Tr 22). Petitioner also stated that Dr. Lubenow placed a spinal cord stimulator in him to treat his CRPS in 2007 and that the batteries lasts 7 or 8 years and they are going to have to be replaced within probably the next year (Tr 22-23). Petitioner is also requesting mileage reimbursement for his trips to see Dr. Lubenow (Tr 23).

On cross-examination, Petitioner testified that his last visit with Dr. Lubenow was on May 25, 2014 (Tr 23). Before that, his last visit with Dr. Lubenow was in July 2013 (Tr 24). Petitioner had no problems with Cincinnati Insurance Company for the May 25, 2014 visit as the new adjuster had the appointment approved immediately (Tr 24). Petitioner's mother typed up Px8 (Tr 24). The medications circled on Px8 are the ones Petitioner is taking for the CRPS (Tr 24). There are no other medications that his is taking for his right arm (Tr 25). All the other medications listed on Px8 that are not circled are for something else (Tr 25). The circled medications on Px8 are prescribed by Dr. Lubenow (Tr 25). The other medications not circled on Px8 are prescribed by other doctors (Tr 25). The circled medications on Px8 are Baclofen, Amitriptyline, Olanzapine, Morphine Sulfate, Topiramate and Duloxetine (Tr 26). Petitioner takes Hydroxyzine, but it is not for RSD (CRPS); Dr. Lanzotti prescribes that for anxiety (Tr 26). Magnesium Oxide is an over-the-counter medication prescribed by Dr. Lubenow which costs $6.00 and Petitioner was not going to circle it on Px8 because it is over-the-counter (Tr 26). Magnesium Oxide promotes bone strengthening as RSD weakens bones (Tr 27). Petitioner has not taken Celebrex in a long time (Tr 27). Celebrex is not listed on Px8 (Tr 27). Px8 was admitted into evidence (Tr 28).

5. Px8 consists of a list of medications prescribed by Dr. Lubenow. The following prescribed medications are circled: Baclofen, Amitriptyline, Olanzapine, Morphine Sulfate, Topiramate and Duloxetine.

6. In his June 1, 2006 deposition, Px7, Dr. Lubenow testified he is board certified in anesthesiology and pain medicine. He is medical director of the Rush Pain Center and director for the section of pain management at Rush University Hospital. Petitioner is a patient who he diagnosed with CRPS. Sixty to seventy-five percent of his patients have CRPS. Dr. Lubenow first saw Petitioner on February 27, 2002 for an independent medical evaluation. Petitioner then began treating with him. Petitioner continued to have good response with the spinal cord stimulator, but continued to have persistent ongoing pain. Petitioner's pain condition affects both the chest wall and his right arm (Dp 28). Dr. Lubenow opined that Petitioner will have a chronic, permanent condition of CRPS (Dp 28). Dr. Lubenow opined Petitioner will need to be monitored by a qualified pain management practitioner for the remainder of his life to assess his response to medications and to monitor and maintain the spinal cord stimulating system (Dp 29). Dr. Lubenow opined that Petitioner may have flare-ups from time to time and he may need to have an intermittent series of injections from time to time (Dp 29). Dr. Lubenow opined that once the pulse generator of the spinal cord stimulator runs out, with his next replacement he will be upgraded to the rechargeable and programmable pulse generator which gives a greater flexibility of stimulation options and a greater battery life (Dp 29).

Dr. Lubenow noted that Zyprexa and Remeron are medications termed neurotransmitter modulators and they fall into the compounds of antidepressants and are intended to facilitate sleep. Remeron is also useful for anxiety. Topamax is an anticonvulsant which is used for a variety of different types of chronic pain conditions including CRPS. Protonix is for medication induced gastritis. Baclofen is a muscle relaxant which is an adjuvant analgesic for patients who have nerve related pain. Welbutrin is a neurotransmitter modulator that falls into the family of antidepressants and is useful to help stabilize mood and control anxiety. Norco is an analgesic. (Dp 30-31). Dr. Lubenow opined that Petitioner will continue to need medications of this nature (Dp 31-32). The battery of the spinal cord stimulator Petitioner has needs replacement every 6 years at an approximate cost of $40,000 (Dp 33). Dr. Lubenow opined that Petitioner will need to follow-up with a pain physician every 6 months indefinitely (Dp 34).

On cross-examination, Dr. Lubenow testified that Petitioner falls into the response category that he does well and continues to do so and needs very little reprogramming of his spinal cord stimulator system. Changing the battery requires surgery (Dp 47-48). On re-direct examination, Dr. Lubenow testified that even with a good outcome from spinal cord stimulation, there is not complete pain relief. There is usually 50% and at best 70% improvement in pain. Petitioner still has some degree of chronic, persistent pain. Petitioner has some degree of restricted activities because if he goes above a certain threshold of activity, he will have more pain, more edema and more tenderness (Dp 55).

7. According to the medical records from Rush Pain Center, Px1, Dr. Lubenow saw Petitioner on February 23, 2011 and in his Pain Center Progress Note that date he noted the diagnosis of right upper extremity CRPS. Petitioner reported he had undergone a RFTC one month ago and he had immediate significant improvement after the procedure. His pain was worse with cold weather. Petitioner reported heavy leg restlessness with Remeron and he was to decrease the dosage. Dr. Lubenow prescribed Baclofen, Topamax, Remeron, Percocet, Magnesium Oxide and Sonata.

8. The medical records from Springfield Clinic, Px6, indicate Petitioner saw Dr. Lanzotti on May 24, 2011 and he noted that Petitioner wanted him to take over prescribing his medications. Dr. Lanzotti noted that Petitioner had been getting these from Dr. Lubenow in Chicago, but there were problems with refills. Dr. Lanzotti told Petitioner he would prescribe his medications and did so. Dr. Lanzotti refilled his medications on July 6, 2011.

9. In his Pain Center Progress Note of August 4, 2011, Dr. Lubenow noted he diagnosed right upper extremity CRPS. Petitioner reported increased pain and aching in his right upper extremity and right face, but that he was, "feeling a lot better than I have in a long time." Petitioner reported that he began part-time work. On examination, Dr. Lubenow found his gait to be within normal limits, minimal allodynia in the right upper extremity, strength 4/5 in his right upper extremity, shoulder strength 4+/5, elbow strength 4/5, wrist strength 4/5 and his right upper extremity was without erythema or edema. Dr. Lubenow released Petitioner back to work. Dr. Lubenow prescribed Baclofen, Topamax, Remeron, Percocet and Magnesium Oxide.

In a letter dated August 4, 2011 to Kelly Ward of Cincinnati Insurance Company and Dr. Lanzotti, Dr. Lubenow informed that Petitioner had followed-up for his chronic pain associated with his right upper extremity CRPS and he continued to improve. Petitioner rated his pain at 4-5/10. Petitioner reported he was feeling much better than previously and that he had been able to obtain some part-time employment. Petitioner reported his spinal cord stimulator seemed to be functioning well and that good coverage continued. Dr. Lubenow noted Petitioner was to continue his current management, that he was quite stable and therefore needed to only follow-up every 6 months. Dr. Lubenow noted that Petitioner would continue to follow-up with Dr. Lanzotti for monthly Percocet prescriptions. Dr. Lubenow noted, "The patient and myself are both appreciative to Dr. Lanzotti for providing prescriptions in between the patient's visits here to Rush Pain Center. He was last seen here and had radiofrequency ablation. He is doing quite well and it was very successful." However, Dr. Lubenow noted that Petitioner still continued to have decreased strength in his right upper extremity and some associated pain. He noted Petitioner was stable on his current regimen. (Px1). Dr. Lanzotti refilled Petitioner's medications on August 30, 2011, September 27, 2011, October 25, 2011 and December 27, 2011. (Px6).

10. In his January 17, 2012 Follow Up Notes for CRPS, Dr. Lubenow noted that Petitioner rated his pain at 5/10. Petitioner reported that since his last visit, he had stopped working and was on disability and takes care of his brother. Petitioner reported increased right upper extremity pain. Dr. Lubenow noted that his spinal cord stimulator needed a new recharging belt. Dr. Lubenow prescribed Baclofen, Topamax, Remeron and Percocet. (Px1). Dr. Lanzotti refilled Petitioner's medications on February 23, 2012. (Px6).

11. In a letter dated September 20, 2012 to Kelly Ward of Cincinnati Insurance Company, Dr. Lubenow noted that Petitioner was seen that day for follow-up for CRPS of his right upper extremity. Dr. Lubenow noted Petitioner currently had a Medtronic spinal cord stimulator that was placed September 10, 2007. Petitioner reported he had a recent exacerbation of pain in the right upper extremity and a new onset of pain in his left upper extremity. Petitioner rated this pain at 7-8/10. Dr. Lubenow noted Petitioner was seen by the Medtronic representative, who reprogrammed the spinal cord stimulator and Petitioner stated that his pain had decreased to 4-5/10 in the right upper extremity. Petitioner had also complained of neck pain, which was resolved after the spinal cord stimulator was reprogrammed. However, in spite of the reprogramming, Petitioner was still complaining of persistent pain. Dr. Lubenow's plan was to continue the prescribed medications of Baclofen, Topamax, Remeron and Percocet. He also prescribed Lunesta. Dr. Lubenow opined that because of Petitioner's refractory symptoms in spite of the spinal cord stimulator, he was a very good candidate for a stellate ganglion block. Dr. Lubenow noted that he highly recommended this as it would help Petitioner and he had a good response to this in the past. Dr. Lubenow noted that if the stellate ganglion block did work, then in the future he may be a candidate for a radiofrequency ablation.

In a September 20, 2012 letter to Dr. Lanzotti, Dr. Lubenow informed of the above. He noted that Lunesta was being prescribed for sleep. Dr. Lubenow noted that he was aware that Dr. Lanzotti's office provided prescriptions between Petitioner's visits to him at the Rush Pain Center. Dr. Lubenow noted that Petitioner would schedule for a stellate ganglion block on the right and put a plan in place for a future radiofrequency ablation. Dr. Lubenow noted, "This will

hinge on the patient getting approval through Workman's Compensation." (Px1). Dr. Lanzotti refilled Petitioner's medications on October 17, 2012. (Px6).

12. In a letter dated October 31, 2012 to Kelly Ward of Cincinnati Insurance Company, Dr. Lubenow noted that Petitioner used the spinal cord stimulator daily, which helped his pain to a certain degree. Petitioner reported he had been having increased pain in his right lower extremity, increased anxiety and decreased sleep and thus increased usage of his pain medications over the last couple months. Petitioner rated his pain at 10/10. Petitioner had decreased range of motion on internal and external rotation of his right shoulder. Dr. Lubenow gave Petitioner a stellate ganglion block and he reported that immediately after the procedure, he had great relief of his right upper extremity pain and rated his pain at 2/10. Dr. Lubenow prescribed Baclofen, Topamax, Remeron and Percocet. Petitioner reported that Lunesta/Nucynta prescribed at his last visit was not approved by the workers' compensation insurance company. Dr. Lubenow opined that patients with CRPS will sustain improved pain relief secondary to improved sleep, which, in this case, is contributory to his overall pain symptoms, including his right upper extremity pain. Dr. Lubenow opined that if Petitioner continued to have good pain relief, but for a short duration, which he anticipated, he believed it is medically necessary at that point to perform a radiofrequency ablation of the stellate ganglion. Dr. Lubenow noted that normally the radiofrequency ablation will extend his pain relief for 6 months to 1 year and refrain him from potentially having more stellate ganglion blocks, reduce his ER visits, decrease his narcotic medication use, improve his functionality and decrease his pain.

13. In a letter dated December 13, 2012 to Kelly Ward of Cincinnati Insurance Company, Dr. Lubenow noted that Petitioner was seen for follow-up for right upper extremity CRPS. Petitioner reported that the stellate ganglion block provided no relief of his right upper extremity symptoms, but he got some left upper extremity relief of his burning pain and tingling. Petitioner reported continued pain and allodynia in his right upper extremity, particularly in his right hand, with mild to moderate relief with his medications. One of his major complaints this day was insomnia. Petitioner was currently on Remeron 30mg daily. He had tried Ativan nightly with no improvement in sleep pattern. At this time, Dr. Lubenow prescribed Elavil, which Petitioner had been on before and tolerated well. He was to wean off Remeron in 1 week. Dr. Lubenow noted, "The reason for this letter is also to rebut an earlier medical report stating that the patient was not in need of the above-stated medications for controlling his CRPS symptoms. At present, the patient has a dire need for these medications. They improve his pain, improve his mood, and help increase his level of functionality. His diagnosis of right upper extremity CRPS places him in need of these medications. He states that he still has a lot of difficulty with Workman's Compensation coverage of the meds, and I am sending this letter to appeal for coverage of these medications to begin." (Px1). Dr. Lanzotti refilled Petitioner's medications on February 19, 2013. (Px6).

14. According to the medical records from Rush Pain Center, Px2, Dr. Lubenow saw Petitioner on February 28, 2013. Petitioner rated his pain 10/10 with pain distribution in the left upper extremity, right upper extremity and right lower extremity. Petitioner reported increased stress and pain. Dr. Lubenow prescribed the same medications and added Morphine. Dr. Lanzotti refilled Petitioner's medications on March 11, 2013. (Px6).

On March 20, 2013, it was noted that there was a telephone conversation with Petitioner's mother, who informed that Petitioner missed his scheduled appointment this day. She informed that Petitioner was admitted to Memorial Hospital psychiatric unit. It was noted that since his last visit there on February 28, 2013, Petitioner had stomach problems with Percocet, which was changed to Morphine. Petitioner then became very paranoid and was hospitalized. Petitioner believed his house and car were bugged. It was noted that the workers' compensation insurance would not pay for any medications. Dr. Alexander was noted as a physiatrist. It was noted that Dr. Lubenow said he would be willing to have Petitioner admitted at Rush Medical Center. It was noted that Petitioner's mother was informed that she and Petitioner should talk about this with his doctor there if Petitioner wanted this transfer and then Memorial could contact a Pain fellow for follow-up. Petitioner's mother informed she could talk with the doctor in the morning. Dr. Lanzotti refilled Petitioner's medications on March 29, 2013. (Px6).

15. In his April 10, 2013 Follow-up Notes for CRPS, Dr. Lubenow noted that Petitioner rated his pain at 7/10. The rest of the Notes were unreadable. In Slips that date, Dr. Lubenow prescribed MS Contin. Dr. Lubenow also ordered a lumbar CT scan for a diagnosis of low back pain. (Px2). On April 16, 2013, Dr. Lanzotti noted that as per Dr. Lubenow's order, he ordered a lumbar CT. Petitioner reported that through the workers' compensation adjuster, he was given a couple names of doctors in town that also do chronic pain management. It was noted that Petitioner said he would check with them to see if they were willing to take a new patient. (Px6).

In a letter dated June 18, 2013 to Kelly Ward of Cincinnati Insurance Company, Dr. Lubenow noted he had seen Petitioner on April 10, 2013 and he had rated his pain at 7/10. At that time, Petitioner reported less nausea with MS Contin as compared with OxyContin and some other narcotics in the past. Petitioner felt less sedated than previously. Dr. Lubenow noted that Petitioner reported a complaint of a new onset of low back pain. Dr. Lubenow noted the medication regimen of the following: MS Contin, Baclofen, Topamax, Dexilant, magnesium oxide, Hydroxyzine, Zyprexa and Astelin nasal spray. Dr. Lubenow noted that the Medtronic representative adjusted Petitioner's spinal cord stimulator. Dr. Lubenow noted he ordered a lumbar CT scan as Petitioner had positive straight leg raises on examination. Petitioner was to follow-up in 3 months. (Px2). On July 3, 2013, Dr. Lanzotti noted he refilled Petitioner's medications. Petitioner reported he continued to see Dr. Lubenow in Chicago. (Px6).

16. In a letter dated July 24, 2013 to Kelly Ward of Cincinnati Insurance Company, Dr. Lubenow noted that he had seen Petitioner this day and he rated his pain at 8/10. Petitioner reported significant pain in his right upper extremity, described as freezing and burning at the same time and this was very disabling for him. Petitioner also reported trouble sleeping. Petitioner reported continued low back pain with radiating pain down his right lower extremity with sensitivity and numbness in his right foot, the same way his CRPS presented in his right upper extremity. Petitioner's examination was similar to his prior examination. Dr. Lubenow's plan was to decrease MS Contin dosage, wean down Zyprexa for the next 3 weeks, then stop this medication to help him sleep; increase Elavil dosage; prescribe Celebrex for back pain. Dr. Lubenow noted he was concerned about Petitioner's pain down his right lower extremity would worsen secondary to the degenerative changes noted in the lumbar CT scan and he is now presenting with symptoms that are consistent with the symptoms of CRPS in his right upper

extremity. Dr. Lubenow noted he would like to pursue a series of lumbar steroid injections to help with this flare-up and would do a series of 3 injections two weeks apart. Dr. Lubenow noted that regarding the CRPS in his right upper extremity, the plan was to do a series of Ketamine infusions over the course of 3 days with the goal to prevent his CRPS in his right upper extremity from worsening despite his current medications and with the hope of going down or weaning him off narcotics. Dr. Lubenow requested authorization for the Ketamine infusions. Dr. Lubenow also requested authorization for the lumbar epidural steroid injections. (Px2). In his Patient Instructions dated July 24, 2013, Px4, Dr. Lubenow scheduled September 17, 18 and 19, 2013 for Ketamine infusions and lumbar epidural steroid injection.

17. Petitioner saw Dr. Lanzotti on August 2, 2013 and complained of more back pain. Dr. Lanzotti noted that Petitioner had been seen by Dr. Lubenow since 2001. Dr. Lanzotti noted Petitioner saw Dr. Lubenow last week and he added Celebrex, but insurance would not approve it. Dr. Lanzotti informed Petitioner that he would not prescribe any further narcotics, but since Dr. Lubenow had prescribed Celebrex, he gave Petitioner some samples of this. (Px6).

18. In a September 4, 2013 e-mail to Ms. Kozak at Cincinnati Insurance Company, Px5, Petitioner's attorney attached a letter he had sent her dated August 30, 2013 wherein he requested approval for the scheduled appointments for pain management injections. Because travel plans and hotel reservations were needed to be made as soon as possible, Petitioner's attorney requested approval as soon as possible. In his e-mail, Petitioner's attorney requested the same.

19. Dr. Lanzotti refilled Petitioner's medications on October 22, 2013, November 20, 2013 and January 15, 2014. On February 13, 2014, Dr. Lanzotti noted that Petitioner underwent a lumbar CT scan, which showed osteophyte and some disc bulging at L4-L5 and it was suggested he consider epidural steroid injections, but that was recommended in Chicago and Petitioner never did that. Dr. Lanzotti referred Petitioner for chiropractic treatment for his low back. Dr. Lanzotti refilled Petitioner's medications. On March 11, 2014, Dr. Lanzotti refilled Petitioner's medications. Dr. Lanzotti also referred Petitioner to Dr. Narla for evaluation for lumbar epidural steroid injections. On April 10, 2014, Dr. Lanzotti refilled Petitioner's medications. (Px6).

20. Petitioner submitted travel records for his mileage to see Dr. Lubenow in Chicago and his return from there. This was admitted into evidence as Px6. Petitioner submitted mileage for every date that he saw Dr. Lubenow from November 4, 2010 through July 24, 2013, a total of 14 trips at 386 miles per trip. Total miles were 5,404. Petitioner requested reimbursement for mileage of $1,269.94 (23.5 cents per mile).

21. At Respondent's request, Dr. Fischer performed a Physician Review. In her Physician Review Recommendation Report dated September 10, 2013, Rx1, DepEx2, Dr. Fischer noted Petitioner's diagnoses of right upper extremity CRPS and lumbar pain with radiculitis. Dr. Fischer noted his May 8, 2000 accident and treatment for CRPS. Dr. Fischer specifically noted his medications. Dr. Fischer reviewed Petitioner's medical records. Dr. Fischer denied certification for the lumbar epidural steroid injections. In doing so, Dr. Fischer noted that the Official Disability Guidelines (ODG) indicate that epidural steroid injection alone offers no

significant long-term functional benefit. Dr. Fischer noted that radiculopathy must be documented, objective findings on examination need to be present and corroborated by imaging studies and/or electrodiagnostic testing. Dr. Fischer noted that Petitioner's physical examinations noted in the medical records did not show any abnormalities and there were no radicular signs. Dr. Fischer noted that it is mentioned that Petitioner has lumbar disc degeneration on the CT, but the report was not submitted. Dr. Fischer noted corroboration between the imaging studies and the clinical examination could not be established. Dr. Fischer also noted that the ODG do not recommend a series of three epidural steroid injections. Dr. Fischer opined that due to these considerations, she advised non-certification of this request.

Dr. Fischer denied certification of the series of Ketamine Injections over 3 days. Dr. Fischer noted that the ODG indicates with respect to Ketamine: "Not recommended. There is insufficient evidence to support the use of ketamine for the treatment of CRPS. Current studies are experimental and there is no consistent recommendation for protocols, including for infusion solutions (in terms of mg/kg/hr), duration of infusion time, when to repeat infusions, how many infusions to recommend, or what kind of outcome would indicate the protocol should be discontinued. The safety of long-term use of the drug has also not been established, with evidence of potential of neurotoxicity. Ketamine-induced liver toxicity is a major risk, occurring up to 50% of the time, and regular measures of liver function are therefore required during such treatments." Dr. Fischer opined that the guidelines (ODG) do not recommend this form of treatment. Dr. Fischer opined that therefore, she advised non-certification of this request.

Regarding the prescribed medication Amitriptyline, Dr. Fischer noted that the ODG recommended this medication for neuropathic pain and especially CRPS. Dr. Fischer noted that the provider Dr. Lubenow is using a higher dosage. However, Petitioner has very minimal control with the pain medication. Dr. Fischer advised modification to a one month supply. Regarding the prescribed medication Baclofen, Dr. Fischer noted that the provider Dr. Lubenow is not using it as a muscle relaxant medication. Dr. Fischer noted that Baclofen is indicated for neuropathic pain such as the pain in CRPS. Therefore, Dr. Fischer advised modification to #120 for one month supply. Regarding the prescribed medication Topamax, Dr. Fischer noted this medication is indicated for neuropathic pain. Dr. Fischer advised modification for #90 for one month supply. Regarding Hydroxyzine, Dr. Fischer noted the ODG does not specifically address this medication or its use for CRPS. Dr. Fischer recommended non-certification of this request. Regarding Magnesium Oxide, Dr. Fischer noted that the ODG did not apply. Dr. Fischer could not find any recommendation for the use of this medication for CRPS. Therefore, Dr. Fisher advised non-certification of this request. Regarding MS Contin/Morphine Sulfate, Dr. Fischer noted that Petitioner did not have any improvement in his pain with the increase in dosage. The ODG CRPS treatment lists opioid medications as a form of treatment for CRPS. Dr. Fischer noted that Dr. Lubenow is now weaning Petitioner down on his dosage. Dr. Fischer recommended a modification of this request for a gradual weaning. Regarding Zyrexa 20mg QD X 2 weeks, the 10mg x 1 week, then discontinue, Dr. Fischer noted that this medication is not recommended by ODG and that Dr. Lubenow is weaning Petitioner off it. Dr. Fischer recommended certification of the request. Regarding Celebrex, Dr. Fischer noted it is a NSAID used for inflammation and pain. Dr. Lubenow prescribed this medication for low back pain. Dr. Fischer noted that NSAIDs are recommended for low back pain, however, it is not clear why this

was prescribed versus another NSAID as there is no documentation for GI upset with other NSAIDs. Dr. Fischer noted that the medical records he was provided did not note any GI upset. Therefore, Dr. Fischer advised non-certification of this request until there is confirmed documentation.

22. In her June 2, 2014 deposition, Rx1, Dr. Fischer testified she is board certified in pain medicine. She practices in California at the Pain Institute of Central California since 2007. She performs Utilization Reviews. Dr. Fischer testified that for the treatment of CRPS, the standard of care is the same and the ODG is used. Dr. Fischer performed a Utilization Review for the treatment proposed by Dr. Lubenow and wrote a report dated September 10, 2013. For the medications requested, Dr. Fischer did not receive the quantities prescribed (Dp 12). During this deposition, the parties stipulated that Respondent need not pay for lumbar epidural steroid injections because they are unrelated to Petitioner's injuries in this case (Dp 13). Dr. Fischer recited from her report, noted above. Regarding Amitriptyline, Dr. Fischer actually certified it, approving the request (Dp 15-16). Regarding Baclofen, Dr. Fischer certified it and approved the request (Dp 16-17). Regarding Topamax, Dr. Fischer certified it and approved the request (Dp 18-19). Regarding Hydroxyzine, Dr. Fischer did not certify the request (Dp 19-20). Regarding Magnesium Oxide, Dr. Fischer did not certify the request (Dp 20-21). Regarding MS Contin, Dr. Fischer certified it and approved the request (Dp 21). Regarding Zyprexa, Dr. Fischer certified and approved for weaning, not long-term use Dp 21-22). Regarding Celebrex, Dr. Fischer did not certify it (Dp 23).

On cross-examination, Dr. Fischer testified that the medications that were certified would be appropriate for renewal on a monthly basis. Dr. Fischer acknowledged that she was not asked to provide any opinions as to causation (Dp 26). The medical records she reviewed were from August 4, 2011 and after that time. Dr. Fischer did not receive medical records from 2000 to 2011 (Dp 28). Dr. Fischer testified she did not certify the Ketamine injections because the ODG do not recommend the use of Ketamine for the treatment of CRPS (Dp 29).

Based on the record as a whole, the Commission grants Petitioner's §8(a) Petition to the extent of the costs of the prescribed medications listed and circled in Px8, finds that Petitioner is entitled to prospective medical care of Ketamine infusions prescribed by Dr. Lubenow, but denies Petitioner's request for mileage reimbursement. The Commission notes that there is no causation opinion for Petitioner's lumbar condition and the parties stipulated that Respondent is not liable for lumbar epidural steroid injections.

Petitioner requests that the Commission award medical benefits as set forth in his exhibits, including payment of prescribed medications listed in Px8. However, Petitioner did not submit any medical bills and he did not testify to any medical bills not being paid. The Commission grants the §8(a) Petition to the extent of the costs of the medications listed and circled in Px8, based on Dr. Lubenow's records, which show continuous treatment for right upper extremity CRPS. The Commission finds that based on Dr. Lubenow's records, Petitioner's treatment was causally related, reasonable and necessary. The Commission orders Respondent to authorize and pay for the costs of the prescribed medications listed and circled in Px8. Regarding Ketamine infusions, Dr. Lubenow opined that the goal is to prevent Petitioner's

15IWCC0239

right upper extremity CRPS from worsening despite his current medications and with the hope of going down or weaning him off narcotics. Utilization Review Dr. Fischer opined the ODG did not recommend this form of treatment. The Commission finds that Petitioner has proven he is entitled to prospective medical care of Ketamine infusions prescribed by Dr. Lubenow. The Commission finds Dr. Lubenow's opinions are persuasive. Dr. Lubenow has been Petitioner's treating physician for many years. The Commission denies Petitioner's request for mileage reimbursement. Petitioner chose to treat with Dr. Lubenow in Chicago when there were pain specialists in Springfield who could provide the same treatment to him.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §8(a) Petition is hereby granted to the extent of the costs of the medications listed and circled in Px8. Respondent shall pay to Petitioner the costs of the medications listed and circled in Px8 under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care and orders Respondent to authorize and pay for Ketamine infusions prescribed by Dr. Lubenow.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for mileage reimbursement 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: MAR 3 0 2015
MB/maw
o01/29/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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 correct TTD rate	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria D. Flores,

Petitioner,

15IWCC0240

vs.

NO: 08 WC 45414
08 WC 45415

Gilster- Mary Lee Corporation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent/Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, temporary total disability, maintenance benefits, benefit rates, vocational rehabilitation, medical expenses, prospective medical care, two doctor rule, permanent partial disability, evidentiary rulings, and credit, and being advised of the facts and law, modifies/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).

15IWCC0240

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The Commission affirms and adopts the Arbitrator's findings and rulings on all other issues, except, the Commission finds while the Arbitrator correctly adjusted the maintenance benefits rate on the corrected decision, the Arbitrator erred in failing to adjust the benefit rate regarding the temporary total disability benefits at the same time, the Commission, therefore, herein, modifies/corrects the temporary total disability rate to the minimum for the dates of accident, married with 2 dependents for accident dates February 12, 2007 and February 21, 2007 to $251.32.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $251.32 per week for a period of 34-2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, and maintenance benefits 3/23/10-10/17/13, 186-4/7 weeks at $251.32 ($46,889.13 total maintenance benefits), 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 $34,042.72 for medical expenses under §8(a) of the Act and Respondent shall provide Petitioner ongoing maintenance and provide vocational rehabilitation benefits, per §8(a) of the Act.

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

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

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

15IWCC0240

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:
o-2/5/15
DLG/jsf
45

MAR 3 1 2015

David L. Gore

Stephen Mathis

Mario Basurto

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

15IWCC0240

FLORES, MARIA
Employee/Petitioner

Case# **08WC045414**
08WC045415

GILSTER MARY LEE CORP
Employer/Respondent

On 5/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1042 LAW OFFICE OF OSVALDO RODRIGUEZ PC
1010 LAKE ST
SUITE 424
OAK PARK, IL 60301

0693 FEIRICH MAGER GREEN & RYAN
BRANDY L JOHNSON
2001 W MAIN ST
CARBONDALE, IL 62901

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

AMENDED ARBITRATION DECISION

19(b) (MAINTENANCE RATE AMENDED BELOW)

MARIA FLORES
Employee/Petitioner

v.

GILSTER MARY LEE CORP.
Employer/Respondent

Case # **08** WC **45414**

Consolidated cases: **08 WC 45415**

15IWCC0240

An *Application for Adjustment 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 **New Lenox** , on **October 17, 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 **Maintenance and Vocational Rehabilitation**

15IWCC0240

FINDINGS

On the date of accident, **February 12, 2007 & February 21, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,284.35**; the average weekly wage was **$350.86**.

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 $ **1,183.38**for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,183.38**.

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 **$233.91**/week for **34 2/7** weeks, commencing **July 9, 2007-July 25, 2007, November 14, 2007-December 4, 2007 & September 2, 2009- March 22, 2010**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$251.32**/week for **186 4/2** weeks, commencing **March 23, 2010** through **October 17, 2013**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of **$34,042.72**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall provide Petitioner ongoing maintenance benefits and provide vocational rehabilitation benefits, as provided in Section 8(a) of the Act.

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

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

#01 George J. Andros
Signature of Arbitrator

May 9, 2014
Date of Amended Award

MAY 15 2014

Maria Flores v. Glister Mary Lee Corp. 08 WC 045414 & 08 WC 45415

FINDINGS OF FACT

The Arbitrator finds below that the Petitioner sustained repetitive trauma accidents under the law on both dates of manifestation in the above two Applications. The Arbitrator's use of the singular term "accident" below is to facilitate the writing of the Award(s) but refers to both dates of accident/manifestation which are legally compensable as a matter of fact and law.

On February 12, 2007, the Petitioner states that she was lifting a box and felt pain shooting from just above the left elbow to the left shoulder area. On February 21, 2007, the Petitioner stated that she began to experience pain to her right wrist. The Respondent submitted into evidence the Workers Compensation-First Report of Injury or Illness for the February 12, 2007 and the February 21, 2007 accident dates. The February 12, 2007 report states the part of the body affected was "upper extremities-U" while "employee was going to lift a Silgan box of empty bottles, as she pulled the box, she felt left shoulder to elbow pull. The February 12, 2007, form states the injury was reported on February 15, 2007. The February 21, 2007 form states the part of the body affected was the "upper extremities-wrist" while "allegedly, strained rt. Wrist packing bottles in boxes. The February 21, 2007 form states the injury was reported on February 21, 2007.

On February 21, 2007, the Petitioner presented to Dr. Alexander E. Michalow, at Oak Orthopaedics, with complaints of numbness and pain to her right hand at night similar to what she had experienced years before. The Petitioner stated that she was using a brace that was helping her. Dr. Michalow opined that her symptoms were consistent with very mild carpal tunnel syndrome and that part of the symptoms might he due to a mild tendinitis that had its origin in the kind of work that she was doing at the chocolate factory. Dr. Michalow opined that the Petitioner has to learn to live with the pain, use the brace part time, use ice after work and moist heat other times. Also, Dr. Michalow recommended anti-inflammatory pills, a shot of cortisone into the carpal tunnel and/or to consider alternate work that does not require such repetitiveness. Dr. Michalow gave the Petitioner a work note stating that it would be better for the Petitioner if she could rotate some of her job description (PX #3, p. 185).

On February 22, 2007, the Petitioner presented to Dr. Dean Shouclair, at Riverside Health Care, complaining of pain just above the left elbow to the left shoulder area. The Petitioner testified that she was sent there by the Respondent. The Petitioner also complained of pain to the right wrist, which she stated had gradually increased over the past year. Dr. Shouclair noted that the Petitioner had been treated for a right wrist injury two years prior, and was seen at Riverside Corporate Health Services and Orthopedics Associates of Kankakee and then she was released from care. The Petitioner denied any specific re-injury to the wrist, but stated that over time, after returning to work on the line, her right wrist pain gradually increased. Dr. Shouclair opined that the Petitioner was experiencing a right wrist sprain with possible paresthesia and left triceps strain. The Petitioner was to return to work with restrictions of no lifting greater than ten pounds with occasional lifting, occasional pushing and pulling, occasional use of the hands bilaterally with rare pinch gripping and rare tight gripping. Dr. Shouclair explained to the Petitioner that these restrictions also applied to non-work hours.

On March 1, 2007 complained of pain to the left wrist that radiates to the elbow and also to the middle and ring fingers of the right hand. Relative to the left triceps, the Petitioner stated that this occurred when she was lifting a box and felt pain from the triceps area, above the left elbow, to the left shoulder. The Petitioner was instructed to return to work with the same restrictions and referred to occupational therapy. He sought an EMG-NCV.

On March 7, 2007, Donna Cummings, from Gallagher Bassett Services, Inc., sent a letter stating that, "Please note this is an acknowledgment letter and NOT an acceptance letter. If your claim is accepted, we will provide all your eligible benefits on a timely basis." (PX #20).

On the March 8, 2007 follow up visit with Dr. Shoucair, the Petitioner complained of pain to her right wrist. The Petitioner stated that her pain is sometimes on the dorsal aspect and sometimes on the palmar aspect of her right wrist. The 3/23/2007 EMG read bilateral median mononeuropathy at the wrist, more pronounced on the right side and accompanied by denervating changes on the right as well as left cubital tunnel accompanied by denervating changes (PX #4, p. 38).

On 3/27/07 she reported has been following her work restrictions yet her treatment has not helped as she has not experienced change to her injury. The diagnosis was bilateral carpal tunnel syndrome, left cubital tunnel syndrome, right wrist sprain, and left triceps strain. Dr. Shoudair referred the Petitioner to Dr. Mohammed, a hand specialist, from Orthopaedics Associates of Kankakee. The Petitioner was told to continue with the same return to work restrictions and that further restrictions would be determined by the hand specialist (PX, #4, pp. 31-32). A report of this visit was faxed to the Respondent's company contact, "Gary" at 815-472-6064 (PX # 3, p. 158). A workers compensation approval form, for approval of referral of Petitioner to Dr. Mohammed, was sent to Gallagher Bassett and Anita Green, the adjuster, approved it (PX #3, p. 154, p. 152, p. 147).

On April 11, 2007, the Petitioner presented to Dr. Michalow, at Orthopaedics Associates of Kankakee, and stated that since she went back to regular work, her symptoms have gotten worse. Dr. Michalow noted that the Petitioner had an EMG which showed some early carpal tunnel on the right, which is more progressed than on the right. Dr. Michalow noted that the left carpal tunnel was borderline. Dr. Michalow discussed different options with the Petitioner and told her that with early carpal tunnel syndrome, surgery is a last resort. Dr. Michalow recommended bilateral wrist injections. Dr. Michalow noted that the Petitioner has cubital tunnel symptoms on the left and was shown on the EMG, but explained to the Petitioner that injections generally do not have a good track record for helping the ulnar neuropathy at the cubital tunnel. The Petitioner was recommended to use the braces and was placed on light duty with restrictions of no repetitive gripping or grasping. The Petitioner was to follow up in one month on her progress with the brace and the injection. Dr. Michalow stated surgery would be considered as a last resort for the right wrist if it continued to be a problem (PX 3, p. 142). Dr. Michalow noted that the injections had been approved by workers' compensation adjuster, Anita Green (PX #3, p. 144). The Arbitrator comments that notably absent is any indicia of assistance to the worker from what is commonly referred to as "medical management" by an RN or certified case manager or anyone.

On the May 9, 2007 follow up visit, the Petitioner stated that the carpal tunnels are not getting better with conservative care and that the right one bothers her a little bit more than the left. Dr. Michalow noted that they both showed some carpal tunnel changes on the EMG. Since the Petitioner is failing conservative care, Dr. Michalow recommended carpal tunnel release on the right and gave the Petitioner restrictions of no repetitive grasping duties and to follow up after the surgery, if it is approved (PX #3, p. 142). On June 20, 2007, Anita Green, the adjuster, approved the surgery for the Petitioner (PX #3, p. 140). On July 9, 2007, the Petitioner underwent a right carpal tunnel release by Dr. Michalow at the Oak Surgical Institute, LLC (PX #2, p. 36).

On 7/19/07 Petitioner was able to return to one handed work with limited repetitive work for the left hand. Dr. Michalow stated that the Petitioner was approved for the left carpal tunnel release and if the Petitioner was well enough in a three weeks time, they would schedule her for left carpal tunnel release at that time (PX #3, p.114). On July 23, 2007, Anita Green left a message for Dr. Michalow asking if he had taken the Petitioner off work from July 10-July 18, and if so she required a slip indicating this (PX 3, p. 114).

On July 23, 2007, the Petitioner presented for an occupational therapy initial evaluation. On the August 15, 2013 visit with Dr. Michalow, her symptoms are as before with some slow progress. In the right wrist, there is a little bit less pain and little more strength. The Petitioner was to continue therapy, continue light duty and follow up in five weeks. Dr. Michalow stated that if she made enough progress at that time, then they will progress with her left carpal tunnel release.

The Petitioner stated that she has some pain around the trapezius, the muscle around the elbow, which Dr. Michalow opined that it could be that her body doesn't tolerate any kind of repetitive work. Dr. Michalow stated that he does not have an answer for the diffuse aches and pains that the Petitioner experiences. Dr. Michalow stated that they would concentrate on treatment for the right carpal tunnel and have the Petitioner follow up in a month. The Petitioner was to continue working light duty (PX #3, p. 101).

On September 19, 2007 she was making slower progress than expected with swelling over the pillar. The Petitioner stated that she still experiences some pain and weakness. The therapy report stated that the Petitioner is limited by some pain with full activity but her strength has improved. Dr. Michalow recommended further occupational therapy and the Petitioner was to continue light duty. Dr. Michalow stated that if she could not tolerate regular duty, then she should consider alternate type of work, and explained to the Petitioner that most patients get back to regular duty after a carpal tunnel release within one to four months (PX #3, p.99).

On the October 17, 2007 he noted that the left carpal tunnel syndrome is still a problem and they are awaiting surgery approval for left carpal tunnel release. The Petitioner was to hold on therapy until after left carpal tunnel release and continue with the same work restrictions of no lifting over five pounds, no repetitive motion, no gripping, pushing, pulling bilateral wrists (PX #3, p. 93-94). That same day, authorization was approved by the workers compensation adjuster, Anita Coomer (PX #3, p. 92). On November 1, 2007, the Petitioner underwent a left carpal tunnel release at Oak Surgical Institute, LLC by Dr. Michalow (PX #2, p. 19).

On the December 5, 2007 she was to return to light duty with left hand assisting the right, on light tasks if available, otherwise no work. The Petitioner was referred for OT on 12/11/07 & attend therapy three times per week for four to six weeks On the January 9, 2008 visit Petitioner stated that she was working light duty without problems and was making progress in occupational therapy. Dr. Michalow opined that the Petitioner should continue occupational therapy for strengthening and no therapy for numbness of left middle finger, which should improve over the next months. The Petitioner was to continue with light duty and follow up in one month and possibly consider returning to regular duty. Dr. Michalow also discussed the possibility of cortisone shot into the right carpal tunnel for persistent pillar pains (PX #3, p. 60).

On the February 6, 2008 Dr. Michalow recommended work conditioning and consider a second opinion or IME. The Petitioner was also recommended to consider EMG for left hand/wrist in three to six months if the numbness was persistent. The Petitioner was instructed to continue medication and the ice /heat treatment. Dr. Michalow stated that vocational rehab should be considered for alternate work in the future (PX #3, p. 55).

On February 15, 2008 the therapist opined that the Petitioner would benefit from three to four hours daily work hardening program at four to five days per week for four to six weeks (PX #1, p. 73).On the March 5, 2008 follow up, the Dr. Michalow opined that the Petitioner had not made the typical progress with her carpal tunnel releases. The Petitioner also complained of pains in both shoulder, both elbow and persistent aches and pains over pillars, at base of hand, and mild numbness in the right hand third finger. Dr. Michalow opined that the Petitioner has symptoms beyond the typical post op carpal tunnel patient, since most patients have pillar pains for one to three months, but the Petitioner has had pillar pains for many months and there is no obvious reason for such persistent pains. Dr. Michalow opined that the shoulder and elbow pains are unknown, especially since the patient has not been doing excessive work. Dr. Michalow recommended a second opinion and considered a work up for multiple joint pains that are not explained by carpal tunnel syndrome. Dr. Michalow discussed that some patients do not tolerate the type of work the Petitioner does and she might have to consider alternate work that is less physical in the future. The Petitioner was to continue with occupational therapy and continue with same work restrictions (PX #3, p. 50).

On the April 16, Dr. Michalow noted that the Petitioner was awaiting an IME or a second opinion and that she was making gradual progress also with physical therapy. The Petitioner was given restrictions of no lifting over twenty-five pounds and was to follow up in two months. The Petitioner was to continue with occupational therapy two to three times per week for six weeks (PX #3, p. 39, 41).On June 11, 2008 Petitioner was diagnosed with mild right hand pillar ache, right elbow medial lateral epicondylitis and left elbow mild triceps tendinitis. Dr. Michalow opined that there was no optimal treatment for these syndromes other than modified work. Dr. Michalow recommended a shot for the right elbow but not for the left, and opined that surgery would be of last resort if failed conservative care and if pain worsened significantly over time. Dr. Michalow recommended that the Petitioner was to seek a second opinion. The Petitioner was to continue with same recommendations and treatment (PX #3, p. 37).

On the August 13, 2008 The Petitioner was referred, by Dr. Michalow, to Dr. Muhammad or another hand surgeon for evaluation and treatment for the bilateral upper extremity. The Petitioner was to continue light duty and Dr. Michalow opined that she is at MMI. Dr. Michalow recommended that the Petitioner continue light duty indefinitely or may eventually try regular duty, and if not tolerated she may need a job that is less physical (PX #3, p. 17-18).

On October 9, 2008, the Petitioner was seen for a second opinion by Dr. Leah Urbanosky, from Hinsdale Orthopaedics Dr. Urbanosky recommended a new EMG/NVC testing and requested review of medical records to make further treatment recommendations (PX #5, pp. 55-56). Dr. Urbanosky referred the Petitioner to the doctors at Health Benefits Physician Services.On October 24, 2008, the Petitioner was seen by Dr. Rizwan Arayan from Health Benefits Physician Services, LLCAt the time, the Petitioner was working light duty. Upon examination, Dr. Arayan recommended electrodiagnostic testing to evaluate for upper extremity neuropathies and/or cervical radiculopathy. Dr. Arayan also suggested a comparison with previous electrodiagnostic test (PX #6, p. 90, 91). On October 24, Dr. Urbanosky instructed the petitioner on taking the medications. Dr. Urbanosky also opined that given the fact that the Petitioner's symptoms have not improved and she is constantly dropping things, a repeat carpal tunnel surgery may be ultimately indicated which would be a wide open procedure. For the pilar pain, Dr. Urbanosky opined that continued observation versus recurrent carpal tunnel release with hypothenar flap would be warranted. For the right elbow and left shoulder, Dr. Urbanosky opined that given the failure of conservative treatment, MRIs will be obtained in order to assess intraarticular, as well as tendinous pathology. Dr. Urbanosky also stated that she would contact the neurologist to see whether or not a C7 radiculopathy was assessed to be able to determine further recommendations and to address the complaints of the left long finger numbness and tingling, along with triceps symptoms (PX 5, p. 48-49).

On November 5, 2008, the Petitioner underwent an MRI of the left shoulder. The MRI revealed a mild distal supraspinatus tendinopathy and bursal surface tendinitis of the supra and infraspinatus tendons without rotator cuff tear or tendon retraction and maintained labral structures. The Petitioner also presented for an MRI of the right elbow, which revealed no abnormalities (PX #5, pp. 45, 46).On November 21, 2008 per advice of Dr. Arayan, Dr. Urbanosky decided to change the medication to help the P with generalized pain complaints. Dr. Urbanosky stated that the MRI of the right elbow was normal, but the MRI of the left shoulder reveals a bursal-sided rotator cuff tear. Dr. Urbanosky recommended a trial of left elbow joint injections. The Petitioner underwent a left sided shoulder bicipital tendon injection and acromioclavicular joint injection. The Petitioner was to follow up in a month and was to remain on light duty of no use of the left extremity and right sedentary work (PX #3, pp. 43-44).

On December 26, 2008 doctor recommended laboratory workup to exclude any systemic diagnosis for her pains and recommended a left shoulder arthroscopy with subacromial decompression and debridement of possible bursal-sided rotator cuff tear and debridement of the bicipital tendon as necessary. In a separate surgical time, Dr. Urbanosky recommended a left elbow arthroscopy with inspection of the posterior medial and lateral joint compartments and debridement, as necessary, given the relief on elbow pain with an intraarticular injection. She was injected for carpal tunnel and an injection for the right lateral epicondylitis (PX #5, p. 40).

On the February 13, 2009 follow up visit, the Petitioner stated that she had temporary relief to the left shoulder and elbow with the injections, however on the right side, her pain was actually worse for the right lateral epicondylitis and carpal tunnel. Dr. Urbanosky noted that since the last visit, the Petitioner has increased symptoms of right hand swelling, as well as left shoulder pain radiating up to the neck. Dr. Urbanosky recommended new blood work (PX #5, p. 38). On May 11, 2009 Dr. Urbanosky noted that the carpal tunnel injection as well as the medications failed to help the Petitioner's symptoms. The Petitioner complained mainly of numbness and tingling to her bilateral hands. Dr. Urbanosky ordered a repeat on an EMG for the carpal tunnel. As for the left arm, Dr. Urbanosky opined that she would like to assess whether the Petitioner has ulnar nerve symptomology, as it was not apparent in EMG of October. Dr. Urbanosky prescribed new pain medication (PX #5, p. 32).

On July 10, 2009 Dr. Urbanosky noted EMG testing which showed improvement since her October 2008 exam relative to the median nerve function in the right upper extremity. However, the Petitioner stated that she experiences night time numbness and tingling and daytime cramping in the hand, yet the ulnar nerve did not show any abnormality in either upper extremity. Relative to the residual symptoms, Dr. Urbanosky noted that the Petitioner's right elbow seems to be the greatest complain where she has tenderness of the lateral epicondyle with failure to resolve with cortisone injection and splinting. The Petitioner stated that the splint seems to make her hand more bothered. The Petitioner stated that she has no relief with pain or therapy but that the left shoulder seems to have decreased pain and the left elbow pain was still present. Dr. Urbanosky recommended an FCE. In regards to the lateral epicondlitis, Dr. Urbanosky stated that she did not recommend surgery as the results would be unpredictable, as well as if she had a carpal tunnel release on the right as the EMG she still showed improvement in her recovery. For the left upper extremity, the Petitioners' testing and Dr. Urbanosky's exam does not necessarily match or correlate with the area of pain complaints on the posterolateral elbow. Dr. Urbanosky opined that the ulnar nerve was fine based on the nerve testing, so shoulder seems to be improved (PX #5, p. 26).

On August 4, 2009, the therapist doing an FCE reported Petitioner's current physical demand level is sedentary. She had consistent effort to perform different tasks (PX #7, p. 1).On the August 28, 2009 follow up visit, the Petitioner stated that she had no change in her overall pain complaints. Per FCE, the Petitioner has sedentary level of functioning, which Dr. Urbanosky opined was permanent and that she should seek an IME or a possible referral to a pain center for pain control (PX 5, p. 7). Dr. Urbanosky referred her for pain management.

On November 2, 2009 she was see for pain management Dr. Anthony Rivera from Health Benefits Physician Services. Dr. Rivera felt her symptoms were secondary to a combination of carpal tunnel syndrome and epicondylitis. He prescribed neuropathic pain medication and a short-acting opioid to help control her pain issues (PX #6, p. 84, 85). On the November 30, 2009 follow up visit, the Petitioner complained of pain to her wrist that radiates to digits three and four predominantly with numbness and tingling. The Petitioner stated that she continued to drop objects and has burning symptoms in her arms due to lack of sensation. The Petitioner stated that she had pain over her left shoulder area with predominant overhead activity. The Petitioner stated that she had failed conservative measures such as physical therapy and injections and is being treated with pain medications. Upon examination, Dr. Rivera stated that she was at maximum medical improvement and would require long-term pain management. Dr. Rivera prescribed her Neurontin and Vicoprofen for the pain (PX #6, p. 81, 82). Again, this Arbitrator sees no attempt by the claims functionary to provide any medical management to this worker with deminimus education, work skills and language barriers.

On the December 28, 2009 follow up visit, the Petitioner still complained of pain in her wrist radiating to all the fingers in both hands with numbness and tingling and also towards her elbow bilaterally. She continues to drop objects due to lack of sensation and has burning symptoms on both hands. The Petitioner stated that the pain medication is not helping her symptoms.

On January 25, 2010, the Petitioner was seen for a follow up, and she still complained of pain in her wrist radiating to all the fingers in both hands with numbness and tingling towards her elbow bilaterally. The Petitioner stated that she felt the Opana was giving her insomnia and noted no improvement with it. Dr. Rivera discontinued the Opana and increased her medication to help control her neuropathic pain issues (PX #6, p. 75, 76).

On the February 22, 2010 follow up visit, the Petitioner stated that she still had pain in both wrists, which radiated to all fingers in both hands with numbness and tingling towards both elbows the Petitioner stated that she continued to drop objects due to lack of sensation. Dr. Rivera noted that there was no relief with the medication increase. The Petitioner reported continued insomnia issues. Dr. Rivera provided her with a topical neuropathic/anti-inflammatory combination cream and adjusted her pain and neuropathic pain medication (PX #6, p. 72, 73).

On March 22, 2010, the Petitioner followed up with Dr. Urbanosky with complaints of pain in the bilateral upper extremities including bilateral hands, bilateral epicondyles and left shoulder. The Petitioner stated that she had been off work for seven to eight months. The Petitioner stated that she has taken very strong medications, narcotics, without any relief and Dr. Rivera has placed her at MMI. Dr. Urbanosky opined that the Petitioner can obtain approval for a sedentary work level which would be permanent and stated that the Petitioner is at maximum medical improvement and should be managed further with pain control under the direction of Dr. Rivera (PX #5, p. 4).

CAUSATION: On the April 19, 2010 follow up visit, the Petitioner continued to have upper extremity complaints. The Petitioner stated that the neuropathic pain medication did not provide any relief. Dr. Rivera noted that symptoms appeared to be secondary to carpal tunnel syndrome and a combination of epicondylitis. Due to the pain issues of her hands, numbness and tingling, the Petitioner has had to use her arms in an unconventional manner, which Dr. Rivera opined may have precipitated epicondylitis bilaterally. Dr. Rivera noted that her symptoms are all secondary to her initial injury that she sustained at work. The Petitioner noted no benefits with previous pain medication. Dr. Rivera made medication adjustments (PX #6, p. 69, 70).On May 24, 2010 Dr. Rivera noted that sensation diminished in the bilateral hands as compared to her proximal upper extremities. new medication prescribed made her feel nauseous.

On July 6, 2010, the Petitioner was seen by Dr. Zaki Anwar at Health Benefits Physician Services LLC. In this visit, the Petitioner complained of numbness and weakness in the bilateral hands, as well as pain in the forearm area around the epicondyle. The Petitioner continued to work light duty. The Petitioner stated that she was told by the orthopedic surgeon that she was not a candidate for any surgery due to the neuropathic pain that she was developing.

Upon examination, the Petitioner had working diagnoses of complex regional pain syndrome type II *and causalgia*. Dr. Anwar considered her an excellent selective candidate for a spinal cord stimulator trial because of the way that her condition is affecting her mentally and socially p. 65).

On January 14, 2011, the Petitioner followed up with Dr. Urbanosky. The Petitioner stated that she has not had relief with any medication only the one day relief with the cervical injections that Dr. Patel administered and that her arm just felt numb and heavy and she doesn't feel she is any better. The Petitioner stated that this affected her activities of daily living such as cooking, cleaning and the course of completing job activities due to symptomatic complaints. The Petitioner complained of getting hand cramps and dropping things and releasing the steering wheel when driving. Dr. Urbanosky opined that the Petitioner should see a neurologist for an additional evaluation and stated that she did not have further medical recommendations.

On February 23, 2011, the Petitioner presented for an evaluation by Dr. Watson. The Petitioner complained of severe bilateral hand and wrist pain. The Petitioner stated that she has undergone multiple treatment modalities, medication and therapy without any significant pain improvement and her

symptoms seem to be worsening. The Petitioner stated that she has hand spasms that cause her to drop objects. The Petitioner informed Dr. Watson that initially it was proposed that she would be a candidate for spinal cord stimulator, however she did not get any significant improvement with stellate ganglion blocks. The Petitioner also complained of some occasional left proximal extensor muscle swelling. The Petitioner was diagnosed with bilateral carpal tunnel syndrome and de Quervain's tenosynovitis. Dr. Watson recommended an updated EMG to assess the severity of the carpal tunnel. The Petitioner was to take medication and wear a thumb spica splint for the de Quervain's tenosynovitis. Dr. Watson opined that the Petitioner was still temporary total disability and should be off work (PX #6, p. 60). On March 8, 2011 the Petitioner underwent an EMG, which indicated evidence of bilateral mild chronic median neuropathy at the wrist (CTS) with the right side being more affected than the left, as well as evidence for a Martin-Gruber anastamosis in the right forearm, which is just an anatomical variant found only when CTS is present (PX #3, p.55).

On the March 30, 2011 follow up visit with Dr. Watson, the Petitioner stated that she experiences wrist pain and hand numbness. The Petitioner stated that she has difficulty driving and on one occasion she experienced hand pain and paresthesias which caused her to drive into a ditch. Also, the Petitioner stated that when she is driving her hands involuntarily open while she is holding on to the steering wheel. The Petitioner stated that she has difficulty putting on her earrings and combing her hair. The Petitioner states that she drops pots and pans and has difficulty using the knife at home. She states that at times her extensor forearm swell. The Petitioner was diagnosed with bilateral upper extremity pain second to cumulative trauma disorder. Dr. Watson opined that the Petitioner was at MMI as she would not benefit from any further invasive procedures. Dr. Watson opined that the Petitioner she could not return to any physically demanding job that requires hand dexterity. Dr. Watson opined that the Petitioner is permanently disabled and she could benefit from a left spica split and over the counter ibuprofen. The Petitioner was to follow up in a one month's time (PX #6, p. 53).

On April 27, 2011 Petitioner stated that she has not received the recommended spica splint. The Petitioner was diagnosed with bilateral carpal tunnel syndrome, bilateral epicondylitis and left de Quervain's tenosynovitis.

Dr. Watson opined that the Petitioner is at MMI and due to the uncertain nature of nerve regeneration, it seems unlikely that the Petitioner will regain complete grip strength in the bilateral upper extremities (PX #6, p. 52). On May 25, 2011 Dr. Watson noted that the Petitioner has not received the spica splint for the left wrist. The Petitioner stated that her activity level is limited by the hand pain and paresthesias. Dr. Watson opined that the Petitioner was at MMI. On the June 22, 2011 he noted chronic bilateral upper extremity pain. The Petitioner reported occasional paresthesias in the dorsal surface of the bilateral hands. The Petitioner stated that she received her left spica splint. (PX #6, p. 48).On July 20, 2011 follow up visit, the Petitioner complained of chronic arm pain. The Petitioner stated that she is awakened with bilateral hand numbness and has a frequent burning sensation in the bilateral index and middle finger. The Petitioner stated that she has been using the splint as often as possible. The Petitioner stated that she occasionally has intermittent bilateral elbow pain. Dr. Watson recommended that the Petitioner modify her activities.

DOCTOR OPINION ON CHRONICITY & MEDICAL DISABILITY : On the August 17, 2011 Petitioner complained of worsening of her right hand pain. The Petitioner stated that she began wearing a previously prescribed right hand splint but it is not providing any additional pain relief. Dr. Watson told the Petitioner that she will have chronic pain the rest of her life. Dr. Watson opined that the Petitioner is permanently disabled due to chronic upper extremity pain secondary to cumulative trauma disorder (PX #6, p. 45). On September 14, 2011 follow up visit, the Petitioner stated that the pain has noticeably increased with the change in cold weather and her activities are severely restricted due to hand pain. Dr. Watson opined that the Petitioner is permanently disabled and unable to work in any capacity due to her hand pain. The Petitioner was to follow up in a month (PX #6, p.43).

On the October 12, 2011 follow up visit, the Petitioner complained of chronic bilateral upper extremity pain and stated that her hands always feel tired and heavy. The Petitioner stated that she is never pain free and that her pain is decreased with Tylenol but never pain free. Dr. Watson opined that the Petitioner is permanently disabled and has reached MMI (PX #6, p. 41).

On the November 9, The Petitioner stated that sometimes when she removes the splint she notices worsening of her pain and her hand 'shakes'. Dr. Watson opined that the Petitioner is at MMI and is permanently disabled. On the December 7, 2011 follow up visit, the Petitioner stated that she has episodes of pain and spasms in the hands that cause her to drop objects. The Petitioner stated that she also has elbow and wrist pain. The Petitioner was to continue with activity modifications. Dr. Watson opined that the Petitioner has reached MMI and is permanently disabled (PX#6, p. 37). On the January 4, 2012 follow up visit, the Petitioner complained of bilateral arm and hand pain. Dr. Watson opined that the Petitioner has reached MMI, is permanently disabled and cannot return to work in any capacity (PX#6, p. 37).

On the February 1, 2012 follow up visit, the Petitioner complained of bilateral upper extremity pain and stated that she experiences tiredness in the bilateral upper extremities. The Petitioner stated that she is frequently awakened at night with her arms feeling heavy and fatigued and that her pain fluctuates. The Petitioner stated that she has intermittent upper extremity pain as well as numbness. The Petitioner stated that she has pain on the radial side of the left wrist and parasthesias along the left ulnar distribution and pain in the right upper extremity. The Petitioner stated that she wears her splits at night. Dr. Watson opined that the Petitioner has reached MMI and is permanently disabled and should follow up in one month (PX #6, p. 33).On the February 29, 2012 follow up visit Petitioner stated that she burned her arm while eating because her hands got weak and gave out. Dr. Watson recommended an updated EMG due to the Petitioner reporting worsening of her symptoms. Dr. Watson opined that the Petitioner is permanently disabled

On the March 28, 2012, follow up visit, the Petitioner complained of bilateral upper extremity pain, numbness, paresthesia, and weakness. The Petitioner stated that she is still dropping objects. Dr. Watson noted that the Petitioner had undergone the EMG, which revealed a slight improvement in the nerves of the upper extremities. Dr. Watson opined that the Petitioner still required medication and the use of the splints. Dr. Watson opined that the Petitioner is at MMI and is permanently disabled (PX #6, p. 23).On the April 25, 2012 follow up visit, the Petitioner still complained of chronic upper extremity pain secondary to a cumulative trauma disorder. Dr. Watson noted that the Petitioner has different manifestations of her pain. Dr. Watson opined that the Petitioner is at MMI and is permanently disabled (PX #6, p. 21).On the May 23, 2012 follow up visit, the Petitioner still complained of bilateral upper extremity pain secondary to cumulative trauma disorder. The Petitioner stated that she is never pain free and requires assistance with minimal chores at home. The Petitioner stated that she has difficulty grasping objects and does not feel safe driving. Dr. Watson opined that the Petitioner is permanently disabled as a result of a job causing repetitive stress to her upper extremities. Dr. Watson opined that the Petitioner has reached MMI and is to return to the clinic in one month (PX #6, p. 19). On the June 20, 2012 follow up visit, the Petitioner still complained of chronic bilateral upper extremity pain. The Petitioner stated that when she was originally injured, she had pain in the left upper arm that extended up to the shoulder region and subsequently noticed bilateral distal arm pain. The Petitioner stated that her pain is daily and that she does not feel safe driving or handling hot objects. Dr. Watson opined that the Petitioner has reached MMI and has a cumulative trauma disorder (PX #6, p. 17).

On July 18, 2012 the problems continued. On September 26, 2012 Petitioner stated that there are still times when her hand involuntary opens and she still feels occasionally the sensation of bugs crawling on her arms. Dr. Watson stated that the Petitioner should refrain from driving due to the unpredictability of her grip strength. On October 24, 2012, the Petitioner stated that she occasionally burns herself and does not feel it. She also has paresthesias that run along the volar aspect of the bilateral wrist into the hands and diffuse tenderness in the bilateral upper extremities. The Petitioner stated that she occasionally drops cups and plates at home.

The Petitioner also stated that she does not feel safe driving because her hands involuntary open and has noticed significant decrease in grip strength. Dr. Watson opines that it is her professional opinion that based on these findings, the Petitioner is permanently disabled and unable to return to work. Dr. Watson stated that he encouraged the Petitioner to continue the Biofreeze and follow up with him in one month (PX #5, p. 9). On November 21, 2012 doctor recorded Petitioner has reached maximum medical improvement and is permanently disabled (PX #6, p. 7). On December 19, 2012, the Petitioner complained of chronic upper extremity pain and weakness. The Petitioner also reported bilateral hand numbness and reported decreased grip strength. Dr. Watson opined that Ms.Flores has reached MMI and unable to work in any capacity (PX #6, p. 5).

On July 3, 2013, the Petitioner followed up with Dr. Watson stating that she had not recently seen him due to the fact that her family was in Mexico because her mother died. The Petitioner still complained of weakness that impairs her daily activities and stated occasionally being awakened with severe stiffness in the right middle and ring finger. The Petitioner stated that she 'ran out of Biofreeze' and restarted self medicating with over the counter ibuprofen. However, she stated that Biofreeze helped more. Dr. Watson opined that the Petitioner has reached MMI and unable to work in any capacity. The Petitioner was to restart Biofreeze to her upper arms twice a day (PX #6 p. 3). On August 14, 2013, the Petitioner complained of bilateral upper extremity numbness, pain paresthesias and spasms. The Petitioner stated she has some relief from Biofreeze but still requires periodic ibuprofen tablets. Dr. Watson opined that the Petitioner has reached MMI and unable to work in any capacity;follow up six weeks .

FCE: On August 4, 2009, the Petitioner presented for an FCE at Premier Physical Therapy. The FCE revealed that the Petitioner had difficulty in performing the non-material handling tests: she had difficulty in grasping and fine manipulation using both hands. The Petitioner had difficulties with all upper extremities repetitive activities tests. She had difficulty with the crawling test. The Petitioner was able to perform the rest of the non-material handling tests successfully. The Petitioner's ability to perform grasping and fine manipulation is occasional which does not match her job requirement. In the material handling test, the Petitioner can do occasional lifting of four pounds from the floor to the waist, five and a half pounds from twelve inches to waist, five and a half pounds form waist to shoulder and zero pounds from shoulder to overhead. The Petitioner was able to carry up to ten pounds with both upper extremities. The Petitioner was able to push sixty pounds and pull forty-five pounds for twenty feet. The conclusion was Petitioner's current physical demand level is sedentary. Hers participation was affected by the severe pain at both the upper extremities inspire of her consistent effort to perform different tasks. The therapist evaluator opined that the Petitioner appears appropriate to participate in rehabilitation and pain management program that would address her physical deficits and pain level (PX #7, p. 1). The Arbitrator notes the shortcomings of FCEs herein. The concentration on floor lifting and the focus on the dictionary of occupational titles in matching this to levels of work e.g. light et cetera does not clearly match the nature of this upper body and extremity cumulative trauma.

DR. WATSON: Dr. Artelio Watson testified that he went to Chicago Medical School, did a preliminary year at Mount Sinai, and then did physiatrist training, physical medicine and rehab at Schwab. Afterwards, he did a pain fellowship and also pain training at the Interventional Pain Management at the University of Chicago. As part of his practice, he treats patients with repetitive or cumulative traumas plus treated the Petitioner. Dr. Watson reported chief complaints were bilateral hand and wrist pain and spasms, which included dropping objects such as plates and cups. According to Dr. Watson, the Petitioner stated that her symptoms were getting worse. Dr. Watson testified that during that time period, he was able to diagnose the Petitioner with bilateral carpal tunnel syndrome and DeQuervain's tynosynovitis.

He recommended that the Petitioner should refrain from work because she was dropping objects at home and he didn't think it was safe for her to be in a work environment. He added that besides the carpal tunnel syndrome diagnosis, the Petitioner was complaining of occasional proximal arm swelling and pain. He reported that he was just keeping an eye on that at the time

Dr. Watson testified his diagnosis for the Petitioner was bilateral carpal tunnel syndrome, bilateral lateral epicondylitis and left DeQuervain's tynosynovitis. Dr. Watson defined bilateral lateral epicondylitis as an inflammation where the extensor forearm muscles insert into the bones into the elbow, and sometimes it can become inflamed or painful . Dr. Watson testified that on this follow-up visit, he still said the Petitioner was permanently disabled and should refrain from work Moreover, based on the diagnosis that he gave Petitioner of bilateral carpal tunnel syndrome, bilateral epicondylitis and left DeQuervain's tynosynovitis, he opined based upon a reasonable degree of medical and surgical certainty, that the diagnosis were related to her work activities and work accident of February 12, 2007.

He reported that this opinion was based on the time he got to know Petitioner and hear her complaints and do her musculoskeletal exam. Dr. Watson reported being familiar with the syndrome since it is often seen in industrial workers who do repetitive activities. He added that these workers have vague nerve complaints, swelling, spasms, pain, and sometimes it follows a nerve distribution and sometimes it has a nondermatomal pattern. It doesn't present necessarily in any textbook form, but when put all together, they often have carpal tunnel, epicondylitis and DeQuervain's (Watson Depo, p. 15).

Dr. Watson concluded Petitioner's prognosis was very poor based upon a reasonable degree of medical and surgical certainty. According to Dr. Watson, although nerves do regenerate very slowly, at the time it was almost four years later considering her injury was in 2007, that the Petitioner still had weakness and pronounced neuropathic pain. This treater concluded he didn't think she can safely return to the work force using her hands. He also testified that based upon medical and surgical certainty, the Petitioner's complaints were consistent with his observations during the physical exam. Dr. Watson reported to not seeing any evidence of any type of symptom magnification. Dr. Watson also reported that the Petitioner's complaints were consistent with EMG tests and other objective tests.(pp. 15-16).

Dr. Watson testified that the Petitioner was permanently and totally disabled from returning to the work force. He reported that this was based on the Petitioner's physical symptoms and the Petitioner's subjective complains being consistent. Dr. Watson reported that he did not feel safe for the Petitioner to return to any activity that required lifting because it was unsafe for her and the company, and he was not sure that her symptoms would not get worse.

Dr. Watson also reported that he believed the permanent disability restriction that he gave Petitioner was related to her work injuries. He added that although he didn't treat her from the beginning, based on her records and on her complains, her conditions and diagnoses of cumulative trauma disorder and cumulative trauma syndrome were related to her work injury. Based upon a reasonable degree of medical and surgical certainty in his field, the repetitive forceful motions of the wrist and hands are associated with the development of these carpal tunnel syndrome are repetitive trauma syndrome. Dr. Watson testified that the basis of his opinion was experience. According to his testimony, literature supports that people who do repetitive work are more prone to conditions, a cumulative trauma disorder. The other names for it are occupational stress syndrome and carpal tunnel.

Dr. Watson testified that upon reasonable degree of medical and surgical certainty, he believed that the Petitioner should receive follow-up treatments regularly to make sure that the nerve impingement would not get worse on a twice a year basis.

Dr. Watson reported that the section 12 doctor (Dr. Delheimer)gave a great synopsis of the care. If all of what the IME doctor stated is true then Dr. Watson has a good idea of the reasonableness of treatment that that Petitioner received prior to coming to his facility. Everything appeared to be reasonable. Finkelstein's test served as an objective test to measure the Petitioner's condition. This test is one not too many people have the insight to fake. Petitioner is unable to do activities at home as far as cooking and cleaning because she has difficulty and relied on her husband and sons to do a lot of the household activities.

DR.DELHEIMER: Dr. Steven Delheimer, Respondent expert witness as section 12 examiner, testified that he received a synopsis or chronology prepared by Respondent's law firm Dr. Delheimer testified that he had no reason to doubt the qualifications of the doctors or evaluators who previously performed those tests. He added that he had no reason to doubt the accuracy of those tests done by different evaluators and doctors.

Dr. Delheimer testified that the Petitioner had four different positions that she did while being employed for Respondent. He reported that the Petitioner rotated these positions throughout the day. Dr. Delheimer testified that the Petitioner worked eight to ten hours a day. He testified that although the job might be repetitive, he didn't believe that this is the type of job that would cause carpal tunnel. Dr. Delheimer defined repetitive as doing the same action over and over. He reported the job as being medium duty.

Dr. Delheimer reported that his website advertised that he did depositions, medical reviews and examinations, and evaluations. He testified that as of that date, in the past two or three years, he gave 30 depositions a year. He reported that at one time he was doing about one deposition a week, or about 52 a year. Dr. Delheimer reported that at the time, he charged $1,200 per hour, with a minimum charge of $1,800. At the time, Dr. Delheimer testified that in the past five to six years, he did up to 250 to 700 medical evaluations per year. He reported that he charged between $1,250 and $5,000 per evaluation. Dr. Delheimer reported that about 80 percent of these are done for respondent or insurance companies. According to his testimony, Dr. Delheimer made approximately $450,000 through Innovative Medical Evaluations for his evaluations and reviews and depositions (Delheimer Depo, p. 25-26).

Dr. Delheimer testified that 89 percent of his practice has to do with the spine. It had been three or four months since he had done a carpal tunnel surgery. Dr. Delheimer believed are occupational causes for repetitive traumas. (see Dep. RX 3 at p.28). Dr. Delheimer defined carpal tunnel as an entrapment of the median nerve as it passes under the transverse carpal ligament, and then the median nerve runs from the forearm to the wrist. Dr. Delheimer testified that the risk factors for occupational carpal tunnel syndrome include working with vibratory tools. Dr. Delheimer stated that one of the occupational risk factors for carpal tunnel syndrome could be working on an assembly line that required prolonged repetitive flexing of the wrist. Dr. Delheimer reported that the tests to diagnose carpal tunnel syndrome and repetitive traumas in general are a factor for the history and symptoms of the patient. He reported that other tests that can be factors included physical exams, EMG tests, and the NCV test.

Dr. Delheimer reported that one of the job activities that the Petitioner had was making boxes. He added that she packed boxes and she placed bottles in a container and then put these containers on the assembly line and moved down. Dr. Delheimer testified that he assumed that the Petitioner was required to have the constant use of both of her hands. Dr. Delheimer reported that the Petitioner's job activities involved constant gripping and grasping with both hands. According to his testimony, that is all the Petitioner did for eight to ten hours. Dr. Delheimer testified that it was fair to say that the Petitioner's job required her to use both upper extremities. Dr. Delheimer reported that he believed these activities comprised one hundred percent of the activities of the Petitioner. No other off-work activities or outside activities that could be related to carpal tunnel or repetitive trauma syndrome were reported. Dr. Delheimer testified that he did not document any systemic diseases that could lead to the development of carpal tunnel or repetitive trauma syndrome. Dr. Delheimer testified that the Petitioner kept her hands in a neutral position and she did not flex or extend her hand. Petitioner did not describe any flexion or extension activities that she performed in her job. He asked the cooperative Petitioner questions.

Dr. Delheimer testified that the Petitioner complained of bilateral pain during that last exam. He added that she complained of tingling, numbness, and cramping bilaterally. Petitioner also complained specifically of cramping and pinching, as well as occasional burning and swelling sensation in her hands. Petitioner stated that these pain complaints traveled up the arm, and that they have gotten worse over time. Petitioner had these complaints since 2007 (Delheimer Dep, p. 34). Numbness and tingling of the thumb, index, middle and the medial aspect of the ring finger are a classic symptom of carpal tunnel.

He added that the little finger is usually not included; carpal tunnel can involve pain from the wrist to the upper arm to which the Petitioner complained. Page 36 at lines 1-3.He did not believe that carpal tunnel symptoms do not involve weakness of the hand, but rather goes to neuroanatomy. He added that carpal tunnel does "usually" not involve the tendency to drop things @ line 21.(Delheimer Dep, pp. 35-36).

Dr. Delheimer testified that he believed her treatment has been excessive, which is unusual. He had not seen anywhere in the medical records Petitioner had ever been pain free. He reported that once pain has lasted over six months, it becomes chronic pain. Dr. Delheimer testified that in some cases, pain can be disabling. In some cases, a person who has been diagnosed with chronic pain can be impaired or prevented from performing their usual and customary line of employment. He added that hypothetically, it could impair a person from functioning within their daily living activities. Her symptoms were atypical for carpal tunnel.Dr. Delheimer reported that the EMG report from March 2007 showed that there was bilateral median mononeuropathy with the left cubital tunnel. It also revealed multiple entrapment neuropathies. EMG report findings from March 2011 revealed mild chronic carpal tunnel, right greater than left. In the past year, he had done around one hundred cervical and lumbar surgeries. He reported that up to that date of the deposition, he had done five to ten carpal tunnel surgeries. in the past year. Luanne Hallberg in staff did the medical summaries for him.

PATSAVAS CRC: At his evidence deposition of May 16, 2013, David Patsavas testified that he is a certified rehabilitation and vocational consultant, which is a national certification by the Commission of Rehabilitation Counselors certified since 1982. Mr. Patsavas testified that this certification needs to be re-upped or re-certified every five years based on the 100 hours of training, 10 of those hours in ethics.

The main aspect of code of ethics is to represent and work with the client. He added that the client is the main goal and objective of the organization, and that it does not matter if the referral comes from the insurance company or plaintiff attorney because they are obligated by code of ethic to provide a level of expertise and professionalism in trying to provide the best services on behalf of the client. Mr. Patsavas testified that he reviewed all of the Petitioner's medical reports, including surgical reports from Dr. Michalow, Dr. Urbanosky, a functional capacity report, and independent medical evaluations by Dr. Delheimer and Dr. Watson.

Mr. Patsavas described the Petitioner as a forty two-year-old woman, who attended up to 6th grade in Mexico, with no further training in the U.S. Mr. Patsavas added that the Petitioner indicated that she did not go to any further type of training or education after 6th grade. Mr. Patsavas testified that the majority of the Petitioner's job experience, including the most recent one at the Respondent, would be considered two different occupations. He described the first one as being a packer with the Respondent. According to Mr. Patsavas' testimony, the dates of employment were from 2001 through February 12, 2007, which is considered the date of injury. Mr. Patsavas reported that the hand packer is considered in the median category of physical demands with lifting, carrying, pushing and pulling twenty to fifty pounds occasionally, ten to twenty five pounds occasionally, and up to ten pounds constantly. He added that the DOT also indicates different skill levels for each occupation. On a scale of one through nine, the Petitioner's was considered level two, which means pretty much unskilled up to one month on-the-job training. Mr. Patsavas added that additional physical demands pertinent to the case included constantly reaching, handling, and fingering. He described the Petitioner's job as an unskilled jobt Based on the Petitioner's job description and the Dictionary of Occupational Title printout, the Petitioner's job would be considered medium category with constant reaching, handling and fingering. He added that the reasoning, math and language would be at a sixth grade level or below, and it would therefore be unskilled level two. He learned other significant length of employment at a place called Vendrune Farm out of Momence, Illinois, from approximately 1988 to 1996. Based on the Petitioner's description, Mr. Patsavas described the job position as working agricultural produce sorter; she would separate, freeze food, dry fruits and vegetables, and remove dirt.

Mr. Patsavas reported that the position would be considered being the light category of physical demands, lifting, carrying, pushing, pulling 20 pounds occasionally, frequently up to 20 pounds, negligible amount constantly, reasoning, math and language all at a level , so that would be third grade level or less, for a specific vocational preparation level two (Patsavas Dep, p. 17).

Mr. Patsavas reported that the Petitioner indicated that besides those two jobs, she had short-term employment with a flower shop, where she would pack flower bouquets, also worked three months packaging cartons for a company, and worked six months for M & M Chocolate, where she would count and package M & M candies out of Manteno. Mr. Patsavas testified that none of these jobs were in the skilled category. He reported that from all her job history, none of her job skills were transferable to other jobs given her lack of education, the overall transferrable skills and physical restrictions Her ability to speak and communicate in English was minimal. She required the use of an interpreter in the office. He testified that Petitioner said she understood very little, and most of her reading would be in Spanish.

Mr. Patsavas testified that based on the FCE results of August 2009, the Petitioner was released under sedentary category. He reported that the Petitioner's physician indicated that he supported those findings and later indicated from the pain doctor that Petitioner was not employable. Mr. Patsavas reported that age plays a component taken into consideration when making recommendations or opinions in the vocational field. Petitioner's age indicated that she may be a candidate for further rehab or training, but based on the fact that she only had a sixth grade education, and given the restrictions and lack of transferrable skills, Mr. Patsavas felt that his overall finding were not impacted. He did not think that there is a viable and stable job market for an individual with all of the factors that he identified. on that date. Mr. Patsavas reported that approximately eleven percent of all jobs are available for a person with sedentary restrictions and no other factors. He added that with the additional factors found in the Petitioner's case, unskilled sedentary level one, out of over twelve thousand different jobs, six jobs are available; under level two for unskilled, one hundred and thirty one are available.

Mr. Patsavas testified that based upon his reasonable degree of certainty in his field, he did not think there is some type of rehabilitation program that is economically feasible to perform on the Petitioner.The basis of his opinion was that he did not believe there is a viable and stable labor market available to her based on all other factors. He reported that if the Petitioner was to complete a GED, her chances would improve and there would be a viable and stable labor market available to her. Based on the Petitioner's educational background and skills, he would imagine that it would take her three-plus years to get a GED in language skills. He was unsure if the GED alone would make her a viable and stable labor market. Therefore he did not believe that there was a reasonable and economically feasible program for her to attempt.

He didn't think enrolling in an English as a second language would have a significant bearing on her ability to be employed. He based his opinion on the fact that there was very limited availability of jobs based on the sedentary category and the Petitioner's additional restrictions of use of the upper extremity. Petitioner's lost job security was a result of her current job restrictions based on the fact that there's not a viable and stable labor market available to her. He did not believe the Petitioner had sufficient skills to even look for a job based on lack of education, lack of resources, lack of computer skills, and being able to present to a job market. Importantly, he did not think it would be reasonable for the Petitioner to conduct a job research based on the lack of opportunity that she could even identify within her restrictions. Until that day, he was not made aware that the Petitioner had been approved for social security disability benefits. He added that being aware that the Petitioner was approved supports his opinions because it's difficult for people under the age of 50 to qualify for social security disability.

HAMMOND-NON C.R.C: Mr. Bob Hammond, not a Certified Rehabilitation Counselor, expert witness for the Respondent, described the Petitioner as a younger individual. Mr. Hammond testified that he thought that if you take the sedentary level of restrictions and limitations, that the Petitioner could return to some gainful activity in the general labor market within the general labor market of her home. He also reported that the Petitioner needed some testing and she needed some further education to enhance her future to return to the work force by getting education, training, and learning English as a second language, possibly getting a GED so that it would enhance her abilities in the future. Mr. Hammond reported that he thought the Petitioner needed training to get better jobs, but he thought she could work at the time.

Mr. Hammond testified that he believed the Petitioner was employable in the open labor market under Dr. Urbanosky, Dr. Rivera, Dr. Michalow's and Dr. Delheimer's restrictions (Hammond Dep, pp. 57-58). Mr. Hammond testified that he wrote three reports. According to his testimony, at the time he authored the first report of September 13, 2011, he had not met the Petitioner. He reported that at that time, he didn't know anything about the Petitioner's physical condition. Mr. Hammond testified that he read some medical records that were provided to him by the attorney yet did not know her employment history.

Mr. Hammond reported that he believed that the Petitioner could return to a wide variety of positions, even her previous jobs as a line worker, based on Dr. Delheimer's restrictions He reported that the opinions and recommendations section did not state that the Petitioner can go back to work because of the sedentary restrictions. Mr. Hammond reported that based on who had seen the Petitioner on a regular continuous basis up to that time of the reports he had read, Dr. Delheimer had seen her more over time than any other doctor. The Arbitrator compared this statement to the Findings of Fact above finding this conclusion strange or out of context.

According to Mr. Hammondy, Dr. Delheimer had done three evaluations of the Petitioner, therefore if you took Dr. Delheimer, then the Petitioner can return to medium work activity Mr. Hammond reported that he did not know why Dr. Delheimer was hired, nor did he know if he was a treating doctor. Mr. Hammond reported that when he read Dr. Delheimer's report, Dr. Delheimer said he was an IME doctor at that point in time. Mr. Hammond defined an IME as an independent medical exam, which tends to be in some cases a non-treater. He reported that he did not know if Dr. Delheimer was an independent doctor. He testified that he was initially hired to review the records and write the report. Mr. Hammond reported he was not hired to help the Petitioner look for a job.(Arbitrator cites Rule 7110 regarding rehabilitation within 120 days) Mr. Hammond was never requested to assist the Petitioner in seeking medically appropriate employment. He thought that the Petitioner needed to be tested, but it had not been approved. He had not provided the Petitioner with any job-seeking skills or any job leads. Mr. Hammond interviewed Petitioner on August 2012. None of the Petitioner's jobs had any transferrable skills. Mr. Hammond reported that he was not a certified rehabilitation counselor.

He reported that that his group's code of ethics stated that he is to evaluate, assess, make a determination about a medically appropriate employment, and work with an individual to assist them in returning to medically appropriate employment. He did not think Petitioner would be able to find a job if she had sedentary work restrictions without some type of job-seeking skills and further assistance and training, and English classes. He reported that the Petitioner would need help to find work. Mr. Hammond reported that the Petitioner would need some sort of job placement assistance because she would not be able to go out on her own and find work. He reported that he did not know if this assistance should have been provided by the Respondent. (Arbitrator cites section 8(a) of the Act regarding rehabilitation plus IWCC Rule 7110.

The Arbitrator adopts the above material findings of Fact. The Arbitrator relies upon the totality of the evidence in determining the following:

CONCLUSIONS OF LAW

(F) DID THE PETITIONER SUSTAIN AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH THE RESPONDENT?

Based on the totality of the evidence, the Arbitrator finds as a matter of fact and as a conclusion of law Petitioner in the case at bar sustained accidents that arose out of and in the course of her employment for the February 12, 2007 for the left hand and arm and on February 21, 2007, for the right hand and arm. The Arbitrator further finds the above referenced shoulder symptoms as part of this repetitive accident complex.

The Petitioner reported the accidents within forty five days as required by the Act. The Respondent's witness, Kevin Johnson, a supervisor, confirmed that she reported the accidents. Mr. Johnson has worked for the Respondent for thirty three years. He testified that he was familiar with all the tasks that the Petitioner was required to perform. Mr. Johnson corroborated that the Petitioner was required to perform the four different tasks that the Petitioner testified to. He admitted that the Petitioner's job was repetitive and required the constant use of her hands. Mr. Johnson testified that the Petitioner would have to bend her hands at the wrist in order to fold cartons into boxes. Mr. Johnson confirmed that he personally knew that the Petitioner was having problems with her hands and arms in February of 2007. He also confirmed that she reported these problems to the company. He also testified that the Petitioner was a good employee. He also testified that the assembly line the Petitioner worked at could not accommodate somebody with light duty work restrictions. He also confirmed that after September 2009, the Petitioner was not offered any work within her restrictions.

The Arbitrator notes that the Petitioner was required to perform tasks that required the constant and repetitive use of both hands and arms. The tasks required gripping with the hands and the flexion of the hands at the wrist. The Petitioner reported these same job tasks to all of her treating doctors and the Respondent's Section 12 Examiner. The Arbitrator notes that our Appellate Court has held that a claimant need not show a certain percentage of the workday is spent on a particular task in order to establish a work-related repetitive trauma injury. Edward Hines Precision Components v. Industrial Commission, 356 Ill. App. 3d 186, (2005).

(F) IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Based upon the totality of the evidence,including treating medical records, and the testimony of Dr. Watson and Dr. Delheimer, as well as the testimony of Kevin Johnson, the Arbitrator finds in the case at bar as a matter of fact and as a conclusion of law Petitioner herein has proven that her current conditions of ill-being ares causally related to the repetitive trauma injuries manifesting on February 12, 2007 and February 21, 2007.

The Arbitrator concludes that the Petitioner was a credible witness, based upon her testimony, demeanor, correlation of said testimony to the records, and, an insightful, well organized cross examination. Though the Petitioner's testimony on her job activities was not always crystal clear, it was corroborated by the histories and statements given to his medical treaters. The Arbitrator was able to get an understanding of the Petitioner's work activities. The Petitioner's, supervisor, Kevin Johnson, confirmed the testimony of the Petitioner's work activities and that she reported her problems to her hands and arms in February of 2007. Essentially, Respondent's witness bolstered Petitioner's case and made it easier for the Arbitrator to put the worker's testimony in the broader context of the activities in the plant.The Arbitrator adopts the totality of the evidence in findings as a matter of fact and as a conclusion of law that Petitioner's current conditions of ill being as defined by the treating doctors in evidence are causally connected to the repetitive trauma accidents in the cases at bar.

The Arbitrator finds the testimony of Dr. Watson to be clearly more persuasive on this issue than the testimony of Dr. Delheimer. The opinions and treatment records of this worker further support this determination. The background, preparedness or lack thereof and content of testimony of Dr. Delheimer did not seem suitable to both the medical nature of this case and the complex medical treatment that preceded his testimony. The Arbitrator finds Dr. Delheimer in this case not at all persuasive in the least way. The early medical development of the Petitioner's cumulative trauma sequelae appears totally ignored by claims and or medical management in its years of development.

At the risk of duplication, the Arbitrator finds that the opinions and conclusions in the Petitioner's treating medical records establish by the preponderance of the evidence, that her multfactorial conditions of ill being were was related to her work activities at the Respondent which manifested from a legal sense on the two dates alleged in both Applications.

The Petitioner need only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury. Teska v. Industrial Comm'n, 266 Ill.App.3d 740, 742 640 N.E.2d 1,3 (1994). See the Supreme Court cases as far back as 1978 under Goldblatt Brothers, Inc for the same analysis. The claimant must show, *inter alia*, that some aspect of his employment was *a causal factor* that resulted in the complained of injury. Teska at 742.

(J) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY?

The Petitioner testified to a continuous course of treatment to her bilateral arms and hands. This testimony is corroborated by the medical records. The medical bills submitted into evidence also corroborate the treatment provided. The one line comment from Dr. Delheimer about the treatment is the only indicia of evidence for the Respondent as follows: "It's been excessive". See Rx. 3, pages 36-38 including line two at page 37.

Therefore, the Arbitrator concludes as a matter of fact and as a matter of law that the treatment was related to the accidents plus reasonable and necessary under 8(a. Moreover, the corresponding medical bills were reasonable under section 8 subject to application of the fee schedule. A retroactive utilization review was not generated by claims management. Dr. Delheimer's statement that the care for this chronic condition is "excessive" is about the weakest medical treatment defense to a case I have seen in over 40 years in this industry.

Therefore, the Respondent shall pay the following medical charges to the Petitioner and his attorney (Pursuant to Fee Schedule):

Health Benefits Physician Services, LLC	**$9,863.62**
IWP	**$957.74**
Frankfort Surgical Center/Pain Mgmt. Inst.	**$1,390.48**
Hinsdale Orthopedics	**$2,498.01**
Illinois Pharmacy Management, LLC	**$12,152.67**
Joliet Open MRI	**$4,128.23**
Medsource	**$85.74**
Premier Physical Therapy	**$1,902.40**
Professional Neurological Services, Ltd.	**$1,063.87**
Total:	**$34,042.72**

(K) WHAT IS THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY AND MAINTENANCE?

Pursuant to Section 8(a) of Act, the Petitioner is entitled to have and receive the sum of **$233.91**/week for **34 2/7** weeks for temporary total disability, commencing **July 9, 2007 through July 25, 2007, November 14, 2007 through December 4, 2007, and September 2, 2009 through March 22, 2010.**

The Arbitrator relies upon the totality of the evidence emphasizing Petitioner's treating medical records, the Deposition of Dr. Watson, the testimony of Kevin Johnson, and the Petitioner's testimony to determine that the Petitioner is as a matter of fact and as conclusion of law entitled to TTD. The Arbitrator specifically finds that the Petitioner has not reached a state of medical improvement that would allow her to work beyond the work restrictions imposed on her by Dr. Urbanosky, Dr. Rivera and Dr. Watson. Dr. Watson at more that one examination found her unable to work.

(N) OTHER: PROSPECTIVE MEDICAL TREATMENT

Further, pursuant to Plantation Manufacturing Co. v. Industrial Commission, 294 App.3d 705, 691 N.E.2d 13 (2d Dist. 1997), the Respondent is ordered to provide written approval for the continuing pain management recommended by the Petitioner's treating doctors. The medical records submitted into evidence establish that the Petitioner is in need of further medical care.

(L) SHOULD THE RESPONDENT PROVIDE MAINTENANCE AND VOCATIONAL REHABILITATION?

Based on the above discussion, the Respondent shall pay the Petitioner the sum of $233.91 per week, beginning on March 23, 2010 through October 17, 2013 as provided in Section 8(a) of the Act, because the Petitioner requires maintenance. Moreover. The Arbitrator orders 8(a) vocational rehabilitation. Further, based upon the totality of the evidence and noting IWCC Rule 7110, Respondent shall authorize to the Petitioner vocational rehabilitation services by David Patsavas CRC who testified in the case at bar.

The Petitioner offered the testimony of Mr. David Patsavas, a certified vocational rehabilitation counselor. Mr. Patsavas opined that a reasonable and stable job market did not exist for the Petitioner, since her impairments do not allow her to be able to consistently sustain any competitive work effort. The Arbitrator finds that the Petitioner and the Petitioner's vocational expert testimony to be credible. Mr. Patsavas testified that based upon his reasonable degree of certainty in his field, he did not think there is some type of rehabilitation program that is economically feasible to perform on the Petitioner. He reported that if the Petitioner was to complete a GED, her chances would improve.Mr. Patsavas testified that if the Petitioner were to enroll in English as a second language, it might improve her overall quality of life, but he didn't think it would have a significant bearing on her ability to be employed. He based his opinion on limited availability of jobs based on the sedentary category and the Petitioner's additional restrictions of use of the upper extremity. He did not believe the Petitioner had sufficient skills to even look for a job based on lack of education, lack of resources, lack of computer skills, and being able to present herself into a job market The Respondent's expert also agreed that without any professional assistance the Petitioner would not be able to find work.

Mr. Patsavas reported that he did not think it would be reasonable for the Petitioner to conduct a job research based on the lack of opportunity that she could even identify within her restrictions. Mr. Patsavas testified that until that day, he was not made aware that the Petitioner had been approved for social security disability benefits. He added that being aware that the Petitioner was approved supports his opinions because it's difficult for people under the age of 50 to qualify for social security disability benefits. The Arbitrator concludes a good faith effort by both parties for vocational rehabilitation may be the best option for both parties to avoid the future legal outcome of being deemed permanently and totally disabled under the Act at the next hearing on Arbitration.

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

15IWCC0240

FLORES, MARIA
Employee/Petitioner

Case# **08WC045415**

08WC045414

GILSTER MARY LEE CORP
Employer/Respondent

On 1/8/2014, 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 0.08% 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

0693 FEIRICH MAGER GREEN & RYAN
BRANDY L JOHNSON
2001W MAIN ST
CARBONDALE, IL 62901

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0240

MARIA FLORES
Employee/Petitioner

v.

GILSTER MARY LEE CORP.
Employer/Respondent

Case # **08** WC 45415

Consolidated cases: **08 WC 45414**

An *Application for Adjustment 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 **New Lenox** , on **October 17, 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 **Maintenance and Vocational Rehabilitation**

15IWCC0240

FINDINGS

On the date of accident, **February 12, 2007 & February 21, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,284.35**; the average weekly wage was **$350.86**.

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 $ **1,183.38** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,183.38**.

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 **$233.91**/week for **34 2/7** weeks, commencing **July 9, 2007-July 25, 2007, November 14, 2007-December 4, 2007 & September 2, 2009- March 22, 2010**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$233.91**/week for **186 4/2** weeks, commencing **March 23, 2010** through **October 17, 2013**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of **$34,042.72**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall provide Petitioner ongoing maintenance benefits and provide vocational rehabilitation benefits through David Patsavas CRC, as provided in Section 8(a) of the Act.

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

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

#07 George J Lewis
Signature of Arbitrator

December 30, 2013
Date

JAN 8 - 2014