STATE OF ILLINOIS)
) SS.
COUNTY OF HENRY)

☒ 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

Lare Ferguson,

Petitioner,

vs.

NO: 03 WC 38589
07 WC 02851

Lowe's,

15IWCC0310

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 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.

15IWCC0310

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $57,800.00. 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: MAY 1 - 2015
TJT:yl
o 3/10/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FERGUSON, LARE
Employee/Petitioner

Case# **03WC038589**

07WC002851

LOWE'S COMPANIES
Employer/Respondent

15IWCC0310

On 11/5/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

0149 WARREN E DANZ PC
MICHAEL SUE ESQ
710 N E JEFFERSON ST
PEORIA, IL 61603

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

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

Lare Ferguson
Employee/Petitioner

v.

Lowe's Companies,
Employer/Respondent

15IWCC0310

Case # **03 WC 38589**

Consolidated cases: **07 WC 02851**
(duplicate filing)

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Mathis**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **5/14/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/27/02**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,777.60**; the average weekly wage was **$668.80**.

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

Respondent shall be given a credit of **$88,555.08*** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$11,236.12*** for other benefits, for a total credit of **$14,357.00**. (*Petitioner was entitled to receive TTD in the amount of $85,434.20, resulting in a net credit for overpayment of TTD in the amount of $3,120.88 plus a credit for PPD advances in the amount of $11,236.12. See Addendum to Arbitration Decision.)

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 **$445.86**/week for **0** weeks.

Respondent shall pay Petitioner permanent partial disability benefits of **$401.28**/week for **40** weeks, because the injuries sustained caused the **20%** loss of the **petitioner's left leg**, as provided in Section 8(e) of the Act and for **25** weeks because the injuries sustained caused **5%** loss of the **petitioner's whole person** as provided by Section 8(d)(2) of the Act.

Respondent shall be given a total credit of **$14,357.00** against the award for TTD and PPD benefits.

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 rendered to Petitioner from November 27, 2012 through June 17, 2008 for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

S J Mathis
Signature of Arbitrator

10-30-2013
Date

NOV - 5 2013

PROCEDURAL HISTORY

Pursuant to the Petitioner's Lare Ferguson's (hereinafter "Petitioner") Petition for Immediate Hearing under Section 19(b) of the Illinois Workers' Compensation Act, this matter was heard by Arbitrator Neva Neal at the Illinois Workers' Compensation Commission in Peoria on June 17, 2008. Arbitrator Neal filed her Decision on July 17, 2008. In the Arbitration 19(b) Decision (Exhibit A attached hereto), Arbitrator Neal denied Petitioner's claim for further medical benefits, specifically a lumbar fusion, pursuant to Sections 8(a) of the Illinois Workers' Compensation Act. The Arbitrator was not asked to address the petitioner's entitlement to TTD benefits and the nature and extent of Petitioner's work injuries at that time. Those issues were preserved for future hearing.

Petitioner filed a timely review of the Arbitration 19(b) Decision with the Illinois Workers' Compensation Commission on July 25, 2008. In its unanimous Decision and Opinion on Review entered on February 2, 2009 (Exhibit A attached hereto), the Illinois Workers' Compensation Commission affirmed and adopted the Arbitration 19(b) Decision of Arbitrator Neva Neal.

Petitioner filed a timely circuit court appeal of the Illinois Workers' Compensation Commission's Decision and Opinion on Review with the Peoria County Circuit Court on February 17, 2009. Following the presentation of the parties' briefs and oral arguments before the Peoria County Circuit Court, the Peoria County Circuit Court on April 19, 2010 entered an Order confirming the Illinois Workers' Compensation Commission's Decision and Opinion on Review. (Exhibit B attached hereto) No further appeal was taken by either party to the proceedings after that Order thus making the Arbitration Decision of Arbitrator Neal entered on July 17, 2008 final and binding on this Illinois Workers' Compensation Commission.

When the case was tried on June 17, 2008, at which time medical records and reports for treatment up to the date of the hearing were submitted into evidence, findings of facts were rendered on issues of medical causal connection and the reasonableness and necessity of incurred and prescribed medical treatment. The parties specifically reserved the issue of any claimed unpaid TTD benefits for future hearing. In light of this, the Arbitrator reviews medical records and reports pre-dating the June 17, 2008 Trial solely for determining what, if any, TTD benefits are owed to the petitioner. The Arbitrator does not review medical reports or records for treatment incurred or prescribed prior to the June 17, 2008 19(b) Trial to address reasonableness and necessity of medical treatment or medical causal connection up to June 17, 2008 as those issues were addressed in the prior hearing. The final hearing of this case took place over three dates: April 21, 2010, April 12, 2012 and May 14, 2013. In light of the time span between these hearings, the Arbitrator has requested and received transcripts of the testimony from each of these hearings referenced below as TR I, TR II and TR III, respectively.

GENERAL FINDINGS OF FACTS

This case was tried previously on June 17, 2008, pursuant to Section 19(b) of the Act and an Arbitration Decision was entered at that time. It is a well-settled matter of principle in Illinois that judicial notice may be taken of factual evidence where the facts are capable of immediate and accurate demonstration by resort to easily accessible sources of indisputable accuracy. In re Marriage of DeBow, 236 Ill.App.3d 1038, 1040, 602 N.E.2d 984, 985, 177 Ill.Dec. 89, 90 (Ill.App. 5 Dist.,1992) (citing *People v. Davis* (1976), 65 Ill.2d 157, 2 Ill.Dec. 572, 357 N.E.2d 792.) Additionally, judicial notice of other proceedings may be proper where the same parties are involved and the allegations from those proceedings have been proved. Id. (citing *Walsh v. Union Oil Co.* (1972), 53 Ill.2d 295, 291 N.E.2d 644.)

Furthermore, it has been accepted practice that the Illinois Workers' Compensation Commission may take judicial notice of its own records, including prior decisions and awards. For example, the Illinois Industrial Commission on review affirmed an Arbitration Decision in which the Arbitrator took judicial notice of the records of the Illinois Industrial Commission revealing the outcome of two earlier 19(b) proceedings in the cases of Alejandro Irizarry v. Dynaweld, Inc., 2001 WL 952599, Redman v. Southern Illinois Services Inc., 2003 WL 22213728. The Commission has also taken judicial notice of prior Decisions in determining what to award for PPD benefits. Mike Reid v. Temperature Equipment Corp., 2010 WL 1544686, 6. (where the Arbitrator took judicial notice of a prior award for back injuries) and Magee v. State Dept. of Corrections-Stateville Correctional Center, 2006 WL 1704122, 6 (where the Arbitrator took judicial notice of a prior case in which he awarded 65% loss-of-use of the right leg to a bakery delivery man in determining what to award in PPD benefits in the case he was deciding.) The purpose of allowing judicial notice of prior awards and decisions is to effectuate provisions of the Illinois Workers' Compensation Act to award Respondent allowable credits for previously awarded benefits and to eliminate the necessity of calling witnesses from the prior adjudication to lay a foundation for the award or decision. This is consistent with the general principle stated above.

For this reason, the Arbitrator takes judicial notice of the previous Arbitration 19(b) Decision, which was affirmed on review to the Illinois Workers' Compensation Commission and further affirmed following an appeal to the Peoria County Circuit Court. In addition, that prior Decision was admitted into evidence by Petitioner without objection from Respondent.

Based upon the prior Arbitration 19(b) Decision, Petitioner and Respondent were engaged in an employee-employer relationship on November 27, 2002, when Petitioner was injured in an accident arising out of and in the course of his employment with Respondent. Timely notice of that accident was also provided to Respondent, and on November 27, 2002, Petitioner was single with no dependent children and earning $668.80 per week while employed with Respondent. The issues presented at the time of the June 17, 2008 19(b) Trial were whether Petitioner's condition of ill-being for which he was seeking authorization from Respondent for lumbar spine

surgery was medically causally related to the work accident and whether the lumbar spine surgery for which Petitioner was seeking authorization was a reasonable and necessary procedure. Based upon that prior decision, the Arbitrator finds that Petitioner's condition of ill-being for which his lumbar fusion surgery was recommended as of June 17, 2008, and for which he subsequently underwent the lumbar fusion, was not medically causally related to the November 27, 2002 work accident. Similarly, the Arbitrator finds that the lumbar fusion procedure and any treatment related to that fusion was not reasonable and necessary treatment for injuries resulting from the November 27, 2002 work accident. These are proven facts following a hearing on the record (the transcript from which was also admitted into evidence and reviewed as part of this Decision) and the Arbitrator finds these credible facts.

For this final hearing, the parties stipulated:

On November 27, 2002 the petitioner and respondent were in an employee-employer relationship, at which time the petition was earning $668.80 per week. The petitioner was 48 years of age, married with no children under the age of 18 on that date.

At the time of the final hearing, the issues in the case were whether the petitioner's condition of ill-being is medically causally related to the accident on November 27, 2002; whether the petitioner is entitled to temporary total disability benefits for the period of March 26, 2004 through May 18, 2004, June 3, 2004 through November 1, 2004, and August 2, 2008 to April 21, 2010; whether the respondent is liable for the claimed medical expenses of the petitioner shown in Petitioner's Exhibit 10; and the nature and extent of the petitioner's permanent disability resulting from the accident.

Based upon the prior Arbitration 19(b) Decision and the testimony of Petitioner in this final hearing, the Arbitrator finds:

Petitioner sustained an accidental injury arising out of and in the course of his employment on November 27, 2002 while he was assisting a customer. As he was attempting to lift a box containing a book case for the customer, Petitioner felt a pop in his neck, back and left leg.

The Arbitrator adopts and incorporates herein the facts concerning the petitioner's medical history between November 27, 2002 and the previous trial on June 17, 2008 as stated in the Arbitration 19(b) Decision. (Exhibit A attached hereto)

Subsequent to the 19(b) Trial on June 17, 2008, Petitioner underwent surgery with Dr. Dinh on March 13, 2009. In the interim, Petitioner continued under the care of Dr. Chien for pain management for his neck and arms. (TR I, p. 29)

Following his surgery on March 13, 2009, Petitioner was examined again by the respondent's independent medical examiner, Dr. Van Fleet, on July 28, 2009. (TR I, p. 31) Petitioner testified to the brevity of that examination and the fact that the doctor refused to allow a witness

to the examination to remain in the room during the IME. (TR I, pp. 31-35) The Arbitrator interprets this as evidence that the independent medical examination was completed quickly in the opinion of Petitioner.

On August 2, 2008, Petitioner's temporary total disability benefits were terminated by Respondent, and Petitioner has not received any temporary total disability benefits since that date. (TR I, p. 35)

Petitioner continued to follow care with Dr. Chien subsequent to his March 2009 surgery for a complication after his surgery and for continued pain management relative to a burning pain sensation in his legs. (TR I, pp. 28, 36) In August 2009, Petitioner moved to Colorado. (TR I, p. 37) In Colorado, Petitioner resumed monthly medical treatment with Dr. Lisa Cwerdlinger at Rocky Mountain Family Practice, where Petitioner continues to receive pain management treatment. (TR I, p. 38) Petitioner testified that prior to his March 2009 surgery his pain level was a 10/10 that was subsequently reduced by the surgery to 8/10 because he continues to have pain radiating down his legs. With respect to his left knee, at the time of the hearing on April 21, 2010, Petitioner described his left knee pain as 8/10 and stated that he has difficulty walking long distances, climbing hills and climbing stairs. Petitioner rated his neck pain as "still pretty bad" and 9/10. With respect to his back, Petitioner stated that he does not use a cane any longer, unless walking on ice and snow. Petitioner stated that he is no longer able to hunt and trap or build stuff. As of the date of the start of this final hearing, Petitioner was receiving social security disability benefits and was not and has not been employed since his March 2009 surgery. (TR I, pp. 38-44)

On cross-examination, Petitioner admitted that he has not seen Dr. Dinh, the physician who performed his lumbar surgery, since May 2009 and that he has not seen Dr. Chien since July 2009. (TR I, pp. 45-47) Petitioner also testified that the "witness" to his July 28, 2009 IME with Dr. Van Fleet was Brandon Parks, who Petitioner met for the first time two weeks prior to that IME in response to a request to the petitioner's attorney's office for someone to drive him to the IME. (TR I, pp. 48-50) (There is no testimony or evidence indicating that the petitioner was incapable of driving, restricted for driving or made any requests for the respondent to provide Petitioner with transportation to the IME.) Petitioner also testified that he drove from Colorado to Peoria for the hearing on April 21, 2010 by himself, stating that the 1200 miles took him about 2 ½ days, but that he needed to stop every hour and a half to take a break. (TR I, pp. 47, 55)

On March 25, 2004, Petitioner ended his employment with Respondent. (TR I, p. 10) Petitioner provided three weeks' notice to his employer at that time on the basis that he believed Respondent was violating his work restrictions, requiring him to lift steel and's and climb ladders to do inventory when he had a 10-pound lifting restriction. (TR I, p. 11-12) Petitioner also claimed that he was threatened that he would lose his job, which Petitioner testified it was running three different departments. (TR I, pp 13-15) Respondent's counsel objected to Petitioner's testimony regarding any conversations concerning these alleged threats, and after

reviewing the testimony and the record, the Arbitrator sustains those objections as Petitioner was unable to lay a foundation for the conversation between Petitioner and representatives of Respondent. Petitioner testified that he was under restrictions as of March 25, 2004 from Dr. Hankins that prohibited the climbing of ladders. (TR I, p. 19)

The final hearing in this case resumed on April 9, 2012 at the IWCC in Kewanee, Illinois, at which time Petitioner was again present to testify. (TR II) At the start of the hearing, the Arbitrator was asked to address objections by Respondent's counsel to the admission of Petitioner's Exhibit 5 and Petitioner's Exhibit 7, which was that Respondent objected to the introduction of any treating medical records contained within those exhibits for treatment rendered prior to the previous June 17, 2008 19(b) Trial of this case. The Arbitrator has reviewed the transcript of proceedings, including the evidence exhibits submitted in that prior trial, and upon further review sustains the objection by respondent with respect to the introduction of Petitioner's Exhibits 5 and 7, rejecting any and all medical records contained within those exhibits for treatment rendered prior to June 17, 2008, and accepting only those medical records for treatment rendered subsequent to that prior hearing. The reason for this is that the Arbitrator notes that there was a substantial discussion on the record at the previous hearing regarding certain portions of those medical record exhibits and a request for redaction of certain commentary by the doctor contained within those treating records that was found in the previous hearing to be irrelevant to the issues in the case and specifically redacted from the evidence. Those medical records for treatment prior to June 17, 2008 are contained within Petitioner's Exhibit 1, and as indicated previously, the Arbitrator reviews records of medical treatment prior to June 17, 2008 solely for the purpose of determining the periods for which the petitioner was entitled to receive temporary total disability benefits.

The purpose of the second hearing on April 9, 2012 was to close proofs, and Respondent's counsel objected to Petitioner testifying to any matters prior to the April 21, 2010 start of the final proceedings and asked that the testimony of Petitioner be limited to only developments in his condition since April 21, 2010. It is the position of Respondent that Petitioner's testimony was completed with Respondent's counsel's cross-examination of Petitioner and the subsequent re-direct testimony of Petitioner at the April 21, 2010 hearing. The Arbitrator agrees with the position of Respondent and stated so on the record on April 9, 2012. For that reason, the Arbitrator disregards any testimony of Petitioner at the April 9, 2012 trial that does not involve events between April 21, 2010 and April 9, 2012 relevant to this case. The Arbitrator specifically disregards any direct testimony solicited from the Petitioner concerning any matters Petitioner testified to or occurring prior to the April 21, 2010 hearing. In doing so, the Arbitrator disregards the offer of proof provided by Petitioner as seen on pages 16-22.

Petitioner then provided testimony regarding conversations he had with representatives of Respondent regarding his work restrictions in place in March 2004 and whether Respondent did or did not accommodate those restrictions. (TR II, p. 23) Petitioner testified that he had to resign because Kevin Gardener, the Store Manager for Respondent, and Randy Kobes, Assistant

Store Manager for Respondent, continually violated Petitioner's work restrictions. (TR II pp. 24-25) Petitioner testified that the restrictions in place at that time were no lifting greater than 25 pounds. (TR II, p. 26) Petitioner still failed to lay a foundation as to specifically when these conversations with Mr. Gardner and Mr. Kobes took place, and Respondent's counsel objected on the basis of foundation and hearsay with regard to any alleged threats by one of these employees against Petitioner. (TR II, p. 27) Upon further review of the testimony of Petitioner, the Arbitrator sustains the objections of Respondent finding that Petitioner failed to lay a proper foundation for testimony of any conversation or conversations Petitioner may have had with Mr. Gardener and Mr. Kobes regarding Petitioner's work restrictions and accommodations on the part of Respondent. For that reason, the Arbitrator disregards the testimony of Petitioner as contained in the April 9, 2012 Tr., pages 24-28.

Petitioner resigned his employment on March 24, 2004, at which time he provided to and a half weeks' notice, during which time he continued working and was never offered a raise. (TR II, p. 29) On cross-examination, it was clarified that Petitioner's notice of resignation was tendered to and a half weeks prior to March 24, 2004 with March 24, 2004 being the petitioner's last day of employment with Respondent. (TR II, p. 49) Petitioner testified that he remained under light-duty restrictions from March 26, 2004 through May 18, 2004 and again from June 3, 2004 through November 1, 2004, during which time he did not receive temporary total disability benefits from Respondent. (TR II, pp. 30-31) Petitioner testified that he was "off work or on light duty after August 2, 2008, without specifically stating when he was medically authorized off work or when he was under some form of work restriction. (TR II, p. 32) Petitioner testified that he is not received payment of any benefits from Respondent since August 2008. (TR II, p. 57)

Petitioner testified that prior to his lumbar fusion on March 13, 2009, he had functional limitations, and these limitations have not changed since his March 13, 2009 lumbar fusion. (TR II, p. 41) Those limitations include no lifting greater than 25 pounds and no ladder climbing. (TR II, p. 41) Petitioner also claims that he has claimed a neck injury as result of the November 27, 2002 accident and always has made that claim. (TR II, p. 43) Petitioner still has symptoms in his neck, including pain and numbness down to his hand. (TR II, pp. 43-44) When asked if he still has symptoms in his leg, Petitioner testified to continue to pain along the right side of his knee And problems with bending his knee. (TR II, pp. 44-45)

Petitioner's witness, Brandon Parks, testified as follows:

Brandon was asked by counsel for Petitioner to drive Petitioner to the July 20, 2009 independent medical examination of Dr. Van Fleet. (TR II, pp. 60-61) Brandon observed part of the independent medical examination, during which time he believed that Dr. Van Fleet was pay more attention to Brandon than two Petitioner. (TR II, pp. 62) Brandon observed Dr. Van Fleet perform a physical examination of Petitioner, until Brandon was escorted from the room by a nurse. (TR II, p. 63) The nurse also took the notes that Brandon had been writing and did not

give them back to him. (TR II, p. 64) Brandon estimated that he was in the examination room for no more than 30 seconds and that Petitioner subsequently returned to Brandon in the waiting room approximately 2-3 minutes later. (TR II, p. 65) on cross-examination, Brandon testified that he performs odd jobs for Attorney Warren Danz and that it was through that office that Brandon met Petitioner. (TR II, p. 66) Brandon had been asked by Petitioner or Petitioner's counsel to not only drive Petitioner to the IME but to "make sure everything went smooth." (TR II, pp. 67, 70) For this, Brandon was paid $30-$40 by Attorney Mike Sue. (TR II, p. 68) Brandon also testified that he had a full page of notes on the paper that was taken from him by Dr. Van Fleet's nurse. (TR II, p. 68)

Respondent's witness, Dee Stawicki, testified as follows:

Ms. Stawicki is an HR Manager for Respondent for the Peoria store, a position she has held for 12 years. (TR II, pp. 71-72) Prior to this, she had been employed as an Assistant Store Manager for a total of four years and as an Operations Manager for a couple of years. (TR II, p. 72) as HR Manager, Ms. Stawicki is responsible for interviewing, hiring, disciplining, managing, overseeing benefits, including Worker's Compensation, and managing the payroll and training of Respondent's employees. (TR II, p. 73) When asked whether Respondent has a policy regarding accommodations for employees on restricted work duties, Ms. Stawicki identified Respondent's Ex. six as Respondent' workers compensation policy, which in a nutshell states that Respondent will do everything and anything in its power to accommodate an injured employee who has restrictions. (TR II, p. 74) She testified that while the employee may not always be accommodated in the department where the employee is normally assigned, the Respondent always has a position to go with any guidelines of the issued restrictions. (TR II, p. 74) All Department managers and supervisors are instructed to follow these policies and that employees are instructed to let a manager know if they are being asked to do anything beyond the issued restrictions, I receive including reporting any violations to Ms. Stawicki. (TR II, pp.74-75)

In her twelve years as HR Manager, she has rarely had to handle any issues with an employee being asked to perform work beyond his or her restrictions. (TR II, p. 76) Department Managers and Supervisors are instructed on these policies to assure proper accommodations are provided, and this included Petitioner, who at the time of his accident was a Department Manager. (TR II, pp. 76-77)

Ms. Stawicki recalled Petitioner tendering his resignation effective March 24, 2004, and the stated reason for his voluntary resignation was "health reasons." (TR II, p. 77) At no time prior to this was Ms. Stawicki ever approached by Petitioner, Kevin Gardener or Randy Kobes regarding Respondent's failure to accommodate restricted duties. (TR II, p. 77-78) But for Petitioner's voluntary resignation from employment, Respondent could have continued to accommodate Mr. Ferguson's restricted duties, and Respondent, in fact, continues to accommodate employees through the present under restricted duties. (TR II, p. 78) When asked

on cross-examination as to the type of employee Petitioner was, Ms. Stawicki graded Petitioner as a C+ employee. (TR II, p. 80) On re-direct, Ms. Stawicki testified that Petitioner, as a Department Manager, would have had store employees that would be required to report to him and over whom Petitioner had authority to instruct those employees to perform certain work-related tasks, including climbing ladders to perform inventory. (TR II, pp. 84-85)

Mr. Ferguson was called in rebuttal to Ms. Stawicki's testimony. (TR II, pp. 85-88) Petitioner testified he did not know he was to report violations of work restrictions to Ms. Stawicki and that he never talked to Ms. Stawicki at all. (TR II, p. 87) Petitioner also testified that he could not direct other employees to perform inventory to which he was assigned. (TR II, p. 87) Petitioner concluded that he continued working for Respondent even while his restrictions were being violated because he "loved working there." (TR II, p. 88)

After further review of all of the testimony of Petitioner introduced at the April 9, 2012 hearing, with the exception of Petitioner's rebuttal testimony following Ms. Stawicki's testimony, all of Petitioner's testimony was essentially a second direct examination of those matters to which Petitioner testified at the April 21, 2010 hearing. The Arbitrator, at the start of the hearing on April 9, 2012, advised Petitioner that his testimony was to be limited to an update of his condition since he initially testified in April 2010, but Petitioner added testimony to his prior testimony on direct. This is impermissible, and for that reason, the Arbitrator sustains Respondent's objection and strikes the direct examination and corresponding cross examination testimony of Petitioner on April 9, 2012.

The final hearing was then continued for close of proofs on May 14, 2013 for Respondent to call a witness as to Petitioner's testimony from April 2010 regarding instruction he received from the Store Manager and the Assistant Store Manager to perform work beyond his restrictions. Respondent called Randy Kobes to testify. Randy Kobes testified that he was familiar with Petitioner as he was his direct supervisor and the Assistant Store Manager at the location where Petitioner was employed prior to March 24, 2004. Randy Kobes testified consistently with the testimony of Ms. Stawicki that Respondent makes every effort to provide accommodations for store employees placed on restricted duty following a work accident. Mr. Kobes denies that Petitioner's restrictions were not accommodated prior to his voluntary termination of employment on March 24, 2004 and denies that Petitioner was ever threatened to work beyond his restrictions. Mr. Kobes confirmed that had Petitioner been threatened, it would have been Mr. Kobes' obligation to report this to upper management and that he consequences would have been severe. He confirmed that when Petitioner resigned it was for health reasons, but never explained to him beyond that.

<u>The medical records of treatment subsequent to June 2008, provide the following history:</u>

On the morning of August 18, 2008, the petitioner contacted Dr. Chien's office and spoke with Dr. Chien's assistant stating that he wanted to talk to Dr. Chien about the insurance company

stopping his disability payments. (PX. 7) The petitioner stated that he needed a way to make income and stated that, "They are trying to make him settle." Dr. Chien responded to this by stating that he contacted Petitioner by phone stating he had "no idea what to do about this," but stated that he needed to see the petitioner because it had been too long since he had last seen him. It appears that an appointment was then scheduled for August 20, 2008. (PX. 7)

Later on August 18, 2008, the petitioner stopped by Dr. Chien's office and spoke with one of his nurses for assistance. (PX. 7) The petitioner requested a letter from Dr. Chien stating that the petitioner's "injury (the tear)" was not from degenerative disc disease, but was from his work injury. The petitioner wanted Dr. Chien to read the paperwork that he brought to the office, and he needed a note stating that he cannot work so that maybe his disability payments would be reinstated. The petitioner also asked that Dr. Chien speak with Dr. Atwater to see if he would also write a letter. Finally, the petitioner indicated that he was changing his Fentanyl patches every three days as he was noticing symptoms similar to withdrawal by the third day. (PX. 7)

On August 20, 2008, Dr. Chien re-examined the petitioner for the first time in 17 months. Dr. Chien actually labeled this as a "mandatory re-evaluation owing to his requirement for prescriptions." (PX. 7) The petitioner reported that he was not doing well. Dr. Chien noted that the petitioner had a halting gait. The petitioner also complained of sweats and chills on the third day using a Fentanyl patch and stated that he had to sleep in an upright position on pillows as he has no other comfortable position and is unable to walk more than 200 feet without resting. The doctor recommended 60-hour Fentanyl patches and stated that if the petitioner was unable to obtain these then the petitioner would have to be placed on Methadone. (PX. 7)

On September 2, 2008, the petitioner contacted Dr. Chien's office stating that the 60-hour patches were "working great." (PX. 7) He said that he "feels a whole lot' better'." The doctor then continued to renew those Fentanyl patches through the rest of 2008 and into 2009. (PX. 7)

On October 13, 2008, the petitioner contacted Dr. Chien's office to see if he could go bow hunting. The petitioner indicated that he would be seated in a blind and that he would not be carrying any of the kills. Dr. Chien responded by leaving the petitioner a voice message stating that he did not think this was a good idea. (PX. 7)

On March 13, 2009, the petitioner underwent an anterior lumbar interbody fusion of the L4-L5 though L5-S1 with hardware placement. The post-operative diagnosis by Dr. Dinh was listhesis at L4-L5 and spondylosis at L5-S1. (PX. 5)

The petitioner returned to Dr. Chien on March 27, 2009, approximately three weeks following his anterior lumbar fusion. (PX. 7) Dr. Chien noted that the wound was healed well and that the petitioner was back on Fentanyl patches. Dr. Chien reduced the dosage of Fentanyl that the petitioner was receiving and stated the petitioner would have "eight of the worst days of his life" following that reduction. Otherwise, he indicated the petitioner was doing well and

recommended that the petitioner limit his daily walking to one mile per day, not the three miles per day the petitioner was attempting. (PX. 7)

On April 30, 2009, the petitioner contacted Dr. Chien's office stating that he was having really bad pain in his back and neck and was hardly able to get out of bed. Dr. Chien left a voice message stating that the petitioner may have a disc problem in his neck and issued another script for Fentanyl. (PX. 7)

The petitioner contacted Dr. Chien's office again on May 14, 2009 stating that he was still having really bad pain and now problems in his right hip area. Dr. Chien spoke with the petitioner to determine what type of hip pain, lateral or posterior, and the petitioner stated that it only occurred with weight bearing. He suggested that the petitioner schedule an appointment for an updated evaluation. (PX. 7)

On May 19, 2009, the petitioner returned to Dr. Chien about nine weeks post-operatively. The petitioner now complained of a "new onset of pain right paraspinally and down the right buttock to the posterior calf." It was noted the petitioner had been off the narcotics completely for 28 days, but then was restarted on the Fentanyl without much relief. On examination, the petitioner continued to wear his brace. Dr. Chien noted that the petitioner's SI joints were completely benign, both posteriorly and anteriorly. The petitioner complained that he was unable to lie flat without his right hip flexed. The petitioner had a positive straight leg raise test on the right at 60 degrees. Dr. Chien recommended that they begin an *evaluation for possible loosened hardware from the lumbar fusion* and prescribed a bone scan and CT scan. He also increased the dosage of Fentanyl to the level that the petitioner was at prior to the lumbar fusion. (PX. 7)

On May 19, 2009, the petitioner's attorney sent a letter to Dr. Chien stating that the respondent had denied liability for the petitioner's claim on the basis that the November 27, 2002 work accident was not causally related to the petitioner's current condition, specifically referencing the recent double fusion that the petitioner had had on March 13, 2009. (PX. 7) The petitioner's attorney then attached a statement that he apparently prepared asking that if the doctor agreed with that statement to please sign and fax it back to his office in time for the May 22, 2009 trial. The petitioner's attorney provided Dr. Chien with a copy of the March 13, 2009 operative report for his reference. The statement that was attached to the May 19, 2009 letter from Mr. Sue to Dr. Chien states that based upon a reasonable degree of medical certainty that the petitioner's condition of ill-being is causally related to his November 27, 2002 work accident, that the work accident was, "definitely a causal factor" and that the work injury was also a causal factor to the March 13, 2009 "double fusion." He also asked the doctor to agree that the petitioner had an "inner and outer annular tear at L4-L5 and L5-S1 that was exacerbated from the 11/27/02 accident." Furthermore, he asked that the doctor agree that there was a kinked nerve prior to the March 13, 2009 surgery that was also exacerbated by the November 27, 2002 accident. (PX. 7)

On May 20, 2009, Dr. Chien issued a letter to the petitioner's attorney stating that within a reasonable degree of medical certainty, the petitioner's condition was at least contributed to by the lifting of a bookcase on November 27, 2002, and that but for that accident the surgery would not have occurred. Dr. Chien went on to state that the known annular tears at L4-L5 and at L5-S1, "cannot have benefited from the incident." He concluded by stating that all of the petitioner's subsequent back pain can be said without much doubt to have been exacerbated by the November 27, 2002 lifting/twisting event. (PX. 7)

The petitioner underwent a bone scan at Methodist Medical Center on May 27, 2009 at the request of Dr. Chien. According to the report, this revealed no significant abnormal uptake in the cervical spine, but increased uptake bilaterally at the facet joints between L4-L5 and in the inferior endplate of L5 and superior endplate of S1. The radiologist indicated that those findings were consistent with the petitioner's prior lumbar fusion. The CT scan performed the same day at Methodist Medical Center showed anticipated post-surgical changes present from L4-L5 through L5-S1. *There was some spondylolisthesis at L4, which the radiologist indicated was new compared to the February 2007 study. The radiologist also indicated that there was partial compression of the L5 vertebral body, which was also new when compared to the study in 2007.* The petitioner also had central spinal stenosis at L4-L5. (PX. 7)

On May 27, 2009, Dr. Chien issued a note to Methodist Radiology stating that the petitioner had been under his care for approximately five years and had recently (six months earlier) undergone lumbar surgery. He then indicated that the petitioner *suffered a recent L5 compression fracture*, and needs evaluation for kypho/vertebroplasty. It appears that Dr. Chien's office did fax the results of the bone scan and the CT scan to a vertebroplastic clinic and the petitioner was scheduled for an initial evaluation there on June 3, 2009. (PX. 7)

On June 3, 2009, Dr. Michael Zagardo at the Interventional Vascular Clinic, along with Ms. Jessica Mitchel, A.P.N., examined the petitioner at the request of Dr. Chien. The petitioner provided a history of severe back pain with right radicular symptoms radiating to the right posterior thigh and calf. It was also noted that the petitioner was seven weeks post surgery to his lumbar spine and noticed an acute onset of pain approximately two weeks earlier when he was attempting to discontinue his narcotic therapy. It is noted that petitioner had undergone a recent CT scan of his lumbar spine to evaluate the status of the petitioner's surgical hardware and that this revealed some *findings that were new when compared to the February 2007 studies*. He was being evaluated in this clinic for possible vertebroplasty or kyphoplasty. Following the clinical evaluation of the petitioner, he was diagnosed with severe low back pain following a two-level lumbar fusion with associated right buttock and posterior thigh and calf pain. They did not find any signs of an active infection or an acute vertebral compression fracture. They believed that the findings on the recent CT scan are related to his previous surgical changes and suggested that the petitioner return to Dr. Dinh's office for further evaluation. It was recommended that he continue with his current pain management and use of the brace, as well as the limitations on his

activities. They did not believe the petitioner was a candidate for vertebroplasty or kyphoplasty as an effort to reduce the petitioner's pain levels. (PX. 7)

On June 8, 2009, the petitioner contacted Dr. Chien's office stating that he went to the vertebroplastic clinic as scheduled, but that he was sent away after being told that he did not have a compression fracture. (PX. 7) The petitioner indicated that he had been referred back to Dr. Dinh and that the nurse at Dr. Dinh's office stated that he might be having "reactive changes." The petitioner requested to talk to Dr. Chien regarding this. Dr. Chien apparently called the petitioner back stating that the petitioner needed a right S1 joint injection and needed to schedule an appointment in his office for this. (PX. 7)

On June 12, 2009, Dr. Dinh issued a letter to Dr. Chien following a phone call that he had received from Dr. Chien regarding the petitioner. Apparently, Dr. Chien had contacted Dr. Dinh's office to see why Dr. Dinh had referred the petitioner to Dr. Amod Surek at the Illinois Neurological Institute (where Dr. Dinh is affiliated) for evaluation. Dr. Dinh indicated that he had referred the petitioner back to Dr. Chien following a post-operative visit for an SI (sacroiliac) injection, but instead of performing an injection, Dr. Chien referred the petitioner to interventional radiology for a vertebroplasty. Dr. Dinh indicated that the petitioner did not have a compression fracture and was thus not a candidate for procedure, at which time he was then contacted regarding further treatment options. Dr. Dinh then indicated that he then referred the petitioner to Dr. Surek because Dr. Chien did not perform the SI injection that Dr. Dinh had previously requested. Dr. Dinh indicated that he only intention of referring the petitioner to Dr. Surek was to ensure that the petitioner received the SI injection that Dr. Dinh had previously recommended and hopefully would relieve the petitioner's pain. Dr. Dinh indicated that it was now his understanding that the petitioner had now scheduled that procedure to take place in Dr. Chien's office, and Dr. Dinh hoped that this would occur as scheduled and that they would continue to have a working relation. (PX. 5)

On June 25, 2009, Dr. Chien scheduled the petitioner for bilateral S1 and S2 hot radiofrequency medial branch blocks for what he diagnosed as sacroiliitis. The procedure was scheduled to take place on July 6, 2009. It appears, however, this actually took place on June 23, 2009 according to the report in the file. In the report, Dr. Chien indicated that the petitioner had complaints of right lower extremity pain from the buttock to the calf that, "incredibly on Thursday the 18th, switched" to the left side. Following the injections, Dr. Chien indicated that it was his impression that the petitioner had active left sacroiliitis that appeared to be identical to the discomfort the petitioner had on the right side for the past five weeks, thus making the petitioner have bilateral sacroiliitis. (PX. 7)

On July 6, 2009, the petitioner's attorney contacted Dr. Chien's office asking to speak with Dr. Chien, "before you speak w/secretary," Dr. Chien then noted that he will be deposed on the question of "was Larry disabled prior to surgery." (PX. 7)

On September 14, 2009, Dr. Chien issued a note transferring the petitioner's care to Leadville, Colorado, where the petitioner had moved. (PX. 7)

The various medical experts testified as follows:

Dr. Dzung Dinh (3/11/09)

On March 11, 2009, two days prior to Petitioner's two-level lumbar fusion, Dr. Dzung Dinh, the petitioner's treating neurosurgeon, testified for a second time in relation to this case. (Dr. Dinh's deposition was taken previously in relation to this matter on April 28, 2006. The transcript from that deposition was introduced into evidence during the first 19(b) Trial of this case and is included in the exhibits presented in the present trial of this case. (PX. 1))

At the start of the deposition, Respondent's counsel set out objections regarding this deposition and certain testimony anticipated that the petitioner's attorney would solicit during the course of this deposition. These objections consisted of soliciting any testimony from the doctor regarding treatment that he rendered to the petitioner prior to the April 28, 2006 evidence deposition, as well as any opinions on the issue of medical causation. The objection raised by Respondent's counsel is consistent with the argument set out in Respondent's Motion to Bar Testimony and Evidence referenced below and ruled upon below in this Arbitration Decision. Notwithstanding that ruling, the Arbitrator outlines the testimony of Dr. Dinh from his March 11, 2009 deposition relevant to the Arbitration Decision.

During the deposition, Petitioner's attorney did attempt to solicit a positive medical causation opinion from Dr. Dinh with respect to Petitioner's current condition of ill-being to the work accident. Dr. Dinh testified that the described work accident "precipitated the petitioner's symptoms," but never testified that the accident aggravated the pre-existing degenerative disk disease. Dr. Dinh also stated that an x-ray examination of the lumbar spine on January 26, 2009 showed degenerative changes from L4-S1, but also listhesis at L4-L5 not seen on previous x-rays. It was confirmed during Dr. Dinh's cross-examination that the work accident precipitated the symptoms, but at no time during that deposition did Dr. Dinh testify that the petitioner's pre-existing degenerative disc in his lumbar spine was in any way aggravated by or accelerated by the petitioner's work accident. Additionally, Dr. Dinh did not testify at any time concerning what he believed to be petitioner's current functional status, but simply stated that the petitioner had been authorized off work by Dr. Chien pending surgery.

Dr. Bruce Chien (9/24/09)

On September 24, 2009, Dr. Bruce Chien testified for the third time in this case. (He testified two times prior to the previous June 27, 2008 trial, and his testimony is included as part of the transcript of proceedings from the prior hearing introduced into evidence. (PX. 1)) Similarly as in the start of the deposition of Dr. Dinh, Respondent's counsel outlined, at the start of the deposition, a preliminary objection to certain testimony that would be solicited from Dr. Chien

by Petitioner's counsel, and the Arbitrator rules upon that objection below relative to Respondent's Motion to Bar Testimony and Evidence.

Notwithstanding the Arbitrator's ruling on Respondent's Motion to Bar Testimony and Evidence, the Arbitrator notes the following testimony of Dr. Chien relevant to the Arbitration Decision in this case. Dr. Chien testified as he did in 2005 that he believed that the petitioner's current condition of ill-being is medically causally related to the November 27, 2002 accident. On cross-examination, when asked whether or not there had been any significant change in the petitioner's condition of ill-being between that accident date and the present, the doctor initially stated that there were none. When specifically asked about the lumbar fusion in March 2009, the doctor did concede that this obviously made some changes in the petitioner's lumbar spine, but Dr. Chien maintained that the petitioner's overall condition with respect to his low back had not really changed.

However, Dr. Chien admitted that the petitioner complained in July 2009 that his sacroiliac joints were bothering him, and this was diagnosed by Dr. Chien as bilateral sacroiliitis. Dr. Chien testified that this was medically causally related to the accident of November 27, 2002. Dr. Chien testified that the petitioner would have developed the bilateral sacroiliitis regardless of whether he underwent the lumbar fusion.

On the issue of temporary disability, Dr. Chien testified that the petitioner was totally disabled up through the date of the lumbar fusion secondary to his chronic pain complaints and the heavy narcotics that the petitioner was taking to treat those complaints. He testified that the petitioner remained totally disabled from the date of the surgery, March 13, 2009, through the date that Dr. Chien last saw the petitioner, July 18, 2009. Dr. Chien indicated that he actually saw the petitioner on July 23, 2009 "through the window" at his office, but did not perform a physical examination of the petitioner at that time. He testified he was unable to state whether or not the petitioner remained totally disabled on July 23, 2009 because he did not perform an examination of the petitioner. Dr. Chien confirmed on cross-examination that he would only be speculating to say that the petitioner was still totally disabled at the present time since he had not examined the petitioner since July 18, 2009. Dr. Chien indicated that the petitioner told Dr. Chien's office on July 23, 2009 that he was doing very well following his lumbar fusion and following the SI joint injections (described by Dr. Chien as a "sacroiliac blockade") on July 18, 2009.

The doctor went on to testify that on September 14, 2009, Dr. Chien issued a note transferring the petitioner's care to Leadville, Colorado, where Petitioner was moving. At the time of his testimony, on September 24, 2009, Dr. Chien was unaware of the physician now assuming the petitioner's care in Colorado, but stated he was surprised that any physician would want to take over the petitioner's care given its long and convoluted history. Dr. Chien also indicated that had the petitioner not moved, Dr. Chien's next objective would have been to wean the petitioner off of the Fentanyl patches, after which he hoped the petitioner would be able to return to some form of gainful employment. Dr. Chien stated, however, that if the petitioner remained on the

Fentanyl patches, he did not believe the petitioner was capable of any gainful employment given the side effects of that heavy narcotic.

Dr. Tim Van Fleet (12/9/09)

Dr. Van Fleet previously testified in relation to this case in 2007, and the transcript of his testimony is contained within the transcript of proceedings from the June 2008 proceedings, which are admitted into evidence. (PX. 1) Dr. Van Fleet testified for the second time in this case on December 9, 2009.

Respondent's counsel, consistent with the objections raised at the start of the depositions of Drs. Dinh and Chien, limited the direct examination of Dr. Van Fleet to events subsequent to the prior trial of the case, including his evaluation of Mr. Ferguson on July 28, 2009 and his opinions regarding the petitioner's condition of ill-being with respect to his lumbar spine and cervical spine at that time. Dr. Van Fleet did testify regarding medical causal connection with respect to the cervical spine (a condition not addressed in the prior 19b Trial), but did not ask him to address medical causal connection between the alleged accident and the petitioner's condition of ill-being with respect to his lumbar spine at the time of the examination of July 28, 2009. Dr. Van Fleet did testify, however, that he believed that the petitioner was status post-lumbar fusion when he examined the petitioner on July 28, 2009 and that he did not believe that the lumbar fusion was related to the work accident.

Dr. Van Fleet testified that there is no medical causal connection between Petitioner's cervical spine complaints and the November 27, 2002 work accident. Dr. Van Fleet stated that based upon the medical history that he had at the time of the examination, there was nothing to suggest any of petitioner's complaints involving his cervical spine in 2009 were in anyway related to the work accident on November 27, 2002.

As to functional status, Dr. Van Fleet believed that petitioner was still under care from his lumbar fusion at the time he examined him on July 28, 2009, so he really did not have an opinion whether the petitioner could return to work at that time in any capacity as he was recovering from his lumbar fusion and had ongoing pain complaints related to same. He had stated that he would anticipate the petitioner will be able to return work in a light duty capacity at some point in time four to six months following the surgery and then hopefully transition to full-duty sometime in the future.

Finally, the doctor did not have any opinion with regard to the petitioner's permanent partial disability, if any, with respect to his lumbar spine and the petitioner's cervical spine at the time he examined him on July 28, 2009 because the petitioner had not yet reach maximum medical improvement with respect to both conditions. Again, Dr. Van Fleet confirmed that the treatment recommendations he had for the petitioner with respect to his cervical spine were unrelated to the work accident in November 2002.

Dr. Myron Stachniw (7/12/10)

Dr. Stachniw examined the petitioner at the request of the respondent on February 9, 2004, approximately a year and a half after the accident at work. In reviewing the proceedings from the June 2008 19(b) Trial, the Arbitrator notes that Dr. Stachniw's report was not introduced into evidence by any party at that time. Respondent objected to the introduction of any opinion testimony from Dr. Stachniw on the issue of medical causal connection on the basis that those opinions of Dr. Stachniw were made prior to previous 19(b) Trial and thus should have been introduced at the time of that hearing. Respondent also argued that this issue was previously addressed in that prior 19(b) Trial consistent with Respondent's Motion to Bar Testimony and Evidence.

Notwithstanding the Arbitrator's ruling on that Motion, the Arbitrator notes that Dr. Stachniw found that the petitioner did have an injury to his left knee and an injury to his low back, both of which were aggravations to pre-existing degenerative changes in those areas. Dr. Stachniw stated that the accident was the "straw that broke the camel's back" finding that there was a medical causal connection between the work accident and the petitioner's conditions of ill-being with respect to his left knee and his lumbar spine at the time of the February 9, 2004 IME. He did not make any recommendations at that time regarding treatment for the petitioner's lumbar spine and simply testified in his deposition that he would have referred the petitioner to an orthopedic spine surgeon for evaluation and treatment recommendations. With respect to the left knee, he believed that the petitioner was a candidate for another cortisone injection into that left knee and that if that did not provide significant relief, the petitioner would be a candidate for arthroscopic surgery on the left knee. (The petitioner did, in fact, have that arthroscopic surgery on his left knee by Dr. Below to repair a torn medial meniscus.) Dr. Stachniw saw the petitioner on only that one occasion in 2004 and was unable to render any opinions regarding the petitioner's condition of ill-being subsequent to his examination of the petitioner in 2004.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

With respect to **Respondent's Motion to Bar Testimony and Evidence** presented at the start of the final hearing in this matter on April 21, 2010, the Arbitrator finds and rules as follows:

In its Motion, Respondent contends that the issue of medical causation between the petitioner's work accident on November 27, 2002 and his condition of ill-being were addressed and ruled upon following the June 17, 2008 19(b) Trial of this case and that for this reason, the issue cannot be re-litigated in this final hearing.

As indicated previously, the Arbitrator takes judicial notice of the prior Arbitration 19(b) Decision, including the findings of fact and conclusions of law from those proceedings. In doing so, the Arbitrator reviewed the transcript of proceedings, including the Request for Hearing form submitted in the June 17, 2008 proceedings (PX. 1, Arb. Ex. 1). The Request for Hearing form confirms that medical causal connection was an issue addressed as part of that hearing. The Arbitrator also reviewed the Arbitration 19(b) Decision of Arbitrator Neva Neal dated July 7,

2008, and the Arbitrator notes that Arbitrator Neal did, in fact, address this issue and Arbitrator Neal stated in her Decision:

> Based upon the evidence presented, the Arbitrator finds that the petitioner has failed to prove that there is a medical causal connection between the currently recommended two-level lumbar fusion he is requesting and the work accident of November 27, 2002. (PX. 2, p.6)

Prior to this, in her Decision, Arbitrator Neal finds, "There is no medical evidence to indicate that the [lumbar spine] condition is related to the work accident of November 27, 2002, and Dr. Van Fleet credibly testified that the petitioner's current condition is degenerative in nature and the result of years of degeneration in the petitioner's lumbar spine." (PX. 2, p. 5) From this, Arbitrator Mathis in this present proceeding concludes that the issue of medical causal connection between the petitioner's condition of ill-being with respect to Petitioner's lumbar spine and the accident of November 27, 2002 was addressed by Arbitrator Neal in the prior trial of this case. The Decision of Arbitrator Neal was affirmed on Review and on appeal to the circuit court. Based upon these findings, Respondent argues that medical causal connection between the petitioner's lumbar spine condition and the November 27, 2002 work accident was an issue that was addressed and ruled upon at the time of the June 17, 2008 19(b) Trial and that Petitioner is barred from re-litigating this issue in the final hearing under the doctrine of collateral estoppel. The Arbitrator agrees that Petitioner is not allowed to relitigate the issue of medical causation in this present proceedings, but not for the reason set forth in Respondent's Motion.

The Arbitrator's review of relevant case law confirms that the doctrines of res judicata or collateral estoppel are invoked by final judgments in separate, prior actions. Under circumstances such as exists in Illinois Workers' Compensation cases where issues are addressed in prior proceedings in the same case, the bar that Respondent requests stems from the "law of the case" doctrine. Irizarry v. Industrial Com'n, 337 Ill.App.3d 598, 606, 786 N.E.2d 218, 224, 271 Ill.Dec. 960, 966 (Ill.App. 2 Dist. 2003). That doctrine has been explained as follows:

> The rule of the law of the case is a rule of practice, based on sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit." Id. (citing *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill.App.3d 1083, 1086–87, 81 Ill.Dec. 314, 466 N.E.2d 1116 (1984)).

The Illinois Workers' Compensation Commission has ruled in similar cases when the issue of causal connection was previously determined by an Arbitrator in an earlier 19(b) Decision, the parties are barred from raising the issue of causation again. Richard Messerly, v. Thomas Industrial Coating, 2009 WL 2520945. Issues determined in a prior § 19(b) decision that are final and cannot be raised again. Griffith v. Rollex Corp., 2005 WL 2450262, 8 (citing *Hood v. Stanadyne*, 97 IIC 71). An arbitrator's final decision finding on the issue of causation is binding on a subsequent arbitrator who is assigned to hear the case. Id. (citing *Treece v. Lyons Township H.S.*, 90 IIC 51). (See also Raymond Santiago v. American Airlines, 2000 WL 33534274, 2)

Based upon legal authority and the "law of the case," the Arbitrator finds that the Arbitrator is prohibited from addressing medical causal connection between the petitioner's lumbar spine condition and the work accident of November 27, 2002 and for that reason the Arbitrator disregards any evidence or testimony presented addressing that issue at trial.

With regard to the Arbitration Decision pertaining to: **Whether there is a medical causal connection between the petitioner's current condition of ill-being and the work accident on November 27, 2002**, the Arbitrator finds as follows:

The petitioner sustained injury to his left knee in the November 27, 2012 work accident, and the medical evidence presented at trial in June 2008 as well as at this final hearing supports a medical causal connection between that injury and the treatment the petitioner received for that injury to the work accident.

The petitioner claims in this final hearing that he sustained an injury to his cervical spine in the November 27, 2002 work accident. Following a review of the prior Arbitration Decision, the Arbitrator finds no evidence presented or findings related to any injury to the cervical spine. In reviewing the medical records submitted into evidence in this final hearing, the Arbitrator finds no testimony or medical evidence to support Petitioner's claim that he injured his cervical spine in the November 27, 2002 work accident. To the contrary, only Respondent's IME, Dr. Van Fleet, provided an opinion as to medical causal connection between the alleged condition of ill-being with respect to Petitioner's cervical spine and the work accident, and that opinion was that there is no medical causal connection between the two. In his testimony, Dr. Dinh was asked if he had treated Petitioner's neck, but did not recall providing any treatment and admitted he could not render an opinion regarding the neck. (PX. 6, pp. 23-24)

For those reasons stated above in my ruling on Respondent's Motion to Bar Testimony and Evidence, the Arbitrator finds that there is no medical causal connection between the petitioner's condition of ill-being with respect to his lumbar spine and the work accident of November 27, 2002. This issue was previously ruled upon by Arbitrator Neal in her July 7, 2008 Arbitration 19(b) Decision, which was affirmed by the Illinois Workers' Compensation Commission on February 2, 2009. That Decision and Opinion on Review was affirmed by the Circuit Court of Peoria County on April 19, 2010.

Notwithstanding that ruling, the Arbitrator finds that the medical evidence and testimonial evidence presented after the June 17, 2008 19(b) Trial fails to prove a medical causal connection between the petitioner's current condition of ill-being with respect to his lumbar spine and the work accident on November 27, 2002. Most relevant to this conclusion is the fact that the petitioner underwent a two-level lumbar fusion on March 13, 2009, and the Arbitrator finds that his is a supervening event that caused new injury to the petitioner and broke the causal link between the work accident of November 27, 2002 and the petitioner's condition of ill-being with respect to his lumbar spine after March 13, 2009.

An "intervening cause," or supervening cause, is an event that occurs after the initial accident and causes a new injury, creating a new accident. The superseding or intervening cause then relieves the Respondent from responsibility for the benefits related to the new injury since the original accident is no longer the proximate cause. Jaroslaw Piwowarski v. B&L Automotive Repairs. Inc., 2012 WL 5928229, 14 The evidence is clear that the petitioner had a two-level lumbar fusion on March 13, 2009, and according to the operative report, this changed the structure of the petitioner's lumbar spine from that which existed at the time of the June 17, 2008 trial. Additionally, a post-operative CT scan of the petitioner's lumbar spine on May 27, 2009 showed *new findings* when compared to a February 2007 study, including a partial compression fracture of the L5 vertebra along with central spinal stenosis at L4 – L5, both levels at which the petitioner had undergone surgery on March 13, 2009. Based upon this evidence, the Arbitrator finds that this two-level lumbar fusion constitutes a significant intervening event that broke any possible medical causal connection between the November 2002 work accident and the petitioner's current condition of ill-being with respect to his lumbar spine.

For the foregoing reasons, the Arbitrator finds that the petitioner's condition of ill-being with respect to his left knee is medically causally related to the work accident on November 27, 2002, but the Arbitrator finds that the petitioner's condition of ill-being with respect to the his lumbar spine is not related to the work accident on November 27, 2002.

With regard to the Arbitrator's Decision pertaining to: **Whether the medical expenses incurred by Petitioner are reasonable and necessary**, the Arbitrator finds:

It was previously determined following the 19(b) Trial on June 17, 2008, that the lumbar fusion recommended by Drs. Atwater and Dinh was not medically causally related to the work accident and that this treatment was not reasonable and necessary. As such, the Arbitrator finds that any and all medical expenses incurred by Petitioner in connection with that surgery are not reasonable and necessary for the treatment of any injury the petitioner sustained in the work accident of November 27, 2002.

The Arbitrator finds the medical expenses incurred by the petitioner for treatment of his left knee from November 27, 2002 through the date he was discharged at MMI by Dr. Below on or about July 2, 2004 were reasonable and necessary for treatment of that condition. This is supported by the treating medical records of Dr. Below as well as the testimony from his deposition on June 20, 2005. There is no evidence to the contrary.

The Arbitrator, after reviewing the medical testimony and the medical records, finds that the medical treatment Petitioner has received since his lumbar spine surgery on March 13, 2009 is all for post-operative complaints relative to that fusion surgery. Based upon the prior findings and the law of the case, that surgery was not related, reasonable or necessary treatment for a

condition resulting from the November 27, 2002 work accident. As such, logic would have it that the treatment stemming from that lumbar fusion is also not related, reasonable or necessary.

For these reasons, the Arbitrator concludes that medical expenses incurred by the petitioner for treatment of his left knee between November 27, 2002 and July 2, 2004 were reasonable and necessary. However, any and all medical expenses incurred by Petitioner for treatment of his lumbar spine subsequent to his June 17, 2008 19(b) trial is not related, reasonable or necessary.

With regard to the Arbitrator's Decision pertaining to: **For what periods was the petitioner temporarily totally disabled from injuries related to the work accident and whether the respondent is liable for TTD benefits for those periods,** the Arbitrator finds as follows:

In reviewing Petitioner's treating medical records from November 27, 2002 through June 17, 2008, solely for determining those periods for which Petitioner was temporarily totally disabled, the Arbitrator finds that Petitioner was temporarily totally disabled from May 19, 2004 (the date for which he underwent surgery to his left knee with Dr. Below) through June 2, 2004 (the date upon which Dr. Below released Petitioner to return to work with restrictions). Respondent paid Petitioner TTD benefits for this period at $445.87 per week.

With respect to Petitioner's claim for TTD benefits for March 26, 2004 through May 18, 2004 and again from June 3, 2004 through November 1, 2004, the Arbitrator finds no medical evidence in the record to support that claim. Petitioner did not return to Dr. Below for follow up after the June 2, 2004 examination, at which time Petitioner was released by Dr. Below to return to work with restrictions. Based upon this evidence, the Arbitrator finds that Petitioner was under restricted work duties for those periods he is claiming, and the Arbitrator also finds the testimony presented by Respondent's witnesses more credible than that of Petitioner on the Respondent's accommodation of light duty during those periods. The Arbitrator further finds that but for Petitioner's voluntary resignation of employment on March 26, 2004, Respondent would have continued accommodating Petitioner's restrictions, as it had in the years between the work accident and March 24, 2004. For these reasons, the Arbitrator finds that Petitioner is not entitled to receive TTD benefits for the periods claimed in 2004 and for any subsequent periods for which Petitioner was under light duty restrictions.

In his depositions, Dr. Chien testified that Petitioner was unable to work in any capacity while under the medications for his back pain complaints leading to the trial of the case in June 2008. The Arbitrator notes that Respondent presented Respondent's Exhibit 2, which shows that Petitioner was paid TTD benefits in the amount of $88,555.08 for the periods: May 19, 2004 – June 2, 2004 and November 2, 2004 - August 7, 2008. The parties stipulated at the previous hearing that Petitioner had been paid TTD benefits up do the date of that previous trial, although Petitioner reserved the issue for a subsequent hearing. Based upon the law of the case as set forth by the prior Decision, the Arbitrator finds that Petitioner is not entitled to any further TTD benefits subsequent to the June 17, 2008 trial, and that Respondent is thus entitled to a credit for the overpayment of TTD from June 18, 2008 through August 7, 2008, or $3,120.88.

Based upon the Arbitrator's finding that the petitioner's condition of ill-being subsequent to June 17, 2008 is not medically causally related to the work accident of November 27, 2002, the Arbitrator finds that regardless of any period for which the petitioner was or may have been temporarily totally disabled or on restricted duties subsequent to June 17, 2008, Respondent is not liable for any temporary disability benefits after June 17, 2008, and it is not necessary for the Arbitrator to determine the periods for which Petitioner was temporarily totally disabled.

Notwithstanding the findings of the Arbitrator as stated in the preceding paragraph, the Arbitrator finds that all periods subsequent to the petitioner's March 13, 2009 lumbar fusion surgery are unrelated to the November 27, 2002 work accident, but instead the direct and sole result of Petitioner's lumbar fusion. For that reason, the Arbitrator finds that any periods of temporary total disability or restricted functional capacity subsequent to the surgery are not medically causally related to the work accident, and Respondent is not liable for payment of TTD benefits during those periods.

The Arbitrator also finds that the medical evidence presented at trial shows the petitioner was temporarily totally disabled only during those periods from March 13, 2009 through July 18, 2009, after which Dr. Chien was unable to provide any opinion regarding Petitioner's functional status as he did not see Petitioner after that date. The medical records of Petitioner from Rocky Mountain Family Practice are, for the most parts, records authored by a physician's assistant and reference multiple diagnoses for which Petitioner is receiving treatment at that facility. (PX. 11) There is no clear opinion as to causation for any of those conditions to the work accident or what, if any, functional limitations Petitioner has as a result of the work accident contained within those records. For those reasons, the Arbitrator finds that Petitioner failed to prove any entitlement to TTD benefits subsequent to July 18, 2009.

The Arbitrator finds Petitioner has proven he was temporarily totally disabled from May 19, 2004 through June 2, 2004, November 2, 2004 through August 7, 2008 and March 13, 2009 through July 18, 2009, but not for any other periods. The Arbitrator finds, however, that Petitioner's temporary total disability for the period of March 13, 2009 through July 18, 2009 resulted from his recovery from his unrelated lumbar fusion surgery and thus finds Respondent is not liable for TTD benefits for this period.

Based upon these findings, the Arbitrator finds that Petitioner is not entitled to the payment of any additional TTD benefits over what has previously been paid to him by Respondent and finds that Respondent is entitled to a credit of $3,120.88 toward the award for PPD benefits for Respondent's overpayment of TTD benefits to Petitioner.

With respect to the Arbitration Decision pertaining to: **the nature and extent of the petitioner's permanent disability**, the Arbitrator finds as follows:

Petitioner claims that as a result of the work accident, he is permanently totally disabled, and for the reasons set forth in this Arbitration Decision, the Arbitrator finds Petitioner has failed to prove he is permanently totally disabled as a result of the November 27, 2002 work accident. There was no credible medical evidence presented by Petitioner at trial indicating that Petitioner is medically permanently totally disabled. The Arbitrator has reviewed all of the medical evidence as well as the testimony of the witnesses and also concludes that there is insufficient evidence to establish that Petitioner is permanently totally disabled under an odd lot theory as well.

If the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. Once the employee has established that he falls in what has been termed the "odd-lot" category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. Valley Mould & Iron Co. v. Industrial Commission of Illinois, 84 Ill.2d 538, 546-547, 419 N.E.2d 1159, 116, 50 Ill.Dec. 710, 714 (Ill., 1981). In the present case, Petitioner does not meet any of the qualifications to establish permanent total disability under an "odd lot" theory.

By his own testimony, Petitioner has permanent restrictions of no lifting greater than 25 pounds and no climbing ladders. This, however, is not supported by medical evidence, but only the testimony of Petitioner. There is no evidence that Petitioner is not employable within those restrictions and with his work experience and training. Petitioner testified as to his skill set with his past experience building homes from the ground up while in business for himself. He testified that running his own business meant he did everything from managing employees, documenting payroll, performing estimates for construction jobs, supervising the work on those construction sites and performing the actual labor. Petitioner also testified he worked for Respondent managing three different departments, and he testified as to a previous law enforcement background. The Arbitrator finds it hard to believe that Petitioner, with the restrictions he has and the vast experience and knowledge he has, cannot find employment. Additionally, the Arbitrator finds the testimony of Respondent's witnesses credible that had Petitioner not resigned his employment with Respondent, his restrictions would still be accommodated by Respondent. Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove he is permanently totally disabled as a result of the accident on November 27, 2002.

Petitioner sustained a torn medial meniscus in his left knee for which he underwent arthroscopic surgery with Dr. Below on May 19, 2004. Petitioner failed to return to Dr. Below for any follow up care after June 2, 2004, and Dr. Below testified that he had no opinion as to any permanent restrictions for Petitioner because of this. Based upon the evidence presented, the Arbitrator finds Petitioner sustained a 20% loss of use of his left leg as a result of the work accident.

With respect to Petitioner's injury to his lumbar spine, the Arbitrator finds that Petitioner suffered a lumbar strain as a result of the work accident and a temporary aggravation of underlying lumbar degenerative disk disease, but that the subsequent condition for which he underwent a fusion in 2009 was not medically causally related to the work accident. As a result, the Arbitrator finds that Petitioner has only proven that he sustained a 5% loss of use of his whole person pursuant to Section 8(d)(2) of the Act as a result of the work accident, but that his subsequent condition following the lumbar fusion is unrelated to that work accident and that permanency at this time cannot be apportioned or related in any way to the work accident due to the supervening change in the condition of Petitioner's lumbar spine that resulted from that lumbar fusion.

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

Nicholas Melin,

Petitioner,

vs.

NO: 12 WC 34439

15IWCC0311

Firestone,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 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.

15IWCC0311

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,900.00. 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: MAY 1 - 2015
TJT:yl
o 4/7/15
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

Respectfully, I disagree and dissent from the decision of the majority. The Arbitrator found Petitioner proved there was a causal connection between Petitioner's work accident and the traumatic contusion to his right foot. The Arbitrator found Petitioner's other conditions, including problems with the bottom of his right foot and subsequent chest pain were not related to the 7-21-2012 accident.

The reasons for my dissent are as follows:

Petitioner, Nicholas began working for Firestone in March of 2012. He was 18 years old, attending automotive school and living on his own for the first time. He worked as a technician, working 30 hours a week, six days a week. He performed his duties standing on concrete while wearing steel toed boots, per company policy. He testified that the boots weighed a few pounds each and were stiff, heavy, hot and tight.

On July 21, 2012, he was performing an oil change, and while working overhead dropped a dog bone wrench weighing about (two) 2 pounds on his right foot. The wrench fell from a height of about seven (7) feet. The point of impact was just beneath the steel toe. He immediately felt pain. Notice was provided the following day to his supervisor. Since he was attending automotive school, he was required to wear those same heavy boots while attending classes in addition to the time he was at work.

Petitioner testified that he examined his injured foot every day beginning July 21, 2012. He never noticed nor saw punctures or broken skin. He did, however, note increased pain, swelling, redness and heat on his right foot.

He went to Business Health through Central DuPage Hospital on July 24, 2012. When it was clear that the condition of his foot was getting worse not better, he sought medical attention. He was examined, diagnosed with a "right foot contusion" and was returned to work light duty. The records do not reflect any finding of a puncture or broken skin. Shortly thereafter, Petitioner

returned home to his mother as his symptoms increased. He noticed a black growth that had started to come out on the bottom of his foot. His mother arranged for an evaluation by an orthopedic surgeon who had previously treated him for an unrelated injury. It was noted "on examination of the right foot there is significant swelling. He is most tender over the plantar aspect of the foot at the 2nd and 3rd metatarsals." Again, the medical records showed no findings of a puncture or broken skin.

The next day he and his mother noticed the object that had been black and a pencil eraser sized growth the day before, had turned green in a matter of six (6) hours grown into the size of a quarter. As a precaution he went to Urgent Care on July 28, 2012. The history showed he had a right foot injury when he was hit on the top of the foot. On exam, the doctor found right foot swelling at the ball part and sole, no bruise. In the middle of the right foot ball, there was swelling with fluids. Again, the medical records show no findings of a puncture or broken skin.

On July 30, 2012 he was treated by Orthopedic Associates of DuPage and diagnosed with an abscess on the plantar aspect of his right foot. The records further confirm that Petitioner did not recall any injury other than the "original work incident." The x-ray indication states: "dropped heavy object on the dorsum of the foot a few weeks ago. Open wound to the plantar aspect of the foot."

Petitioner was hospitalized through August 3, 2012. He never returned to Orthopedic Associates of DuPage as no further treatment was authorized. He did, however, return to Occupational Health on August 6, 2012. At that time, he was having difficulty breathing. Occupational Health indicated he should be seen by a Pulmonologist.

Shortly thereafter, Petitioner and his mother returned to Minnesota. There he saw his Pulmonologist at Children's Respiratory and Critical Care.

He was then treated at a wound clinic in Minnesota. The wound clinic notes dated August 15, 2012 state, "date of onset/exacerbation: 7-21 while at work dropped a dog bone wrench on foot with subsequent edema, abscess and cellulites." The wound type is described as "abscess. Cellulites' Trauma." Further, the assessment is "right plantar foot wound s/p trauma/abscess/mssa infection." On August 21, 2012 the notes reveal "the patient states that it started after he dropped a wrench on the top of his right foot while at work. He was wearing a steel toed shoe. This occurred 7/21/2012, I believe. It was initially evaluated and was told he had no fracture but over time his foot symptoms worsened. Ultimately, he was identified to have an abscess and had an I and D performed in Illinois." He was treated there until they discharged him in September of 2012 with direction to obtain a referral for physical therapy.

The medical evidence supports a finding that the foot contusion is casually connected to the undisputed work accident, consequently all medical bills that resulted from the treatment should have been paid. The chain of medical events was unbroken from the trauma to the foot to the development of infection. Try as he may, Respondent's Section 12 examiner, Dr. Rodarte's fantasy of what might have happened is nothing more than just that,"pure fantasy". The undisputed evidence is that Petitioner sought appropriate medical treatment for his injury until the abscess healed and he was able to use his right foot again.

Petitioner clearly injured the top of his right foot during the work accident. Within a matter of days he developed an infection that led to an abscess on the bottom of his right foot. His medical records note he suffered from "MSSA", which stands for Methicillin-Sensitve Staphylococcus Aureus. Contrary to Dr. Rodarte's suggestion that Petitioner's abscess may have been caused by a hole or puncture he suffered outside of work is just not credible when viewed alongside Petitioner's testimony and the medical records. Additionally, Dr. Rodarte's reasons for questioning the treatment do not appear valid; he's concerned about the treatment because he cannot read the medical records, which quite obviously would be imperative to conduct a valid review. This is certainly not a valid reason to find the treatment unreasonable or unnecessary. Further, Dr. Rodarte's expert status is suspect as he never personally examined Petitioner, and had to review basic literature before making his findings, and stressed his lack of expertise in the field.

Beyond the fact that Petitioner supplied causation opinions, Respondent supplied zero evidence to suggest that Petitioner had any prior issues with his foot. Proof of prior good health which changed immediately following and continuing after an injury may establish that an impaired condition was due to the injury. Navistar International Transportation Corp. v. Industrial Comm'n, 315 Ill.App.3d 1197, 1205 (2000).

Additionally, On August 1, 2012, Dr. Kelly Voung signed off on a report by Vibe Pearl L. Guillergan, APRN-BC that showed a diagnosis of "Right foot abscess w/cellulites' secondary to recent trauma s/p I&D (7/30/12)."

Further evidence of causation exists in the August 15, 2012 note of Martha McNutt, a nurse practioner who noted that on "7-21, while at work dropped a dogbone wrench on foot with subsequent edema, abscess and cellulitis." Her diagnosis that date was "Cellulitis, foot. Trauma. Abscess."

Therefore, I feel compelled to disagree with the Arbitrator and the majority, my review of the entire record, the undisputed facts and the law oblige me to recommend the award be modified in part and reversed in part so that the Petitioner receives eight (8) weeks of temporary total disability, at the rate of $220 per week from July 25,2012 through September 18,2012, the nature and extent of his injury to be 25% loss of use of the foot and 7.5% loss of use of man as a whole.

Thomas J. Tyrrell, Commissioner

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MELIN, NICHOLAS
Employee/Petitioner

Case# **12WC034439**

FIRESTONE
Employer/Respondent

15IWCC0311

On 7/28/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1071 VASILATOS & COTTER LLC
ANITA DeCARLO
555 W JACKSON BLVD SUITE 700
CHICAGO, IL 60661

4234 RIPES NELSON BAGGOT ET AL
CRIS NELSON
2353 HASSELL RD SUITE 115
HOFFMAN ESTATES, IL 60169

STATE OF ILLINOIS)
)
COUNTY OF KANE)

15IWCC0311

☐ 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

NICHOLAS MELIN
Employee/Petitioner

v.

FIRESTONE
Employer/Respondent

Case # **12** WC **34439**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **6/13/14**. 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 _____

15IWCC0311

FINDINGS

On **7/21/12**, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$13,299.00**; the average weekly wage was **$255.75**.

On the date of accident, Petitioner was **18** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 8.35 weeks, because the injuries sustained caused the 5% loss of the right foot, as provided in Section 8(e) of the Act.

Petitioner's condition related to the bottom of his right foot and his complaints regarding chest pains are not related and therefore any claim for benefits related to those conditions are denied, including TTD and medical expenses.

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

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

7/24/14
Date

JUL 28 2014

15IWCC0311

FINDINGS OF FACT

This matter came to be heard on Petitioner's Motion for Hearing, scheduled and heard to completion on June 13, 2014. At issue in the case is whether Petitioner's current condition of ill-being, as it relates to the right foot is causally connected to the accident of July 21, 2012. Also at issue is whether the Petitioner is entitled to any TTD, Medical or surgical benefits as a result of said injury. Finally, the parties have put into dispute, the Nature and Extent of Petitioner's injuries of July 21, 2012.

Petitioner, Nicholas Melin, was employed by Respondent, Bridgestone Firestone, on July 21, 2012. At that time, Petitioner was 18 years old. He was employed as a technician for Respondent and performed such tasks as oil changes, tire changes and assisted other technicians in the performance of their duties for Respondent. On July 21, 2012, Petitioner states that he was performing an oil change with a wrench in his right hand. He was using the wrench overhead when it slipped out of his hand, dropped approximately 6.5 feet, and landed on the top of his right foot. He estimated that the wrench weighed approximately 2 lbs. Petitioner testified at trial that the wrench landed approximately mid-foot, at the base of his toes. He estimated that this was "above" the ball of his foot, just past the steel toe of his boots. Petitioner was wearing steel toe boots at the time of the incident. While Petitioner testified that wearing the steel toe boots was a requirement, he was not able to state unequivocally that he was required to wear them.

Petitioner reported the accident to his employer the day after the accident. He did not go to the doctor on the date of accident, or the next day. Petitioner testified that there was nothing unusual about his foot following the accident, and that "he didn't think it was a big deal". Petitioner was off work on July 23, 2012 for his regularly scheduled day off. At that time, he was also attending automotive school. Petitioner was required to wear steel toe boots for his schooling. He wore his boots to school on July 23, 2012 and stated that at that time, walking was becoming "uncomfortable". He did not note any cuts or abrasions on his right foot at all.

On July 24, 2012, Petitioner returned to his regularly scheduled work. He advised Kevin, his supervisor, that he was having pain in his right foot. Petitioner also went to school after work on July 23, 2012 and noted that his foot was "hot" in his boots. He noted swelling in the foot. His socks also seemed wet in his boots. After school on July 24, 2012, the Petitioner went to the doctor. The records reflect that Petitioner was initially seen at Cadence Occupational Health wherein he advised that he was performing and oil change on July 21, 2012 when he dropped a two pound tool on his right foot that had missed his steel toe protection. Petitioner reported a worsening of pain since the accident. The physician rendered a diagnosis of right foot contusion. Petitioner underwent x-rays that revealed no fracture. Petitioner was advised to apply ice daily. Petitioner was released to sedentary light duty work. (PE #1)

Petitioner travelled home to MN for his birthday on July 25, 2012. There, he stayed at his parent's home. Petitioner testified that on July 25, 2012, he started to notice swelling on the bottom of his foot. He specifically denied any swelling or bruises to the top of his foot, where the wrench landed at the time of the accident. He noticed further swelling on the bottom of his foot, as well as redness on the bottom of his foot on July 26 and 27, 2012. He was having difficulty walking on the bottom of his foot, and was ambulating with crutches that he had at home. Again, Petitioner testified that he noticed no injury or bruising or lacerations/broken skin on the top of his foot where the wrench landed.

Petitioner saw Mark Alexander, MD in MN at his mother's request on July 27, 2012. At that time, he noted a black growth on the bottom of his right foot. He testified that this growth was the size of an eraser. He testified that he did not notice any injury/bruising or lacerations to the top of the foot where the wrench fell. Upon exam, the doctor found swelling in the right foot, and tenderness over the plantar aspect of the right foot, near the 2nd

and 3rd toes. X-rays taken were negative for any fracture, subluxation and/or joint space abnormalities. The Petitioner was diagnosed with right foot pain, with contusion. There was no evidence of any black growth noted in the medical records. Suggested treatment included a boot, with icing and elevation. (PX 2)

On July 28, 2012, Petitioner was brought by his mother to Fairview Oxboro Clinic. Petitioner noted an injury one week prior when he was hit by a heavy hammer on the top of the right foot. He noted no bruising to the top of the foot, or direct injury to the bottom of the foot. Petitioner was diagnosed with an abscess on the bottom of his right foot. He was prescribed Bactrim and released. (PX 4)

Petitioner returned to Illinois on July 29, 2012 for work and school. On July 30, 2012, Petitioner was seen in follow up at Cadence Health wherein he reported increased swelling and redness on the bottom of his right foot. He advised that he was seen on two occasions in Minnesota for a right foot infection. Petitioner was given antibiotic medication. He was advised to remain off work. (PX 1)

On July 30, 2012, according to an initial consultation with Dr. Senall, Petition presented with right foot pain and abscess on the plantar aspect of the right foot. Petitioner reported that he sustained an injury at work on July 21, 2012 when he dropped a tool on the top of his foot. He did not notice the abscess on the bottom of his foot until three days prior to this visit. He denied any injuries other than the work accident of July 21, 2012. Examination revealed a 3 centimeter by 2 centimeter abscess on the plantar aspect of the right foot over the second and third metatarsal heads. Petitioner was referred for a MRI of the right foot to determine the extent of the abscess. Petitioner was scheduled to undergo surgery, with performed was an irrigation and debridement of a deep abscess of the right plantar foot. Subsequent to surgery, Petitioner was admitted for observation. Petitioner was eventually discharged from Central DuPage Hospital on August 3, 2012. (PX 5, 6)

On August 6, 2012, Petitioner was seen in the emergency room at CDH in Illinois, wherein he complained of pain to the left side of his chest with deep breath. Examination was positive of cough and shortness of breath. The physician diagnosed a small pleural effusion. The Petitioner and his mother advised they were driving back to Minnesota where they would seek follow up care. Of note, on August 6, 2012, Petitioner underwent a CT scan of the chest that revealed a small left pleural effusion but no evidence of pulmonary embolus. (PX 6)

Petitioner testified that from August 17, 2012 through September 12, 2012, he was seen at the wound clinic for the abscess on the bottom of his right foot. Petitioner noted a significant decrease in pain and initially utilized crutches for ambulation. He underwent debridement of necrotic tissue. As time passed, the edges of the wound were found to be dry with no sign of infection. Eventually, it is noted that the Petitioner had significant movement of the scar with flexion of the toes and it was anticipated that he would need to slowly progress to normal walking. The therapist noted that he would likely be able to return to a classroom setting environment in one to two weeks. He was given authorization to begin driving and wearing a normal shoe for driving only. On September 7, 2012, Petitioner was seen in follow up at the wound clinic and noted that he was healed. The therapist noted that Petitioner had attended thirteen sessions at the wound clinic. Petitioner was discharged from care.

Petitioner testified that he left the employ of Respondent in February 2013 voluntarily. As of the date of trial, he occasionally notices pain throughout the day when he is standing. Walking on hard surfaces without footwear causes increased pain in the bottom of the right foot. Petitioner began working for Crown Lift Trucks on April 8, 2013 and works full time, where he is required to wear steel toe boots for work. He testified that his feet sweat when he wears the steel toe boots and that this sweating causes his scar tissue on the bottom of his foot to ache. He stated that the "scar tissue on the bottom of my foot doesn't soften".

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Petitioner testified on cross examination that at no time after the accident on July 21, 2012 did he notice any injury/swelling/bruise or laceration to the top of the right foot, at the location where the wrench fell onto his foot. Petitioner also testified that he has no open wound on the foot as of the date of trial.

The Arbitrator notes that the Petitioner's mother testified on Petitioner's behalf. She confirmed the dates of treatment offered to the Petitioner via the medical providers in MN. Petitioner's mother also testified that she noted no injury to the top of the Petitioner's foot where the wrench fell. Moreover, she did not notice any bruising, or cut sustained.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being in his right foot is in part related to his undisputed accident on July 21, 2012. The medical evidence and witness testimony support the finding that the Petitioner sustained a traumatic contusion to his right foot when a tool landed on the top of his foot on the date in question. However, the Arbitrator finds that the Petitioner's other conditions, including the problems with the bottom of his right foot and his subsequent pain in his chest are not related to his accident from July 21, 2012. The Arbitrator notes that no opinion was offered by any treating doctor to address the Petitioner's alleged injury to the bottom of his foot to the initial trauma to the top of the foot. Moreover, there is no opinion in the record relating the hospital admission on August 6, 2012 and the alleged pulmonary effusion to the trauma to the top of the right foot. Reviewing the complete medical record, and the testimony of the Petitioner and his mother, the Arbitrator finds persuasive the expert opinion of Dr. Rodarte in this case. As such, the Arbitrator finds that there is no any causal connection between the Petitioner's medical condition relating to the bottom of the right foot and the wrench dropping incident of July 21, 2012. Moreover, the Arbitrator finds that the hospital admission on August 6, 2012 is not related to the contusion type injury sustained by Petitioner on July 21, 2012.

2. Based on the findings with regard to the issue of causation, the Arbitrator finds that the Petitioner's medical treatment for his right foot as it relates to the traumatic contusion on the top of his foot were reasonable and necessary and Respondent shall be responsible for those charges. As the Arbitrator finds unrelated to the accident the Petitioner's condition of ill-being as it relates to the bottom of the right foot and his chest pain complaints, any medical expenses incurred for treatment of those conditions are denied.

3. Based on the Arbitrator's findings with regard to the issue of causation, the Petitioner's claim for TTD is denied. The Arbitrator notes that the Petitioner was medically taken off work for conditions the Arbitrator has found unrelated to his July 21, 2012 accident.

4. With regard to the nature and extent of the Petitioner's injuries, 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 notes: (i) there was no reported level of impairment provided pursuant to the AMA Guides; (ii) Petitioner was an automotive school student while working for Respondent as a general automotive technician, but has since graduated and moved on to another company where he works full time repairing forklifts; (iii) Petitioner was 18 years old at the time of the injury; (iv) there was no evidence of any loss of Petitioner's earning capacity: and

15IWCC0311

(v) Petitioner's complaints of foot problems stemming from the contusion to the top of his foot were evidenced in the initial medical records. Based on these factors, the Arbitrator concludes that the Petitioner sustained 5% loss of use of his right foot.

STATE OF ILLINOIS)
) SS.
COUNTY OF La SALLE)

☒ 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

Brian Duran,
Petitioner,

vs.

NO. 14 WC 12164

Peru Volunteer Ambulance,
Respondent.

15IWCC0312

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 accident temporary total disability 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,700.00. 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: MAY 1 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/22/15
jdl/wj
68

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

DURAN, BRIAN A
Employee/Petitioner

Case# **14WC012164**

PERU VOLUNTEER AMBULANCE
Employer/Respondent

15IWCC0312

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:

0190 LAW OFFICES OF PETER F FERRACUTI
JENNIFER L KIESEWETTER
110 E MAIN ST
OTTAWA, IL 61350

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSALLE)

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

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

15IWCC0212

Brian A. Duran
Employee/Petitioner

v.

Peru Volunteer Ambulance
Employer/Respondent

Case # 14 WC 12164

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **May 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. [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, **March 20, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** sustain an accident resulting in a low back injury 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 **$18,078.32**; the average weekly wage was **$347.66**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **1** dependent child.

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 9 & 5/7th weeks, commencing March 21, 2014 through May 27, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 21, 2014 through May 27, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay reasonable and necessary medical bills and out-of-pocket expenses totaling $2,163.41 as provided in Sections 8(a) and 8.2 of the Act.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective left knee MRI and treatment recommended by Dr. Heifleit pursuant to Section 8(a) of the Act.

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

15IWCC0312

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

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

Signature of Arbitrator

July 7, 2014
Date

ICArbDec19(b)

JUL 10 2014

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

Brian A. Duran
Employee/Petitioner

v.

Peru Volunteer Ambulance
Employer/Respondent

Case # **14** WC **12164**

Consolidated cases: **N/A**

15IWCC0312

FINDINGS OF FACT

The issues in dispute include accident, causal connection, Respondent's liability for payment of certain medical bills, a period of temporary total disability, and Petitioner's entitlement to the recommended left knee MRI. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that on March 20, 2014 he worked for Respondent as a paramedic and had been so employed for just over 2 years. Petitioner testified that his work days were scheduled 20 hours on shift/on call, which is determined by the shift person, Mark.

While Petitioner is on call, he needs to be at the station. Other than an ambulance call requiring him to leave the station, Petitioner is only allowed to leave the station for groceries, going to the hospital to take care of laundry, or other business to take care of medical needs at a hospital or as assigned by the chief. There is also training and there are also chores to be done between business hours from 8:00 a.m. to 4:00 p.m. After business hours, Petitioner testified that he is allowed to rest, watch television, and work on other projects (work-related or personal hobbies) so long as he can answer calls. Petitioner testified on cross examination that he also smokes about ½ pack of cigarettes, so he is outside about 10 times throughout a shift and, in addition to being outside on these occasions, he may also engage in other hobbies or personal activities.

Within the station, there is no particular area in which Petitioner needs to be located on Respondent's property. Petitioner testified that he and other employees smoke, so they may do so outside in an assigned area on a concrete patio by a picnic table where the grill is located. Employees have a wheel rim that some crews use to set a fire for employees to sit around. Petitioner testified that it was common to spend time in this area and that employees engaged in hobbies in this area.

March 20, 2014

On March 20, 2014, Petitioner testified that he injured himself at approximately 5:00 p.m. while on the concrete patio. He testified that other co-workers were with him, including Woodrow Olson ("Mr. Olson"), measuring a piece of wire that was cut. While carrying his tools back to his car, Petitioner testified that he fell face first into the parking lot. Petitioner testified that he did not lose consciousness.

[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.

On cross examination, Petitioner testified that at the time of this accident he was working with Mr. Olson on Petitioner's HAM radio, which is not connected to his job with Respondent. Petitioner was cutting wire to fabricate an antenna, using his own tools, and then taking the tools back to his vehicle. He also testified that the canopy erected had been up before his accident.

The patio area was near the parking lot and Petitioner testified that his tool boxes were near his head. Mr. Olson asked Petitioner if he was ok. Petitioner testified that he had pain to the left side of his head and face and pain in the left knee. He got up, looked around and noticed a bent green stake in the path to his vehicle. Petitioner testified that this stake was there to hold the canopy over the patio area above the picnic table. The canopy frame was up at the time, but not the canopy itself.

Respondent offered photographs of the patio area. RX1. The first photograph shows the patio area and the pole that holds up the canopy, and the subsequent photographs show that the canopy has been removed. *Id.* Petitioner noted that the bent stake was located in the sixth photograph and marked that area on the photograph. The Arbitrator notes that the area marked by an "X" by Petitioner is located between the concrete patio area and the parking lot in a gravel and grass border between the two. *Id.*

After he fell, Petitioner testified that Mr. Olson went in to get his supervisor. He was placed on a stretcher, brought into the station, and given an ice pack. Benjamin Brown ("Mr. Brown") and Brent Hanson ("Mr. Hanson") came out and Petitioner was transported by Mr. Olson and Mr. Hanson in the back of an ambulance.

Medical Treatment

Petitioner testified that he went to the occupational health clinic first, which was closed. He was then taken to the emergency room.

The medical records reflect that Petitioner presented to the Illinois Valley Community Hospital ("IVCH") Emergency Room at approximately 6:00 p.m. on March 20, 2014 and provided a history that he tripped over a fence post and fell face first onto the concrete. PX2 at 12, 18. He reported jaw and left knee pain, and was noted to have obvious abrasion injuries. *Id.* He underwent left knee x-rays, which showed no fracture, dislocation or bone destruction, very little in the way of degenerative changed, and no loose joint body or joint effusion. PX2 at 8. The interpreting radiologist noted that the examination was unremarkable. *Id.* Petitioner was diagnosed with a left knee contusion, prescribed medication and an immobilizer, and advised to follow up with Occupational Health in a day or two. PX2 at 13-14.

The following day Petitioner testified that he followed up with occupational health and saw the nurse practitioner, Deb. The medical records reflect that Petitioner went to IVCH Occupational Health on March 21, 2014. PX2 at 25-26. He reported that he was carrying a toolbox while working for Peru Volunteer Ambulance when he tripped over a metal stake, fell forward, and hit his face on the ground. *Id.* He also reported a burning sensation in his left knee and aggravated left knee discomfort when changing position and pivoting. *Id.* On examination, the nurse practitioner noted edema and tenderness to palpation over the medial aspect of the left knee, medial collateral ligament pain, a limping and crutch-assisted gait, and inability to perform McMurray testing due to guarding of the left knee. *Id.* She diagnosed Petitioner with left knee pain and a strain. *Id.* She prescribed medication and placed Petitioner on work restrictions with weighbearing as tolcratcd. *Id.* Dr. Leifheit concurred with the nurse practitioner's assessment and treatment plan.

On March 31, 2014, Petitioner reported to Dr. Leifheit that his symptoms continued. PX2 at 27-28. He reported swelling, pain, limited range of motion, and limited weightbearing. *Id.* He also reported that his left knee pain was aggravated with range of motion, stair climbing, and position change as well as associated popping in the knee. *Id.* On examination of the left knee, Petitioner had tenderness and edema over the medial aspect of the knee, tenderness over the medial joint line, guarded limited range of motion, and a limping gait. *Id.* Dr. Leifheit diagnosed Petitioner with left knee pain and strain, rule out internal derangement. *Id.* He ordered a left knee MRI and returned Petitioner to work with restrictions. *Id.*

Additional Information

Petitioner testified that paperwork was given to Mr. Roberson, but there was no work for him within his restrictions and he has not worked since March 2014. He has not received any temporary total disability check.

Regarding his current condition, Petitioner testified that his left knee is still puffy. He can still feel his knee patella shift and he falls backwards. In the morning his left knee is number and after sitting or standing too long he has pain. Petitioner testified that he had no left knee problems before his accident.

Petitioner testified that he has been unable to have the MRI performed and he has no private medical insurance. Petitioner would like to undergo the MRI.

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:

After consideration of all the evidence proffered at trial, the Arbitrator finds that Petitioner established that he sustained an accident that arose out of and in the course of his employment with Respondent as claimed. In so concluding, the Arbitrator finds *Eagle Discount Supermarket v. The Industrial Comm'n*, 82 Ill. 2d 331, 339-340 (1980) and *Elvery v. Village of Lombard*, 06 IWCC 1076 to be instructive given the facts of this case.

As an initial matter, 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 2011). 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).

In *Eagle Discount Supermarket*, the Illinois Supreme Court adopted the doctrine of "personal comfort" citing various cases whereby the course of employment is not broken when the employee engages in certain acts related to his personal comfort (i.e., eating lunch, getting fresh air, seeking relief from heat and humidity, showering in a locker room provided by the employer). *Eagle Discount Supermarket*, 82 Ill. 2d at 339-340 (*citations omitted*). The claimant and other employees were engaged in a personal activity (i.e., playing with a Frisbee in the company parking lot during their lunch break) at which time the claimant fell and injured himself. *Id.*, at 334-35. The court noted that the employer did not dictate how the employees took lunch or restrict their lunch-time activities, and also noted that it was aware of the employees' activity. *Id.*, at 335. Ultimately, the court affirmed the Commission's inference that the claimant's participation in the lunch-time activity fell within the personal comfort doctrine and that, even if the claimant's activity fell into the category of non-compensable injuries stemming from unnecessary and unreasonable risks taken by the employee during personal comfort activities, the Commission could reasonably have found that the employer "knew, acquiesced and possibly participated in the employees' routine games." *Id.*, at 340-341.

The Commission has also applied the personal comfort doctrine to a factually similar case to the one at bar in *Dudley Elvery v. Village of Lombard*, 06 IWCC 1076. This case involved a firefighter/paramedic who was injured while playing softball after completing his daily activities for the fire department, but while on its premises during his 24-hour shift. *Id.* The Commission found *Eagle Discount Supermarket* to be controlling.

In this case, Petitioner testified that he was engaged in a personal hobby, working on a HAM radio, after fulfilling his duties for Respondent during his shift, but while still on call on Respondent's premises. Petitioner testified that he was unable to leave the Respondent's premises except for work-related activities or limited personal activities such as getting groceries. Petitioner testified that he and another fire fighter, Mr. Olson, were on the patio area engaged in personal activities shortly before his accident when he tripped over a bent stake in the ground while walking from the patio area to his car to store his tools. Petitioner further testified that it was common for him and other fire fighters to engage in personal activities on the patio area. Petitioner's testimony is uncontroverted[2].

Based on all of the foregoing, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent while participating in a personal comfort activity.

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 detail above, the issue of accident has been resolved in favor of Petitioner. Additionally, the Arbitrator finds that Petitioner's testimony was credible and consistent with the medical records submitted into evidence that he sustained injuries to the face and left leg as a result of his fall on the concrete at work on March 20, 2014. There is no evidence that Petitioner had any pre-existing conditions in the affected body parts prior to his accident or any evidence indicating a break in causal connection. Based on all of the foregoing, the Arbitrator finds that Petitioner's current condition of ill being is causally related to his injury at work on March 20, 2014.

[2] While Respondent provided photographs of the patio area without the bent stake noted by Petitioner at the time of his injury, the photographs were not taken before the accident and the Arbitrator does not find that they accurately reflect the patio area at the time of the accident.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

As explained above, Petitioner has established that he sustained a compensable accident and causal connection between his condition of ill being and his accident at work. The Arbitrator finds that the bills from IVCH, for radiology services, and for out-of-pocket expenses related to prescription medications were reasonable and necessary. Thus, the Arbitrator finds that Petitioner shall be entitled to an award of $2,163.41 for his medical expenses to date subject to the limitations of the medical fee schedule and Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current condition of ill being is causally related to his accident as claimed. Thus, the Arbitrator awards the recommended prospective medical care in the form of a left knee MRI pursuant to Section 8(a) of the Act as it is reasonable and necessary to alleviate Petitioner from the effects of his injury at work.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

As explained above, the issue of causal connection between Petitioner's current condition and his accident has been resolved in Petitioner's favor. Moreover, the record does not reflect that Petitioner's condition has yet stabilized or reached maximum medical improvement. Thus, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits commencing March 21, 2014 through May 27, 2014 as claimed.

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

Charlotte Volland,
Petitioner,

vs.

NO. 11 WC 01240

Holiday Inn Express Harrison Limited,
Respondent.

15IWCC0313

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 accident, temporary total disability, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

15IWCC0313

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: MAY 1 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/22/15
jdl/wj
68

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

VOLLAND, CHARLOTTE
Employee/Petitioner

Case# **11WC001240**

HOLIDAY INN EXPRESS HARRISON LTD
Employer/Respondent

15IWCC0313

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:

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

1596 MEACHUM STARCK BOYLE & TRAFMAN
DEBORAH A BENZINH
225 W WASHINGTON ST SUITE 1400
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHARLOTTE VOLLAND
Employee/Petitioner

v.

HOLIDAY INN EXPRESS; HARRISON, LTD.
Employer/Respondent

Case # 11 WC 1240

Consolidated cases: N/A

15IWCC0313

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn DOHERTY**, Arbitrator of the Commission, in the city of **Chicago**, on **June 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0313

FINDINGS

On the date of accident, **10/30/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$12,636.97**; the average weekly wage was **$302.79**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$46,156.15** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$46,156.15**.

Respondent is entitled to a credit of **$34,426.40** under Section 8(j) of the Act.

ORDER

Respondent shall authorize and pay for the prospective left knee surgery and the attendant care pursuant to Sections 8 and 8.2 of the Act.

Respondent shall pay Petitioner the sum of **$253** /week for a period of **188 5/7** weeks commencing **October 31, 2010** to **present**, as provided in Section 19(b) of the Act.

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

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

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

Carolyn D Kerdy
Signature of Arbitrator

8/7/14
Date

AUG - 7 2014

FINDINGS OF FACT

At the time of the accident, Petitioner was a 39 year old front desk clerk working full-time for Respondent, Holiday Inn Express. (Tr. 7-8). Petitioner is single with one dependent. (Tr. 6-7). At trial, the parties stipulated that Petitioner sustained a work related accident on October 30, 2010 when Petitioner tripped over a mat and fell on her left knee. (Tr. 9). Petitioner's left knee immediately swelled up. (Tr. 13). Petitioner reported the accident to her manager who sent her to Northwest Community Hospital for medical treatment at the end of her shift. (Tr. 12-13). Accident and notice are not at issue. ARB EX 1. Petitioner testified that she had no prior injury, problem or treatment to her left knee.

X-Rays were taken of Petitioner's left knee and were deemed unremarkable. Petitioner received a knee immobilizer and crutches and was restricted from all work activity under a diagnosis of acute internal derangement of the left knee and effusion of the left knee. (Px. 1). The Arbitrator notes and Petitioner testified that before and during her knee injury treatment she was prescribed medication for an ongoing unrelated low back issue referred to in the medical records as "chronic back pain since 2005." The medication taken for the low back condition included oxycodone and morphine. PX 1.

With regard to her left knee injury, Petitioner was referred to Dr. David Shafer for an orthopedic evaluation. (Tr. 13). MRI of the left knee performed on November 4, 2010 revealed:

1) Mild strain of the proximal medial collateral ligament;
2) Small subtle focus of bone marrow edema beneath the medial tibial plateau that probably represents mild reactive bone marrow edema secondary to early degenerative change, or less likely, a tine bone contusion;

3) Small joint effusion (Px. 2)

Dr. Shafer diagnosed Petitioner with a tear of the medial collateral ligament grade II based on his reading of the MRI films. (Px. 2). No evidence of a meniscal tear was seen on film. Dr. Shafer also noted early degenerative change in the medial knee and meniscus. PX 2. Petitioner was issued a knee brace to wear at all times at work and prescribed physical therapy treatment. (Px. 2). Petitioner was issued light duty sedentary work restrictions. (Px. 2). Multiple physical therapy sessions failed to relieve Petitioner's left knee pain and Petitioner reported left lateral knee pain in addition to left medial knee pain to Dr. Shafer. PX 2. The lateral knee pain became more apparent during PT and as the medial pain lessened. PX 2. Dr. Shafer prescribed surgery on 12/30/10 under a diagnosis of left knee MCL sprain and possible lateral meniscal tear. Dr. Shafer noted his belief that Petitioner had a peripheral tear that was not seen on MRI. PX 2. He also consistently noted that Petitioner had a prior back surgery and chronic back pain. PX 2.

On January 27, 2011 Dr. Schafer performed a left knee arthroscopy with synovectomy. (Px. 1). The pre-operative diagnosis was left knee possible lateral meniscal tear. The post-operative diagnosis was left knee extensive synovitis. PX 2. At the post-op visit on 2/9/11, Dr. Shafer noted that Petitioner's lateral pain and popping sensations in the knee prior to surgery were gone after the "synovectomy of the overgrown abnormal appearing tissue in the lateral knee which

was likely a result of the trauma. However, the doctor believed petitioner was doing poorly because of her chronic back pain and "high level of narcotic medications she has been on." Petitioner was restricted from all work activity and received physical therapy treatment throughout February, March, April, May, June and July 2011. (Px. 2).

Post-operatively Petitioner's left knee remained swollen as she continued to complain of ongoing knee pain. (Px. 3). On April 26, 2011 Petitioner's left knee hemarthrosis was aspirated and she received a cortisone injection. (Px. 2). On May 3, 2011, Schafer observed that petitioner was improving and released petitioner back to regular work duties in one week, and opined that he did not expect another setback. Resp. Ex. #2 pgs. 33-34. Petitioner was to continue physical therapy. PX 2.

A follow up MRI of the knee performed on May 12, 2011 revealed "no evidence of a meniscal tear. The medial meniscus is slightly extruded medially. There is slight edema involving the proximal medial aspect of the tibia. The bone marrow otherwise normal. There is a moderate sized joint effusion. No Baker's cyst. The ligaments are intact. The articular cartilage is mildly deficient laterally involving the tibia and femoral surfaces. Articular cartilage is otherwise normal." (Px. 2). The impression was "There is some loss of articular cartilage with associated subchondral marrow changes in the lateral compartment. Otherwise unremarkable" (Px. 2).

The swelling and recurrent effusion in Petitioner's knee continued and a repeat knee aspiration was done by Dr. Shafer on May 19, 2011. (Px. 2). Petitioner was placed back on light duty restrictions for a sedentary job only. At that time, Dr. Shafer did not see any reason for Petitioner to continue to have the effusions based on the MRI. The aspiration was done to relieve symptoms and rule out infection. PX 2. A third aspiration of the left knee followed by a corticosteroid injection was done on June 21, 2011. (Px. 2). Petitioner was continued on a sedentary work restriction.

At petitioner's July 20, 2011 visit with Dr. Schafer, it was noted that "I see significant improvements in her swelling today, range of motion and signs of pain on examination today. She has continued to call the office for narcotic medications, often times after hours to avoid talking to my staff or myself which has been trying to wean her from the medications and more tightly regulate her use. I feel that her recent trips to the emergency room are secondary to drug seeking behaviors. She has a known history of high narcotic use secondary to a chronic back condition. I discussed this at great length with the patient today. I am not going to refill her again after this office visit, but will give her some pills to try to wean from the use over the next few weeks. I do not think that she has a current cellulitis, but recommend that she finish the current course of antibiotics in case this is a different appearance than she had in the emergency room. She should restart the therapy. I will see her back in 4 weeks to evaluate her progress. I recommend that she return to light duty job activities with no prolonged walking or standing over one hour. I expect return to regular duty in 4 weeks following the therapy." Resp. Ex. # 2, PX 2.

On July 25 2011, Petitioner was seen at Northwest Community Hospital following a motor vehicle accident and increased complaints of lower back pain. RX 3. Dr. Ahsan noted that Petitioner was seen for "high risk narcotic use and management as well as recent trauma of motor vehicle accident with a complaint of lower back pain." Petitioner reported that she

"blacked out" and drove into a pole. In July 2011, physician's assistant Tracy Moscato also reported petitioner has a "history of chronic opioid and benzodiazepine use and has filled her prescriptions from multiple providers in the area." RX 3. Physician Assistant Moscato noted that when discussing petitioner's use of the painkiller Norco, petitioner denied using the drug even though she had her prescription refilled two weeks earlier. RX 3. It was noted that Petitioner's sister may have filled the prescription without Petitioner's knowledge.

Petitioner saw Dr. Schafer for her knee was on 10/20/11 at which time Dr. Schafer indicated "There are no current signs of infection or significant swelling/effusion in the knee today. She is still very weak and I feel this is responsible for the continued symptoms. She has not yet started the therapy secondary to health issues. She states that she has been in the hospital for workup of a brain tumor and dizziness issues. She is going to start the therapy again, but she was told it is essential that she also perform her home exercise program that she admits she has not performed. I will see her back in 4 weeks to evaluate her progress. I anticipate return to regular duty work in 4 weeks if she is compliant with the exercise program." PX 2.

Petitioner saw Dr. Brian Cole for a second opinion consultation in October 2011. Based on his review of the operative report and his exam of Petitioner, Dr. Cole recommended a series of synvisc injections for Petitioner's left knee pain. Beyond injections, Dr. Cole recommended another MRI. (Px. 4). Petitioner was last seen by Dr. Shafer on November 22, 2011. Mild effusion and weakness in the knee were noted at that time. (Px. 2). Petitioner had good range of motion and no instability of the knee. She had significant quad atrophy. Petitioner demonstrated "diffuse pain to palpation in the medial knee which is not able to be localized to any specific area. The pain to palpation medially in the knee elicits reactions from the patient which are out of proportion to the physical exam." PX 2. Dr. Shafer noted continued significant weakness in the knee which he felt was related to leg weakness and poor rehab. He noted a cortisone injection may be beneficial on her next visit and that Petitioner should return to work with no walking or standing over 1 hour per day. (Px. 2).

Petitioner testified that she relocated to Colorado in the Spring of 2012 and sought medical treatment for her left knee with Dr. Robert D'Ambrosia at the University of Colorado. On April 2, 2012 Petitioner saw Dr. D'Ambrosia complaining of left knee pain/popping/locking/cracking/grinding/giving out along with constant swelling. (Px. 6). Petitioner reported the same history of injuring her left knee at work tripping over a mat. (Px. 6). X-Rays of the left knee revealed:

1. No acute bony abnormality;
2. An effusion may indicate the presence of an internal derangement such as meniscus or ligament tear;
3. Minimal medial compartment predominant degenerative change. (Px. 6)

MRI of the left knee performed on April 3, 2012 revealed the following:

1. Small knee effusion;
2. Small regions of Grade 2 cartilage loss along the inferior margin of the patella at the median ridge;
3. Small Grade 2 defect at the superior margin of the trochlea;

4. Small Grade 2 and grade 3 cartilage loss in the medial compartment;
5. Small Grade 2 defects at the lateral femoral condylar surface.

The cartilage findings were most conspicuous in the center of the medial femoral condyle and peripheral aspect of the medial tibial plateau. (Px. 6). The radiologists' impression of the MRI was foci of partial-thickness cartilage defects are visible in the medial, lateral and patellofemoral compartments. Most significantly involved is the peripheral aspect of the medial femoral condyle where foci of grade 3 cartilage defects are present. (Px. 6)

Petitioner discussed the MRI results with Dr. D'Ambrosia who noted "evidence of osteoarthritis present in the knee." (Px. 6) He further advised Petitioner that the newest MRI did not show evidence of a meniscal tear. Dr. D'Ambrosia recommended a series of synvisc injections and prescribed tramadol for pain. (Px. 6).

Upon arriving in Colorado, Petitioner also established care for her other ongoing health problems including chronic low back pain, anxiety and a diagnosed seizure disorder. PX 6. Petitioner testified that she signed a narcotic contract with the University of Colorado Hospital stating that her narcotics would be dispensed by her hospital providers. T. 50. RX 1 contains records indicating that Petitioner received or attempted to receive narcotic medication in violation of this agreement. RX 1. Contrary to this, petitioner testified that she never sought pain medications from any providers other than the University of Colorado Hospital while being treated there, and was never spoken to about violating her contract. T. 50, 63.

The initial injection administered by Dr. D'Ambrosia in July 2012 failed to relieve Petitioner's ongoing left knee pain. Another injection was administered on August 10, 2012. Dr. D'Ambrosia also removed fluid from the knee and sent it for testing along with blood testing. PX 6. On August 10, 2012, Dr. D'Amrbosia also noted that Petitioner requested a total knee replacement. Dr. D'Ambrosia indicated in the records that he "clearly could see no indication for doing a total knee replacement" after reviewing the operative notes and pictures from the arthroscopy. RX 1. The two "had [an] extensive discussion lasting approximately 45 minutes because the patient has wanted relief of her pain and swelling that is in her knee," but D'Ambrosia "could not give her a definitive answer." RX 1.

Petitioner returned to Dr. D'Ambrosia on August 20, 2012 with ongoing swelling of her left knee. The lab studies were within normal limits. Dr. D'Ambrosia referred Petitioner to Dr. Akuthota "for evaluation and workup as for the etiology of her localized swelling of this left knee which has been going on for several years since she has had an arthroscopy of that knee and an extensive synovectomy". (Px. 6). Dr. Akuthota examined Petitioner on August 27, 2012 and per his examination and review of the April 2012 MRI diagnosed her with left knee cartilage defects and left medial meniscus tear s/p knee arthroscopy 1/27/11 (Px. 6). Dr. Akuthota referred Petitioner to Dr. McCarty for possible cartilage transplantation (PX. 6).

Petitioner was examined by Dr. McCarty on August 29, 2012. X-Rays of the left knee revealed minimal medial compartment predominant osteoarthritis of the left knee. After examining Petitioner and reviewing the April MRI showing grade 2 to 3 changes, he determined Petitioner was not a candidate for articular cartilage transplantation. PX 6. Dr. McCarty recommended Petitioner be seen by a rheumatologist for further workup of non-surgical etiologies of her

persistent knee pain and recurrent effusions and ordered an MRI of the knee to check for meniscal pathology. (Px. 6). Dr. McCarty further noted that Petitioner is currently unable to work due to pain.

Final results of the MRI of the left knee performed on September 14, 2012 revealed:

1) Grade 4 cartilage defect on medial femoral condyle. Grade 2 cartilage defects in the lateral and patellofemoral compartments; allowing for differences in image quality, likely not significantly changed.
2) New, free edge fraying body of medial meniscus. PX 6.

Dr. McCarty reviewed the MRI with Petitioner on January 16, 2013 and recommended knee surgery for a partial medial meniscectomy, micro fx. (Px. 6). Dr. McCarty believes the MRI shows a medial meniscus tear and medial condyle cartilage defect. Petitioner remains restricted from prolonged standing and limited climbing of stairs.

Orthopedic surgeon Dr. Kevin Tu reviewed petitioner's medical records and MRIs. Dr. Tu specifically noted that at the time of petitioner's original injury, the original November 2010 MRI showed small effusion, no meniscus tearing, no evidence of an ACL tear and no evidence of ligament disruption. RX 8, p. 10. The operative report from January 2011 indicated a small area of chondromalacia in the medial tibial plateau, no changes over the medial femoral condyle and no area of chondromalacia over the medial femoral condyle. RX 8, p. 11. Dr. Tu noted that Petitioner's most recent MRI that he reviewed taken in September 2012 showed grade 4 chondromalacia of the medial femoral condyle and a possible medial meniscus tear. In his opinion, Petitioner's current condition in her left knee is not related to petitioner's original work injury as these were "new" conditions not previously seen during her surgery. RX 8, p. 12,35,36. Dr. Tu opined that Petitioner's ongoing left knee swelling and effusion following her surgery in 2011 and continuing thereafter was "not necessarily" proximately related to the trauma of October 2010 in that there could be "underlying cause" that "no one is familiar with." RX 8, p. 43. He believes there may be an unrelated systemic cause of her current symptoms. RX 8, p. 43,45. In terms of petitioner's original injury work-related injury, Dr. Tu stated that as of his records review on 2/26/13, Petitioner could return to full duty work as of February 26, 2013 and did not need any additional treatment. RX 8, 12-13.

CONCLUSIONS OF LAW

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

WITH RESPECT TO ISSUE F - IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY? THE ARBITRATOR FINDS AS FOLLOWS:

It is undisputed that Petitioner sustained injury to her left knee on October 30, 2010 as a result of a fall at work. ARB EX 1. Petitioner tripped on a mat, twisting her left knee and fell to the floor. Petitioner received emergency room medical treatment for her left knee injury. (Px. 1).

Petitioner has consistently treated for her left knee complaints through the time of trial. Petitioner underwent an initial surgery in January 2011 during which Dr. Shafer performed a left knee arthroscopy with synovectomy. Dr. Shafer noting a post-operative diagnosis of left knee extensive synovitis. PX 2. The operative report reflects "such severe synovitis in the area laterally and extended up towards the pattelofemoral joint". Grade 2 arthritis of the medial tibial plateau and grade 1 changes of the lateral tibial plateau were also noted. PX 1. No medial collateral ligament tear was noted during surgery.

Post-operatively, Petitioner's left knee remained swollen and painful. A course of physical therapy treatment and corticosteroid injections failed to relive Petitioner's left knee pain. May 12, 2011 MRI of the left knee revealed "The medial meniscus is slightly extruded medially. There is a slight edema involving the proximal medial aspect of the tibia." Px. 1 The radiologist impression was "loss of articular cartilage with associated subchondral marrow changes in the lateral compartment." (Px. 1)

Petitioner continued to experience left knee pain and swelling throughout 2011. Dr. Shafer aspirated Petitioner's left knee on three separate occasions. Following her move to Colorado, Petitioner continued to receive medical treatment for her ongoing left knee pain and swelling with Dr. D'Ambrosia.

MRI of the left knee performed on April 3, 2012 revealed:

1. Small knee effusion;
2. Grade 2 cartilage loss along the inferior margin of the patella at the median ridge;
3. Grade 2 defect at the superior margin of the trochlea;
4. Grade 2 and grade 3 cartilage loss in the medial compartment;
5. Grade 2 defects at the femoral condyle.

The cartilage findings were most conspicuous in the center of the medial femoral condyle and peripheral aspect of the medial tibial plateau. (Px. 6).

Petitioner completed blood work testing which was within normal limits. Ultimately, Petitioner was referred to Dr. McCarty for possible cartilage transplantation. Dr. McCarty ordered an updated MRI of the left knee in September 2012 which revealed:

1) Grade 4 cartilage defect on medial femoral condyle. Grade 2 cartilage defects in the lateral and patellofemoral compartments;
2) New, free edge fraying body of medial meniscus;

Thereafter, Dr. McCarty reviewed the MRI findings with Petitioner and diagnosed her with a medial meniscus tear and medial condyle cartilage defect. (Px. 6). Dr. McCarty recommended left knee surgery for partial medical meniscectomy, micro fx.

Based on Petitioner's testimony regarding her continued complaints of pain in her left knee as buttressed by the medical records documenting extensive, consistent and continuous medical treatment to her left knee following the accident of October 2010, the Arbitrator finds

Petitioner's current condition of ill-being in her left knee causally related to the accident of 10/30/10. In so finding, the Arbitrator places greater credibility on the foregoing evidence than on the opinion of Dr. Tu following his review of some of Petitioner's medical records. The Arbitrator's findings are based on the cumulative opinion of several treating physicians following their review of Petitioner's numerous MRI exams through September 2012 resulting in the currently pending surgical recommendation.

Further, the Arbitrator notes that Petitioner's left knee was asymptomatic prior to the injury at work. Petitioner's underlying osteoarthritis of the left knee was clearly aggravated by the trauma sustained from the fall at work. Therefore, in the absence of any subsequent trauma to Petitioner's left knee, the Arbitrator finds Petitioner's current condition of ill-being is causally related to her October 30, 2010 injury at work. In that regard, the Arbitrator specifically finds that there is no evidence in the record of any relationship between Petitioner's current knee condition and any of her syncopal or seizure episodes reflected in the medical records. To so find would be speculative. Finally, Petitioner's use and reliance on narcotic medication is not lost on the Arbitrator. However, that reliance does not sufficiently affect Petitioner's credibility so as to preclude a finding of causal connection for Petitioner's current condition of ill-being in her knee as cited. The finding of causal connection is supported by a preponderance of the credible evidence at trial.

WITH RESPECT TO ISSUE K - IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE? THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings of causal connection the Arbitrator finds that Petitioner is entitled to the prospective medical care (left knee partial medial meniscectomy, micro fx) recommended by Dr. McCarty. Respondent shall authorize and pay for the prescribed surgery and the attendant care pursuant to Sections 8 and 8.2 of the Act.

WITH RESPECT TO ISSUE L – WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE IN DISPUTE? THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings of causal connection the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period October 31, 2010 through June 12, 2014. Petitioner was not released back to work full duty and remains restricted from prolonged standing and limited climbing of stairs. (Px. 6). The Arbitrator further notes that all of the ordered TTD has been paid by the Respondent and that Respondent is entitled to a credit for the total paid. ARB EX 1. T. 54.

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

Alexander Murillo,
Petitioner,

vs.

NO: 08 WC 48534
10 WC 17360
13 WC 31028

United Parcel Service,
Respondent.

15IWCC0314

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Black finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on October 9, 2008 and experienced a temporary aggravation of the work injury on April 18, 2010 and July 18, 2013. As a result Petitioner was temporarily totally disabled from October 11, 2008 through October 23, 2009, April 18, 2010 through May 29, 2010 and July 18, 2013 through July 26, 2013 for 60-6/7 weeks under Section 8(b) of the Illinois Workers' Compensation Act, is entitled to $9,790.63 in medical expenses under Section 8(a) of the Act and is permanently partially disabled to the extent of 12.5% man as a whole under Section 8(d)2 of the Act. Respondent is entitled to a credit of $9,790.63. The Issues on Review are whether Petitioner sustained an accidental injury arising out of and in the course of his employment on October 9, 2008, April 10, 2010 and July 18, 2013, whether a causal relationship exists between Petitioner's current condition of ill-being and the alleged October 9, 2008, April 18, 2010 and July 18, 2013 work accidents, and if so, the extent of Petitioner's temporary total disability and the nature and extent of Petitioner's permanent disability and the amount of reasonable and necessary current medical expenses as well as whether Petitioner is entitled to prospective medical expenses. The Commission, after reviewing the entire record, views this case differently than the Arbitrator and finds that the claims should be reviewed under the Occupational Diseases Act as opposed to the Workers' Compensation Act. Upon reviewing the claims under the Occupational Diseases Act, the

15IWCC0314

Commission reverses the Arbitrator and finds Petitioner failed to prove he was exposed to an Occupational Disease that resulted in a disablement under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified that prior to October 9, 2008 his lungs and breathing were very good and he had not ever experienced or sought any medical treatment for difficulty breathing. Petitioner subsequently testified he previously misspoke when he said he had not seen a doctor for breathing issues. Petitioner then testified that prior to October 9, 2008 he saw Dr. Andrew Roth, the doctor his wife works for, and the doctor told him he had some wheezing and he was going to put him on Prednisone and prescribed an inhaler to help him through it. It may have been asthma but he is not quite sure. Petitioner said he used the inhaler once or twice a month.

2. The medical records show that on October 8, 2005 Petitioner seen by Dr. Roth. Petitioner indicated he was 38 years old and was experiencing shortness of breath, cough and wheezing. On November 1, 2005 Petitioner returned stating that he had experienced 1-1/2 weeks of upper respiratory congestion with some sneezing and he stated he had a history of asthma. On May 25, 2006, Petitioner was seen for flu like symptoms. On September 5, 2006, Petitioner reported having a history of asthma and stated he was currently using Singulair and Albuterol. At that time, it was noted that he had a history of asthma and he was diagnosed as having a sinus infection. On April 19, 2007 Petitioner reported having a history of asthma and he was diagnosed as having some upper respiratory congestion with no shortness of breath. On September 20, 2007 Petitioner was diagnosed as having upper respiratory infection. It was noted at that time that Petitioner had a history of severe asthma in the past and he had required the use of steroids.

3. Petitioner testified he was employed as a maintenance mechanic on October 9, 2008, April 18, 2010 and July 18, 2013 for Respondent. His duties consisted of preventative maintenance and investigation of the conveyor systems at the facility. He performed preventative maintenance, inspections and welding and electrical repairs.

4. Paul Elza testified he is the district hazardous materials coordinator for Respondent. He was Petitioner's supervisor in 2008. When he arrived on October 9, 2008 some of his porters told him that there was a spill of some sort on one of the conveyors. Cleanup people were sent to deal with the spill. Later that day he was told that they were still having problems with packages transitioning over the chute between one leg of the conveyor and the next. He assigned Petitioner to spray Slidewax, a lubricant, on the chute. The next day Petitioner telephoned and said he had an issue after leaving work. He

felt that he breathed in something while he was cleaning the slide and it caused an asthma attack and caused him to seek treatment in the emergency room. Mr. Elza testified that they investigated the spill in order to see what substance was involved. They could not locate the package the spill had originated from, but they were able to locate the rags Petitioner used to clean up the spill they sent them to a chemist for analysis. The substance on the rags was identified as toner. He stated that Simple Green is an eco-friendly cleaning product and the printer toner is a non-hazardous material that is not regulated by the government.

5. Petitioner testified that on October 9, 2008 he was dispatched by Mr. Slza to conveyor track PD11, which was not functioning. Ryan Shields, the manager, said there was a substance all over the belt that was stopping the packages from moving and he needed him to clean it up with degreaser. Petitioner testified that the substance on the belt was a fine black powder that was easily airborne and he did not know exactly what the substance was. Later on he was told the black power was toner from a cartridge. At first, he tried to dry sweep the powder off but the power went up in the air. He was wearing a dust mask at that time. After he cleaned up the substance with Simple Green he noticed he was experiencing shortness of breath. He did not go to the doctor that day. Instead, he used his nebulizer at work but it did not help. The following day he went to Urgent Care and then to Central DuPage Hospital. Dr. Huml took him off of work, gave him a nebulizer, prescribed Symvicort and referred him to Midwest Heart Specialists. Petitioner testified that he used the nebulizer three to four times a day and he took a course of steroids on two occasions. He was off of work from October 11, 2008 to October 21, 2009.

6. On October 17, 2008, Petitioner was seen at Suburban Lung Association. At that time Petitioner reported that he had been diagnosed with asthma approximately three years ago. While he was at work a package was damaged/opened and black power was expelled. He used his albuterol inhaler that day and the next day he went to Danada Urgent care. Petitioner reported his asthma was well controlled until one week ago when he had to clean powder off a conveyer belt at work. Since then, he had an increase in dyspnea. He was seen in urgent care where he was treated with a nebulizer and he was sent home with prednisone and nebulizer. Dr. Robinson noted yesterday Petitioner still had symptoms of dyspnea, which he says is somewhat worse in the morning and which improves with nebulizer treatments. He was diagnosed with having asthma and increased symptoms related to the inhalation of dust at work. The doctor opined that most likely Petitioner had a component of reactive airway dysfunction syndrome (RADS). He also had an abnormal EKG. In light of Petitioner's family history, he needed to undergo a stress test.

7. On November 3, 2008 Petitioner followed up at Suburban Lung Association. He was diagnosed as having asthma and it was noted that it was probably a component of RADS. On clinically examination it was noted that he is improved. His PF is better and he is now free of wheezing.

8. On November 17, 2008 Petitioner again followed up at Suburban Lung Association. The doctor noted that he had two albuterol nebulizer treatments while in the office. The material he inhaled has been identified as toner for a fax machine. He was diagnosed with probably having a component of RADS, CXR and CRT-infiltrates. Despite prednisone, his wheezing persists. Petitioner's medication was altered.

9. On November 24, 2008 Petitioner underwent a chest CT which showed scattered tiny bilateral nodules opacities. Minor scattered low grade bronchiectasis. No interstitial pneumonitis, ground glass opacity or interstitial destructive changes.

10. On February 26, 2009 Petitioner followed up at Suburban Lung Association. Petitioner reported he is feeling better and is currently off prednisone. He still uses the albuterol treatment. He was instructed to continue his present treatment, was told to return in four weeks and it was noted that if Petitioner was doing well at that time they might consider a stepdown in medication.

11. Petitioner's September 25, 2009 chest CT showed that there are a number of small, scattered, non-calcified lung nodules, predominantly peripherally located within both lungs. There are all unchanged in size when compared to November 24, 2008 study.

12. An October 23, 2009 letter from Dr. Otteman addressed To Whom It May Concern stated that he had been following Petitioner for the past year. Petitioner has been under his care for the treatment of RADS. Since that time he has shown improvement overall. He feels that Petitioner has very strong urge and desire to return to work at this time and he has a very strong work ethic. We agree he can return to full duty work, but he should be able to operate with his nebulizer 2 times a day and wear masks in exposed dust areas with other chemical irritants.

13. Petitioner testified, on direct examination, that the Respondent did not provide any masks, respirators, fans or ventilators. While at work, he welded in enclosed spaces. On cross-examination, Petitioner testified that Respondent did provided dust masks, but they did not provide respirators. Paul Elza testified that, in terms of protection, the employees are issued face shields for welding along with welding gloves, jackets, sleeves as a matter of course and most of the employees wear a bandanna/handkerchief over their faces underneath their masks. The dust masks that are provided are N95 masks manufactures by 3M.

14. On April 16, 2010 Petitioner was seen at Suburban Lung Association. At that time, Petitioner complained of shortness of breath with exertion, wheezing and increased use of relief medication, but he denied experiencing a cough. He reports since starting prednisone he feels much better. He was diagnosed as having asthma with an acute exacerbation and he was treated with medication.

15. Petitioner testified that on April 18, 2010 he was cutting off some hinges with a welding torch. There were some embers that ignited underneath the frame of the conveyor and they started smoking. At that time, he started experiencing a little shortness of breath so he left the area. Dr. Otteman took him off of work from April 18, 2010 through May 29, 2010

16. On April 23, 2010, Petitioner returned to Suburban Lung Association. It was noted that Petitioner presents with asthma following exacerbation. It was further noted that Petitioner was exposed to smoke fumes at work and he has started Prednisone. He feels jumpy but appears to be breathing fine at this time. He has asthma with an acute exacerbation and he is being treated with medication.

17. On May 28, 2010 it was noted at Suburban Lung Association that Petitioner was given the okay to work and on September 9, 2010 the Petitioner reported that his asthma is well controlled. However, on June 10, 2011, Petitioner reported to Suburban Lung Association that his asthma is not well controlled at times with use of a nebulizer up to 4-5 times a day.

18. Petitioner testified that two days before July 18, 2013 he advised Tom Heda that he was having some issues and needed to take a few breathing treatments before coming to work. Petitioner testified that on July 18, 2013 he was in a heated area and experienced sweating and trouble breathing. He used his nebulizer but it did not seem to help. Dr. Otteman took him off of work from July 18, 2013 through July 26, 2013.

19. On July 18, 2013 Petitioner was seen at Adventist LaGrange Memorial Hospital and reported he was having difficulty breathing over the last thirty minutes. His course/duration of symptoms is constant and improving from severe to moderate. The exacerbating factor is heat. He has experienced prior occasional episodes. In addition, he had a history of RAD symptoms, which has increased over the last two days. He had experienced no improvement with inhaled corticosteroid and a rescue beta agonist. He is improving and he feels better. He was told to follow up with the pulmonologist or his own personal physician if he is not better in a day or two.

20. On July 26, 2013 Petitioner was seen at Suburban Lung Associates where it was noted that Petitioner experienced an asthma exacerbation while at work and was taken by ambulance to the emergency room. He reported he was working in the heat that was approximately 115 degrees and was wearing a mask when he started gasping for air. He used his nebulizer but it only helped a little bit. Currently, he is feeling much better but he is not working.

21. On September 5, 2013 during a follow up visit at Suburban Lung Association it was noted that Petitioner's asthmas is well controlled. During the December 2, 2013 follow-up visit, it was noted that Petitioner is doing well but he had cold symptoms a few weeks ago. On March 6, 2014, Petitioner was diagnosed with having unspecified allergic rhinitis, asthma and a viral infection. He was told to follow up in three months.

22. Currently, Petitioner states he has minimal tolerance to extreme cold or heat, humidity and different chemicals. He defined minimal tolerance as finding it hard to be around/inhaling certain substances. When he is, he has to use a rescue inhaler or get treatment. He is still working in the Chicago Area Central Hub (CACH). Ninety percent of his time is spent maintaining the conveyors. Paul Elza testified that Petitioner never stated that he was unable to weld and he currently does that as part of his duties today.

23. Dr. Huml was deposed on February 3, 2010. He is board certified in internal, pulmonary and critical care medicine. He testified that RADS is defined as reactive airway dysfunction syndrome. It is a clinical scenario where a patient has no or minimal airway symptoms and is exposed to some entity which is an irritant to the airways and causes reactive airway or asthma type symptoms or worsening of asthma type symptoms superimposed on a prior mild disease. In October of 2008, Petitioner had a full history and physical examination performed along with a spirometry test and a measurement of his blood oxygen level. Petitioner has a history of having asthma for three years. His asthma was well controlled until one week prior to his October 2008 visit when he cleaned powder off a conveyer belt at work. Dr. Huml opined that Petitioner's symptoms as of October/ November of 2008 were clearly related to his exposure of October 9, 2008. Since October of 2008 Petitioner had an increase in his dyspnea or shortness of breath. The last time he saw Petitioner was on July 23, 2009. His diagnosis was still RADS at that time, which continued to slowly improve but still required a fair amount of medication. He was discharged with Prednisone. He diagnosed Petitioner with asthma. Since then Petitioner was seen at urgent care on October of 2010 and treated with a nebulizer. Dr. Huml stated that Petitioner's increase in symptoms was related to inhalation of dust at work. It was his conclusion that Petitioner most likely had a component of RADS. Normally patients who have RADS have persistent symptoms for up to two years and there is gradual improvement in symptoms over time. He reviewed

the safety data sheets for the dust particles and he may/may not have reviewed it for Simple Green data. He doesn't see the material safety data sheets (MSDS) in his file. In reviewing the MSDS sheets he would look for any evidence of an irritant into the mucosal membranes or evidence for pulmonary symptoms that characteristically occur after exposure to the agent. He agreed that he did not cite the MSDS sheets in his May 29, 2009 or June 9, 2009 reports. At most he mentioned Simple Green in his May 29, 2009 report as being one of the two entities Petitioner was exposed to at work. Dr. Huml testified that he does not know if Simple Green was a causative factor in bringing about RADS. All he knows is that the symptoms were temporally related to exposure to two entities. One, was dust at work and the second was the cleaning solution. He testified that there need not be an immediate adverse reaction upon his inhalation of Simple Green because it depends on the immunologic response to the inhalation. There are two types of immunologic responses. One is immediate and the other one is delayed. So, it could be both in this case. Off hand, he cannot say what the black powder was that Petitioner was exposed to at that time. He got the information that he was exposed to black powder from the patient. He agreed that for the black power to be ingested into his lungs/throat/nose a component of it would have to be aerosolized and there was no mention that there was any aerosolization of the black powder. He has no independent recollection of Petitioner reporting that he walked into a cloud. He can only say what is documented in the medical records. He was asked to assume that Petitioner was exposed to the black powder at all times and was asked that if by wearing the covering over his mouth/nose consisting of cotton fibers would that likely eliminate any effect that this black power had. Dr. Huml testified that it would depend on the type of the mask and the size of the particles being filtered effectively by the mask. It was his impression that Petitioner was initially exposed and then he subsequently wore a mask to clean it up spill. He cannot tell say how frequently Petitioner used the inhaler prior to the work event. In his opinion prior to the work exposure Petitioner's asthmas was well controlled with a beta-agonist alone as therapy. He opined that if the black powder is from an ink cartridge for a printer that it may be sufficient to cause RADS.

24. Dr. Moisan was deposed on May 18, 2011. He specializes in pulmonary diseases. He is board certified in internal medicine, pulmonary diseases and occupational health. The bulk of his pulmonary medicine private practice consists of treating airway diseases and occupational lung diseases are his primary focus. He evaluated Petitioner. Petitioner told him he was in a facility where there was spilled powder. Although he was not present during the spill, there was a black powder that had spilled in the area of the conveyer and he was asked to clean it up. He used some Simple Green, wore gloves and a cotton mask. The cleanup took about an hour. He stated about a half an hour to an hour later he developed shortness of breath. He later went to urgent care. When he was asked by a pulmonologist about the dust, Petitioner said there was no obvious aerosolized dust in the area that he could see such as a midst or a cloud. So, he could not determine whether

there was an airborne component. The black powder was found to be ink jet printer toner. As time went on, Petitioner reported experiencing more asthmatic symptoms. Petitioner had been on a couple of doses of steroids and had been using an inhaler. Petitioner stated three months ago that he was on his last dose of oral cortisone and he was feeling pretty good on his current medication. Petitioner had a history of adult onset of asthma which was worse often with respiratory tract infections. He also stated that with the rare use of albuterol/bronchodilator/rescue inhaler he had not had to use any other asthma medications prior to the work exposure. On examination Petitioner's oxygen saturation test was normal. He had obstructive rhinopathy. He had significant inflammation of the turbinates in the nasal passages which caused some blockage. Dr. Moisan opined that Petitioner had chronic nasal allergies. On a forced exhalation, Petitioner had a very minimal wheeze. However, there is not much significance to this as most people generate a wheeze when they forcibly exhale. Most asthmatics, if they have active bronchospasm, the wheezing will not require a force exhalation. So, that would be practically considered normal. Petitioner's spirometry test showed no evidence of obstruction, which is the hallmark of asthma. Petitioner did appear to have a restrictive defect, meaning his lung volumes may be smaller than normal. This would not be an asthmatic-type thing. So, basically Petitioner had a negative or normal spirometry with respect to asthma. Petitioner's medical records show that back in 2006 he saw an allergist who prescribed Advair, which is a cortisone and bronchodilator medicine for asthma and Medrol which is a steroid. So, that means he had a pretty significant flare of his bronchial asthma. On September 2, 2007 Petitioner's asthma was quiet. He was told to continue with Singulair, which is used in asthma particularly if there are allergic features. On October 10, 2008 a cough and shortness of breath were noted. His CAT scan showed low-grade bronchlectasis, which is a destructive process of the bronchial tree. This is usually due to longstanding infections, hereditary features or IGA deficiencies. So, Petitioner had an abnormal CT scan which was not related to asthma. His spirometries tests were normal. His total lung capacity is low-normal. The doctor noted purulent, which is a pus-like bronchitic type and this was interesting to him because of Petitioner's bronchiectasis on the CT scan. These two things are consistent. People with bronchiectasis get recurrent infections. So, it started to fit why Petitioner might have bronchiectasis or chronic airway symptoms. Petitioner said he had mild asthma, but his medical records suggest he had more than mild asthma. So, he commented that people who have a significant flare in their pre-existing asthma and who have a significant exposure to a volatile agent (a solvent of some sort) or aerosolized agent, are extremely irritated. So, for there to be an effect on the lungs, a couple of things have to occur. One, there has to be a definite exposure and it has to be in the respirable zone. It has to be either allergenic or highly irritating and it is usually of sufficient quantity to be noticed. He told me that he did not see a cloud in the air. He was wearing a mask. So those features generally mitigates against a significant respiratory exposure. In order to affect the bronchial area, it requires a more prolonged exposure and it requires something that penetrates into the lower

airways. Additionally, you have to look at whether something is an irritant or an allergen. The latter may require an un-measurable amount while the former usually requires a higher concentration which has to be extremely disagreeable with mucosa, the lining of the bronchial tree. In terms of permanent damage, it has to be a massive exposure. By definition, Petitioner has a very minimal or de minimis type of exposure. He did not note it in the air. He was wearing a mask. His symptoms did not come on immediately. This type of exposure is not known to be something that causes permanent damage. So, this was a very minimal bystander-type exposure. Speaking of the substances itself, it was later discovered to be some sort of printer ink for a fax machine or printer, which by themselves are a minimal, low grade irritants. Petitioner also used a cleaning solution called Simple Green, which has a fairly low vapor concentration and is marketed as being safe. It would be an extremely minimal irritant. Once the cleaning product is applied to the power it means you cannot aerosolize it. What he thinks happened is that Petitioner had longstanding asthma along with other airway diseases such as low grade bronchiectases and recurrent purulent bronchitis, which required steroids in the past. He also has a lot of allergies. He was scrubbing and exerting himself to some degree and a half an hour to an hour later his asthma flared. If this was a significant exposure to a highly noxious or irritating chemical, it would have happened in minutes. So, he does not know that the asthma Petitioner had later in the day was even related to this activity or if it was just part of his underlying asthma. At worst, it could have caused a temporary flare in his symptoms but even that, would be a generous statement. Could it have happened? Yes, he cannot exclude it. Would it have been responsible for a permanent alternation in Petitioner's airway reactivity. Absolutely, it would not result in any permanency. There is no biologic plausibility or medical evidence to suggest that this type of exposure changes one's asthma from being moderately controlled to being poorly controlled.

25. Dr. Moisan testified that RADS is caused by being exposed to extremely high prolonged levels of irritating chemicals that are breathed it. It causes damage to the bronchial tree and presents itself like asthma. In other instances, it is similar to what we see after the flu is over. It causes protractive inflammation of the bronchial tree and can cause asthmatic-like condition. RADS is clearly not Petitioner's diagnosis based on the fact that he has longstanding asthma and at/around the time of the incident his asthma flared up. RADS implies that someone has developed something that they have never had before due to a massive exposure. Unfortunately, it has been bastardized over the years to the point that everyone who coughs a little bit after they get an exposure had their doctor saying they have RADS without any biologic or physiologic backup. In traditional medicine, we look for cause and effect through association and this is valid. However, in toxicologic aspects/environmental/occupational aspects, one also has to look at the cause and effect chain as mere coincidence. One has to look at a few things. One, being the exposure and the biologic plausibility of the condition. It is not enough to have a temporal relationship.

In regard to the alleged April 18, 2010 exposure apparently there was a small ember fire where the torch accidently ignited some loose papers in his vicinity. There was some smoke in the area. Petitioner reported that he was wearing a mask every day. He was using his daily medications. So he prophylacticlly gave himself a nebulizer treatment and he did not notice any significant shortness of breath immediately, but he later required a Prednisone pulse.

On examination Petitioner had a slight expiratory wheeze. No obstruction was noted on the spirometry. So, he felt that based on his interval exam that Petitioner's had longstanding asthma occasionally required steroids. The brief exposure in April of 2010 may have increased Petitioner's airway reactivity to some degree, but the reactivity would be short lived and would only be over a few days to weeks.

Dr. Moisan opined that Petitioner could continue to work with respiratory protection to eliminate anything that could be triggering his asthmatic episodes. At most this was a flare of his asthma. It did not permanently damage him or change his underlying condition. He expected that Petitioner returned to his baseline within a couple of weeks thereafter.

On December 19, 2013 Dr. Moisan authored an independent medical evaluation report. Dr. Moisan noted that on July 18, 2013 Petitioner was seen at the emergency room with difficulty breathing. A review of the emergency room records suggested his dyspnea was improving at the time of the evaluation and the exacerbating factor appeared to be heat. Although technically his breath sounds were clear, he was given a prednisone pulse.

Petitioner was examined on December 19, 2013 and at this time he appeared to have stable mild persistent asthma well controlled by his medications with an occasional flare induced by various changes in ambient conditions. Dr. Moisan opined that this would not be consistent with an exposure that would permanently alter one's airways given this was presumably a nuisance or irritant dust with relatively low level exposure. This was not the type of exposure known as RADS. Nor was it chronic low level irritant exposure that is associated with irritant–induced asthma. Therefore, he continued to opined that Petitioner has had pre-existing asthma with normal fluctuations in asthmatic symptoms given the nature of the disease. Petitioner has no residual airway obstruction. He would continue to conclude based on the additional data that there is no permanency from the prior exposure. He further opined that Petitioner continues to work in the facility which is apparently well environmentally controlled except for some changes in heat during the summer months. Lastly, he opined that he sees nothing in Petitioner's current exposure that would materially affect his bronchial asthma in any material way.

Having reviewed the entire record, the Commission finds that Petitioner is not credible. The Commission finds Petitioner either flatly denied that he has a pre-existing condition of asthma, bronchitis or any other respiratory illness prior to the claims or he tried to significantly downplay the same. Petitioner initially testified that prior to October 9, 2008, the first alleged date of exposure, his lungs and breathing were very good and he had not ever experienced any difficulty breathing or sought any medical treatment for difficult breathing. Petitioner had also indicated on Dr. Moison's intake form that he did not now or had not ever had asthma, bronchitis or any other respiratory illness. When Petitioner is asked a second time during the Arbitration hearing whether he had breathing issues, he then testified he had some wheezing and he was prescribed some Prednisone to help him through what may have been asthma but he and Dr. Roth were not quite sure what his condition was. When he is asked a third time on cross-examination, Petitioner states he does not recall giving Dr. Roth a history of asthma and it is possible that he treated for asthma with more than a Prednisone inhaler. When Pet. is asked about the use of his relief inhaler he indicates both in the January 30, 2009 treating records and with Dr. Moisan that he had an emergency relief inhaler that he "rarely" used prior to his work exposures. He testified that "rare" was one to two times a month on a rescue basis. As Dr. Roth's records clearly indicate, Petitioner did in fact have a history of asthma, which was even labeled "severe" asthma at one point and which required more potent steroid medication than a rare use of a Prednisone inhaler. Additionally, when Petitioner is asked if Respondent provided mask, respirators, fans or ventilators, Petitioner denies the same on direct examination and when Petitioner is asked that question a second time on cross-examination, he contradicts his earlier testimony and states that he was wearing a dusk mask at the time of the October 9, 2008 clean up. He further states that Respondent provided dust masks but tries to down play the same as being inferior to respirators. Petitioner's testimony is also subsequently rebutted by Paul Elza's testimony when Mr. Elza not only states that dust masks are provided. He specifically identifies that make/model of the dust masks. Lastly, Petitioner reports that at the time of the alleged October 9, 2008 exposure that the power was airborne and caused a "cloud of dust to emerge". Yet, this same history is not provided in the treating records and the same history was flatly denied when Petitioner was evaluated by Dr. Moisan. As such, the Commission finds that Petitioner is not credible and find that Pet. presented inconsistent histories to the doctors.

In terms of causation, the Commission finds that Dr. Huml appears to have both misdiagnosed Petitioner's condition as RADS and his causation opinion lacks foundational support. Contrary to Petitioner's medical records, Petitioner reported to the doctor that his asthma was "well controlled" until one week prior to October 9, 2008. Additionally, Dr. Huml's testimony provides numerous examples that he did not understand what Petitioner was actually allegedly exposed to and which show that he clearly lacks a foundational understanding of the said alleged exposure. Specifically, Dr.

Huml diagnoses Petitioner with both asthma and RADS due to inhalation of "dust", and not black powder, at work along with the use of a cleaner solution. Yet, he does not specifically identify the cleaning solution as Simple Green by name. When Dr. Huml is asked if the cleaner Simple Green was a causative factor in bringing on RADS, he states, contrary to his earlier testimony regarding a cleaner, that he does not know. He subsequently states that he may/may not have reviewed the MSDS sheet for Simple Green. He reviewed the MSDS sheet for "dust", again not black power/ink from a toner cartridge, that he does not have either the dust or Simple Green MSDS sheet in his file nor did he mention the MSDS sheets in his reports. When he is asked specifically about the "black powder" that Petitioner injected, he states that "off-hand he cannot tell you what the black powder" is and his understanding that there was black powder came from Petitioner's history itself. He agrees that in order for the black powder to be ingested into Petitioner's lungs/throat/nose that it would have had to be aerosolized/air born and he further agrees there was no mention of the same having occurred. At best, he gleaned this fact from the medical records. When asked if the use of a mask would have eliminated any effect of the exposure to the powder, Dr. Huml said it would depend on both the mask itself and the size of the powder. He then went on and stated that he "assumed" that Petitioner was initially exposed to the powder prior to donning the mask. Lastly, Dr. Huml is directly asked on redirect examination if the black powder is from the printer ink cartridge, whether that is sufficient to cause RADS the best he can come up with is "it may have". The basis of Dr. Huml's causation opinion is strictly placed on the timing of the events. Having reviewed his deposition, it is clearly evident numerous times over that Dr. Huml did not understand what Petitioner was actually allegedly exposed to and he clearly lacks a foundational understanding of the said alleged exposure. Based on the above, the Commission finds that Dr. Huml's causation opinion lacks the proper foundational understanding necessary in which to assign sufficient weight to his causation opinion and in which to overcome Petitioner's burden of proof that his claims are compensable.

Having review Dr. Moisan's deposition, it is evident that Dr. Moisan had a commanding grasp of the facts surround the alleged work incidents. Dr. Moisan provides a good understanding of what asthma is, how it affects a given individual and how it is treated. Additionally, Dr. Moisan spent a significant amount of the laying out what RADS is and how one contracts RADS. He specifically points out the overuse of the diagnosis that is being made by many of the doctors in the medical field. Once he sets forth the given facts in this case along with his breath of knowledge on the topics of asthma and RADS, he concludes that Petitioner does not have RADS and any reaction Petitioner may have had is related to his pre-existing underlying asthmatic condition which periodically and temporarily flaring up with no residual permanent damage having occurred. Having reviewed both depositions, the Commission finds that Dr. Moisan's causation opinions should clearly be weighed significantly heavier than those of Dr.

15IWCC0314

Huml's causation opinions and the Commission reverses the Arbitrator's findings. The Commission finds that Petitioner failed to provide sufficient evidence to support his claim that on his work exposure on October 9, 2008, April 18, 2010 and July 18, 2013 resulted in a disability under the Occupational Disease Act and the Commission finds that Petitioner's claims are not compensable under the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained an Occupational Disease arising out of and in the course of his employment on October 9, 2008, April 18, 2010 and July 18, 2013 or which became aggravated and rendered him disabled as a result of the exposure of the employment, his claims for compensation are 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: MAY 1 - 2015

MB/jm

O: 4/9/15

43

Mario Basurto

David L. Gore

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott A. Holocker,

Petitioner,

15IWCC0315

vs.

NO: 12 WC 33397

Komatsu America Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of average weekly wage, temporary total disability, §19(l) penalties and §16 attorney fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On the date of accident, Petitioner was a 46-year-old transportation operator for Respondent. Petitioner sustained an undisputed work-related injury on September 11, 2012 when he was struck in the face and chest with a crane chain, sustaining dental injuries. Petitioner attempted to operate a crane after returning to work and experienced a panic attack. Respondent's examining physician and Petitioner's physician diagnosed Petitioner with anxiety and recommended that he avoid crane work for a period of time and resume crane work at his own pace. The existence of Petitioner's anxiety condition was not disputed. Petitioner continued working for Respondent as a transportation operator while entirely avoiding cranes. It is undisputed that "transportation operator" is a job classification that encompasses many different jobs within Respondent's company and that many jobs do not involve any work with cranes.

Petitioner was discharged from his employment on October 15, 2013 for reasons unrelated to his claim. Petitioner testified that he immediately began looking for other jobs, but he also demanded temporary total disability benefits pursuant to *Interstate Scaffolding, Inc. v.*

Illinois Workers' Compensation Commission, 236 Ill.2d 132, 337 Ill.Dec. 707 (2010) on the basis that his work-related condition had not yet stabilized. The Court in *Interstate Scaffolding* held that an employer's obligation to pay temporary total disability benefits to an injured employee does not cease because the employee had been discharged--whether or not the discharge was for "cause." When an injured employee has been discharged by his employer, the determinative inquiry for deciding entitlement to temporary total disability benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to temporary total disability benefits. *Id.* at 149.

Petitioner claimed that he had not reached maximum medical improvement for his dental injuries and post traumatic anxiety and he remained under temporary restrictions at the time of his termination. Petitioner alleged that Respondent's refusal to pay temporary total disability benefits after October 15, 2013 was vexatious, unreasonable, and contrary to the law. Respondent refused to pay temporary total disability benefits on the contrary basis that Petitioner's condition had in fact stabilized by the date of termination. Respondent indicated that Petitioner was not temporarily totally disabled from work and his restrictions with respect to crane usage did not prevent him from obtaining employment elsewhere. At the time of termination, Petitioner was performing full duty work for Respondent within his regular job classification.

It is pertinent that in *Interstate Scaffolding*, the claimant's ability to find work in the open labor market was significantly limited or precluded by his work-related condition. After the claimant was terminated for reasons unrelated to the injury, the court found that Petitioner was entitled to temporary total disability benefits until his condition stabilized. We find that *Interstate Scaffolding* is distinguishable from the case at hand. Although both Petitioner and the claimant in *Interstate Scaffolding* had yet to reach maximum medical improvement at termination, maximum medical improvement is not alone dispositive on the issue of whether a claimant's condition has stabilized. Petitioner required additional dental work and continued to have symptoms of anxiety and therefore he had not been placed at maximum medical improvement by the date of termination. However, Petitioner was working full duty within his job classification of "transportation operator" until he was terminated; he performed one of the numerous jobs that did not involve any crane usage. The evidence shows that it was not necessary for Respondent to either modify an existing job or create an accommodating job on account of Petitioner's restrictions. Respondent's representative, Mr. Dubois, testified credibly that Petitioner could have continued to work for Respondent indefinitely without any mandatory crane exposure.

Furthermore, Petitioner offered no evidence that he was significantly limited or precluded from reentering the labor market because he needed to temporarily avoid cranes. In fact, Petitioner offered no explanation at all for why he had been unable to secure employment since termination, despite testifying that he performed a self-directed job search and locating potential employers. Respondent's vocational expert, Ms. Massat, testified that a labor market survey found several employers within the Peoria area who were hiring for positions that matched Petitioner's qualifications and salary and did not involve crane usage. Furthermore neither Petitioner nor Ms. Massat indicated that Petitioner's need for dental care had any impact on his employability in his usual and customary field of employment. The evidence shows that at

termination, Petitioner's work related injuries had stabilized and had no impact on his employment.

We do not find that Petitioner is entitled to temporary total disability benefits beginning after his termination on September 13, 2013, therefore Petitioner's argument that the Arbitrator erred in not awarding penalties and fees on unpaid temporary total disability benefits from October 15, 2013 through January 29, 2014 is moot. Nevertheless, we find that a genuine dispute existed with respect to whether Petitioner's condition had stabilized such that he was not entitled to temporary total disability benefits after termination and we find no evidence that Respondent acted unreasonably or vexatiously in denying benefits.

Both parties also appealed the Arbitrator's decision on the issue of average weekly wage. Petitioner alleges an average weekly wage of $1,200.00. Respondent disputes Petitioner's average weekly wage and claims $1,063.81 per week. The Arbitrator found an average weekly wage of $982.78. After considering all of the evidence with respect to average weekly wage, we find that Petitioner's average weekly wage is $1,008.34. We note that there was very little testimony at arbitration with respect to Petitioner's earnings. Furthermore, the earnings-related documents submitted as Respondent's exhibit #1 were not corroborated or explained by the testimony of Petitioner or Mr. Dubois. On direct examination, Petitioner testified that between September of 2011 and September of 2012 he had to work every Saturday except for one Saturday per month. Petitioner did not recall whether there were mandatory Sundays. However, he testified that overtime was first offered to senior employees before being offered to junior employees like himself, and Petitioner further testified that some of the overtime he worked during the year was voluntary. He estimated that in the year 2012 he worked forty-eight hours per week. (T. 42-43) Mr. DuBois, did not recall Petitioner's wage rate but on cross-examination he agreed that twenty-five dollars per hour was probably a "fair" estimate. (T. 71-72)

The wage records contained in Respondent's exhibit #1 contain handwritten calculations. They purport to show that Respondent originally calculated an average weekly wage of $1,063.81 after the injury and provided that figure to the insurance company. Internal email correspondence dated September 20, 2012 estimates that eighty hours of overtime were mandatory out of 144 hours; that twenty-seven out of fifty Saturdays were mandatory, and that two Sundays were mandatory. Respondent's exhibit #1 also contains earnings records showing that for the period of September 15, 2011 through September 13, 2012 Petitioner's total pay was $72,769.98.

Petitioner's argument that his average weekly wage is $1,200.00 is very simply based on his testimony that he worked forty-eight hours per week in 2012, and the agreement of Mr. DuBois that twenty-five dollars per hour "sounds fair" for Petitioner's job classification. The Arbitrator and Respondent used the information in Respondent's exhibit #1 to calculate the average weekly wage, but came to different results. After considering all of the evidence, we find that Petitioner's average weekly wage is $1,008.34. This conclusion is most consistent with the credible evidence. We agree with the Arbitrator's finding with respect to mandatory overtime hours worked, 312 hours, but we find that voluntary overtime hours were not excluded from the total hours worked, 599 hours. Section 10 of the Act provides that the method for calculating a claimant's average weekly wage is to divide by fifty-two the "actual earnings" of the claimant

over the fifty-two weeks period preceding the date of injury. It is well settled that voluntary overtime cannot be used in calculating the average weekly wage. *Airborne Express, Inc. v. Illinois Workers' Compensation Commission*, 372 Ill.App.3d, 549, 554 (2007).

Medical expenses and the nature and extent of the injury were not placed in dispute at hearing and therefore the Arbitrator did not award medical bills or permanent disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of temporary disability benefits of $612.29/week for 15 and 1/7 weeks, commencing October 15, 2013 through January 29, 2014, as provided in Section 8(a) of the Act is vacated for the reasons set forth above and no other benefits are awarded herein.

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

DATED:
RWW/plv
o-3/3/15
46

MAY 4 - 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0315

HOLOCKER, SCOTT
Employee/Petitioner

Case# **12WC033397**

KOMATSU AMERICA CORP
Employer/Respondent

On 2/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

15IWCC0315

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Scott Holocker
Employee/Petitioner

Case # **12** WC **33397**

v.

Komatsu America 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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **January 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 11, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the Petitioner's average weekly wage was **$982.78**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$7,193.44** for TTD paid to Petitioner prior to hearing.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of **$612.29**/week for **15 1/7** weeks, commencing **October 15, 2013** through **January 29, 2014**, as provided in Section 8(a) of the Act.

No other 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

February 19, 2014
Date

FEB 25 2014

FACTS:

The facts of the instant matter are essentially undisputed. On September 11, 2012, the Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent. As part of his regular job duties, the Petitioner was operating an overhead crane when the metal chain mail strap he was using snapped and hit him in the face and chest. The Petitioner testified that the blow knocked him backwards, knocked out four of his teeth, injured his cheek bone, and caused bruising to his chest.

The Petitioner was taken from the scene of the accident by ambulance to St. Francis Medical Center where he was noted to have facial and dental fractures, as well as a large laceration of his lower lip extending into his chin. Diagnostic studies showed multiple fractures of his right maxillary sinus and right maxilla, as well as hemorrhage within the right maxillary sinus, the loss of four teeth, and a left chest wall contusion. The Petitioner underwent repair of his mouth laceration that day and he was discharged with prescriptions for pain medications and follow-up recommendations.

Thereafter, the Petitioner followed up with plastic and oral surgeons and he underwent four surgical procedures to his face and mouth. The Petitioner also treated with a dentist and underwent several attempts at restoring his teeth. The Petitioner testified that he continues to treat with a dentist and is in the process of obtaining dental implants.

The Petitioner was off work from September 12, 2012, until October 16, 2012, when he returned to work under light duty restrictions. The Petitioner was then released to work full duty with no restrictions on December 14, 2012. The Petitioner was also off work following dental surgery from May 23, 2013 through June 12, 2013. The Petitioner testified that he was paid Temporary Total Disability benefits during the periods of time he was off work.

The Petitioner testified that after his return to work in October of 2012, he was uncomfortable operating cranes and he requested that he not be assigned any crane duties. This request was accommodated. The Petitioner testified that from December 14, 2012, through July 3, 2013, he was required to operate a crane on only two or three occasions. He testified that on July 3, 2013, he was again required to operate a crane and, on that occasion, he experienced a panic attack. The Petitioner testified that he immediately visited the onsite occupational nurse who took him off work until he was cleared by his primary care physician, Dr. Vilatte.

On July 11, 2013, the Petitioner was seen by Dr. Vilatte, who noted that the Petitioner was experiencing panic attacks and anxiety while doing his job and prescribed the Petitioner a non-sedating anti-anxiety medication. Dr. Vilatte then recommended that the Petitioner be placed at another job while he adjusted to his medication.

Chris Dubois, the Respondent's Human Resource Manager, testified that the Petitioner did bid for another job following his visit with Dr. Vilatte. According to Mr. Dubois, a janitorial position was offered, but Petitioner declined. According to Mr. Dubois, the janitorial position

15IWCC0315

was permanent and full time in Petitioner's union, where Petitioner would be earning the same wage and would not require Petitioner to work on or near cranes.

On July 22, 2013, the Petitioner was evaluated by Dr. Moody, the Respondent's company doctor. Dr. Moody cleared the Petitioner without restrictions for the janitorial position and recommended a restriction of no crane operation for six to eight weeks if he returned to his previous position as a transportation utility worker.

Mr. Dubois testified that it was not difficult to let Petitioner return to his previous position as a transportation utility worker and assign him to perform the other various duties that did not require crane operation. Thus, Petitioner was able to return to work on July 23, 2013, as a transportation utility worker.

On August 13, 2013, the Petitioner began counseling sessions with Jennifer Boehs, a Licensed Clinical Social Worker, for his crane related anxiety. On September 18, 2013, Ms. Boehs diagnosed the Petitioner with post traumatic stress disorder as a result of his work injury. She recommended that the Petitioner avoid operating a crane for at least one year and indicated that if he does need to operate a crane, he should do so gradually in order to build his tolerance.

On January 9, 2014, the Petitioner underwent a psychological evaluation with Dr. Nancy Landre at the request of the Respondent. Dr. Landre opined that the Petitioner satisfied the criteria for an Adjustment Disorder with Mixed Anxiety and Depression and she opined that it was reasonable to conclude that the Petitioner's current anxiety symptoms were attributable to his injury on September 11, 2012. Dr. Landre also opined that the Petitioner was able to perform all of the duties required in his usual occupation except for the crane operation. Dr. Landre placed the Petitioner on full duty with the restriction that he not be required to operate a crane for six months.

On October 15, 2013, the Petitioner's employment with the Respondent was terminated as a result of his failure to call in or report to work for three consecutive days in violation of the terms contained in the collective bargaining agreement between Petitioner and Respondent. The Petitioner testified that since his termination he has been actively seeking work for positions within his union. He testified that he has some promising leads out of state, in San Diego, but has made no effort to find employment in Central, Illinois.

Alla Massat, a Certified Rehabilitation Counselor, testified that based on the Petitioner's job experience, job description, and medical evaluations, the Petitioner's restriction of no crane operation did not preclude the Petitioner from re-entering the work force. Ms. Massat opined that there were various employers in Peoria, Illinois who were hiring for positions that matched the Petitioner's qualifications, salary, and restriction of no crane operation.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (G.), What were Petitioner's earnings, the Arbitrator finds and concludes as follows:

Respondent's Exhibit # 1 reflects that during the 12 month period preceding the Petitioner's injury, he was paid $40,382.97 for regular time, $13,207.26 for overtime at time and a half pay, $10,514.80 for overtime 2 at time and a half pay, $2,661.12 for holiday pay, $863.24 for personal time, $2,544.25 for vacation, and $1,347.50 for a night bonus. The Petitioner did not testify as to what his hourly pay rate was during the period although the Respondent's H.R. Manager, Chris DuBois, estimated it to be "approximately $25.00 per hour".

The Petitioner testified that he was required to work scheduled Saturdays and that he only had one Saturday off each month for the whole year. The Petitioner acknowledged, however, that overtime was offered to employees based upon seniority and that some of the overtime he worked was voluntary. The Petitioner could not recall if he worked any mandatory Sundays during that period. Respondent's Exhibit # 1 indicates that, out of 50 weeks, the Petitioner had mandatory overtime for 27 Saturdays and 2 Sundays. During the work week Petitioner had roughly 80 mandatory hours through the whole period.

Therefore, utilizing Respondent's Exhibit # 1, out of 599 overtime hours worked by Petitioner, 216 were mandatory hours on Saturday (8 hours x 27 Saturdays), 16 mandatory overtime hours on Sundays (8 hours x 2 Sundays), and 80 hours of mandatory overtime during Petitioner's normal work week through that period. The Arbitrator finds that Petitioner has worked a total 312 mandatory overtime hours from September of 2011 to September 2012.

Respondent's Exhibit # 1 indicates Petitioner's average hourly wage to be $15 ($40,382.97 yearly wage/ 2696 standard hours worked). This provides Petitioner with $4,680 in mandatory overtime wage ($15 x 312 mandatory overtime hours) for AWW purposes. Taking into account Petitioner's yearly pay of $40, 382.97 + $4,680.00 for mandatory overtime + $2,661.12 for holiday + $2,544.25 for vacation + $836.24 for personal time gives Petitioner a yearly wage of $51,104.58. Dividing $51,104.58 by 52 weeks results in an average weekly wage of $982.78. The Arbitrator notes that, pursuant to Section 10, the Petitioner's bonus and voluntary overtime were not considered in calculation of Petitioner's average weekly wage. The Arbitrator finds that average weekly wages stipulated by Respondent and Petitioner were incorrectly calculated.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner claims entitlement to Temporary Total Disability benefits based upon the Appellate Court decision in *Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation*

Commission, 236 Ill.2d 132 (2010) because, at the time his employment was terminated by the Respondent, the Petitioner was still treating for his injury and he was still subject to work restrictions imposed by Jennifer Boehs, a Licensed Clinical Social Worker, as well as Dr. Moody, the Respondent's company doctor, and Dr. Nancy Landre, the Respondent's examining psychologist. The Respondent asserts that the Petitioner is not entitled to Temporary Total Disability benefits because the Petitioner's condition of ill being had stabilized and his restriction does not preclude him from re-entering the work force.

The Arbitrator notes that a review of the record demonstrates that, as of the date his employment was terminated by the Respondent, the Petitioner had not been released to unrestricted full duty work. Although the Petitioner had been released to return to work with restrictions and he was able to perform that work, none of the physicians who examined or treated the Petitioner indicated that the Petitioner had reached maximum medical improvement. The medical evidence establishes that the Petitioner continues to be treated for his injuries and that he continues to experience symptoms connected with his work related injury. Thus, the Arbitrator concludes that the Petitioner's condition had not stabilized as of the date his employment was terminated by the Respondent.

Based upon the foregoing, and having considered the totality of the credible evidence, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from October 15, 2013, the date the Petitioner's employment with the Respondent was terminated, through January 29, 2014, the date of Arbitration, a period of 15 1/7 weeks.

In Support of the Arbitrator's Decision relating to (M.), Should penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

With regard to the issue of whether penalties and fees under sections 19(k), 19(l) and section 16 should be imposed, the Arbitrator finds that Respondent's failure to pay temporary total disability was not unreasonable and vexatious or without good and just cause. Therefore, the Arbitrator declines to impose such penalties and fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AUBURN JOHNSON,

Petitioner,

15IWCC0316

vs.

NO: 11 WC 35742

JIFFY LUBE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Sections 8(a) and 19(b) of the Act having been filed by both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, order for vocational assessment, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator and denies compensation.

Findings of Fact and Conclusions of Law

1. Prior to the alleged accident which is the subject of the current claim, Petitioner worked for Respondent and had a work-related injury to his back in July of 2009. That injury resulted in a settlement which was approved by the Commission in December of 2010. (see Respondent's Exhibit 1). The Petitioner testified on September 3, 2011, he was working sedentary duty for Respondent because of that earlier work injury. His duty included greeting customers, occasionally working the cash register, and "doing tests on the computer." He was not supposed to do any lifting.

2. The Petitioner asserted that day was slow and the assistant manager, Justin, began sending people home. However, a little later "the place just got swarming with cars." The assistant manger demanded he begin working as "courtesy tech." That job entailed vacuuming out cars, checking the tires and washing the windows, and "dry the cars out." When Petitioner reminded him he was on light duty and could not "mess with doing the work or anything," he was threatened with termination.

3. Petitioner also testified he bent over to vacuum a sports car with a wet-vac. He heard something pop in his back and neck. He felt a burning sensation in his low back and then shooting pains in the right leg. Petitioner went to the lounge area, sat down, and told the assistant manager that he had to go to a hospital. Petitioner was told to wait, but he called someone to take him to a hospital because he could not drive. Petitioner was taken to an emergency room later that day. The Petitioner testified that this accident happened at around 3 pm, but the written report of accident shows it happened at 10 am (see Respondent's Exhibit 6). The Emergency Room records indicate that he did not present there until after 10 pm.

4. Petitioner stated he was working light duty for almost a year and a half after the first work accident. During that time he never called in sick due to his back or sought additional medical treatment for his back. This testimony was belied by the time sheets and wage records introduced as Respondent's Exhibit 7, indicating he returned to work in May of 2011. Moreover, following the earlier injury, Petitioner had extensive treatment including, physical therapy, injections, and a discectomy. His back was worse than his neck. Fusion surgery was recommended after the earlier injury

5. Petitioner further testified that he currently had no pain in his neck. His back felt better after the surgery. Sometimes he has shooting pains in the right leg, but he "can deal with it." He wants to return to work in some capacity and started looking for jobs in February. He informs prospective employers about his sedentary work restrictions. Nobody has hired him. He maintained a list of all the places he looked for work.

6. On cross examination, Petitioner testified he did not remember the exact dates he applied for different positions, but they were "about March." He went to all the places on his list even if he applied on line. He had people take him places in his search. The Respondent introduced subpoenas from locations where Petitioner asserted he applied for work; none of the responses show an application having been made.

7. Petitioner agreed that he was able to sit while working the cash register. The "computer tests" Petitioner performed appeared to be for tests for job applications; "that's what Mark set it up for." He did not perform tests on cars. He did not remember the exact time of his September 3, 2011 accident, but he thought it was around 3 pm.

8. His girlfriend took him to the emergency room, but he could not remember whether they went directly from Respondent's location; he "was hurting that bad" and "laying in the back seat." He did not remember when he left Respondent's facility or when he arrived at the emergency room where they examined his neck, back, and right leg.

9. Petitioner testified he fell down stairs and complained of injuring his back and neck in his previous workers' compensation claim. At that time he was treated for his back, but he did not recall any treatment for his neck. He did not recall Dr. Erickson recommending fusion surgery after the first accident. Petitioner also saw Dr. Michael after the fall down the stairs. He guessed he would not disagree with Dr. Michael's records if they indicated he recommended fusion surgery after the first accident.

10. Petitioner had surgery after the first injury and the initial claim was settled. Petitioner testified he was working at the time of the settlement. At the time of the second accident he worked full time. Petitioner denied that he continued to complain of back pain after the first surgery; he was fine. He was riding his bike to work.

11. Petitioner agreed that "immediately" after the September 2011 accident he went to a lawyer who referred him to Integrity Medical Center and Dearborn Medical. After the latest surgery, Petitioner did not return to work for Respondent or ask to come back to work for Respondent. At the time of his injury, Petitioner was holding the hose of the wet-vac and pulling it toward the car. The wet-vac was on wheels. He did not know the weight of the hose, but the wet-vac weighed about 55 lbs when filled.

12. On redirect examination, Petitioner testified he cannot currently ride a bike because it would hurt his back. He called Respondent that he was not coming to work four times until his lawyers started sending letters. Petitioner has prior training as a mechanic, bricklayer, painter, and asbestos remover. He has certificates. On re-cross, Petitioner testified he has a high school diploma, and "a GED too."

13. Justin Stovall testified he is assistant manager/customer service advisor for Respondent and was in the same position on September 3, 2011 and worked with Petitioner at that time.

14. On September 3, 2011, Petitioner's job was to greet customers in the parking lot and to fill out forms specifying details about the cars being serviced. Justin Stowall did not recall Petitioner being injured on that date. The day was not slow; there "was a nice pace." He did not send people home.

15. Mr. Stovall also testified Petitioner was not required to use a wet-vac on that date. Respondent does not use the wet-vac to vacuum cars; they use it to "suck out drains." The wet-vac would damage the carpeting of a car. Petitioner left early that day to get his car; he never returned. He did not inform the witness that he hurt his back or neck. Mr. Stovall also denied calling the store manager, Mark, and that Mark told him that Petitioner would be fired if he refused to use the wet-vac.

16. Mr. Stovall stated that Petitioner "attempted to try" to vacuum cars, but the witness would not let him because he said he was "injured prior to then" and the witness "didn't want any liability on our part." Petitioner "would be physically unable to perform" that job.

17. On cross examination, Mr. Stovall reiterated that he did not send people home on September 3, 2011. He would not necessarily keep records if he sent people home, but they would have had to sign out. He did not bring any records of employees' time sheets for the date. They would use the wet-vac to unclog drains. The wet-vac would such debris out of the drains. He would expect it to weigh more than 10 pounds after use. Calling Mark would be one of the first things he would do if an employee was hurt.

While Petitioner left early on September 3, 2011, he did not inform Mr. Stovall that he needed somebody to pick him up.

18. On redirect examination, Mr. Stovall testified the wet-vac is kept in the basement of the facility. He would fill out paperwork in case of an accident; he did not fill out any such paperwork regarding this alleged accident.

19. The medical records indicate on September 3, 2011, Petitioner presented at an emergency room at 10:24 pm complaining of back pain after an injury at work that day. He injured his back after bending over and had pain since 3 pm. Then the treatment note indicates this was a new problem which started three to five hours previously. He had 6/10 lumbar back pain without radiation. X-rays showed minimal loss of lumbar lordosis and minimal narrowing of disc space at L5-S1. Low back sprain/strain was the diagnosis, Petitioner was prescribed Norco, and he was released at 1:24 am.

20. The medical records also indicate that after the first work accident in 2009, Petitioner presented to Dr. Michael for a neurosurgical consultation. Petitioner reported left low back and leg pain with numbness and tingling in the left leg. Dr. Michael indicted Petitioner had three options: learn to live with his condition, a discectomy, or a fusion. The discectomy would address the leg pain and probably would not improve his back pain. Petitioner chose the discectomy and declined the fusion.

21. The Commission also notes that there is conflicting evidence regarding the actual alleged mechanism of injury. Petitioner testified he bent over using the wet-vac when he suffered the injury. When he first presented to Dr. Johnson, his new general practitioner after referral from his lawyer, for her initial evaluation, she noted the that Petitioner "performed repetitive bending, squatting and vacuuming duties" on the day of the injury. In the depositions of his treating surgeon, Dr. Michael, and Respondent's Section 12 medical examiner, Dr. Ghanayem, they both testified that Petitioner reported that he injured his back "lifting" the heavy wet-vac.

22. Finally, Respondent submitted into evidence responses to subpoenas form various companies to which Petitioner allegedly submitted job applications. None of them reported any such applications.

Even though the Arbitrator found accident, she clearly had concerns about his credibility. She specifically found him not to be credible regarding his cervical condition or his alleged job search. She ascribed any inconsistencies to his "easy gong nature" and lack of sophistication. She specifically denied maintenance because of Petitioner's lack of reasonable job search and his failure to try to return to work for Respondent.

On review of the entire record before the Commission we find Petitioner has not sustained his burden of proving a compensable accident. He was simply not a credible witness. Not only did he change the history of the alleged mechanism of injury to different medical personnel, his testimony regarding his alleged job search was completely rebutted by the responses of those prospective employers.

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In addition, the Commission finds the testimony of Mr. Stovall persuasive. He testified that the wet-vac is simply not used to clean the inside of cars because it would damage the carpeting. The wet-vac is kept in the basement where it is used to clean out drains. It is also not reasonable for him not to report a work injury if Petitioner had actually reported one to him. Finally, it seems extremely unlikely that Respondent would have diligently accommodated Petitioner's work restriction for a year and a half and all of a sudden decided to order him to vacuum out cars. Finally, Petitioner returned to work on May 31, 2011 (see Respondent's Exhibit 7). In Petitioner's previous workers' compensation claim (09 WC 28753 – Respondent's Exhibit 1), he alleged a fall down stairs. At that time, fusion surgery was recommended but Petitioner elected to forgo that surgery at the time and elected a less intrusive laminectomy. As noted above that settlement was approved by the Commission on December 16, 2010.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator issued on July 21, 2014 is hereby reversed and compensation is 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: MAY 4 - 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-4/1/15
46

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 Accident Failure to Prove	☐ Second Injury Fund (§8(e)18)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Stevens,

Petitioner,

15IWCC0317

vs.

NO: 12 WC 31266

RG Construction Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability and permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Commission finds that Petitioner failed to prove that he sustained accidental injuries while in the employment of Respondent on August 13, 2012.

Petitioner testified that in 2012 he went to work for RG Construction. He worked at the project of the extension of Bellwood Nursing Home. He testified that that he did not do ceiling work and that he did install studs. He worked with another man and one man would be on the lift and the other man would be on the floor. The man on the lift would measure the height of each stud and would scrape fireproofing material out of the upper track using either hand. (Transcript Pgs. 77-82)

The man on the floor would have to cut each stud to the required length and carry the studs, usually one or two at a time over to the wall. The man on the floor would then hand the top end of the stud to the person on the lift. (Transcript Pgs. 80-82)These studs weighed 20 pounds and the man on the lift would secure the stud in the top track with screws and the man on the floor would secure the lower end with screws. (Transcript Pgs. 81, A-30)

The Petitioner testified that he spent an equal amount of time on the man lift and the floor. The production started at 200 feet per day for two men but was reduced to 150 feet per day for two men. (Transcript Pg. 81)

Petitioner testified that he spent 75% to 80% of his time with the Respondent doing the framing and installing of the studs. However, he did not do any production drywall installing on this job and he just worked the problem areas. He claimed when he did install drywall he used 4 x 12 x 5/8th sheets weighing approximately 120 pounds. (Transcript Pgs. 87-89)

The Petitioner had a 2010 prior claim regarding his right elbow in which the Arbitrator found that Petitioner's claim that he could not straighten out his right elbow was not credible. The Arbitrator denied that his current condition of ill-being regarding that right elbow was causally connected to the 2010 accident. (See 12 WC 38936)

The Petitioner testified that on August 13, 2012, he noticed pain in his right elbow more severe than usual. He also testified that his right shoulder also hurt. He was seen by Dr. Musatieff who referred him to Dr. Robinson of Great Plains Orthopedics. (Petitioner Exhibit 3, Transcript Pgs. 97-98)

Petitioner admitted that he told Dr. Robinson that he injured his elbow two years prior and his elbows were painful. He felt he injured his shoulder because of his right elbow condition. In reaching overhead above his head, he could not straighten out his elbow and he had to maneuver his shoulder in a different way. He testified that he believed that is how he injured his shoulder. (Petitioner Exhibit 3)

Petitioner admitted that he saw Dr. Musatieff on January 3, 2012 and March 3, 2012 for right elbow, back and general body complaints and that the Doctor prescribed Vicodin. He admitted that he would see Dr. Musatieff once every few months in order to have his prescriptions refilled. (Petitioner Exhibit 1, Transcript Pg. A-47 and A-43)

The Petitioner must bear the burden of proof by showing by a preponderance of the evidence that he sustained an accidental injury arising out of and in the course of employment. The Petitioner is claiming a repetitive trauma. In a repetitive trauma case, a claimant may recover if "the claimant can show that a bodily structure has eroded over time to the point of usefulness as a result of the employment." Butler Manufacturing Co. v. Industrial Comm'n 140 Ill.App.3d 729, 733-734 (1986) Cases relying on the repetitive trauma theory, the Petitioner generally relies on medical testimony establishing a causal connection between the work performed and the Petitioner's disability. Williams v. Industrial Comm'n 244 Ill.App.3d 204, 209 (1993) Peoria County Bellwood Nursing Home v. Industrial Comm'n 138 Ill.App.3d 880 (1985)

The Petitioner's testimony of his work duties for Respondent was not similar to the work described to Petitioner's Doctor in his deposition. The Petitioner testimony was that his work in 2012 was in a team of two installing studs and the studs weighed 20 pounds. In the hypothetical given to the Doctor they weighed 30 pounds. The Petitioner testified that he had to install studs

for 150 feet of wall. He testified he installed them at four foot intervals, which would equate to 38 studs per day, not 200 studs per day as the hypothetical proposed to Dr. Garst suggested. Petitioner also indicated that he did not work production installation of drywall sheets for Respondent in 2012. (Transcript Pgs. 87-89) Dr. Garst was asked to assume Petitioner had to install 25 sheets in one day. The hypothetical question proposed to Dr. Garst was clearly flawed. (Petitioner Exhibit 4 Pg. 24)

Dr. Garst also admitted that the exacerbation could be temporary or permanent. (Petitioner Exhibit 4 Pg. 62)

The Courts have held that so long as the witness is not called upon to decide any controverted fact, but is asked to assume the truth of facts testified to, he may give his opinion thereon in any form. The objection, if any, should be a specific one directed to that which might improperly be incorporated or deleted from the hypothetical question. Clifford-Jacobs Forging Co. v. Industrial Com., 19 Ill. 2d 236, 243, 166 N.E.2d 582, 587, 1960 Ill. LEXIS 326, 9-10 (Ill. 1960) "The more expedient and more widely prevailing view is that there is no rule requiring that all material facts be included. The safeguards are that the adversary may on cross-examination supply omitted facts and ask the expert if his opinion would be modified by them, and further that the trial judge if he deems the original question unfair may in his discretion require that the hypothesis be reframed to supply an adequate basis for a helpful answer." Wirth v. Industrial Com., 57 Ill. 2d 475, 480, 312 N.E.2d 593, 595, 1974 Ill. LEXIS 420, 7 (Ill. 1974)

In this case it did not come down to the Doctor not being provided with material matters, but to the Doctor being provided with material matters that were not true. Therefore, the Commission finds that the hypothetical question was flawed and improper.

Neither the hypothetical nor the Arbitrator's description of the Petitioner's work activities matched those of the Petitioner's testimony. Dr. Garst testimony therefore is not persuasive because it was based on a flawed hypothetical and was a "general feeling."

Dr. Alturi was more persuasive than Dr. Garst. He believed, based on a reasonable degree of medical certainty, that Petitioner's right elbow worsened after 2010 and that his recurrent symptoms were simply a manifestation of the natural course of his condition. Petitioner had waxing and waning of his symptoms and pain would be expected to increase regardless of the work activities he performed in 2012. (Respondent Exhibit 1 Pgs. 22-29) He reviewed the job review and the video job review and noted the various activities Petitioner was expected to perform. (Respondent Exhibit Pg. 33) He did not see what he would consider heavy use of the upper extremities on a frequent basis in an overhead position. (Respondent Exhibit 1 Pgs. 33-34) He therefore did not feel that Petitioner's right shoulder condition was related to the work he did in 2012. (Respondent Exhibit 1 Pg. 37)

Therefore, Petitioner's claim for a repetitive trauma injury on August 13, 2012 is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator is reversed and in its place a finding that Petitioner failed to prove he had an accident arising out of and in the course of his employment on August 13, 2012.

15IWCC0317

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 $0.00. 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: MAY 4 - 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

CJD/hf
O: 3/4/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0317

STEVENS, CHARLES
Employee/Petitioner

Case# **12WC031266**

12WC038936

RG CONSTRUCTION COMPANY
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT T NEWMAN
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0317

CHARLES STEVENS
Employee/Petitioner

v.

R.G. CONSTRUCTION COMPANY
Employer/Respondent

Case # **12** WC **31266**

Consolidated cases: **12 WC 38936**

An *Application for Adjustment 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, ILLINOIS**, on **07/18/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0317

FINDINGS

On **08/13/2012**, 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 **$55,706.62**; the average weekly wage was **$1,071.28**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

Respondent ***has 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 **$N/A**.

Respondent is entitled to a credit of **$20,602.33** under Section 8(j) of the Act.

ORDER

Petitioner is awarded the medical bills offered as Petitioner's Exhibit 12. Respondent is given credit for payments referenced in the Exhibit and shall hold the petitioner harmless from the lien contained therein..

Petitioner is awarded T.T.D. benefits for 27 2/7ths weeks (August 28, 2012 – March 5, 2013). Petitioner's claim for additional temporary benefits as well as maintenance is denied.

Petitioner is awarded an 8(d)(1) wage loss award in the weekly amount of $530.13, beginning on March 6, 2013. .

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

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

August 25, 2014
Date

SEP 2 - 2014

15IWCC0317

ATTACHMENT TO ARBITRATOR'S DECISION

Charles Stevens vs. R.G. Construction Co.

IWCC No.: 12 WC 31266

In Support of the Arbitrator's decision regarding **(C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent**, the Arbitrator notes as follows:

This case was consolidated for Arbitration with Petitioner's claim against his previous employer, Morrissey Construction.

Petitioner initially became a union carpenter in 2003 or 2004 at the age of 38. Previously he had been a non-union carpenter employed in the residential construction business. Within the carpentry field, Petitioner had become a specialist in dry wall installation.

In April 2012, Petitioner was contacted by Respondent, R.G. Construction and offered re-employment as a drywaller for a large commercial project constructing the new Peoria County Bel-Wood Nursing Home. He had previously worked for R.G. on several occasions. This was a 151,000 square foot new facility costing between $45 and $48 million dollars. (Petitioner Exhibit 11, p.1)

Petitioner's primary job duties as a journeyman carpenter for Respondent were to frame and hang dry wall. The framing was done first. This involved measuring, carrying, cutting and installing metal or steel studs for attaching the sheet rock to. Petitioner testified in unrebutted fashion that the fireproof coating had already been applied to much of the facility. Once the fireproof coating dries, it becomes hard as a rock. This coating had to first be scraped out of the ceiling tracks. This involved

working from a hoist and using a metal section of framing as a "pick" to forcefully scrape and clean the upper tracks for the framing.

Once the tracks were cleared of the fireproofing, the framing was installed. Petitioner and his apprentice helper, working in two man teams and alternating work duties of cutting versus installing, used 22 foot and 25 foot sections of steel framing to frame the walls and ceilings. These interior sections were 20 to 25 gauge steel which is lighter than exterior framing. The frame segments were carried in bundles of ten by one man. One twelve-foot long section weighed approximately ten pounds. Measuring and cutting of the frames was done on the ground and then handed up, usually one at a time, to the carpenter working from the hoist installing them.

After the framing, came the application of the sheetrock. On this job and on nearly all commercial jobs, Petitioner testified that R.G. used 4 foot by 12 foot sheetrock, 5/8 inches thick. They used the longer twelve foot sheets to reduce seams and therefore mudding and taping labor. One sheet of this sheetrock weighed 128.6 pounds. This weight was confirmed by Petitioner's witness, Roy Eash, who was subpoenaed to testify.

Mr. Eash is also a union carpenter and former co-worker of Petitioner. They are not friends socially. Mr. Eash worked for Respondent R.G. Construction for a total of about two years throughout 2010 and 2011. He was also a foreman for R.G., overseeing their carpenters included their dry walling crews. He left R.G.'s employment on good terms, and later returned to work for R.G. again, this time as a simple carpenter and not a foreman. As a result of his employment with R.G. and of his work in the industry in general, he is familiar with the types and weights of the framing materials and sheetrock used by R.G. He confirmed that interior framing studs are 20 to 25 gauge steel and

usually twelve feet to thirty feet long. He opined that a twelve foot section of 20 gauge framing weighs approximately ten pounds and that they are packaged and transported by carpenters on a jobsite in bundles of ten weighing 100 pounds. Mr. Eash also confirmed that the sheet rock used commercially is 4 foot wide by 12 foot long and is 5/8 inches thick, with a single sheet weighing 128.6 pounds. He knows this is the correct weight because he took a class on it.

Mr. Eash also testified as to the production time expected of R.G. from its' drywallers. One carpenter, working alone, is expected to hang 35 to 40 sheets per day. As for framing expectations, an R.G. carpenter is expected to complete sixty to one hundred feet of wall per day, depending on the wall's height. If a carpenter can't make production quotas, they are usually laid off. Mr. Eash did not work for R.G. on the Bel-Wood project with Mr. Stevens. Mr. Eash confirmed that he is right-handed and that he only operates his screw gun with his dominant hand, similar to the way the Petitioner used the screw gun.

Respondent R.G. had a written Job Analysis created to provide to their independent examining physician. (Respondent Exhibit 2) Mr. Eash reviewed the Job Analysis. Mr. Eash pointed out that the analysis doesn't mention a tool belt, which weighs twenty pounds empty and can weigh eighty pounds when full, and which is worn 90% of the work time. He differed with the analysis that mentioned only "simple" grasping, stating that they have forceful or heavy grasping as they may hold up an entire sheet with only one hand. Mr. Eash testified that he has only seen 1 aluminum ceiling in his twenty-one years of work in the industry. An aluminum ceiling installation is depicted in the job video (Respondent Exhibit 3) and mentioned in the written Analysis. Mr. Eash

pointed out that the Analysis gives a weight of only 73 pounds for a 4 foot by 12 foot wallboard sheet which actually weighs 128.6 pounds. Finally, Mr. Eash pointed out that a bundle of ceiling tiles weighs eighty to one hundred pounds, and are transported in boxes, not individually.

Petitioner also questioned the accuracy of the written Job Analysis. He pointed out that often carpenters/dry wallers worked alone, except for when they are doing ceilings. The analysis suggested that they always work in pairs. Petitioner testified that they only get 1 break per day, not two. While the analysis concedes that lifting above shoulder height and at shoulder level are done frequently, it lists this lifting as "light weights to 2 – man lifts of wallboard – up to 60 lbs". Petitioner testified that one man hands up a sheet weighting 128.6 pounds, not 60 pounds. The analysis states that reaching above shoulders is occasional to continuous. Petitioner estimated that 30% of sheet rocking is reaching above shoulders and 50-80% of framing involves reaching above shoulders.

Respondent also had a job video produced for its' independent examiner. Petitioner testified that the workers in the video were not working at production speed, had two-man teams doing walls, and depicted ceiling framing and ceiling tile installation, which is considered the lightest duty work and is usually reserved for old carpenters or supervisors. Petitioner didn't install any ceiling tiles on the Bel-Wood project. The video did depict carpenters securing dry wall to the framed walls. They used a screw gun which appears to have required some force and required them to reach from the floor to the ceiling, with their arm fully extended overhead.

Respondent R.G. did not produce any rebuttal witnesses at Arbitration.

The Arbitrator notes that the job duties described by Petitioner and confirmed by an independent witness and former foreman of Respondent R.G., involve frequent at and above shoulder level reaching and lifting dry wall sheets which weigh about 128 pounds. Each sheet requires that fifty screws be screwed into the framing studs, with all screwing likely done with the dominant arm.

In claims of repetitive trauma, the issues of accident and causal connection are analyzed together. With respect to whether the work activity, described above, was causally related to the Petitioner's injuries, the Arbitrator finds as follows:

In April 2012, Petitioner was contacted by R.G. Construction and asked to work for them again, as a drywaller, at a large nursing home project they were beginning. This was a new commercial construction project wherein Petitioner worked a total of 726 hours between April and August 2012.

As referenced above, this case was tried by consolidation with another case involving an alleged accident on September 16, 2010 while the Petitioner was working for another employer. In that case, the Petitioner alleged injuries to his right elbow after a day of using a screw gun. He testified that from that day forward he was unable to fully extend the elbow and it was painful. He did not work from that alleged accident until he was hired by the Respondent herein in April 2012. The Petitioner is claiming permanent partial disability from the first accident, and an aggravation of that accident with additional associated disability from the repetitive activity performed for RG Construction. RG contends, among other things, that the elbow treatment and disability to the Petitioner is related to his work at his previous employer, Morrissey Construction.

It is understandable that the Petitioner would claim ongoing problems with the elbow following his first accident as the cases were heard together. It is also understandable that this Respondent would take the position that the elbow problems were present before the Petitioner began his employment. The medical records do not support either contention. Petitioner's Exhibit 1 contains treatment records from his family doctor from August 2, 2011 though August 2012, when began treating in earnest for both his right elbow and shoulder. He was examined twice in August 2011 for poison ivy, and the exam notes mention nothing about elbow issues. On November 1, 2011 he was seen with complaints of bilateral shoulder pain, again with no reference to elbow problems. On January 2, 2012, he was seen with chronic back pain, and on March 3, 2012, he complained of pain in the back, shoulder and arm. There was no reference to the elbow on either date. At the latter exam, the doctor noted generalized aches and crepitus of the extremities. One would expect some reference to the inability to fully extend the right elbow in some of those notes, particular those that reference the shoulder and arm.

When you compare those records with treatment notes after his return to work with this Respondent, you see a contrast. On April 22, shortly after his return to work, the Petitioner complained to his doctor that the heavy lifting associated with his job had caused severe back and right arm pain. On June 12, for the first time since September 28, 2010, you see direct reference to right elbow problems. He was seen with chronic arm pain secondary to his job as a dry waller. The exam notes pain and crepitus in the elbow. On or about August 13, 2012 Mr. Stevens reported a right shoulder and right elbow injury to Respondent R.G. Construction. He was immediately separated from employment upon reporting his injury.

On August 15, 2012, Petitioner saw Dr. Musaitif, his family doctor, with recorded complaints as follows; "This 48 year old male presents w/ chronic right arm pain x 2 years. Patient has difficulty bending and twisting his right elbow. Patient is a laborer and carpenter. Also does drywall. Patient on Flector patch …" (Petitioner Exhibit 1, p.23) Dr. Musaitif referred him to Great Plains Orthopedic for an elbow evaluation. (Petitioner Exhibit 1, p.24)

On August 21, 2012 Mr. Stevens had an initial appointment with Dr. Robinson at Great Plains Orthopedics. (Petitioner Exhibit 3, pp.33-34) His chief complaint was his right elbow but he also reported the more recent onset of right shoulder pain as well. Dr. Robinson allowed him to continue working. He was diagnosed with right elbow pain with moderate to severe osteoarthritis and right shoulder pain with suspected rotator cuff pathology. (Petitioner Exhibit 3, p.32)

On August 28, 2012, Dr. Garst, a partner of Dr. Robinson's and an upper extremity surgeon, saw Mr. Stevens. (Petitioner Exhibit 3, p.31) Dr. Garst diagnosed right elbow inflammation with loose bodies and a suspected rotator cuff tear of the right shoulder and ordered MRI's of each. Dr. Garst did not feel that Mr. Stevens could perform dry wall work and took him off work. The MRI's performed on August 31, 2012 showed osteoarthritis with loose bodies in the elbow (p.43) and a partial thickness supraspinatus tear with bone spurring and degenerative changes in the right shoulder. (Petitioner Exhibit 3, p.44)

On September 21, 2012 Dr. Garst operated on both Petitioner's right shoulder and right elbow. Dr. Garst debrided several areas of arthritis and removed two large loose bodies from the elbow. (Petitioner Exhibit 3, p.4 – Operative Report) As for the

shoulder, Petitioner's long head of his biceps tendon was torn and Dr. Garst performed a tenotomy and released the long head. The supraspinatus had a small full thickness tear which was repaired with two sutures, two anchors, and a screw. Dr. Garst also performed an acromioplasty and distal clavicle excision. (p.5)

On March 5, 2013 Dr. Garst placed Mr. Stevens at maximum medical improvement and placed two permanent restrictions on him. These are; may not lift/pull/carry more than fifteen pounds with the right arm, and no over-chest, above shoulder, or away from body work. (Petitioner Exhibit 3, p.2)

Dr. Garst was deposed twice by the parties. In his first deposition taken on February 27, 2013, he opined that screwing thousands of screws on September 16, 2010 while working for Morrissey did not cause the elbow arthritis but exacerbated it and caused him to take time off and treat it. (Petitioner Exhibit 4, pp.22-23) It bears noting that the Petitioner only worked for Morrissey for approximately 80 hours over a three week period in 2010.

Dr. Garst also opined that the employment duties with R.G. Construction performed for months, rather than 80 hours, exacerbated the elbow and shoulder and made them worse. (Depo, pp.25-26) On cross-examination, Dr. Garst, based upon the quantity of work performed (80 hours versus 4 ½ months) and the proximity to the time that treatment was sought, felt that the work performed for R.G. Construction was more to blame for the treatment and problems in 2012. (Petitioner Exhibit 4, pp.60-61)

Dr. Garst was deposed a second time on July 16, 2014 in order to clarify whether the shoulder injury or elbow injury or both necessitated the two permanent restrictions. (Petitioner Exhibit 5) Dr. Garst opined that the "no overhead, above chest level, or away

from body" work restrictions are related to the right shoulder. These restrictions are meant to avoid re-tearing and pain. (Depo, pp.12-14) As to the restriction of no lift/pull/carry more than 15 pounds, Dr. Garst felt that this restriction was necessary due to both the elbow and shoulder. (Depo, pp.15-16)

Respondent R.G. Construction had Petitioner evaluated by Dr. Prasant Atluri on December 10, 2012. Dr. Atluri was deposed by the parties. (Respondent, R.G. Construction Exhibit 1) Dr. Atluri diagnosed Mr. Stevens with a right shoulder rotator cuff tear, status post repair, right shoulder arthritis, and right elbow arthritis, status post scope with removal of loose bodies. (Depo, pp.23-24) As to causal connection, Dr. Atluri felt that Petitioner had a chronic degenerative elbow condition that was temporarily aggravated by his Morrissey work in 2010. (Depo, pp.25-26) As to causation of the right shoulder, Dr. Atluri initially wanted more details on Petitioner's work. A job video was provided to him, as was a written job description. (Respondent Exhibit 2 & 3 at Arbitration) (Depo, pp.30-31) Dr. Atluri opined that he didn't see anything in the job video that he considered "heavy use of the upper extremities on a frequent basis in an overhead position". (Depo, p.33) Therefore, Dr. Atluri did not feel that Petitioner's rotator cuff and biceps tendon tears were related to his work at R.G. Construction. (Depo, p.33) Dr. Atluri instead felt the tears were due to a chronic degenerative arthritic process. (Depo, p.34)

Petitioner testified that between September 16, 210 and April 2012 he drew unemployment benefits and did not work anywhere or otherwise reinjure his right elbow or injure his right shoulder. Respondents attempted to rebut this assertion by introducing evidence of investment home purchases and antique car purchases by Petitioner.

Petitioner's Exhibit 8 is a compilation of auction fliers, purchase agreements, and photographs of six investment properties Petitioner purchased on or about July 17, 2012. Of these six properties, only one produced any income. Petitioner gave two or three of the properties away to his brother and a friend, and two were demolished by the City of Peoria. The local Peoria newspaper even had an article about the unexpected demolition of one of the homes. (Respondent Exhibit 8) Of importance to the Arbitrator is the fact that Petitioner testified in unrebutted fashion that he never personally performed any remodeling on any of the homes. Several photographs in Petitioner's Exhibit 8 demonstrate that the homes were in the same state of disrepair or even demolished by the winter of 2012. There is no evidence that Petitioner personally did any remodeling on the homes or injured his right arm doing so.

Respondent also asserted that Mr. Stevens may have been self-employed fixing antique cars during his time off of work, and may have injured his right arm performing these activities. Petitioner testified on direct and cross-examination that he purchased a 1940 Dodge in approximately 2008. Petitioner's Exhibit 9 contains seven color photographs of initially, a green Dodge, which was primed, and eventually is shown as a painted red-orange car. Petitioner testified that he paid a friend to paint the vehicle. Petitioner admitted that he worked on the engine himself at various unknown times but has been unable to get the car running. He still owned the vehicle as of the date of Arbitration and has it in storage in his brother's garage. Also, in December 2011, Petitioner purchased a 1955 Chevy with the intention of fixing it up and taking it to car shows. Petitioner's Exhibit 9 contains three color photographs of this car which demonstrate its condition at purchase and the car in the same condition now, while in

storage. Petitioner denied performing any substantial work, either by himself or by others, on this vehicle. There is no evidence that Petitioner injured his right arm working on either car, or that this was a source of income.

Respondent R.G. Construction performed surveillance on Mr. Stevens on a least eleven separate dates between January 29, 2013 and June 14, 2014. They called a surveillance supervisor from PhotoFax Inc., Jon-Carlo Astorina to testify and lay foundation for their five video discs and five written reports. (Respondent's Exhibit 12 & 15) Mr. Astorina personally performed two days of surveillance on Petitioner. He testified that at no time did he observe Petitioner completely straightening out his right arm, working with his right arm, violating his restrictions of no lifting greater than 15 pounds or working above shoulder height with his right arm, or working anywhere for that matter. Upon review of the five video tapes, the Arbitrator observed Petitioner carrying a child's baseball bat with his right hand, carrying two energy drinks, lifting a coffee mug at breakfast, and leaning with his right shoulder against a column. None of the surveillance video rebuts Petitioner's testimony that he didn't manually work anywhere or violate his restrictions.

The Arbitrator specifically relies upon several factors in determining causal connection herein. It is clear that Petitioner had a prior right elbow injury in 2010. While he testified that he had ongoing complaints including an inability to straighten the arm when he came to work for Respondent in April 2012, the medical records do not support that testimony. He was hired by the Respondent full time on a job which required extensive use of the right arm, and soon after beginning that job began to report symptoms to his family doctor. Those symptoms continued. His family doctor referred

him to a specialist, and, on September 21, 2012, surgery was performed revealing osteoarthiritic problems in the elbow and a small full thickness tear of the right rotator cuff, along with arthritic change.

Dr. Atluri relied significantly on a job video and written analysis that are not consistent with the unrebutted testimony of Petitioner and the former foreman of Respondent. (RX 1 at 47) The video showed very little frame building, which required the Petitioner to lift long metal beams weighing 10 to 20 pounds up to a co-worker. It did not show any of the fire material removal which the petitioner did using a flat conduit with overhead force. It also did not depict the workers operating under a quota system which both the Petitioner and Mr. Eash said was present in the employment.

Dr. Garst had a sufficient knowledge of the Petitioner's work duties to support his opinion that the work aggravated both the elbow and the shoulder, bringing about the need for surgery. While the hypothetical to the doctor misstated the weight of the studs used in framing as 30 pounds as opposed to 10, the rest of the hypothetical matched the testimony at trial. Also, the job video itself established the frequent overhead lifting dry wall and reaching with force while using the screw gun to support the claim of repetitive overuse.

Based upon the above, the Arbitrator finds an accident arising out of his employment which was causally related to his condition of ill being.

In Support of the Arbitrator's decision regarding **(J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid**

all appropriate charges for all reasonable and necessary medical services and **(K) What temporary benefits are in dispute**, the Arbitrator notes as follows:

Having found the issues of accident and causal connection in favor of Petitioner, it logically follows that the related medical bills are also awarded.

Petitioner's Exhibit 12 consists of three itemized medical bills and a health insurance lien. The St. Francis bill of $100.00 is related to the September 21, 2012 surgery by Dr. Garst and is awarded. Dr. Musaitif's $5.00 is not related. The bill from Pekin Orthopedic Center pre-dates August 13, 2012 and is therefore not awarded in the present claim. The Respondent is entitled to credit under Section 8 (j) and thus will hold the Petitioner harmless from any attempts at recoupment by the group provider.

The Petitioner is claiming additional TTD benefits after he was released by Dr. Garst on March 5, 2013 until he actually began work at Gabbart Cleaning on April 24, 2014. He is also claiming entitlement to periods of TPD and maintenance after his release. With respect to either temporary benefit, the Petitioner's entitlement began with Dr. Garst's restriction on August 28, 2012 and ended when he reached a point of maximum medical improvement on March 5, 2013, which was when Dr. Garst released him with permanent restrictions. His claim for temporary benefits after that date is denied. Maintenance benefits are payable if the Petitioner proved entitlement to vocational rehabilitation. The evidence does not support that entitlement. While the Petitioner testified that he looked for work after his release from Dr. Garst, no specifics were offered to support his testimony. He did seek social security disability benefits, and his claim was eventually denied. Ms. Stafseth, the vocational expert he hired, reported that at their meeting on May 28, 2013 the Petitioner said that he was not looking for

work. (PX 6 at 15) Ms. Stafseth was also vague as to whether he actually needed vocational help at that time to find a job, suggesting that he be formally assessed. (Id at 17) There was no testimony or evidence from either side that a vocational assessment, referenced in Commission Rule 7110.10 was ever requested or performed. The Petitioner apparently had the ability to find a job on his own, as evidenced by the fact that he was hired as a custodian and remains in that position at the present time.

Based upon the above, the claim for additional temporary benefits and maintenance are denied.

In Support of the Arbitrator's decision regarding **(L) What is the nature and extent of the injury**, the Arbitrator notes as follows:

Petitioner has undergone an arthroscopy of his right elbow for the removal of loose bodies and has undergone a right rotator cuff repair, tenotomy of the biceps long head, acromioplasty and distal clavicle excision. He has had permanent restrictions placed upon him of no lifting over 15 pounds or work above shoulder height with his dominant right arm. His right arm has lost a significant degree of its range of motion, both flexion and especially in extension. Multiple days of surveillance did not call his injuries or restrictions into doubt. Dr. Garst placed the responsibility for these restrictions primarily upon R.G. Construction, and further opined that they prevent the Petitioner from returning to usual and customary line of employment. (PX 4at 26,27) The only vocational expert to testify, Kari Stafseth, also opined that he can no longer perform his usual and customary employment of union carpenter.

Accordingly, the evidence supports the first requirement for a wage loss award under Section 8 (d) (1) of the Act. The Petitioner must also show loss of earnings, and the documentary evidence shows that he would be earning $30.38 an hour at his former job. At issue is what he could earn now in suitable employment. The Arbitrator does not believe the Petitioner's testimony alone satisfies his burden of proof on the issue. After his release by Dr. Garst, there is no evidence that he looked for work. He applied for SSD and lost. He finally went to work as a custodian earning $8.50 an hour on a part time basis, and hopes to find a second custodial job, presumably at the same wage. Ms. Stafseth, however, did provide testimony from which an amount of suitable employment earnings can be determined. She said that the Petitioner was capable, with his previous employment experiences and education, of working as a cashier, driver, assembler and customer service representative earning between $9 and $12.00 an hour. (PX 6 at 17, 18) Under the circumstances, the Arbitrator believes the Petitioner could earn $10.50 an hour on a full time basis. Thus the weekly amount for suitable employment for a wage loss calculation will be $420.00 per week.

Having previously noted the Petitioner would have been making $1215.00 a week had he not been injured, the Arbitrator awards $530.13 per week in Section 8(d) (1) benefits, payable from March 6, 2013 through the present time, payable so long as indicated under 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))
	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura K. Berry,
Petitioner,

vs. No: 12 WC 42751

HMS Host—CBR Special Retail, an Autogrill Co.,
Respondent.

15IWCC0318

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 and prospective medical treatment related to Petitioner's left knee, and being advised of the facts and law, modifies the August 7, 2014 Section 19(b) Decision of Arbitrator Robert Williams as stated below and otherwise affirms and adopts the Decision, which is attached hereto and made a part hereof. The Commission finds that Petitioner proved that her left knee condition is causally related to her November 8, 2011 work 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 Comm'n*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Prior to the July 17, 2014 arbitration hearing in Chicago, the parties stipulated that Petitioner had suffered a compensable accident on November 8, 2011, when she tripped and fell while emptying trash into a dumpster outside the O'Hare Airport concourse. Petitioner served as store manager for two kiosk businesses owned by Respondent and operating in separate terminals at the airport. She continued working after her fall and did not seek medical care until December 28, 2011, when she consulted with Dr. Baker at SportMed Wheaton Orthopaedics for left hip pain. Petitioner reported falling and striking her left hip, experiencing swelling that slowly resolved, and an increase in hip pain a week and a half before her appointment while sitting on the floor. Dr. Baker diagnosed traumatic trochanteric bursitis of the left hip. X-rays were read as negative for acute or chronic bony abnormalities. Respondent accepted liability for Petitioner's hip injury and paid for related medical expenses.

15IWCC0318

On July 3, 2012, Petitioner reported left knee pain to Dr. Erickson at SportMed Wheaton Orthopaedics. She told the doctor that her knee had not been painful immediately after her November 8, 2011 fall. X-rays were normal, and the doctor noted minimal effusion and crepitation of the patellofemoral joint of the left knee. Dr. Erickson diagnosed Petitioner with a medial meniscus tear, administered a cortisone injection in her left hip, and ordered an MRI of her left knee. The September 12, 2012 MRI revealed a complex tear of the posterior horn and body of the medical meniscus. On October 2, 2012, Dr. Erickson recommended a left knee arthroscopy to repair the meniscal tear.

Dr. Bare performed a Section 12 examination on behalf of Respondent on October 29, 2012 and concluded that Petitioner's knee symptoms were age related and not causally related to her November 9, 2011 fall. He opined that Petitioner was capable of working full duty in her management position. On December 3, 2012, Respondent issued a letter denying liability for Petitioner's knee condition and providing notice that it would not pay for any additional medical expenses related to the left knee.

Petitioner filed a Petition for Immediate Hearing, seeking authorization for her recommended left knee arthroscopy. The case was tried on July 17, 2014 on the issues of causation and medical treatment related to the knee injury. Prior to hearing, the parties stipulated to accident and causal connection of the left hip. Arbitrator Williams found that Petitioner had failed to prove a causal connection between her left knee condition and her November 9, 2011 work accident. The Arbitrator awarded Petitioner medical expenses for her left hip treatment and gave Respondent credit for payments made. Petitioner appealed the denial of her claim for her left knee injury.

The Commission views the evidence differently from the Arbitrator and finds that Petitioner did prove causal connection between her left knee condition and her work accident.

Petitioner testified that she did not have immediate left knee pain following her work accident, but she did develop pain throughout her whole left leg, from her hip to past her knee. On July 3, 2012, she reported the knee pain to Dr. Erickson, who had performed arthroscopic surgery on her right knee less than three months before her work accident to repair a non-work related torn meniscus. Petitioner told Dr. Erickson that she had initially attributed her left knee pain to radiating pain from her hip injury, but had determined a few months earlier that the knee itself was injured. Dr. Erickson further noted that Petitioner's hip pain continued and caused her to walk with an altered gait. He opined that Petitioner's traumatic hip bursitis and altered gait could have affected her left knee.

When Petitioner sought authorization for left knee surgery, Respondent obtained a Section 12 evaluation by Dr. Bare. Dr. Bare concluded that Petitioner's left knee condition was degenerative and was not causally connected to her November 9, 2011 work accident. He opined that the left knee degeneration probably paralleled the right knee, for which Petitioner had already undergone arthroscopic meniscal repair. Dr. Bare failed to note that the 2011 arthroscopic surgery on the right knee was necessitated by an acute trauma, specifically a non-work related fall on concrete stairway, rather than degenerative arthritis.

Arbitrator Williams found Dr. Bare's opinions persuasive and those opinions, together with the delayed onset of left knee pain, formed the basis of his finding that Petitioner's left knee condition was not causally connected to her work accident.

The Commission notes that Petitioner reasonably believed immediately following her accident that her knee pain was radiating from her hip injury. The Commission further observes that Petitioner had no prior left knee complaints. The Commission views the evidence differently than did the Arbitrator and concludes the November 9, 2011 work accident was a contributory cause of Petitioner's left knee condition. The Commission finds the left knee condition and need for surgery were causally connected to Petitioner's November 9, 2011 fall.

For the foregoing reasons, the Commission modifies the Arbitrator's Decision. The incurred medical expenses related to Petitioner's left knee and the prospective surgical treatment are work related, and Respondent is ordered to authorize and pay for Petitioner's arthroscopic left knee meniscal repair and related rehabilitation as recommended by Dr. Erickson.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the August 7, 2014 Decision of the Arbitrator is modified as described herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical services as set forth in Petitioner's Exhibit 1A, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall be given credit for $445.72 for medical benefits that have been paid by its group insurance carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services or the subrogation claim of Blue Cross/Blue Shield of Illinois for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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 Notice of Intent to File for Review in the Circuit Court has expired without the filing of such a written notice, or after the time of completion of any judicial proceedings, if such a written notice 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 injuries.

15IWCC0318

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

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/18/15
jdl/dak
68

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

BERRY, LAURA
Employee/Petitioner

Case# **12WC042751**

HMS HOST CBR SPECIALTY RETAIL
Employer/Respondent

15IWCC0318

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:

1973 ATSAVES, LOUIS G LTD
200 W JACKSON BLVD
SUITE 1050
CHICAGO, IL 60606

5001 GAIDO & FINTZEN
JUSTIN KANTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

LAURA BERRY
Employee/Petitioner

Case #12 WC 42751

v.

HMS HOST CBR SPECIALTY RETAIL
Employer/Respondent

15IWCC0318

An *Application for Adjustment 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 July 17, 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. ☒ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On November 9, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $48,100.00; the average weekly wage was $925.00.
- At the time of injury, the petitioner was 53 years of age, with one child under 18.
- The parties agreed that the respondent paid $445.72 in medical bills for which credit is given under Section 8(j) of the Act.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 1/7 week.

ORDER:

- The medical care rendered the petitioner for her left hip was reasonable and necessary and is awarded. The medical care rendered the petitioner for her left knee was not reasonable or necessary and 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.
- The petitioner's request for a left knee arthroscopy is denied.
- The petitioner's request for penalties and fees 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

August 7, 2014

Date

AUG – 7 2014

FINDINGS OF FACTS:

On November 9, 2011, the petitioner, a retail store manager for two locations at O'Hare Airport, caught her left foot and fell on her left side after disposing of garbage in a dumpster outside an airport terminal around dusk. The petitioner continued working and did not seek medical care until she saw Dr. Baker at SportMed Wheaton Orthopaedics on December 28, 2011, for left hip pain. She reported falling and striking her left lateral hip, having ecchymosis and swelling that slowly resolved and an increase in pain a week and a half ago while sitting on a floor. Dr. Baker's examination revealed tenderness over the greater trochanter and his diagnosis was traumatic trochanteric bursitis of the left hip. X-rays of her left hip was negative for acute or chronic bony abnormalities.

On July 3, 2012, the petitioner saw Dr. Erickson and reported left knee pain. Minimal effusion and crepitation of the patellofemoral joint of her left knee was noted. X-rays of her left knee were normal. The doctor's impression was a medial meniscus tear. The petitioner told Dr. Erickson that her left knee did not hurt after falling and injuring her left hip on November 9, 2011. Dr. Erickson administered a cortisone injection in the bursa of the petitioner's left hip. An MRI of her left knee on September 12, 2012, revealed a complex tear of the posterior horn and body of the medial meniscus. Dr. Erickson recommended left knee arthroscopy on October 2, 2012.

A Section 12 evaluation was performed by Dr. Bare on October 29, 2012. Dr. Bare opined that the petitioner's left knee symptoms were age related, that she had limited or no disability for her left hip condition and that she could continue working full duty.

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

The medical care rendered the petitioner for her left hip was reasonable and necessary and is awarded. The medical care rendered the petitioner for her left knee was not reasonable or necessary 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 hip is causally related to the work injury. The petitioner failed to prove that her current condition of ill-being with her left knee is causally related to the work injury. The petitioner did not complain of left knee symptoms when she sought care for her left hip on December 28, 2011, and reported to Dr. Erickson that she had no left knee pain at the time of the injury to her left hip. The petitioner worked full duty after her left hip injury and did not report any left knee symptoms until July 3, 2012.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the left knee arthroscopy recommended by Dr. Erickson is reasonable medical care necessary to relieve the effects of the work injury to her left hip. The petitioner's request for a left knee arthroscopy is denied.

FINDING REGARDING PENALTIES AND FEES:

The petitioner's request for penalties and fees is denied.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darrell Bagwell,
Petitioner,

vs. No: 10 WC 17310

Nestle USA, Inc.,
Respondent.

15IWCC0319

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and notice given to all parties, the Commission, after considering the issues of benefit rates, causal connection, reasonableness and necessity of medical expenses, temporary total disability, nature and extent of the permanent disability, and penalties and fees, and being advised of the facts and law, vacates the award for medical expenses and otherwise affirms and adopts the March 12, 2014 Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that Case Number 10 WC 017310 was consolidated with Case Number 08 WC 034117, and the consolidated cases were heard by Arbitrator Joann Fratianni in Peoria on November 25, 2013. The Arbitrator issued two separate opinions, and both parties timely filed Petitions for Review from both Decisions. The Commission enters separate Decisions and Opinions on Review.

In regard to Case Number 10 WC 017310, Arbitrator Joann Fratianni found that Petitioner proved that his current condition of ill-being was causally related to his March 23, 2009 work accident. The Arbitrator awarded Petitioner 198-5/7 weeks of temporary total disability, $13,909.65 in medical expenses, and wage differential benefits of $143.47 per week for the duration of his disability, pursuant to Section 8(d)1. Arbitrator Fratianni denied Petitioner's Petition for Penalties and Fees.

After considering the entire record, and for the reasons set forth below, the Commission vacates the Arbitrator's award of medical expenses and otherwise affirms and adopts the Arbitrator's Decision.

15IWCC0319

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

The March 12, 2014 Decision of Arbitrator Fratianni included an award of medical expenses totaling $13,909.65. On appeal, Respondent argued that several medical bills had been satisfied prior to hearing and that Petitioner failed to provide current statements for others. The Commission notes the following regarding the medical expenses contained in the record:

(1) $124.00 to Central Illinois NeuroHealth Sciences. Respondent paid $83.01 for the $124.00 bill on May 13, 2010. RX5. The most recent invoice, PX25, notes a $0.00 balance. The Commission finds that no additional payment is required.

(2) $1,088.00 to Bloomington Radiology. Respondent paid a total of $192.64 toward a charge of $597.00: $38.40 on June 27, 2008, $36.80 on September 30, 2008, and $117.44 on October 16, 2008. The remaining $448.51 charge was reversed on October 5, 2009. The invoices attached to PX25 show $0.00 balance as of October 8, 2013. The Commission finds that no additional payment is required.

(3) $12,474.00 to Advocate Bromenn Medical Group. Petitioner offered only a $35.00 balance bill for this provider as part of PX25. Section 8.2(c) of the Act provides that providers are not entitled to balance billing where the fee schedule or contracted rate has been paid. As only the balance was billed, and balance billing is not permitted, nothing more is due.

(4) $223.65 to Applied Pain Institute. No statement from Applied Pain Institute appears in PX25 or elsewhere in the exhibits. Petitioner failed to prove he is entitled to this amount.

The sum of the above listed medical expenses awarded to Petitioner at Arbitration is $13,909.65. As discussed, Petitioner failed to prove that he is entitled to these additional medical expenses. Therefore, the Arbitrator's award of $13,909.65 in medical expenses is vacated.

Regarding the Average Weekly Wage calculation pursuant to Section 10 of the Act, the Arbitrator's analysis and conclusion is affirmed and adopted. In so doing, the Commission further notes that the Arbitrator properly excluded concurrent employment income from the Average Weekly Wage calculation because while certain employees of the employer did know of his religious activities, there was no credible proof that the employer knew during the relevant pre-accident period that the claimant's activities actually constituted gainful employment, rather than volunteering or similar community activities.

After considering the record as a whole, the parties' briefs, and the relevant case law, and after hearing oral arguments by both parties, all else in the Arbitrator's Decision is affirmed and adopted.

15IWCC0319

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 12, 2014 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of $13,909.65 for medical expenses in the Decision of the Arbitrator is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is to pay Petitioner the sum of $424.63 per week for 198-5/7 weeks, commencing March 24, 2009 through January 13, 2013, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that, commencing January 14, 2013, Respondent shall pay Petitioner permanent partial disability benefits of $143.47 per week for the duration of the disability, pursuant ot Section 8(d)1 of the Act.

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

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

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

DATED: MAY 4 - 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-03/03/15
jdl/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BAGWELL, DARRELL
Employee/Petitioner

Case# **10WC017310**

08WC034117

NESTLE USA INC
Employer/Respondent

15IWCC0319

On 3/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SHAUN R BIERY
118 N CLINTON STSUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DARRELL BAGWELL,
Employee/Petitioner

v.

NESTLE USA, INC.,
Employer/Respondent

Case # 10 WC 17310

Consolidated cases: 08 WC 34117

15IWCC0319

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. 08 WC 34117 and heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Peoria**, on **November 25, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

B. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 23, 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 **$33,120.88**; the average weekly wage was **$636.94**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **two** dependent children.

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

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

Respondent shall be given a credit of **$108,230.40** for TTD, **$20,226.75** for TPD, **$ 0.00** for maintenance, and **$ 0.00** for other benefits, for a total credit of **$128,457.15**, for both cases.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$424.63**/week for **198-5/7** weeks, commencing **March 24, 2009** through **January 13, 2013,** as provided in Section 8(b) of the Act.

Commencing **January 14, 2013,** Respondent shall pay Petitioner permanent partial disability benefits of **$143.47**/week for the duration of the disability, pursuant to Section 8(d)1 of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of **$13,909.65**, subject to the provisions of the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act.

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

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

JOANN M. FRATIANNI
Signature of Arbitrator

March 10, 2014
Date

MAR 12 2014

15IWCC0319

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

On June 2, 2008, Petitioner worked for Respondent in the taffy line. Petitioner also worked at the Mt. Zion Missionary Baptist Church in Galesburg as a pastor. Petitioner testified that he worked full duty on the Taffy Line with no medical restrictions. This job required him to stand 8 hours and lift 40-60 pounds. On June 2, 2008, Petitioner was dumping taffy that weighed 50-60 pounds from the floor to his chest. After doing this, he experienced pain in his back and leg.

On June 4, 2008, Respondent referred Petitioner to Health Point. A history of injury was recorded that corroborated Petitioner's testimony. Petitioner complained of back pain that ran down his left leg into his groin area. Petitioner then saw physicians at BroMenn Occupational Medicine who prescribed a lumbar MRI. The MRI was performed on June 11, 2008, and revealed disc bulging at L4-L5 with a broad based left posterolateral and lateral disc herniation, along with moderate to severe spinal stenosis. The herniation contacted the left L4 nerve root. (Px5)

Following the MRI, Petitioner was referred to see Dr. Kattner, an orthopedic surgeon, who prescribed surgery following an examination of June 26, 2008. Dr. Kattner diagnosed a herniated disc at L4-L5. On September 2, 2008, Dr. Kattner performed surgery in the form of a left lateral discectomy at L4-L5 and microdiscectomy.

Post surgery, Petitioner was rehospitalized due to difficulty in urinary retention. On September 18, 2008, a visit at BroMenn Hospital reflected continuing problems with urinary retention. Petitioner was then referred to see Dr. Leak, a urologist, that same day. Dr. Leak felt he had acute prostatitis most likely due to the insertion of a catheter during surgery.

Post surgery, Petitioner saw Dr. Kattner on September 23, 2008. Petitioner complained of a burning sensation to his left foot. On October 21, 2008, he complained of a spastic left leg and was prescribed physical therapy. On December 2, 2008, Dr. Kattner prescribed additional physical therapy and Ultracet. On January 13, 2009, Dr. Kattner felt Petitioner could return to work part-time, and on February 24, 2009 prescribed two weeks of work hardening.

Petitioner returned to work for Respondent on March 1, 2009. Petitioner returned to work in the "Bit O'Honey" lines. He then worked until March 23, 2009, when he sustained a new accident, which is the subject matter of this case, which was consolidated and heard with claim no. 08 WC 34117.

Dr. Kattner testified by evidence deposition on April 10, 2013. Dr. Kattner testified the incident of June 2, 2008 was causally related to the back condition he treated with surgical intervention. Dr. Kattner further testified that he did not nick any bladder or bowel during the surgery. Dr. Kattner felt prostraititis may have been brought about through use of a Foley catheter during surgery. Dr. Kattner also noted that Petitioner had worked on the third shift on March 23, 2009 and was performing an aggressive type of work. Since that date Petitioner developed severe left leg pain that appeared to be down the L5 dermatome. Dr. Kattner diagnosed an L5 radiculopathy and took Petitioner off work.

On April 15, 2009, Dr. Kattner performed additional surgery for a diagnosis of a recurrent disc herniation at L4-L5 on the left. Dr. Kattner at that time performed an exploratory microdiscectomy at L4-L5 on the left with repair of the durotomy at L4-L5. Post surgery, Petitioner remained under the care of Dr. Kattner. On May 11, 2009, Dr. Kattner prescribed a spinal cord stimulator and on June 29, 2009, a TENS unit.

Dr. Kattner testified to his opinion that the conditions he treated were related to the accidental injury of June 2, 2008 along with the injury that occurred on March 23, 2009. Dr. Kattner felt it unlikely that Petitioner would be able to return to any job that he performed prior to these injuries. He felt Petitioner had a small recurrent disc herniation at L4-L5 on the left with battered nerve syndrome on the L5 nerve root. He did not feel Petitioner was going to make a recovery from this condition and would require a sedentary life style.

On January 4, 2010, Dr. Kattner noted continuing complaints of severe pain into the left leg along the L5 nerve root. During examination, he noted weakness with dorsiflexion and plantar flexion. When seen on February 8, 2010, Dr. Kattner felt he had an indurated L5 nerve root from battered nerve syndrome, and prescribed a spinal cord stimulator and a back brace. Dr. Kattner last treated Petitioner on February 8, 2010.

Petitioner was examined by Dr. Ji Li on January 9, 2013. This appointment was by referral from Dr. Pilcher, Petitioner's family physician. Petitioner complained of low back pain with numbness, tingling and burning that radiated through the left leg. Dr. Li diagnosed severe tenderness of the lower back and decreased sensitivity and motor function of the leg with positive straight leg test and Patrick's sign. Dr. Li testified on March 4, 2013 by evidence deposition. Dr. Li testified the decreased left leg sensation and motor function revealed a deficit in sensory functions. The positive straight leg raising revealed a pinching of the spinal nerve. Dr. Li diagnosed lumbar radiculopathy and failed back syndrome. Dr. Li also noted a subsequent MRI revealed scarring on the lateral recess, which he felt contributed to the pain, and which could be impinging on the nerve root. Dr. Li felt the MRI findings corroborated his findings during examination. Dr. Li further felt Petitioner could not work due to severe pain.

Dr. Li further testified to a causal connection in this matter concerning the work injury and the condition of ill-being.

Based upon the above, the Arbitrator finds that the condition to the lumbar spine so treated by Dr. Kattner is causally related to the accidental injury of March 23, 2009. The Arbitrator further finds the prostatitis was causally related to the surgical procedure that occurred on April 15, 2009. Based further upon the above, the Arbitrator finds that all claims made by Petitioner for other conditions of ill-being, including damage to his bladder or bowel area, is not causally related to the accidental injury of March 23, 2009.

G. What were Petitioner's earnings?

A wage statement was introduced into evidence reflecting earnings and an average weekly wage of $636.94 while in the employment of Respondent. Petitioner claims concurrent earnings in this matter.

When a claimant is concurrently employed, all earnings must be considered when calculating wages pursuant to Section 10 of the Act. Wages are included from a second employer only if known by the first employer at the time of the accident.

In this case, Respondent was aware that Petitioner was a pastor. Whether Respondent was aware that Petitioner had a specific paying job as a pastor is less clear. Petitioner introduced into evidence payments received for his pastoral work which included a discrimination charge. He also filed a request with Respondent for religious accommodation (Px31) and a charge of discrimination. The parties settled that claim. In all the evidence in the form of documents introduced before this Arbitrator, none indicate Petitioner was seeking time off for a paying job. During testimony, it was brought out that Petitioner stated in his own words that those pastoral wages were "none of their business," meaning Respondent's. Finally, Respondent subpoenaed tax and wage records from Mt. Zion Baptist Church. Those records were not provided. Petitioner testified he did not provide these records to Respondent on the advise of another attorney who was not his workers' compensation attorney.

Petitioner presented the testimony of a financial secretary at the Mt. Zion Baptist Church, Ms. Kim Mitchell. Ms. Mitchell testified she prepared checks made out to Petitioner that she signed.

Based upon the above, and the wage statement (Px20, Rx3) in evidence, the Arbitrator finds the average wage to be $636.94 per week in this matter. Based further upon the above, there does not appear to be adequate proof that Respondent was aware Petitioner was being compensated for a second job at the time of this accident. The Arbitrator can only speculate that if Petitioner had complied with the subpoena for such records, such records would have proven such knowledge. Under these circumstances all claims for concurrent wages made by Petitioner are hereby denied.

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

Petitioner incurred the following medical charges after the accident of March 23, 2009:

Central Illinois Neurohealth Sciences	$ 124.00
Bloomington Radiology	$ 1,088.00
Advocate BroMenn Medical Group	$12,474.00
Applied Pain Institute	$ 223.65

These charges total $13,909.65.

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator further finds the above charges to represent reasonable and necessary medical care and treatment causally related to this accidental injury, and further finds Respondent to be liable to Petitioner for these charges, subject to the provisions of the medical fee schedule.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "F" above.

The parties have agreed that as a result of this accidental injury Petitioner became temporarily and totally disabled from work commencing March 24, 2009 through January 13, 2013, and is entitled to receive benefits from Respondent for this period of time.

On January 14, 2013, Petitioner met with Mr. Minnich and admitted he had been working as a pastor earning $600.00 a week. Petitioner admitted to Mr. Minnich that he was mainly interested in his work at the church and was not interested in working any job that paid less than $22.00 hourly.

Based upon the above, the Arbitrator finds that Petitioner reached maximum medical improvement on January 14, 2013.

Based upon the above, the Arbitrator finds that as a result of this accidental injury, Petitioner became temporarily and totally disabled from work commencing March 24, 2009 through January 13, 2013, and is entitled to receive benefits from Respondent for this period of time.

All other claims of temporary total disability made by Petitioner in this matter are hereby denied.

15IWCC0319

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

See findings of this Arbitrator in "F" above.

Petitioner completed medical treatment with Dr. Li and Dr. Kattner, who did not feel that he could return to heavy duty work. Petitioner underwent the services of Dr. Daniel Minnich, a vocational rehabilitation counselor. Mr. Minnich recommended that Petitioner undergo a functional capacity evaluation, which was not performed in this matter. Petitioner underwent the services of Mr. Minnich from December 18, 2012 through May 3, 3013. Mr. Minnich identified jobs with salary ranges of $9.49 an hour to as much as $35.82 an hour.

Petitioner was working part time as a pastor and indicated to Mr. Minnich that his main interest was his church and congregation. Petitioner also indicated to Mr. Minnich tht he was not interested in any job that paid less than $22.00 an hour. Petitioner indicated he had a business degree from Illinois State and a masters degree or doctorate in theology from E.L. White Bible School.

Mr. Minnich testified that if Petitioner were limited to sedentary duties, that would rule out his work at Respondent's facility.

Petitioner was also evaluated by a vocational counselor, Dennis Gustafson, at his own request. Petitioner saw Mr. Gustafson on October 1, 2013, who noted he was a high school graduate and attended Illinois State University. Petitioner then transferred to Moody Bible Institute where he graduated with a bachelor's degree in biblical studies. Mr. Gustafson indicated there may be some position that Petitioner could work earning between $8.50 and $11.00 an hour. Mr. Gustafson felt it was his professional opinion that Petitioner's chances of securing such work would be poor given his current age of 57 combined with the availability of job candidates who are younger and possess work histories more closely related to those jobs. Mr. Gustafson testified by evidence deposition on October 9, 2013.

Based on the allegation and evidence presented by Petitioner of an income of $600.00 per week as a pastor, it is noted that both vocational rehabilitation counselors in this case conformed he was employable in some regard, which would negate an award of total and permanent disability. Petitioner testified his church duties were 6-8 hours on Sunday and 2-3 hours on Wednesday for bible study.

Based upon the above, the Arbitrator finds that Petitioner would at best be capable of part time work and entitled to a wage differential award in this case pursuant to Section 8(d)1, representing two-thirds of the $215.20 difference in his current position as a pastor and what he could be earning at Respondent, or $143.47 per week, for the duration of his disability, commencing January 14, 2013.

M. Should penalties or fees be imposed upon Respondent?

See findings of this Arbitrator in "F" above.

Based upon said finding, all claims made for penalties and attorneys fees by Petitioner in this matter are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derek Ballard,
Petitioner,

vs. No: 11 WC 06748

Caterpillar, Inc.,
Respondent.

15IWCC0320

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 causal connection and nature and extent of the permanent disability, and being advised of the facts and law, modifies the February 13, 2014 Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision, which is attached hereto and made a part hereof.

Arbitrator Brandon Zanotti found that Petitioner proved that his current condition of ill-being, including his recurring testicular cysts, was causally related to his February 10, 2009 work accident. The Arbitrator awarded Petitioner reasonable and related medical expenses and permanent partial disability of 15% loss of use of the right testicle. The Arbitrator further found that Respondent was entitled to a Section 8(j) credit of $3,739.72 for medical bills paid through its group plan.

After considering the entire record, and for the reasons set forth below, the Commission finds that Petitioner's testicular cysts are not related to his February 10, 2009 work accident, reverses the award of medical expenses related to Petitioner's cysts, and reduces the permanency award from 15% to 10% loss of use of the right testicle.

15IWCC0320

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 25 year old welder, filed an Application for Adjustment of Claim, claiming injury on February 10, 2009 to his right testicle. Petitioner described the accident as occurring when he was working with a pneumatic grinder when a quick release mechanism attached to the hose released unexpectedly from an air compressor and struck his right testicle.

2. Petitioner testified that the impact of the brass mechanism felt like he was hit by a baseball pitch, and he immediately fell to the ground after being struck.

3. Respondent's on-site medical records reflect that on February 10, 2009, Petitioner presented to the on-site medical facility and completed an Employee Incident Report. Petitioner underwent an ultrasound of his scrotum and a urinalysis and was released from the hospital with a prescription for Trazadone.

4. Petitioner followed up with company medical personnel on February 12, 2009 and received work restrictions for "groin pain--occ."

5. On February 18, 2009, urologist Dr. Scott Morgan at Lake Shore Urology evaluated Petitioner, who reported his current pain at 8 on a 1-10 scale.

6. Petitioner testified that he also treated with Dr. Dan Smith, his primary care physician, for his testicular pain, radiating pain, and erection problems. However, Petitioner did not offer Dr. Smith's records as evidence at hearing.

7. Petitioner described that a cyst started to develop on the back of his right testicle following the accident. According to Petitioner, the cyst took two to three weeks to fully develop to the size of a pellet. Petitioner testified that the cyst would rupture at some sudden event and cause him excruciating pain, before it regenerated to form another cyst. The process had occurred twice since his injury.

8. On March 8, 2011, Petitioner returned to Dr. Morgan at Lake Shore Urology. His diagnosis was scrotal pain, right spermatocele (spermatic cyst) and erectile dysfunction.

9. At the time of hearing, Petitioner reported that his sex life had been affected, as certain positions caused him intense pain, and he testified that he occasionally suffered from erectile dysfunction.

10. Respondent offered medical records from Petitioner's previous primary care physician, Dr. Heim. These records demonstrated prior testicular complaints in 1995, 1997, 1999, and 2003, with diagnoses of a left-sided epididymal cyst which responded favorably to treatment with antibiotics. Similarly, his current complaint of right-sided testicular cyst responded favorably to Dr. Smith's periodic prescription for a Z-pack antibiotic.

Arbitrator Zanotti found that Petitioner was a credible witness and had proved that his current condition of ill-being, including the development of testicular or epididymal cysts, was causally related to his work accident. The Arbitrator awarded Petitioner outstanding medical expenses totaling $332.30 and permanent partial disability of 15% loss of use of the right testicle, as provided in Section 8(e) of the Act.

Respondent timely appealed the Arbitrator's award of benefits to the Commission. After considering the entire record, the Commission specifically notes Petitioner's prior testicular complaints, prior diagnoses of spermatic cysts, and recurrent recoveries after antibiotic treatment. The Commission notes no physician provided a causation opinion relating Petitioner's cysts to his work accident, and the Commission therefore finds the current complaint of testicular cysts to be non-occupational and not causally related to the work accident. Medical expenses related to treatment for the recurrent cysts and resulting pain and dysfunction are, therefore, not causally related to Petitioner's work injury, which was diagnosed by the Emergency Room, Dr. Morgan, and Dr. Smith as a contusion or scrotal pain. The Commission vacates the Arbitrator's award of $332.30 for medical expenses related to Petitioner's testicular cysts and reduces Arbitrator Zanotti's award for permanent partial disability of 15% loss of use of the right testicle to 10% loss of use of the right testicle based on the contusion to the scrotum.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the February 13, 2014 Decision of the Arbitrator is modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of $332.30 for medical expenses is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $451.71/week for a period of 5.4 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 10% loss of use of the right testicle.

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.

15IWCC0320

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,500.00. 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: MAY 4 - 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-03/03/15
jdl/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BALLARD, DEREK
Employee/Petitioner

Case# **11WC006748**

CATERPILLAR INC
Employer/Respondent

15IWCC0320

On 2/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
KEITH SPARKS
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

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

DEREK BALLARD
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # 11 WC 6748

15IWCC0320

An *Application for Adjustment 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 **Springfield**, on **December 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 10, 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 **$36,136.98**; the average weekly wage was **$752.85**.

On the date of accident, Petitioner was **25** years of age, ***married*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit of **$3,739.72** under Section 8(j) of the Act for medical bills paid through its group plan.

ORDER

Respondent shall pay reasonable and necessary medical services from: HSHS Medical Group Inc. totaling $84.98; and St. Mary's Hospital totaling $247.32, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $3,739.72 for medical benefits that have been paid through its group plan, 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 $451.71/week for 8.1 weeks, because the injuries sustained caused the 15% loss of the right testicle, 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

02/07/2014
Date

FEB 13 2014

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEREK BALLARD
Employee/Petitioner

v. Case # 11 WC 6748

CATERPILLAR, INC.
Employer/Respondent

15IWCC0320

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that Petitioner sustained an accident which occurred on February 10, 2009. Petitioner, Derek Ballard, was a twenty-five year old male employed by Respondent, Caterpillar Inc., as a welder at the time of the accident date. Petitioner was married with one dependent child.

On February 10, 2009, Petitioner was working with a pneumatic grinder power tool when he was injured after being struck in the right testicle by the quick release mechanism of the grinder hose. Petitioner described that the grinder tool was connected to an air hose that attached to an air compressor. Petitioner testified that at the end of the air hose was the quick release mechanism, a heavy piece of brass metal and metal bearings.

Petitioner testified that the incident occurred when he completed grinding a certain section of a tandem and as Petitioner pulled on the grinder, the quick release mechanism attached to the air compressor was forcefully detached and propelled into Petitioner's right testicle. Petitioner described that the impact of the quick release mechanism felt like he was hit by a baseball pitch and he immediately fell to the ground after being struck.

The company medical records reflect that on February 10, 2009, Petitioner presented to Respondent's medical facility and completed an Employee Incident Report. (Petitioner's Exhibit (PX) 1; Respondent's Exhibit (RX) 1). After visiting Respondent's medical facility, Petitioner was then transported and treated at St. Mary's emergency room. Petitioner received an ultra-sound on his scrotum and a urinalysis while at St. Mary's hospital. Petitioner was released from St. Mary's hospital and given a prescription for Trazadone. (PX 2).

Petitioner returned to work and followed-up with company medical personnel on February 12, 2009. Petitioner was given work restrictions by the company doctor who noted on the work restriction record that Petitioner's medical problem was "(R) groin pain –occ." (PX 1; RX 1). On February 18, 2009, Petitioner treated with urologist Dr. Scott Morgan at Lake Shore Urology. Petitioner indicated on his intake form that his current pain was an 8 on a 1 -10 scale, and that the pain was of a constant nature. (PX 3; RX 3).

Thereafter, Petitioner testified that he treated with Dr. Dan Smith, his primary care physician, for pain symptoms related to his testicle injury. During this time, Petitioner testified to experiencing radiating pain, tenderness and erection problems. For a period of approximately three months after the February 10, 2009 incident, Petitioner could not have an erection as it was too painful for him.

Petitioner described that after the February 10, 2009 incident a cyst started to develop on the back of his right testicle. Petitioner testified that it would take approximately two to three weeks to fully develop and once fully developed the cyst would be the size of a "BB." Petitioner described that after the cyst fully developed, it would eventually rupture with some sudden event and cause him excruciating pain. After Petitioner ruptures this cyst, Petitioner testified that the cyst will again start to re-develop until another event causes that cyst to rupture. Petitioner described that he has experienced this process at least on two occasions since he sustained his injury. Petitioner indicated that the length of time between cyst ruptures will vary and is dependent on an inciting event such as a rapid or sudden force.

On May 3, 2010, Petitioner ruptured a cyst while at work for Respondent. The company medical records reflect that Petitioner presented to Respondent's medical facility and completed an Employee Incident Report for this occurrence. (PX 1; RX 1). Petitioner testified that he was sitting down waiting for his welding machine to finish its task when he stood up from his chair and felt an intense pain in his right testicle. Petitioner went to St. Mary's emergency room and received treatment on his right testicle. (PX 2).

Petitioner again treated with Dr. Smith after visiting St. Mary's emergency room. Petitioner testified that he would periodically treat with Dr. Smith whenever his testicle pain symptoms would increase.

On March 1, 2011, Petitioner returned to Dr. Morgan at Lake Shore Urology at the referral of Dr. Smith. Dr. Morgan's medical records reflect that Petitioner's condition had been an ongoing issue, one that required him to continually visit his primary care physician until his pain symptoms would subside. The medical records noted that Petitioner's current complaints at that time consisted of fatigue, decreased libido and occasional difficulty maintaining an erection. Petitioner underwent another ultra-sound on March 4, 2011, which was essentially normal. (PX 3; RX 3).

On March 8, 2011, Petitioner again treated with Dr. Morgan at Lake Shore Urology. The Lake Shore Urology medical records reflect that Petitioner's diagnosis was scrotal pain, right Spermatocele (also known as a spermatic cyst) and erectile dysfunction. (PX 3; RX 3).

Petitioner testified to currently experiencing issues related to his testicle injury. Petitioner described that as a consequence of his testicle injury his sex life has been altered, and he and his wife now have to accommodate potential testicle pain during sex. As a result, Petitioner and his wife are restricted from certain activities because it would cause Petitioner too much pain. Petitioner testified that he occasionally suffers from erectile dysfunction during sex whenever his testicle is contacted too forcefully and his testicle starts to radiate pain.

Petitioner testified that prior to the accident from February 2009, he did not have erectile dysfunction issues or difficulty performing sexual activities with his wife. Additionally, Petitioner testified that prior to February 2009, Petitioner did not develop or experience issues with cysts on his testicle.

CONCLUSIONS OF LAW

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

The Arbitrator notes that Petitioner testified in a credible, believable fashion consistent with the medical records. He appeared to be endeavoring to give the whole truth during his testimony.

With reference to causal relationship between the injury and the condition, the Arbitrator notes that it has long been established that proof of good health prior to the time of the injury and a subsequent condition of

ill being involving injury to the affected area creates an issue of fact as to the causal relationship between the injury and the condition of ill being in question. *A.O. Smith Corp. v. Industrial Comm'n.*, 69 Ill.2d 240, 245, 371 N.E.2d 607 (1977).

Therefore, the Arbitrator finds that Petitioner's right testicle condition of ill being is causally related to the injury and relies on Petitioner's credible testimony and the treating medical records. Petitioner testified that he had no problems with cysts on his testicle or impotency prior to his testicle injury, but that after the injury he now has a re-occurring issue with cysts and an occasional issue with erectile dysfunction. Dr. Morgan's medical records diagnose Petitioner with Spermatocele (or spermatic cyst) on his right testicle and also noted his current issues with erectile dysfunction, corroborating Petitioner's 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?; and

Issue (N): Is Respondent due any credit?

According to the medical bills offered into evidence, $332.30 remained outstanding. (PX 4). Therefore, after finding causation, the Arbitrator finds that Petitioner is entitled to $332.30 in reasonable and necessary medical services and allows Respondent a credit for the remaining bills paid by its group medical carrier pursuant to Section 8(j) of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). The bills awarded in Petitioner's Exhibit 4 are as follows:

1. HSHS Medical Group Inc. $84.98
2. St. Mary's Hospital $247.32

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

In making the determination of Petitioner's permanent partial disability, the Arbitrator notes that Section 8(e)(15) of the Act provides that compensation for the "loss of or the permanent and complete loss of the use of" one testicle shall be 54 weeks. 820 ILCS 305/8(e)(15). Additionally, Section 8(e)(16) of the Act provides compensation for permanent partial loss of the use of a scheduled member. 820 ILCS 305/8(e)(16). To give effect to both parts of the Act, partial compensation must be awarded for partial loss of use. *Boston v. Industrial Comm'n*, 125 Ill. App. 3d 789, 794, 466 N.E.2d 625 (4th Dist. 1984).

Illinois has recognized that, to recover for loss of use of a part of the body, the important question is whether its normal function has been impaired. *Boston*, 125 Ill. App. 3d at 793. The "general rule is that direct expert evidence is not essential to establish the permanency or future effects of an injury. These conditions may be inferred from the nature of the injury alone." *A.O. Smith Corp.*, 69 Ill.2d at 245. Regarding the permanence of an injury, the Supreme Court of Illinois has observed that "a long period of time without substantial improvement is sufficient time to justify a finding that an injury is permanent." *Granite City Steel Co. v. Industrial Comm'n.*, 97 Ill.2d 402, 407, 454 N.E.2d 1011 (1983).

Petitioner suffered his injury on February 10, 2009, and since that time has experienced painful episodes dealing with cyst ruptures and incidents of erectile dysfunction related to his testicle injury. Petitioner testified that since the incident he has treated with his personal care physician, Dr. Smith, and urologist, Dr. Morgan; however, he continues to develop cysts on his right testicle. At trial, Petitioner testified to at least two encounters of rupturing his cyst since the February 2009 accident date. Additionally, Petitioner stated that he

currently had a cyst on his right testicle. Dr. Morgan's diagnosis of a Spermatocele on Petitioner's right testicle corroborates Petitioner's testimony.

Petitioner testified that his cyst condition will continue to re-occur. As a result of this testicle cyst, Petitioner testified to changes in his sex life, as he and his wife can no longer engage in some of the same sexual activities as they did prior to the injury. Petitioner's body part has been impaired and justifies an award for permanent partial disability.

The Arbitrator notes that Petitioner testified credibly and consistently with the medical records. Based upon Petitioner's current condition, coupled with the significant impact the injury has had and will continue to have on Petitioner's life, the Arbitrator finds that the injury sustained caused the 15% loss to his right testicle as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH "WAYNE" BILLBE,

Petitioner,

15IWCC0321

vs.

NO: 13 WC 23308

CROSS BROTHERS IMPLEMENT CO.,

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

The Commission notes that two cases were consolidated for hearing. 13 WC 23309 alleged a right shoulder injury on February 8, 2013, while 13 WC 23308 alleged a left shoulder and arm injury on June 24, 2013. The Arbitrator issued two nearly identical decisions, one for each case number, and each of the decisions address both of Petitioner's accident dates and shoulder conditions. Although some of the medical expenses and temporary total disability dates are applicable to both cases, both of the decisions contain the same "orders," which is confusing because they could be read as awarding double the amount of compensation to which Petitioner is entitled. We therefore modify the decisions to more accurately reflect separate awards for each.

In the above captioned case, 13 WC 23308, we award temporary total disability from July 15, 2013 through July 31, 2013 and August 6, 2013 through May 15, 2014, a period of 42-6/7 weeks. The Commission affirms the temporary partial disability award of $160.01. We affirm the Arbitrator's award of medical expenses contained in Petitioner's Exhibit 3 related to the left shoulder but clarify that Respondent is not required to make a double payment for these expenses in

15IWCC0321

13 WC 23309. Petitioner is entitled to prospective medical treatment for the left shoulder as recommended by Dr. Herrin.

On the issue of penalties and attorney's fees, we find that a legitimate dispute existed as to whether Petitioner refused light duty work on August 6, 2013, or if Respondent was unable to accommodate Petitioner's restrictions on August 6, 2013. We find that the delay in payment of temporary total disability benefits until October 8th was not unreasonable under the circumstances of this case. Therefore, we reverse the award of §19(l) penalties and attorney's fees under §16 of the Act and those are hereby vacated.

On the issue of Section 12 examination expenses, we affirm the Arbitrator's award of $169.33 in mileage expenses. However, the evidence is not clear whether Petitioner's food receipts reflect only purchases for himself or if they included meals for his wife, who accompanied Petitioner on the trip. While Petitioner is entitled to be compensated for his own meals, he is not entitled to reimbursement for his wife. Therefore, we find that Petitioner is only entitled to 50% of the $24.43 in expenses indicated on the receipts. The total Section 12 examination expenses that Petitioner is entitled to is $181.55 ($169.33 in mileage plus $12.22 for his own meals) with Respondent receiving credit for $149.86 already paid.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $475.71 per week for a period of 42-6/7 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 $160.01 in temporary partial disability benefits with Respondent receiving credit for amounts already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses in Petitioner's Exhibit 3 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act, with Respondent receiving credit for any amounts paid pursuant to the award in 13 WC 23309.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment for the left shoulder as recommended by Dr. Herrin.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $181.55 for expenses related to his Section 12 examination with Respondent receiving credit for $149.86 already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the awards for §19(l) penalties and attorney's fees under §16 of the Act are hereby vacated.

15IWCC0321

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 $10,000.00. 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: MAY 4 - 2015

Charles J. DeVriendt

Joshua D. Luskin

SE/
O: 3/4/15
49

DISSENTING OPINION

I respectfully dissent from the Decision of the majority. The majority agreed with the Arbitrator who found that Petitioner sustained his burden of proving compensable accident and causation to current conditions of ill-being on February 8, 2013. In my opinion, Petitioner did not sustain his burden of proving that accident. I would have reversed the Decision of the Arbitrator and denied compensation.

Petitioner alleged accidents on February 8, 2013, in which he alleged injury to his right shoulder, and on June 24, 2013, in which he alleged injury to his left neck, shoulder, and arm. The cases were consolidated for arbitration but subject to separate Decisions.

Regarding the alleged February 8, 2013 accident, Petitioner testified he was trying to open large metal sliding doors in order to bring equipment inside because of the cold weather. The door was stuck or frozen and he "jabbed" the door with his right shoulder, but it did not move. He then "rammed" the door with his right shoulder and then grabbed it with his arms and pulled back. He noticed pain in his right shoulder; he denied any previous shoulder condition. The next day Petitioner sought treatment at Primary Care. The treatment note indicated he reported that he felt pain in his right shoulder after opening a large metal door at work the previous day. He also reported feeling similar pain a few days previously, but not at work. Petitioner's treating physician,

Dr. Herrin, testified at deposition that when Petitioner first presented to him on April 18, 2013, Petitioner never made any mention of striking the door with his shoulder. Petitioner also did not mention striking the door with his shoulder to Respondent's Section 12 medical examiner, Dr. Lehman. The first time any mention of striking the door with his shoulder was made to Dr. Herrin, was after Dr. Lehman's deposition testimony.

Respondent's Service Manager of 20 years, Steven Collier, testified that there would no reason for Petitioner to open that metal door on which he was allegedly injured. That was not the main door. Clearly, if it were stuck he could have simply used the main door.

In my opinion, Petitioner has not sustained his burden of proving this un-witnessed accident. Petitioner's testimony was simply not credible. Regarding the alleged February 8th accident, Petitioner's account at arbitration does not make empirical sense. It is hard to believe that a person would run at a stuck metal door and ram it in an attempt to open it, especially considering Mr. Collier's testimony that using that door was not necessary. In addition, there were serious discrepancies between his testimony of the alleged mechanism of injury and the notes in the medical records.

Finally, Petitioner's credibility was undermined by his behavior at arbitration. Respondent presented a witness, Denise Damm, regarding attempts to provide work for Petitioner within his restrictions. Her cross examination testimony had to be suspended when she complained that Petitioner was staring and laughing at her. The Arbitrator apparently considered the tactic to be an attempt at some form of intimidation because he ordered Petitioner to move his seat closer to his lawyer and further away from the witness.

I would have found that Petitioner did not sustain his burden of proving a compensable accident on February 8, 2013, reversed the decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

Ruth W. White

Ruth W. White

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

15IWCC0321

BILLBE, KENNETH "WAYNE"
Employee/Petitioner

Case# **13WC023308**

13WC023309

CROSS BROTHERS IMPLEMENT CO
Employer/Respondent

On 7/16/2014, 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:

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST PO BOX 2485
SPRINGFIELD, IL 62705

2593 GANAN & SHAPIRO PC
MELINDA M ROWE-SULLIVAN
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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)

15IWCC0321

Kenneth "Wayne" Billbe
Employee/Petitioner

Case # 13 WC 23308

v.

Consolidated cases: 13 WC 23309

Cross Brothers Implement Co.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable 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 Reimbursement of Travel Expenses

FINDINGS

On the date of accident, June 24 , 2013, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $37,105.44; the average weekly wage was $713.57.

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 $9,318.37 for TTD, $160.01 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $9,478.38.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 3, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including the treatment to the right and left shoulders as recommended by Dr. Herrin.

Respondent shall pay Petitioner temporary partial disability benefits of $160.01 and temporary total disability benefits of $475.71 per week for 51 2/7 weeks commencing April 19, 2013, through June 16, 2013; July 15, 2013 through July 31, 2013; and August 6, 2013, through May 15, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner penalties of $1,920.00 as provided in Section 19(l) of the Act and attorneys' fees of $384.00, as provided in Section 16 of the Act.

Respondent shall pay Petitioner the sum of $193.76 for expenses incurred in connection with Section 12 examination by Dr. Lehman. Respondent shall receive a credit of $149.86.

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.

15IWCC0321

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

July 11, 2014
Date

JUL 16 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case 13 WC 23309, the Application alleged that on February 8, 2013, Petitioner was pulling on a large sliding door and sustained an injury to his right shoulder. In case 13 WC 23308, the Application alleged that on June 24, 2013, Petitioner was pulling down the ramp of the trailer and sustained an injury to his left shoulder. These cases were previously consolidated for trial and were tried in a 19(b) proceeding in which Petitioner sought an order for payment of medical bills, temporary partial disability benefits, temporary total disability benefits and travel expenses as well as prospective medical treatment. Petitioner also filed a petition for Section 19(l) penalties and Section 16 attorneys' fees. Respondent disputed liability in both cases on the basis of accident and causal relationship.

Petitioner worked for Respondent as a mechanic and his job duties included working on machines and delivering machinery to Respondent's customers. Petitioner testified that on February 8, 2013, he was in the process of attempting to move a large sliding door which had a broken roller. In an effort to move the door, Petitioner struck the side of it with his right shoulder in a manner similar to the way a football player will use his shoulder to block. When Petitioner did this, he experienced what he described as a "popping" sensation in the upper part of his right shoulder. Petitioner stated that he had not sustained any prior injuries or experienced any problems in regard to his right shoulder.

Petitioner initially sought medical treatment the following day, February 9, 2013, when he was seen at Priority Care by Dr. Saira Wahab Silas. According to her record of that date, Petitioner noticed pain in the right shoulder after operating a large sliding door at work on February 8, 2013, and that the pain was worse at the end of the day. The record also noted that Petitioner had experienced a similar pain a few days ago, but not at work. Dr. Wahab Silas' diagnosis was a shoulder strain and she ordered an x-ray and prescribed medications. Dr. Wahab Silas imposed work/activity restrictions of no lifting over 10 pounds and no pushing/pulling over 50 pounds (Petitioner's Exhibit 4).

Petitioner was later seen at Priority Care by Dr. Simone Turner and Dr. Gerard Bitar on February 25, and March 28, 2013, respectively. The records of both visits indicated that Petitioner injured his right shoulder at work. An MRI of the right shoulder was performed on March 13, 2013, which the radiologist read as being positive for a possible small full thickness tear in the supraspinatus as well as some other abnormalities. When Dr. Bitar saw Petitioner on March 28, 2013, he reviewed the MRI scan, authorized Petitioner to be off work and referred him to Dr. Rodney Herrin, an orthopedic surgeon (Petitioner's Exhibits 4 and 5).

Dr. Herrin saw Petitioner on April 18, 2013, and his record of that date noted that Petitioner injured his right shoulder at work on February 8, 2013, when he was pulling on a closed door. Dr. Herrin read the MRI, imposed work restrictions of no overhead lifting in excess of five pounds and ordered physical therapy (Petitioner's Exhibit 8).

Petitioner received physical therapy at St. John's Hospital from April 23, through July 15, 2013. In the record of April 23, 2013, it was noted that Petitioner injured his right shoulder several months prior while pulling open a door at work (Petitioner's Exhibit 6).

When Dr. Herrin saw Petitioner on May 9, 2013, he suggested that Petitioner consider surgical repair of the rotator cuff but continued conservative treatment and Petitioner's work/activity restrictions. When Dr. Herrin saw Petitioner on June 3, 2013, Petitioner's condition had improved and the work/activity restrictions were modified to no lifting over 25 pounds at waist level and no overhead work. Dr. Herrin saw Petitioner on June 17, 2013, and Petitioner continued to improve and Dr. Herrin released Petitioner to attempt to return to work without restrictions; however, he did not release Petitioner from care and opined that Petitioner was not at MMI (Petitioner's Exhibit 8).

On June 24, 2013, Petitioner sustained the second accidental injury that involved his left shoulder. At that time, Petitioner was in the process of delivering some machinery to one of Respondent's customers. Petitioner was pulling down a large metal tailgate and when it dropped quickly, he attempted to catch it with his left hand/arm. When he did this, Petitioner experienced a jerking sensation in his left shoulder. Also, the tailgate struck his left shoulder and arm as it fell. Petitioner testified that tailgate weighed approximately 200 pounds. Petitioner stated that prior to this accident, he experienced some minor problems with his left shoulder that he associated with overuse because of the injury he had sustained to his right shoulder.

Petitioner was seen by Dr. Herrin on June 27, 2013, and Dr. Herrin's record of that date noted that Petitioner injured his left shoulder on the preceding Monday when he attempted to stop a tailgate from hitting a driveway. Petitioner stated that it "jerked" his shoulder and he had pain in the left shoulder up to the neck as well as numbness down to his left thumb. Dr. Herrin opined that Petitioner had either a shoulder strain or possible rotator cuff injury. He ordered Petitioner to continue physical therapy but that Petitioner could continue to work regular duties (Petitioner's Exhibit 8).

Dr. Herrin saw Petitioner on July 15, 2013, and, at that time, Petitioner had significant complaints in regard to both shoulders especially when performing overhead work. Dr. Herrin opined that the right shoulder symptoms were because of a rotator cuff tear. In regard to the left shoulder, he could not rule out rotator cuff pathology, but thought that there might be a cervical spine problem. He imposed work/activity restrictions of no overhead work with either shoulder and no lifting over five pounds with either upper extremity. Because of the potential problem with the cervical spine, he referred Petitioner to Dr. John Watson, an orthopedic surgeon (Petitioner's Exhibit 8).

Dr. Watson saw Petitioner on August 5, 2013. His record of that date noted that Petitioner injured himself while lifting a trailer gate and that he experienced pain in the left shoulder/arm, neck, as well as the right shoulder. Dr. Watson opined that Petitioner's symptoms were consistent with C6 cervical radiculopathy and ordered an MRI scan of the cervical spine and EMG studies. In addition to the restrictions imposed by Dr. Herrin, Dr. Watson imposed restrictions of no repetitive bending, twisting and stooping; no kneeling, crawling or squatting; and no climbing of stairs, ladders or ramps (Petitioner's Exhibit 10).

EMG studies performed on August 13, 2013, were normal; however, the MRI scan performed on that same day revealed a small annular tear and central disc protrusion at C5-C6 which Dr. Watson opined could be contributing to some of Petitioner's symptoms. He recommended Petitioner continue physical therapy. Dr. Watson continued the work restrictions at that time as well as at subsequent office visits of October 3 and November 4, 2013 (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on October 24, 2013. In Dr. Lehman's report of that date, the accident of February 9, 2013, was described as occurring when Petitioner was sliding the doors to the back of a shop when a door came down and injured his right shoulder. The accident of June 24, 2013, was described as occurring when Petitioner was pulling a ramp on a trailer and that he injured his left shoulder. Dr. Lehman examined Petitioner and reviewed medical records provided to him by Respondent. In regard to the right shoulder, Dr. Lehman opined that Petitioner had impingement syndrome, a possible rotator cuff tear and degenerative arthritis of the AC joint. In regard to the left shoulder and neck, he opined that Petitioner had left shoulder impingement syndrome with cervical spine strain (Respondent's Exhibit 6).

In regard to causality of Petitioner's injuries, Dr. Lehman opined that the right shoulder injury was not related to the accident of February 8, 2013, noting that Petitioner did not have a direct traumatic injury to the right shoulder and that closing the door would be consistent with such a condition. Dr. Lehman stated that Petitioner should undergo arthroscopic surgery of the right shoulder but that he was at MMI as it related to the accident of February 8, 2013 (Respondent's Exhibit 6).

In regard to Petitioner's neck and left shoulder complaints, Dr. Lehman opined that Petitioner's symptoms in the cervical spine were not related to the accident of June 24, 2013, because Petitioner's only radicular complaints were in the left shoulder and he found no evidence of pathology in the cervical spine. In regard to the left shoulder, Dr. Lehman recommended that Petitioner have an MRI of the left shoulder performed to determine if there was any pathology in the left shoulder (Respondent's Exhibit 6).

Dr. Lehman subsequently reviewed additional medical records which included the report of an MRI of the left shoulder performed on December 3, 2013, and he opined that the MRI only revealed long-term degenerative changes not consistent with the mechanism of injury (Respondent's Exhibits 7 and 8).

Petitioner testified that he has not been able to return to work because the restrictions imposed by his treating physician, Dr. Herrin, have not been removed. Respondent has not offered work to Petitioner that conforms to these restrictions. Respondent did make a written offer of work to Petitioner on November 23, 2013; however, this was based on the restrictions imposed by Dr. Lehman of no overhead work with the left shoulder and no lifting in excess of 35 pounds (Respondent's Exhibit 3).

In regard to temporary total disability, Petitioner and Respondent stipulated that Petitioner was temporarily totally disabled from April 19 through June 16, 2013; July 15 through July 31, 2013;

and August 6 through December 1, 2013. Petitioner and Respondent also stipulated that Petitioner was temporarily partially disabled from August 1, through August 5, 2013. Accordingly, the disputed period of time in regard to temporary total disability was from December 2, 2013, through the date of trial, May 15, 2014 (Arbitrator's Exhibits 1 and 3).

Respondent did not issue payment of temporary total disability benefits to Petitioner from August 6, 2013, until October 8, 2013, approximately 2 months after Petitioner ceased working for Respondent (Respondent's Exhibit 13). The aforementioned delay in payment was the basis for Petitioner's counsel filing a petition for Section 19(l) penalties and Section 16 attorneys' fees.

Dr. Lehman was deposed on February 19, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Lehman's testimony was consistent with his narrative medical reports and he reaffirmed his opinions that Petitioner's right and left shoulder conditions as well as the cervical spine condition were not related to the accidents of February 8, and June 24, 2013. On cross-examination, Dr. Lehman did agree that if Petitioner ran at the door and struck it with his right arm that this could cause rotator cuff pathology (Respondent's Exhibit 9; pp 13-20; 53-54).

Dr. Herrin was deposed on April 24, 2014, and his deposition testimony was received into evidence at trial. Dr. Herrin testified that there was a causal connection between Petitioner's right shoulder condition and the accident of February 8, 2013, as well as a causal relationship between Petitioner's left shoulder condition and the accident of June 24, 2013. In regard to treatment, Dr. Herrin recommended surgery on the right shoulder. As far as the left shoulder was concerned, Dr. Herrin stated that it if it continued to be problematic that surgery might be required on that shoulder as well (Petitioner's Exhibit 18; pp 38-43).

At trial, Petitioner had complaints in regard to both the right and left shoulders, especially when he attempts to move his arms and in an upward or overhead manner, much more so on the right than on the left. Petitioner wants to proceed with the surgery as recommended by Dr. Herrin.

Petitioner also testified regarding expenses incurred in connection with the Section 12 examination by Dr. Lehman. Various receipts for gas and meal expenses were received into evidence as well as receipts for a new alternator and battery for Petitioner's vehicle. The Exhibit also noted that the round trip mileage distance for the Section 12 examination was 299.7 miles (Petitioner's Exhibit 10). Respondent paid Petitioner $149.86 for travel expenses incurred in connection with the Section 12 examination by Dr. Lehman (Respondent's Exhibit 5).

Petitioner's wife, Janet Billbe, testified at the trial of this case. She stated that Petitioner had no problems in regard to his right and left shoulders until after the accidents of February and June, 2013, respectively. She has also observed the Petitioner experience considerable pain and sleep disruption because of the injuries on a regular basis.

Denise Dom testified on behalf of the Respondent. Dom is Respondent's bookkeeper and she stated that Petitioner left Respondent's place of business in August, 2013, because was unable to do the work. She also identified correspondence directed to Petitioner dated November 23, 2013, in which work conforming to Dr. Lehman's work restrictions was tendered to Petitioner

(Respondent's Exhibit 3). She also stated that the tailgate involved in the accident of June, 2013, did not weigh 200 pounds; however, on cross-examination, she agreed that she did not know how much the tailgate actually weighed.

Steve Collier also testified on behalf of the Respondent. Collier is Respondent's Service Manager and he stated that he directed Petitioner to go home in August, 2013, because Respondent did not have any light duty work to offer to him. He also stated that the tailgate did not weigh any more than 100 pounds.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained accidental injuries arising out of and in the course of his employment for Respondent on February 8, 2013, and June 24, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified about the circumstances of both accidental injuries and he sought medical treatment immediately or shortly after both accidents. The medical records of Petitioner's treating medical providers contained histories of the work-related accidents.

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

The Arbitrator concludes that Petitioner's current conditions of ill-being in regard to his right and left shoulders are related to the work-related accidents of February 8, 2013, and June 24, 2013, respectively.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified that he had no prior complaints/symptoms in his right and left shoulders before the accident of February 8, and June 24, 2013, respectively. Further, Petitioner's testimony was corroborated by the testimony of his wife, Janet Billbe.

Petitioner's treating physician, Dr. Herrin, testified that Petitioner's right and left shoulder conditions were related to the accidents of February 8, and June 24, 2013, respectively. While Dr. Lehman opined the condition was not related to the accident of February 8, 2013, on cross-examination, Dr. Lehman agreed that if Petitioner ran at the door and struck it with his right shoulder that this could cause rotator cuff pathology.

The Arbitrator finds the testimony of Petitioner's treating physician, Dr. Herrin, to be more persuasive and credible than that of Respondent's Section 12 examiner, Dr. Lehman.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 3, as provided by Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including the treatment for the right and left shoulders as recommended by Dr. Herrin.

In support of this conclusion the Arbitrator notes the following:

As aforestated, the Arbitrator found the opinion of Petitioner's treating physician, Dr. Herrin, to be more persuasive and credible than that of Respondent's Section 12 examiner, Dr. Lehman.

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

The Arbitrator concludes Petitioner is entitled to temporary partial benefits of $160.01. Further, the Petitioner is entitled to temporary total disability benefits of 51 2/7 weeks commencing April 19, 2013, through June 16, 2013; July 15, 2013 through July 31, 2013; and August 6, 2013, through May 15, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner and Respondent stipulated as to the amount of temporary partial disability benefits.

Petitioner has remained under the work restrictions imposed by Dr. Herrin and Respondent has not offered work to Petitioner conforming to said restrictions.

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

The Arbitrator concludes Petitioner is entitled to Section 19(l) penalties of $1,920.00 and Section 16 attorneys' fees of $384.00.

In support of this conclusion the Arbitrator notes the following:

Petitioner was unable to work for various periods of time including August 6, 2013, through May 15, 2014, the date of trial. Respondent failed to pay Petitioner temporary total disability benefits from August 6, 2013, until October 8, 2013, a period of 64 days. The Arbitrator finds no basis to deny Petitioner payment of temporary total disability benefits during that period of time. Pursuant to Section 19(l) Petitioner is entitled to a penalty of $30 a day or $1,920.00. Petitioner is also entitled to attorney's fees of 20% of the amount of the Section 19(l) penalties, $384.00.

The Arbitrator declines to assess Section 19(l) penalties from December 1, 2013, through May 15, 2014, because Respondent relied on the medical opinion of Dr. Lehman, its Section 12 examiner.

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

The Arbitrator concludes Petitioner is entitled to payment of expenses from Respondent incurred in connection with the Section 12 examination by Dr. Lehman in the amount of $193.76. Respondent shall receive a credit of $149.86.

Petitioner computed the round-trip mileage to be 299.7 miles. No contrary evidence was offered. Using the IRS standard in effect at the time of the examination of 56.5 cents per mile, the total computes to $169.33. Petitioner tendered into evidence receipts for two meals that total $24.43. The Arbitrator finds these amounts to be reasonable and the total is thereby $193.76.

Petitioner also tendered into evidence receipts for an alternator and battery. The Arbitrator finds Respondent is not liable for offer reimbursement of these expenses. Replacement of these automobile parts would have been required whether Petitioner had been examined or not.

William R. Gallagher, Arbitrator

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

KENNETH "WAYNE" BILLBE,

Petitioner,

15IWCC0322

vs.

NO: 13 WC 23309

CROSS BROTHERS IMPLEMENT CO.,

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

The Commission notes that two cases were consolidated for hearing. 13 WC 23309 alleged a right shoulder injury on February 8, 2013, while 13 WC 23308 alleged a left shoulder and arm injury on June 24, 2013. The Arbitrator issued two nearly identical decisions, one for each case number, and each of the decisions address both of Petitioner's accident dates and shoulder conditions. Although some of the medical expenses and temporary total disability dates are applicable to both cases, both of the decisions contain the same "orders," which is confusing because they could be read as awarding double the amount of compensation to which Petitioner

15IWCC0322

is entitled. We therefore modify the decisions to more accurately reflect separate awards for each.

In the above captioned case, 13 WC 23309, we award temporary total disability from April 19, 2013 through June 16, 2013, a period of 8-3/7 weeks. We affirm the Arbitrator's award of medical expenses contained in Petitioner's Exhibit 3 related to the right shoulder but clarify that Respondent is not required to make a double payment for these expenses in 13 WC 23308. Petitioner is entitled to prospective medical treatment for the right shoulder as recommended by Dr. Herrin. We vacate the awards for temporary partial disability, penalties and fees, and Section 12 examination expenses as these issues are addressed in 13 WC 23308.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $475.71 per week for a period of 8-3/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses in Petitioner's Exhibit 3 that are related to treatment for the right shoulder for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment for the right shoulder as recommended by Dr. Herrin.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

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

15IWCC0322

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. 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: MAY 4 - 2015

Charles J. DeVriendt

Joshua D. Luskin

SE/
O: 3/4/15
49

DISSENTING OPINION

I respectfully dissent from the Decision of the majority. The majority agreed with the Arbitrator who found that Petitioner sustained his burden of proving compensable accident and causation to current conditions of ill-being on June 24, 2013. In my opinion, Petitioner did not sustain his burden of proving that accident. I would have reversed the Decision of the Arbitrator and denied compensation.

Petitioner alleged accidents on February 8, 2013, in which he alleged injury to his right shoulder, and on June 24, 2013, in which he alleged injury to his left neck, shoulder, and arm. The cases were consolidated for arbitration but subject to separate Decisions.

Petitioner alleged an accident on June 24, 2013 allegedly occurring within eight days after he returned to work after another alleged accident. Petitioner testified he was delivering lawn mowers. On his last delivery he was opening the rear tailgate which he claimed was over 200 pounds. There was a lift assist, but it did not work because of the slope of the driveway. The tailgate gave way and struck him on the left forearm and left shoulder, he caught it with his right hand so as to keep it from striking and damaging the customer's driveway, he lost control, it went down to the ground, and almost pushed him off his feet. He then testified that he caught the gate before it smashed into the driveway and it yanked his arm, and pulled him off his feet. He felt immediate pain in his left armpit, shoulder, and neck and numbness all the way down his arm.

Respondent's Service manager for 20 years, Steven Collier testified that he is familiar with the tailgates and works with them every day. They weigh about 100 rather than more than 200 pounds. To the best of his knowledge, the tailgate Petitioner used at the time of the alleged accident was in good working order. He had never experienced such a malfunction. In addition, the method Petitioner described in opening the tailgate did not make any sense. One does not stand behind the tailgate but on the side where the operator would pull out the locking pin releasing the tailgate.

Finally, Petitioner's credibility was undermined by his behavior at arbitration. Respondent presented a witness, Denise Damm, regarding attempts to provide work for Petitioner within his restrictions. Her cross examination testimony had to be suspended when she complained that Petitioner was staring and laughing at her. The Arbitrator apparently considered the tactic to be an attempt at some form of intimidation because he ordered Petitioner to move his seat closer to his lawyer and further away from the witness.

I would have found that Petitioner did not sustain his burden of proving a compensable accident on April 24, 2013, reversed the decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

Ruth W. White

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

FINDINGS

On the date of accident, February 8, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $37,105.44; the average weekly wage was $713.57.

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 $9,318.37 for TTD, $160.01 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $9,478.38.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 3, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including the treatment to the right and left shoulders as recommended by Dr. Herrin.

Respondent shall pay Petitioner temporary partial disability benefits of $160.01 and temporary total disability benefits of $475.71 per week for 51 2/7 weeks commencing April 19, 2013, through June 16, 2013; July 15, 2013 through July 31, 2013; and August 6, 2013, through May 15, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner penalties of $1,920.00 as provided in Section 19(l) of the Act and attorneys' fees of $384.00, as provided in Section 16 of the Act.

Respondent shall pay Petitioner the sum of $193.76 for expenses incurred in connection with Section 12 examination by Dr. Lehman. Respondent shall receive a credit of $149.86.

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.

15IWCC0322

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

July 11, 2014
Date

JUL 16 2014

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case 13 WC 23309, the Application alleged that on February 8, 2013, Petitioner was pulling on a large sliding door and sustained an injury to his right shoulder. In case 13 WC 23308, the Application alleged that on June 24, 2013, Petitioner was pulling down the ramp of the trailer and sustained an injury to his left shoulder. These cases were previously consolidated for trial and were tried in a 19(b) proceeding in which Petitioner sought an order for payment of medical bills, temporary partial disability benefits, temporary total disability benefits and travel expenses as well as prospective medical treatment. Petitioner also filed a petition for Section 19(l) penalties and Section 16 attorneys' fees. Respondent disputed liability in both cases on the basis of accident and causal relationship.

Petitioner worked for Respondent as a mechanic and his job duties included working on machines and delivering machinery to Respondent's customers. Petitioner testified that on February 8, 2013, he was in the process of attempting to move a large sliding door which had a broken roller. In an effort to move the door, Petitioner struck the side of it with his right shoulder in a manner similar to the way a football player will use his shoulder to block. When Petitioner did this, he experienced what he described as a "popping" sensation in the upper part of his right shoulder. Petitioner stated that he had not sustained any prior injuries or experienced any problems in regard to his right shoulder.

Petitioner initially sought medical treatment the following day, February 9, 2013, when he was seen at Priority Care by Dr. Saira Wahab Silas. According to her record of that date, Petitioner noticed pain in the right shoulder after operating a large sliding door at work on February 8, 2013, and that the pain was worse at the end of the day. The record also noted that Petitioner had experienced a similar pain a few days ago, but not at work. Dr. Wahab Silas' diagnosis was a shoulder strain and she ordered an x-ray and prescribed medications. Dr. Wahab Silas imposed work/activity restrictions of no lifting over 10 pounds and no pushing/pulling over 50 pounds (Petitioner's Exhibit 4).

Petitioner was later seen at Priority Care by Dr. Simone Turner and Dr. Gerard Bitar on February 25, and March 28, 2013, respectively. The records of both visits indicated that Petitioner injured his right shoulder at work. An MRI of the right shoulder was performed on March 13, 2013, which the radiologist read as being positive for a possible small full thickness tear in the supraspinatus as well as some other abnormalities. When Dr. Bitar saw Petitioner on March 28, 2013, he reviewed the MRI scan, authorized Petitioner to be off work and referred him to Dr. Rodney Herrin, an orthopedic surgeon (Petitioner's Exhibits 4 and 5).

Dr. Herrin saw Petitioner on April 18, 2013, and his record of that date noted that Petitioner injured his right shoulder at work on February 8, 2013, when he was pulling on a closed door. Dr. Herrin read the MRI, imposed work restrictions of no overhead lifting in excess of five pounds and ordered physical therapy (Petitioner's Exhibit 8).

Petitioner received physical therapy at St. John's Hospital from April 23, through July 15, 2013. In the record of April 23, 2013, it was noted that Petitioner injured his right shoulder several months prior while pulling open a door at work (Petitioner's Exhibit 6).

When Dr. Herrin saw Petitioner on May 9, 2013, he suggested that Petitioner consider surgical repair of the rotator cuff but continued conservative treatment and Petitioner's work/activity restrictions. When Dr. Herrin saw Petitioner on June 3, 2013, Petitioner's condition had improved and the work/activity restrictions were modified to no lifting over 25 pounds at waist level and no overhead work. Dr. Herrin saw Petitioner on June 17, 2013, and Petitioner continued to improve and Dr. Herrin released Petitioner to attempt to return to work without restrictions; however, he did not release Petitioner from care and opined that Petitioner was not at MMI (Petitioner's Exhibit 8).

On June 24, 2013, Petitioner sustained the second accidental injury that involved his left shoulder. At that time, Petitioner was in the process of delivering some machinery to one of Respondent's customers. Petitioner was pulling down a large metal tailgate and when it dropped quickly, he attempted to catch it with his left hand/arm. When he did this, Petitioner experienced a jerking sensation in his left shoulder. Also, the tailgate struck his left shoulder and arm as it fell. Petitioner testified that tailgate weighed approximately 200 pounds. Petitioner stated that prior to this accident, he experienced some minor problems with his left shoulder that he associated with overuse because of the injury he had sustained to his right shoulder.

Petitioner was seen by Dr. Herrin on June 27, 2013, and Dr. Herrin's record of that date noted that Petitioner injured his left shoulder on the preceding Monday when he attempted to stop a tailgate from hitting a driveway. Petitioner stated that it "jerked" his shoulder and he had pain in the left shoulder up to the neck as well as numbness down to his left thumb. Dr. Herrin opined that Petitioner had either a shoulder strain or possible rotator cuff injury. He ordered Petitioner to continue physical therapy but that Petitioner could continue to work regular duties (Petitioner's Exhibit 8).

Dr. Herrin saw Petitioner on July 15, 2013, and, at that time, Petitioner had significant complaints in regard to both shoulders especially when performing overhead work. Dr. Herrin opined that the right shoulder symptoms were because of a rotator cuff tear. In regard to the left shoulder, he could not rule out rotator cuff pathology, but thought that there might be a cervical spine problem. He imposed work/activity restrictions of no overhead work with either shoulder and no lifting over five pounds with either upper extremity. Because of the potential problem with the cervical spine, he referred Petitioner to Dr. John Watson, an orthopedic surgeon (Petitioner's Exhibit 8).

Dr. Watson saw Petitioner on August 5, 2013. His record of that date noted that Petitioner injured himself while lifting a trailer gate and that he experienced pain in the left shoulder/arm, neck, as well as the right shoulder. Dr. Watson opined that Petitioner's symptoms were consistent with C6 cervical radiculopathy and ordered an MRI scan of the cervical spine and EMG studies. In addition to the restrictions imposed by Dr. Herrin, Dr. Watson imposed restrictions of no repetitive bending, twisting and stooping; no kneeling, crawling or squatting; and no climbing of stairs, ladders or ramps (Petitioner's Exhibit 10).

EMG studies performed on August 13, 2013, were normal; however, the MRI scan performed on that same day revealed a small annular tear and central disc protrusion at C5-C6 which Dr. Watson opined could be contributing to some of Petitioner's symptoms. He recommended Petitioner continue physical therapy. Dr. Watson continued the work restrictions at that time as well as at subsequent office visits of October 3 and November 4, 2013 (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on October 24, 2013. In Dr. Lehman's report of that date, the accident of February 9, 2013, was described as occurring when Petitioner was sliding the doors to the back of a shop when a door came down and injured his right shoulder. The accident of June 24, 2013, was described as occurring when Petitioner was pulling a ramp on a trailer and that he injured his left shoulder. Dr. Lehman examined Petitioner and reviewed medical records provided to him by Respondent. In regard to the right shoulder, Dr. Lehman opined that Petitioner had impingement syndrome, a possible rotator cuff tear and degenerative arthritis of the AC joint. In regard to the left shoulder and neck, he opined that Petitioner had left shoulder impingement syndrome with cervical spine strain (Respondent's Exhibit 6).

In regard to causality of Petitioner's injuries, Dr. Lehman opined that the right shoulder injury was not related to the accident of February 8, 2013, noting that Petitioner did not have a direct traumatic injury to the right shoulder and that closing the door would be consistent with such a condition. Dr. Lehman stated that Petitioner should undergo arthroscopic surgery of the right shoulder but that he was at MMI as it related to the accident of February 8, 2013 (Respondent's Exhibit 6).

In regard to Petitioner's neck and left shoulder complaints, Dr. Lehman opined that Petitioner's symptoms in the cervical spine were not related to the accident of June 24, 2013, because Petitioner's only radicular complaints were in the left shoulder and he found no evidence of pathology in the cervical spine. In regard to the left shoulder, Dr. Lehman recommended that Petitioner have an MRI of the left shoulder performed to determine if there was any pathology in the left shoulder (Respondent's Exhibit 6).

Dr. Lehman subsequently reviewed additional medical records which included the report of an MRI of the left shoulder performed on December 3, 2013, and he opined that the MRI only revealed long-term degenerative changes not consistent with the mechanism of injury (Respondent's Exhibits 7 and 8).

Petitioner testified that he has not been able to return to work because the restrictions imposed by his treating physician, Dr. Herrin, have not been removed. Respondent has not offered work to Petitioner that conforms to these restrictions. Respondent did make a written offer of work to Petitioner on November 23, 2013; however, this was based on the restrictions imposed by Dr. Lehman of no overhead work with the left shoulder and no lifting in excess of 35 pounds (Respondent's Exhibit 3).

In regard to temporary total disability, Petitioner and Respondent stipulated that Petitioner was temporarily totally disabled from April 19 through June 16, 2013; July 15 through July 31, 2013;

and August 6 through December 1, 2013. Petitioner and Respondent also stipulated that Petitioner was temporarily partially disabled from August 1, through August 5, 2013. Accordingly, the disputed period of time in regard to temporary total disability was from December 2, 2013, through the date of trial, May 15, 2014 (Arbitrator's Exhibits 1 and 3).

Respondent did not issue payment of temporary total disability benefits to Petitioner from August 6, 2013, until October 8, 2013, approximately 2 months after Petitioner ceased working for Respondent (Respondent's Exhibit 13). The aforementioned delay in payment was the basis for Petitioner's counsel filing a petition for Section 19(l) penalties and Section 16 attorneys' fees.

Dr. Lehman was deposed on February 19, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Lehman's testimony was consistent with his narrative medical reports and he reaffirmed his opinions that Petitioner's right and left shoulder conditions as well as the cervical spine condition were not related to the accidents of February 8, and June 24, 2013. On cross-examination, Dr. Lehman did agree that if Petitioner ran at the door and struck it with his right arm that this could cause rotator cuff pathology (Respondent's Exhibit 9; pp 13-20; 53-54).

Dr. Herrin was deposed on April 24, 2014, and his deposition testimony was received into evidence at trial. Dr. Herrin testified that there was a causal connection between Petitioner's right shoulder condition and the accident of February 8, 2013, as well as a causal relationship between Petitioner's left shoulder condition and the accident of June 24, 2013. In regard to treatment, Dr. Herrin recommended surgery on the right shoulder. As far as the left shoulder was concerned, Dr. Herrin stated that it if it continued to be problematic that surgery might be required on that shoulder as well (Petitioner's Exhibit 18; pp 38-43).

At trial, Petitioner had complaints in regard to both the right and left shoulders, especially when he attempts to move his arms and in an upward or overhead manner, much more so on the right than on the left. Petitioner wants to proceed with the surgery as recommended by Dr. Herrin.

Petitioner also testified regarding expenses incurred in connection with the Section 12 examination by Dr. Lehman. Various receipts for gas and meal expenses were received into evidence as well as receipts for a new alternator and battery for Petitioner's vehicle. The Exhibit also noted that the round trip mileage distance for the Section 12 examination was 299.7 miles (Petitioner's Exhibit 10). Respondent paid Petitioner $149.86 for travel expenses incurred in connection with the Section 12 examination by Dr. Lehman (Respondent's Exhibit 5).

Petitioner's wife, Janet Billbe, testified at the trial of this case. She stated that Petitioner had no problems in regard to his right and left shoulders until after the accidents of February and June, 2013, respectively. She has also observed the Petitioner experience considerable pain and sleep disruption because of the injuries on a regular basis.

Denise Dom testified on behalf of the Respondent. Dom is Respondent's bookkeeper and she stated that Petitioner left Respondent's place of business in August, 2013, because was unable to do the work. She also identified correspondence directed to Petitioner dated November 23, 2013, in which work conforming to Dr. Lehman's work restrictions was tendered to Petitioner

(Respondent's Exhibit 3). She also stated that the tailgate involved in the accident of June, 2013, did not weigh 200 pounds; however, on cross-examination, she agreed that she did not know how much the tailgate actually weighed.

Steve Collier also testified on behalf of the Respondent. Collier is Respondent's Service Manager and he stated that he directed Petitioner to go home in August, 2013, because Respondent did not have any light duty work to offer to him. He also stated that the tailgate did not weigh any more than 100 pounds.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained accidental injuries arising out of and in the course of his employment for Respondent on February 8, 2013, and June 24, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified about the circumstances of both accidental injuries and he sought medical treatment immediately or shortly after both accidents. The medical records of Petitioner's treating medical providers contained histories of the work-related accidents.

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

The Arbitrator concludes that Petitioner's current conditions of ill-being in regard to his right and left shoulders are related to the work-related accidents of February 8, 2013, and June 24, 2013, respectively.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified that he had no prior complaints/symptoms in his right and left shoulders before the accident of February 8, and June 24, 2013, respectively. Further, Petitioner's testimony was corroborated by the testimony of his wife, Janet Billbe.

Petitioner's treating physician, Dr. Herrin, testified that Petitioner's right and left shoulder conditions were related to the accidents of February 8, and June 24, 2013, respectively. While Dr. Lehman opined the condition was not related to the accident of February 8, 2013, on cross-examination, Dr. Lehman agreed that if Petitioner ran at the door and struck it with his right shoulder that this could cause rotator cuff pathology.

The Arbitrator finds the testimony of Petitioner's treating physician, Dr. Herrin, to be more persuasive and credible than that of Respondent's Section 12 examiner, Dr. Lehman.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 3, as provided by Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including the treatment for the right and left shoulders as recommended by Dr. Herrin.

In support of this conclusion the Arbitrator notes the following:

As aforestated, the Arbitrator found the opinion of Petitioner's treating physician, Dr. Herrin, to be more persuasive and credible than that of Respondent's Section 12 examiner, Dr. Lehman.

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

The Arbitrator concludes Petitioner is entitled to temporary partial benefits of $160.01. Further, the Petitioner is entitled to temporary total disability benefits of 51 2/7 weeks commencing April 19, 2013, through June 16, 2013; July 15, 2013 through July 31, 2013; and August 6, 2013, through May 15, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner and Respondent stipulated as to the amount of temporary partial disability benefits.

Petitioner has remained under the work restrictions imposed by Dr. Herrin and Respondent has not offered work to Petitioner conforming to said restrictions.

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

The Arbitrator concludes Petitioner is entitled to Section 19(l) penalties of $1,920.00 and Section 16 attorneys' fees of $384.00.

In support of this conclusion the Arbitrator notes the following:

Petitioner was unable to work for various periods of time including August 6, 2013, through May 15, 2014, the date of trial. Respondent failed to pay Petitioner temporary total disability benefits from August 6, 2013, until October 8, 2013, a period of 64 days. The Arbitrator finds no basis to deny Petitioner payment of temporary total disability benefits during that period of time. Pursuant to Section 19(l) Petitioner is entitled to a penalty of $30 a day or $1,920.00. Petitioner is also entitled to attorney's fees of 20% of the amount of the Section 19(l) penalties, $384.00.

The Arbitrator declines to assess Section 19(l) penalties from December 1, 2013, through May 15, 2014, because Respondent relied on the medical opinion of Dr. Lehman, its Section 12 examiner.

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

The Arbitrator concludes Petitioner is entitled to payment of expenses from Respondent incurred in connection with the Section 12 examination by Dr. Lehman in the amount of $193.76. Respondent shall receive a credit of $149.86.

Petitioner computed the round-trip mileage to be 299.7 miles. No contrary evidence was offered. Using the IRS standard in effect at the time of the examination of 56.5 cents per mile, the total computes to $169.33. Petitioner tendered into evidence receipts for two meals that total $24.43. The Arbitrator finds these amounts to be reasonable and the total is thereby $193.76.

Petitioner also tendered into evidence receipts for an alternator and battery. The Arbitrator finds Respondent is not liable for offer reimbursement of these expenses. Replacement of these automobile parts would have been required whether Petitioner had been examined or not.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ Affirm and adopt (n	☐ 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

Charles Stevens,

Petitioner,

15IWCC0323

vs.

NO: 12 WC 38936

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

The Arbitrator found that Petitioner presented no medical evidence to suggest a causal connection between Petitioner's current state of ill-being and the work he did for Respondent on September 16, 2010. Yet, the Arbitrator found that Petitioner in entitled to have from the Respondent 6.325 weeks of permanency at a rate of $589.44 representing 2.5% loss of use of the right arm.

The Commission finds that since the Petitioner did not prove that his current condition of ill-being is causally connected to the accident of September 16, 2010, he is not entitled to any permanency as a result of that accident.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $66.80 for medical expenses under §8(a) of the Act and pursuant to Section

15IWCC0323

8-2.

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

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

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: MAY 4 - 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

CJD/hf
O: 3/4/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0323

STEVENS, CHARLES
Employee/Petitioner

Case# **12WC038936**

12WC031266

MORRISSEY CONSTRUCTION CO
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

0725 HANSEN & ENRIGHT
ANDREW KOVACS
701 MARKET ST SUITE 200
ST LOUIS, MO 63101-1862

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

15IWCC0323

Charles Stevens
Employee/Petitioner

v.

Morrissey Construction Co.
Employer/Respondent

Case # **12** WC **38936**

Consolidated cases: **12 WC 31266**

An *Application for Adjustment 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 **July 18, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **9/16/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,084.80**; the average weekly wage was **$982.40**.

On the date of accident, Petitioner was **46** 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 **$n/a** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$n/a**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $589.44/week for 6.325 weeks, because the injuries sustained caused the 2.5% loss of the arm, as provided in Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services of $66.80, 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.

D. Dyan McCarthy
Signature of Arbitrator

August 25, 2014
Date

SEP 2 - 2014

Findings

The petitioner was a union carpenter hired by respondent out of the local union hall. His job was to "screw off" drywall meaning that he had to insert the drywall screws that hold the piece of drywall in place on the metal studs that another carpenter had installed. He worked for respondent Morrissey Construction for a total of three weeks in September 2010: Sixteen hours one week, thirty two hours the second week, and sixteen hours the last week. He was laid off after the third week. His last day at Morrissey was September 16, 2010.

At that time they were working on Harrison Homes (apartment building). The screws in the drywall were not properly set so the superintendent required the Petitioner to go to every unit and tighten all the screws. He testified there were approximately 50 screws per sheet and there were 80 to 100 sheets in each apartment. He estimated 20,000 to 25,000 screws, in all. He did this in one day with his right hand. The following day the petitioner testified his arm was stuck at an angle. He could not straighten out his elbow. He testified he was seen at Proctor First Care. He saw Dr. Musatieff at Proctor First Care. Pet. Ex. 1. He also saw an orthopedic physician, Dr. Clark. Pet. Ex. 2. The medical record from Dr. Clark is hand written and difficult to read, but seems to suggest that he gave Petitioner some Bio-freeze and told him to use over the counter analgesics for the complaints of pain.

Petitioner testified that after being laid off he drew unemployment for quite some time. He agreed that by filing for unemployment he was holding himself out as ready, willing and able to work. He was hired again out of the union hall by RG Construction Company in April 2012 and worked there through August 2012. According to the exhibit entered into evidence by counsel for RG Construction Company (Rx. 7), petitioner worked for them for a total of 726 regular hours and 26 overtime hours from April 2012 to August 2012.

Petitioner began treating for complaints of elbow and shoulder pain at Great Plains Orthopedic Group in August of 2012. He underwent elbow and shoulder surgeries with Dr. Garst. He has permanent restrictions and is working as a janitor for lesser wages than his normal union wages.

Dr. Garst was deposed by the petitioner's attorneys on two occasions. Respondent Morrissey construction had a Section 12 examination with Dr. William Strecker, who was also deposed. Respondent RG Construction Company had a Section 12 examination with Dr. Atluri, who was also deposed. In summary, none of the testifying physicians have indicated that the necessity for Petitioner's surgeries in 2012 were related to the 80 hours petitioner worked for respondent Morrissey Construction in 2010. There is agreement that the Petitioner suffered an aggravation of his degenerative arthritis in the right elbow by working for Morrissey Construction in 2010, but there is no evidence of disability from that aggravation other than the Petitioner's testimony that he could not completely straighten his elbow following his work there.

The medical records do not support the Petitioner's contention. Petitioner's Exhibit 1contains treatment records from his family doctor from August 2, 2011 through August 2012, when he began actively treating for his right shoulder and elbow. He was seen twice in August 2011 for poison ivy, and the exam notes mention nothing about elbow issues. On November 1, 2011 he was seen with complaints of bilateral shoulder pain, again with no reference to elbow problems. On January 2, 2012, he was seen with chronic back pain, and on March 3, 2012, he complained of pain in the back, shoulder and arm. There was no reference to the elbow on either date. On the latter exam, the doctor noted generalized aches and crepitus of the extremities. One would expect some reference to the inability to fully extend the elbow in some of those notes, particularly those that reference the shoulder and arm.

Petitioner held himself out as ready, willing and able to work following his layoff from Morrissey Construction. There is no medical evidence to suggest he could not perform his regular job duties, and in fact he did return to his normal job for RG Construction once that work became available. There is no medical evidence to suggest a causal connection between Petitioner's current state of ill-being and the work he did in

2010 for respondent Morrissey Construction. Accordingly, I find that Petitioner suffered a 2.5% permanent partial disability to his right arm pursuant to the provisions of Section 8(e) and that he is entitled to have from respondent Morrissey Construction 6.325 weeks of PPD at the rate of $589.44/week. The disability period has accrued in full therefore the benefit is payable in a lump sum.

Finally, Petitioner presented medical bills of $5.00 owed to Proctor First Care, and $61.80 owed to Pekin Orthopedic. I find Respondent Morrissey Construction liable for these bills and order payment of same.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Ratz,
Petitioner,

vs. No: 12 WC 07336

Dynegy Midwest Generation,
Respondent.

15IWCC0324

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, medical expenses, causal connection, statute of limitations, temporary total disability, and the nature and extent of the permanent disability, and being advised of the facts and law, modifies the date of accident and permanent partial disability awarded, and otherwise affirms and adopts the June 23, 2014 Decision of Arbitrator Brandon Zanotti, which is attached hereto and made a part hereof.

Arbitrator Zanotti found that Petitioner's appropriate date of manifestation was February 10, 2012, when Petitioner consulted with Dr. Hagan and described his job duties as shift technician, a multi-crafted support operations job. He found that Petitioner gave Respondent timely notice in February 2012 and that his condition was causally related to his repetitive work activities. Arbitrator Zanotti awarded Petitioner reasonable and necessary medical services related to his bilateral carpal tunnel syndrome and gave Respondent credit under §8(j) of the Act for $10,674.76 in medical benefits paid by its group insurer. Respondent was ordered to pay Petitioner temporary total disability benefits for 7-6/7 weeks and permanent partial disability benefits for 11% loss of use of each hand.

15IWCC0324

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 61 year old shift technician, alleged that he suffered bilateral carpal tunnel syndrome as the result of cumulative trauma from his work activities. He had been employed by Respondent for 17 years and had served in numerous capacities. As shift technician, he used numerous hand tools, including small impact wrenches, air ratchets, grinders, jackhammer, sledgehammers, poke rods, and a fire hose.

2. Petitioner testified that he began experiencing symptoms in his hands, including tingling and loss of grip strength, in 2011. He reported the symptoms to his primary care physician, Dr. Lattimore, who ordered nerve conduction studies. The tests were performed on December 22, 2011 and confirmed severe bilateral carpal tunnel syndrome.

3. Dr. Lattimore referred Petitioner to Dr. Hagan, a specialist, for treatment. Petitioner testified that he suspected that there was a connection between his job activities and his medical condition at this point.

4. Petitioner met with Dr. Hagan on February 10, 2012 to discuss the test results, his job activities and tools he used at work. The doctor advised Petitioner that his medical condition was causally related to his repetitive work activities. He declined to treat Petitioner further, as he elected not to accept workers' compensation patients.

5. Petitioner testified that he advised Respondent through its safety director, Jason Reynolds, of his claim for a work related injury in early February 2012.

6. Dr. Lattimore referred Petitioner to Dr. Harvey Mirly, who diagnosed Petitioner with bilateral carpal tunnel syndrome on November 6, 2012. On November 21, 2012, Dr. Mirly performed a left carpal tunnel release; he repeated the procedure on the right on December 17, 2012. Petitioner reached maximum medical improvement and was released to return to work full duty on January 15, 2013.

7. Dr. Mirly was deposed and responded to a hypothetical question, opining that Petitioner's job activities could have constituted sufficiently repetitive and vibratory factors in the causation of carpal tunnel syndrome.

8. Respondent did not offer a Section 12 report and neither party offered impairment ratings.

9. Petitioner testified that he suffered a loss of bilateral grip strength and range of motion and that his hands tire faster since the surgery.

10. Petitioner testified that he paid a total of $736.40 for medical services not covered by his group insurance.

15IWCC0324

Respondent filed a timely Petition for Review of the Arbitrator's Decision, raising several issues, including statute of limitations, accident, notice, causal connection, temporary total disability, and nature and extent of the permanent disability. However, in its Statement of Exceptions before the Commission, Respondent addressed only the issue of timely notice. After considering the entire record, and for the reasons set forth below, the Commission modifies the Arbitrator's findings regarding date of manifestation and permanent disability, and affirms and adopts the remaining findings and awards. The Commission finds that the appropriate date of accident is December 22, 2011 and that Petitioner's notice to Respondent in early February 2012 was timely. The Commission modifies the award for permanent partial disability, pursuant to Section 8(e)9, which reduces the value of a hand from 205 weeks to 190 weeks in cases in which the accident occurs on or after June 28, 2011 (the effective date of the amendment) and the accidental injury involves carpal tunnel syndrome due to repetitive trauma. The Commission affirms and adopts all else.

Accident/Manifestation Date and Notice: Arbitrator Zanotti found February 10, 2012 an appropriate manifestation date for Petitioner's injuries. On this date, Petitioner was evaluated by Dr. Hagan and was advised by the doctor that his bilateral carpal tunnel syndrome was causally related to his work activities. The Arbitrator also found that Petitioner gave Respondent timely notice of the injury in early February 2012.

Respondent argues that Petitioner knew or should have known of the causal relationship between his carpal tunnel syndrome and job activities on November 14, 2011, when Dr. Lattimore noted that Petitioner had "a history of a work comp repetitious injury resulting in carpal tunnel of the bilateral wrist" and recommended diagnostic testing. Petitioner admitted at hearing that he knew he had carpal tunnel syndrome on that date and that he had made the connection between his medical condition and job duties. Respondent argues that was the manifestation date, and that Petitioner was obligated to advise Respondent of his claim within 45 days of that date, which he did not do.

Petitioner suggests that on November 14, 2011, Dr. Lattimore needed to confirm his prior diagnosis of carpal tunnel syndrome with a nerve conduction study. Petitioner argues that he was not obligated to provide notice to Respondent of a suspected medical condition. Petitioner cites to *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 531 N.E.2d 174, 126 Ill. Dec. 41 (4th Dist. 1988), in support of his position that the manifestation date need not be the exact time at which the employee becomes aware of the repetitive stress condition and its relationship to his work activities:

> To always require an employee suffering from a repetitive-trauma injury to fix, as the date of accident, the date the employee became aware of the physical condition, presumably through medical consultation, and its clear relationship to the employment is unrealistic and unwarranted.

531 N.E.2d at 176. The Appellate Court noted that an employee would be clearly prejudiced if he were required to provide notice to the employer within 45 days of a definite diagnosis of the repetitive stress condition and its connection to the job,

> since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a potential disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in absence of notice of the accident.

531 N.E.2d at 176. The Appellate Court concluded that the determination of the manifestation date is not an inflexible rule, but is factually determined by the Commission. The Court cited with approval *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 138 Ill. App. 3d 880, 487 N.E.2d 356, 93 Ill. Dec. 689 (3d Dist. 1985) for Professor Larson's two alternative criteria for fixing the date when the injury manifests itself: (1) the time at which the employee can no longer perform his job; and (2) the onset of pain which necessitates medical attention.

The Court in *Oscar Mayer* noted that repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their causal connection to his work activities, but continues to work for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. Similarly, the Court noted, an employee is also prejudiced in the giving of notice to the employer if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive stress condition and its connection to his job, since it cannot be presumed that the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform his job. The Court concluded that the manifestation date is a factual determination that should be made by the Commission after considering the various circumstances in each case. The Court declined to set an inflexible rule, but found that the Commission's finding that the claimant's date of manifestation in *Oscar Mayer* was appropriate, being the last date he worked for the employer prior to surgery.

Here Petitioner developed hand complaints several years before his condition worsened to the point where surgery was required. Dr. Lattimore had diagnosed Petitioner with bilateral carpal tunnel syndrome as long ago as February 16, 2006 and had recommended use of bilateral wrist splints at that time. While aware of the diagnosis, Petitioner had been able to tolerate the symptoms until November 14, 2011, almost six years after the initial diagnosis. At that time, Dr. Lattimore recommended re-testing and related Petitioner's condition to his work activities. Although Petitioner had suspicions of his condition as well as its relationship to his work activities for some time, his current medical condition had not been confirmed until the EMG/NCV of December 22, 2011. Petitioner testified without contradiction that he notified his employer of a claim in early February 2012. The Commission finds this to suffice for timely notice within 45 days of the manifestation date within the parameters of Section 6(c) of the Act.

15IWCC0324

Nature and Extent of the Injury: Arbitrator Zanotti awarded Petitioner 11% loss of use of each hand, based upon a value of 205 weeks per hand. The Commission notes that Section 8(e)9 of the Act provides that a hand is valued at

> 190 weeks if the accidental injury occurs on or after June 28, 2011 (the effective date of Public Act 97-18) and if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma . . . .

Pursuant to Section 8(e)9, the Commission corrects the Arbitrator's permanency award to reflect a value of 190 weeks per hand; the 45.1 weeks of disability awarded by Arbitrator Zanotti is therefore reduced to 41.8 weeks.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the June 23, 2014 Decision of the Arbitrator is modified with regard to the date of accident/manifestation and the award of permanent partial disability.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $1,066.67/week for 7-6/7 weeks, commencing November 21, 2012 through January 14, 2013, as provided in Section 8(b) of the Act. Respondent shall receive a credit for $8,380.95 for non-occupational indemnity disability benefits that were paid to Petitioner during the period he was totally disabled, pursuant to Section 8(j) of the Act and the parties' pre-trial stipulation.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibits 4 and 7, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given credit for $10,674.76 for medical benefits that have been paid by its group insurance carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services or the subrogation claim of Blue Cross/Blue Shield of Illinois for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $695.78/week for a period of 41.8 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 11% loss of use of each hand.

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.

15IWCC0324

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,500.00. 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: MAY 4 - 2015

Joshua D. Luskin

Charles J. DeVriendt

o-03/04/15
jdl/dak
68

DISSENT

I respectfully dissent from the Decision of the majority. The Arbitrator found that Petitioner sustained his burden of proving repetitive trauma work injuries and that February 10, 2012 was a proper date of manifestation of his bilateral carpal tunnel syndrome. February 10, 2012 was the date Petitioner testified he discussed EMG findings with Dr. Hagen. However, Dr. Hagen did not treat Petitioner and no records from him were submitted into evidence. Therefore, a hearsay objection was sustained.

The Arbitrator also found Petitioner's unrebutted testimony that he notified Respondent's safety director in "early February" constituted proper notice based on the February 10, 2012 manifestation date. The Majority found the proper manifestation date was actually December 22, 2011, the date of the latest EMG/NCV, but concluded that the notice was proper nevertheless. In my opinion, the record before the Commission establishes an earlier proper date of manifestation which would defeat Petitioner's claim.

Petitioner presented to Dr. Lattimore, his general practitioner physician, on November 14, 2011. Dr. Lattimore's treatment notes indicated that Petitioner had "a history of a work comp injury resulting in carpal tunnel of the bilateral wrist [which] started 10 year ago." Dr. Lattimore's records also showed that Petitioner had an EMG in 2006 which was positive for bilateral carpal tunnel syndrome. Petitioner admitted in his testimony that when he went to see Dr. Lattimore on November 14, 2011, he was aware that he had carpal tunnel syndrome and that the condition was related to his work activities.

While there may be some latitude in determining the correct manifestation date in repetitive trauma injuries, the requirement that the claimant notify the employer within 45 days of the proper manifestation date still applies, and that requirement is jurisdictional. *White v. Workers' Compensation Commission*, 347 Ill. App. 3d 907 (4th Dist. 2007). The date of manifestation is the date that the claimant knew, or should have reasonably known, of his condition and that it was related to his work activities. *Peoria County Bellwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524 (1987).

In the case now before the Commission, the latest possible date of manifestation was November 14, 2011, and it was likely considerably earlier, based on the treatment notes of his physician, Dr. Lattimore. While Petitioner testified that he notified the safety supervisor in "early February," that would presumably would have been after February 10, 2012, which was the alleged date of manifestation in his Application for Adjustment of Claim. Assuming that Petitioner actually informed the safety supervisor on the alleged date of manifestation, which was 90 days after he testified he was actually aware of his condition and that the condition was related to his work activities; or a period exactly twice as long as required by Section 6(c) of the Act.

I also believe that the delay in notifying Respondent of Petitioner's condition caused prejudice against Respondent. Certainly, if Petitioner had notified Respondent when he was first diagnosed with bilateral carpal tunnel syndrome in 2006, Respondent could have modified his work activities. If treated before the condition progressed for another 6 years, Petitioner may have responded positively to conservative treatment, not needed surgery, and thereby reducing medical costs as well as the permanency award.

In looking at the entire record before the Commission, I would have found that Petitioner did not sustain his burden of proving that he provided proper notice under the Act, reversed the Decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RATZ, MARK
Employee/Petitioner

Case# **12WC007336**

DYNEGY MIDWEST GENERATION INC
Employer/Respondent

15IWCC0324

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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARK RATZ
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

Case # 12 WC 7336

15IWCC0324

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 22, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 10, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$83,200.00**; the average weekly wage was **$1,600.00**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

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

Respondent ***has 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 **$8,380.95** for other benefits, for a total credit of **$8,380.95**.

Respondent is entitled to a credit of **$10,674.76** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibits 4 and 7 (and as discussed in the Memorandum of Decision of Arbitrator), as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given credit of $10,674.76 for medical benefits that have been paid by its group insurance carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services and the subrogation claim of Blue Cross Blue Shield of Illinois for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,066.67/week for 7 6/7 weeks, commencing November 21, 2012 through January 14, 2013, as provided in Section 8(b) of the Act. Respondent shall be given credit of $8,380.95 for salary continuation that was paid to Petitioner.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 45.1 weeks, because the injuries sustained caused the 11% loss of use to each hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

06/13/2014
Date

JUN 23 2014

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARK RATZ
Employee/Petitioner

v. Case # 12 WC 7336

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

15IWCC0324

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Mark Ratz, was hired by Respondent, Dynegy Midwest Generation, Inc. on January 18, 1971, and for 17 years from 1996 until his retirement on June 1, 2013, worked as a shift technician. He testified that this job required him to work on coal crushers, pumps, valves, conveyors and scrubbers. These activities often required the use of hand tools including small impact wrenches, air ratchets, various grinders, jackhammer, sledgehammers, poke rods and a fire hose.

Petitioner began experiencing symptoms with his hands in 2011, including tingling and loss of grip strength. On November 14, 2011, Petitioner presented to his family doctor, Dr. Sean Lattimore, who ordered electro diagnostic testing. (Respondent's Exhibit (RX) 1). Petitioner stated at trial that he complained to Dr. Lattimore of having problems just driving a car, had frequent numbness with doing his job, and that the pain in his hands was waking him up at night. Dr. Lattimore ordered nerve conduction studies that were performed on December 22, 2011, by Dr. James Goldring. (RX 1). The test confirmed severe bilateral carpal tunnel syndromes. Dr. Lattimore reported the findings to Petitioner and referred him to Dr. Hagan, a specialist, for treatment. Petitioner testified that he suspected that there was a connection between his job activities and his medical condition at this point. Petitioner testified that he met with Dr. Hagan on February 10, 2012, discussed the results of the nerve conduction study, his job duties, job activities, tools he used in his work and concluded that his medical condition was connected to his work activities. Dr. Hagan did not treat Petitioner.

Petitioner informed Respondent through Jason Reynolds, its safety director, of his claim for a work related injury in the early part of February 2012.

Dr. Lattimore referred Petitioner to Dr. Harvey Mirly, who first saw Petitioner on November 6, 2012, and diagnosed him with bilateral carpal tunnel syndrome. (PX 1). An operative report dated November 21, 2012 outlines Dr. Mirly's surgery for a left carpal tunnel release. A nearly identical procedure was performed to the right wrist on December 17, 2012. (PX 1; PX 2). Following these procedures, on December 27, 2012, Petitioner was placed at maximum medical improvement and released to return to full unrestricted duty on January 15, 2013. (PX 1).

Dr. Mirly was asked a hypothetical regarding Petitioner's job duties with Respondent, which included a list of tools purported to be used and stated that the jobs required substantial or repeated use of the hands and exposure to vibration from hand tools. (PX 3, pp. 13-16). Dr. Mirly gave a causation connection and opinion in Petitioner's favor based upon his hypothetical. (PX 3, p. 17).

Respondent did not offer a report or contrary causation opinion pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"), and neither party offered an impairment rating.

Petitioner testified that when he returned to work for Respondent after his medical release, he had noticed a loss of grip strength in both hands, some loss of range in motion in both hands and that his hands tended to tire. Petitioner retired in June 2013. He now notices that his hands tire faster when performing yard work than before the claimed repetitive trauma injuries.

Petitioner paid a total of $736.40 for medical services not covered by his group insurance for which he is claiming reimbursement. (PX 7).

CONCLUSIONS OF LAW

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

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

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

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

Petitioner was diagnosed by Dr. Lattimore on November 14, 2011 with bilateral carpal tunnel syndrome. Dr. Mirly testified that it was his opinion that Petitioner had bilateral carpal tunnel syndrome that was work related. No contrary opinions on causal connection were offered by Respondent.

Based on the foregoing, the Arbitrator finds that Petitioner suffered bilateral carpal tunnel syndrome that arose out of and in the course of his employment, and that said condition is causally related to his work duties with Respondent. Petitioner also testified that he gave oral notice to Respondent concerning his injuries through its safety director in early February 2012. No evidence was presented to the contrary, and therefore proper notice was given. Further, February 10, 2012 is an appropriate manifestation date for Petitioner's injuries.

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

Petitioner underwent treatment for bilateral carpal tunnel syndrome, including surgical releases by Dr. Mirly. The charges incurred for the treatment of the carpal tunnel syndrome contained in Petitioner's Exhibits 4 and 7 are found to be reasonable and necessary and are awarded as compensable under the Act. The parties stipulated to the fact that Respondent is entitled to a credit under Section 8(j) of the Act for $10,674.76 in medical benefits paid by Respondent's group health carrier. Petitioner is also awarded $736.40 for medical expenses paid by him directly (co-pays).

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

Petitioner was off work from the time of his first surgery on November 21, 2012 until Dr. Mirly released Petitioner to full unrestricted duty on January 15, 2013. Temporary total disability (TTD) benefits for this period are appropriate and awarded. The parties stipulated to the fact that Respondent paid Petitioner $8,380.95 in salary continuation for which Respondent is awarded a credit toward the TTD award.

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

Petitioner's manifestation date of his carpal tunnel syndrome falls after September 1, 2011, and therefore Section 8.1b of the Act shall be discussed concerning the permanent partial disability (PPD) award being issued. No PPD impairment report pursuant to Sections 8.1b(a) and 8.1b(b)(i) of the Act was offered into evidence by either party. This factor is thereby waived.

Concerning Section 8.1b(b)(ii) of the Act (Petitioner's occupation), Petitioner was a shift technician for Respondent for many years. This job required the repetitive use of various hand tools. However, Petitioner retired from employment in June 2013. He therefore no longer has a current occupation, and only very little weight is placed on this factor when determining the PPD award.

Regarding Section 8.1b(b)(iii) of the Act (Petitioner's age at the time of the injury), Petitioner was 61 years old on the manifestation date of his injuries. As noted above, Petitioner is also currently retired. The Arbitrator considers Petitioner a somewhat older individual, and only some weight is therefore afforded this factor when determining the permanency award.

Concerning Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), there was no real evidence presented concerning Petitioner's future earning capacity. In fact, and as noted above, Petitioner retired from his employment in June 2013. Therefore no weight is given to this factor when assessing the PPD award.

With regard to Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), Petitioner was diagnosed with ***severe*** bilateral carpal tunnel syndrome for which he underwent carpal tunnel releases. (Emphasis added). He returned to full duty work following the surgeries. When he returned to work for Respondent, Petitioner experienced a loss of grip strength in both hands, loss of range of motion and noticed that both hands tired more easily. He has since retired, but still suffers hand symptoms when performing yard work at home. Petitioner testified credibly regarding his current disability. He was a forthcoming and open witness at trial. The Arbitrator places great weight on this factor when determining the permanency award.

The determination of PPD is not simply a calculation but an evaluation of all five of the aforementioned factors stated in Section 8.1b of the Act. In making a PPD evaluation, consideration is not given to any single factor as the sole determinant. Based on all of the foregoing factors, the Arbitrator finds that Petitioner has sustained the 11% loss of use to each hand pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
)
SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Koehler,
Petitioner,

vs.

NO: 11 WC 13781

State of Illinois,
Tamms Correctional Center,
Respondent.

15IWCC0325

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, and permanent disability, and being advised of the facts and law, hereby reverses the Decision of the Arbitrator and finds that Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of employment on March 23, 2011. The June 9, 2014 Decision of Arbitrator Zanotti is attached hereto and made a part hereof.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner began working as a correctional officer at Tamms Correctional Center in 1998 and alleges a work injury that manifested on March 23, 2011 resulting from repetitive stress to his lower extremities. (Tr. 10, AX2)

2. Petitioner testified he worked 7.5 hour shifts at Tamms, generally from 3:00 pm to 11:00 pm, five days a week. He split his work between duties as a pod officer and a control officer. (Tr. 39-40, 44-45)

3. Petitioner testified that in 2006 he suffered an injury to his back after a fall which required surgery and time off work. Petitioner testified that he did develop symptoms in his right foot, including pain, numbness and tingling, stemming from the 2006 back injury. (Tr. 11-12)

4. Petitioner acknowledged that he initiated treatment with Dr. Brown, a podiatrist, in 2006 for complaints in both feet associated with plantar fasciitis, and he was taken off work for those complaints from September of 2006 through February of 2008. (Tr. 11-12, 28)

5. Petitioner returned to work for Respondent from February of 2008 until June of 2008 when he underwent a right plantar fasciotomy with Dr. Brown. (Tr. 13, RX4). Petitioner remained off work after

the foot surgery until January of 2011 (Tr. 14). For the period September of 2006 through January 2011, Petitioner remained off work for foot related complaints for a combined period of approximately 4 years.

6. Petitioner presented to Dr. Gornet, his treating spinal surgeon, for follow-up regarding his 2006 back injury on January 6, 2011. Dr. Gornet noted that Petitioner had no significant issues with his back but was still having some numbness in the right lateral foot for which he was treating with Clonazepam and therapeutic exercises. (RX5)

7. Petitioner returned to work in January of 2011. He testified that he thought his work was contributing to his foot complaints as his pain started in February 2011, and he had not experienced this foot pain when he was off work. (Tr. 16-17)

8. Petitioner presented to Dr. Brown on March 23, 2011 for pain in his feet. Dr. Brown noted Petitioner continued to have pain in his right heel and had been using custom orthotics since surgery in 2008, but was not wearing them at that time. Dr. Brown noted Petitioner complained of pain with any type of pressure or ambulation that increased while walking on hard surfaces at work. Dr. Brown noted that Petitioner now complained of pain in the lateral right ankle that was very tender at the end of the workday. An MRI of the right foot and ankle was ordered, and Petitioner was advised to resume using his custom orthotics and wear supportive shoes. Dr. Brown noted Petitioner had inquired whether this could be a workers' compensation case, and Dr. Brown stated in his record "sometimes plantar fasciitis can be deemed WC but unsure if the lateral ankle ligament would qualify. Patient states he will look into it." Petitioner was restricted to desk work and advised to decrease walking on hard surfaces. (PX3)

9. Petitioner returned to Dr. Brown two weeks later, on April 7, 2011, and advised that he had contacted a lawyer to see if he had any grounds for a workers' compensation claim regarding his recurrent right heel pain. Dr. Brown noted that Petitioner did have surgery two years prior but Petitioner stated he was fine until recently when he noticed recurring pain. Dr. Brown noted, "He is inquiring whether the pounding of the right heel on concrete at his work caused the recurrence. He is a prison guard. He states he walks 7-8 miles a day and up and down steps." Dr. Brown declined to provide a causation opinion and instead recommended a second opinion with Dr. Krause regarding his assessment of chronic thickening of plantar fascia with recurrent plantar fasciitis right heel and peroneal subluxation of the right ankle. (PX3)

10. Petitioner presented to Dr. Krause for second opinion regarding his right foot pain on April 13, 2011. Dr. Krause noted Petitioner gave a history of pain beginning in 2006 with no trauma and then he experienced an injury to his back for which he was taken off work for over a year. Dr. Krause further noted a history of pain in the right foot that continued into 2008, culminating in a plantar fascia release performed by Dr. Brown. Petitioner advised Dr. Krause that the plantar fascia surgery helped his pain but it returned and was worst with weightbearing activities. Dr. Krause diagnosed right plantar fascial pain post release and recommended an aggressive stretching program and continuing activities as tolerated. He did not provide an opinion regarding causation of the Petitioner's condition or complaints. (PX3)

11. An MRI of the right ankle on April 13, 2011 revealed plantar aponeurosis, medial band focus thickening, and internal signal abnormality, which possibly represented postop scarring from the prior release or fibroma formation within the medial band. (PX3)

12. An EMG/NCV of the lower extremities performed on May 26, 2011 revealed ongoing derivation in the right abductor digiti quinti pedis (ADQP) muscle, most likely suggestive of peripheral axonal nerve damage, such as tarsal tunnel syndrome or lateral plantar neuropathy. (PX2)

13. Petitioner followed up with Dr. Brown on June 1, 2011, after the MRI and EMG/NCV of his right foot and ankle. Dr. Brown again noted Petitioner's prior right foot complaints and time off work. Petitioner gave a history of very minimal pain in the right heel when he was off work, but when he returned to work recently, he was required to walk several miles on concrete and climb several flights of steps a day. Dr. Brown noted, "He is inquiring whether the tarsal tunnel is causing the heel pain or the plantar fibroma and he keeps questioning whether his work is causing the symptoms described. I did state there is a correlation with plantar fasciitis and hard surfaces and the tarsal tunnel could perhaps be caused by this as well, but the cause or relationship of tarsal tunnel is not as clear." (PX2)

14. In conjunction with his June 1, 2011 visit with Dr. Brown, Petitioner was examined by Dr. Dickinson for a second opinion at the request of Dr. Brown. Dr. Dickinson noted, "During the 10-15 minutes that I was in the room with him, he talked about wanting to get on disability and mentioned that he had sought several doctors' opinions trying to find somebody that would say that his work caused him injury." Dr. Dickinson noted that Petitioner had indicated Dr. Krause did not recommend additional treatment. Dr. Dickinson went on to note, "He wanted to know if I felt that the plantar fasciitis or the back pain or tarsal tunnel came first ...He pressed me on several occasions to make a statement indicating his plantar fasciitis was an injury due to work. Patient stated that there were 6,7,8 people in his work that had been able to get on disability and that he is trying to do so." Dr. Dickinson further recorded in his note Petitioner's statement, "My work needs to pay me for what they caused me." Dr. Dickinson also noted his conversation with Dr. Brown's main assistant, Elise. Per Dr. Dickinson's recitation in his treatment note, Elise explained "that ever since she has known this patient that he has always talked about his attorneys or WC or trying to find a way to blame others or suggest others have caused his problems. Never once has he requested any form of treatment but when specifically asked he said 'Oh, yes, I do want to have it treated." Dr. Dickenson completed his note by stating, "In summary, Mr. Koehler is a highly litigious patient who has expressed anger and frustration at what Dr. Krause recommended. I have nothing further to offer." (PX2)

15. Petitioner presented to Dr. Brown again on June 29, 2011 with continuing right foot and ankle pain that now radiated up to the right knee. Dr. Brown noted Petitioner again complained of pain with walking long distances at work on hard surfaces and climbing steps during the day. Dr. Brown referred Petitioner to Dr. Wood for an opinion regarding the onset of tarsal tunnel syndrome and noted that he had discussed with Petitioner that he saw a closer correlation with hard surfaces and the plantar fasciitis as opposed to tarsal tunnel syndrome. (PX2).

16. Petitioner was initially examined by Dr. Wood on August 29, 2011 for right ankle pain in the tarsal tunnel and plantar fascial regions. Dr. Wood noted that Petitioner had a prior plantar fasciotomy and had recently returned to work with increased symptoms with walking. Dr. Wood noted Petitioner "has the question today whether this is clearly caused by work. We discussed this at length today and in my clinical experience, the majority of patients that I have that have plantar fasciitis have not been causally related to specific work activities. The tarsal tunnel is hard to say." Dr. Wood diagnosed possible tarsal tunnel syndrome but he stated he lacked reliability of that diagnosis and also noted Petitioner possibly had some recurrent plantar fasciitis. Dr. Wood indicated that surgery possibly could be considered for the tarsal tunnel but would be very unpredictable. (PX6)

17. Petitioner returned to Dr. Brown several months after his referral to Dr. Wood. On October 5, 2011, Dr. Brown noted that on exam, Petitioner was "again inquiring whether the plantar fasciitis was caused by his workplace...Patient states he walks anywhere from 6-8 miles per day. He has 96 flights of stairs that he walks at work." Dr. Brown recommended physical therapy and injections for Petitioner's complaints. Dr. Brown noted, "I did discuss that I felt comfortable stating his plantar fasciitis was due to his workplace as he works on hard surfaces...I did state that I saw less of a relationship with his tarsal tunnel." (PX2)

18. On March 8, 2012, Petitioner presented to Dr. Hagan regarding his right foot pain. Dr. Hagan noted the 2006 back surgery and 2008 plantar fascia release, as well as Petitioner's current complaints of tenderness over the tarsal tunnel and positive Tinel sign on exam. Dr. Hagan opined that "he would be a candidate for releasing the tarsal tunnel and exploring the plantar nerves." (PX7)

19. Petitioner only met with Dr. Wood on the one occasion, August 29, 2011, but a causation opinion was requested by Petitioner's attorney and provided by way of opinion letter dated July 17, 2012. Dr. Wood stated that Petitioner's exam was most consistent with some tarsal tunnel syndrome, as well as probable recurrent plantar fasciitis. Dr. Wood noted that he didn't have details regarding the amount of time Petitioner was on his feet as a correctional officer or the distance he walked, but Dr. Wood opined that if he was his feet greater than 50% of the day, it seemed his symptoms could have been at least exacerbated by work activities. (PX6)

20. Petitioner presented to Dr. Brown on January 7, 2013. Dr. Brown noted that Petitioner could benefit from a more accommodative insert of the right heel and advised him to avoid prolonged standing, stairs, or walking. Dr. Brown declined to recommend surgery at that time. (PX2)

21. Petitioner returned to Dr. Brown on February 4, 2013 and, at that time, Dr. Brown opined Petitioner could benefit from tarsal tunnel surgery and neurolysis of the lateral plantar nerve. Dr. Brown stated that this option might not give total pain relief, but he believed it would provide improvement. (PX2)

22. On May 23, 2013, Petitioner went forward with decompression of the medial plantar, lateral plantar and calcaneal nerves of the right foot and tarsal tunnel release for tarsal tunnel syndrome and compression neuropathy of the medial and lateral plantar nerves. The surgery was performed by Dr. Hagan. (PX7)

23. After examination of Petitioner on March 8, 2012 and performing surgery on the right foot on May 23, 2013, Dr. Hagan provided his opinions by way of deposition on September 27, 2013. Dr. Hagan testified he is a board certified plastic surgeon specializing in hand and extremity surgery. Dr. Hagan testified that he knew Petitioner was a correctional officer, but he didn't know the exact level of walking, stairs, or time on his feet at the initial visit. Dr. Hagan stated that he did not have any treatment records from Dr. Wood, Dr. Gornet, Dr. Schmidt, Dr. Burns, Dr. McCain, Dr. Krause, or Dr. Dickenson and was not familiar with any of their opinions or treatment. He did have a few records of Dr. Brown for review. Dr. Hagan was provided a hypothetical in which Petitioner traversed 96 stairs approximately every 30 minutes throughout his work day. Given that specific quantity, Dr. Hagan opined that this large number of stairs could be an aggravating factor for plantar fasciitis and tarsal tunnel, but it was hard to determine if the stairs would be a cause of the condition. Dr. Hagan admitted on cross-examination if the numbers in the hypothetical he was given changed, that might change his opinions. (PX10)

15IWCC0325

24. Pursuant to Section 12, Dr. Gary Schmidt, an orthopedic foot and ankle surgeon, examined Petitioner on November 29, 2012 for longstanding right foot pain. Dr. Schmidt reviewed the records of Dr. Wood, Dr. Hagan, Dr. Brown, Dr. Dickinson, Dr. Krause, as well as Petitioner's imaging and electrodiagnostic testing results and a job description. Dr. Schmidt noted Petitioner's right foot pain began in 2006 with plantar fasciitis, and Petitioner was off work for 20 months due to a spinal fracture that same year. After being back at work for four months, Petitioner's foot began to hurt again and he underwent a plantar fascial release in 2008 which helped his complaints, but didn't completely resolve them. Dr. Schmidt noted Petitioner now reported that his symptoms had returned with pain in the foot, arch, and heel and also the ankle bone and Achilles tendon. On exam, Dr. Schmidt noted no swelling or more pronounced pain with standing or walking. Dr. Schmidt noted Petitioner gave a history of standing and walking for 6-8 hours per day, depending on his duties that day. Dr. Schmidt opined the EMG results were not consistent with tarsal tunnel, but rather compression of the first branch of the lateral plantar nerve and thickening of the plantar fascia. Dr. Schmidt opined that further treatment or surgery was not warranted, Petitioner was at MMI, and he was able to work full duty. The doctor recommended use of soft over-the-counter orthotics for his complaints. Dr. Schmidt reiterated his opinions in deposition on December 20, 2013 and further opined that, when someone does a lot of stair climbing, there is more strain on the fascia, but he disagreed with a diagnosis of tarsal tunnel syndrome. (RX2)

25. Petitioner testified regarding his job duties as a correctional officer for Respondent at Tamms Correctional Center. Petitioner stated as a pod officer, he was required to walk up and down approximately six flights of 16-18 steps per flight every half hour to perform wing checks in the six wings of a pod (Tr. 17). Petitioner testified that his wing check duties were sometimes divided with another officer (Tr. 18). In addition to the wing checks, he might be charged with feeding, passing out laundry or mail, escorting prisoners for haircuts, or escorting the nurse which would involve additional flights of stairs (Tr. 17-19).

26. Petitioner further testified that while he worked as a pod officer, he also worked as a control officer and would sometimes split his shifts by working half his time as a pod officer and half of his time as a control officer. (Tr. 40). Working as a control officer involved significantly less walking (Tr. 39-40). Petitioner stated there was a duty roster for rotation of the correctional officers but it wasn't strictly followed, so if he wanted to stay downstairs in the control room if his feet hurt, he could (Tr. 39-40).

27. Petitioner was asked at hearing, "What part of your job led you to believe that work was a contributing factor to these new symptoms?" He responded, "Constantly going up and down stairs." (Tr. 17).

28. Petitioner testified on direct examination that he asked each doctor whether his foot condition was work related because, "I knew that if I was going to have surgery, I was going to be off work and that I have a family of four to feed and medical expenses that was going to be coming out of my pocket." He responded in the affirmative when asked, "So you knew that if it was deemed a work-related condition, you would get benefits while you were off work following surgery, correct?" (T24).

After review of the record as a whole, the Commission finds Petitioner failed to establish that he sustained an accident that arose out of and in the course of employment, manifesting on March 23, 2011.

The Commission does not find Petitioner credible. The evidence contained in the record suggests Petitioner's primary objective for filing a claim under the Act was monetary gain. Petitioner worked as a correctional officer at the Tamms Correctional Center for approximately 13 years prior to the March 23,

2011 alleged manifestation date. Petitioner testified he worked as both a pod officer and control officer, and he had the ability to request working shifts or part of his shift as a control officer which was less physically demanding and required less stair climbing. From September of 2006 through January of 2011, Petitioner was off work for extended periods due to non-work related injuries to his right foot and back. Petitioner was off work from September 2006 to February 2008 and again from July of 2008 through January of 2011, working approximately 7 months during a four year period prior to his alleged accident date of March 23, 2011.

Petitioner testified he returned to work in January of 2011, but was still treating with Dr. Brown for his right foot complaints and Dr. Gornet for his back complaints and numbness in the right lateral foot. When Petitioner returned to Dr. Brown on March 23, 2011, he complained of continued right heel pain which had increased while walking on hard surfaces at work over the past month and pain and tenderness in the lateral right ankle at the end of the work day. Petitioner continued to treat with Dr. Brown for foot complaints and attempted to elicit a causation opinion from Dr. Brown regarding his lower extremity complaints. Dr. Brown requested his colleague, Dr. Dickinson examine Petitioner in June 2011 after which Dr. Dickinson authored a treatment note that colored Petitioner as being driven by financial gain in his pursuit of treatment for the right foot and ankle. After Petitioner was unable to elicit a causation opinion from Dr. Brown, Dr. Krause, or Dr. Dickinson, Dr. Brown referred Petitioner to Dr. Wood for a consultation. Dr. Wood found after a single examination that Petitioner's symptoms were most consistent with tarsal tunnel syndrome and probably recurrent plantar fasciitis which were at least exacerbated by his work activities but Dr. Wood admitted that he didn't have details regarding the amount of time Petitioner spent on his feet or the distance he walked for his job.

Petitioner first treated with Dr. Hagan on March 8, 2012 and there is no evidence in the record Petitioner treated with the doctor again before surgery on May 23, 2013. Dr. Hagan testified by way of deposition on September 27, 2013 that he was aware Petitioner was a correctional officer but he did not know the extent of walking, stair climbing, or time spent on his feet until after surgery. Dr. Hagan further confirmed he had not reviewed any of Dr. Wood, Dr. Gornet, Dr. Schmidt, Dr. Krause or Dr. Dickenson's records and was not familiar with any of their treatment of Petitioner or opinions. Dr. Hagan's opinions regarding causation were based on Petitioner traveling up and down 96 steps every 30 minutes throughout his workday and, on cross-examination, Dr. Hagan confirmed that if the numbers in the hypothetical changes, his opinions might change, as well.

At hearing, Petitioner testified he felt the act of going up and down the stairs at work contributed to his condition. Petitioner testified he did wing checks and would climb and descend a flight of 16-18 steps a minimum of 16 times a shift and would also walk additional flights if he passed out laundry or mail or escorted prisoners or nurses. Petitioner's testimony equates to a minimum of 256 steps a shift. Dr. Brown noted in his October 5, 2011 office visit that Petitioner advised he climbed 96 flights of stairs a day at work. The hypothetical presented to Dr. Hagan was Petitioner traversed 96 steps every 30 minutes throughout his shift, approximately 1200 steps. The number of stairs Petitioner was required to climb a day while working on a wing varied in the record from approximately 250 steps to 1700 steps and he testified that while he would climb steps for work on the wings, he could be assigned to the control room for all or part of a shift or choose to work in the control room as the duty roster wasn't strictly followed.

Dr. Schmidt performed an examination of Petitioner pursuant to Section 12 of the Act on November 29, 2012 and testified regarding his opinions at deposition on December 20, 2013. Dr. Schmidt reviewed Petitioner's relevant treatment records for conditions of the right foot prior to and

15IWCC0325

after the alleged manifestation date. He also reviewed Petitioner's job description and examined Petitioner. Dr. Schmidt, like Dr. Wood, could not opine Petitioner suffered from true tarsal tunnel syndrome. Dr. Schmidt opined Petitioner did not require further treatment, was at maximum medical improvement, and could work full duty as a correctional officer while using over-the-counter orthotics in his shoes.

After review of the record as a whole, the Commission finds Petitioner's testimony regarding the onset and extent of his right foot and ankle complaints, as well as the quantity of walking and stair climbing required at work, to be varied and not credible and the causal connection opinion of Dr. Schmidt to be more credible than that of Dr. Hagan. Petitioner's repeated inquires about disability and workers' compensation with his treating physicians within months of returning to work after extensive absences, coupled with his testimony at arbitration that the reason he asked his doctors about causation for his complaints was his desire not to have the cost of surgery and time off work come out of his pocket, negatively color his credibility before the Commission. The Commission further finds Dr. Hagan's causation opinion is based on an incomplete medical history and rests upon a hypothetical representation that Petitioner walks up and down 96 stairs every 30 minutes while at work, which is inconsistent with Petitioner's trial testimony and his statements to his treating providers.

For the foregoing reasons, the Commission finds Petitioner failed to prove by a preponderance of the evidence he sustained an accidental injury arising out of and in the course of employment with Respondent manifesting on March 23, 2011 and failed to prove he suffered any identifiable lower extremity condition that had its origin in some risk connected with, or incidental to, his employment so as to create a causal connection between the employment and an accidental injury.

All other issues are moot. Benefits are denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2014, is hereby reversed. Benefits are denied.

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: MAY 4 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/03/15
jdl/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOEHLER, ROBERT
Employee/Petitioner

Case# **11WC013781**

15IWCC0325

ST OF IL-TAMMS CORRECTIONAL CENTER
Employer/Respondent

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0355 WINTERS BREWSTER CROSBY & SCHAFER
JONATHAN R CANTRELL
111W MAIN ST PO BOX 700
MARION, IL 62959

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN - 9 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT KOEHLER
Employee/Petitioner

v.

STATE OF ILLINOIS – TAMMS CORRECTIONAL CENTER
Employer/Respondent

Case # 11 WC 13781

15IWCC0325

An *Application for Adjustment 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. ☒ 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 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.

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

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

In the year preceding the injury, Petitioner earned **$53,560.00**; the average weekly wage was **$1,030.00**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **3** dependent children.

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

Respondent is entitled to a credit for all amounts that have been paid through Respondent's group medical plan, pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as outlined in the Memorandum of Decision of Arbitrator and as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $686.67 per week for 11 2/7 weeks, commencing May 23, 2013 through August 8, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $618.00/week for 41.75 weeks, because the injuries sustained caused the 25% loss of use to the right foot, 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

05/28/2014
Date

JUN 9 - 2014

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT KOEHLER
Employee/Petitioner

v.

Case # 11 WC 13781

STATE OF ILLINOIS –
TAMMS CORRECTIONAL CENTER
Employer/Respondent

15IWCC0325

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner's Testimony

Petitioner, Robert Koehler, alleges he injured his right foot on March 23, 2011, as a result of repetitive trauma during his employment with Respondent, the State of Illinois Department of Corrections. Petitioner has been employed by Respondent for over 16 years. In 2006, Petitioner was taken off work by Dr. Daniel Brown, his podiatrist, for a right foot condition. While he was off work, Petitioner fell and broke his back. Petitioner's back injury necessitated major surgery, and he continued to treat with Dr. Brown as he recovered from back surgery. Petitioner admitted the back injury caused some symptoms in his right foot, which he described as pain, numbness and tingling on the right side of the foot near his little toe. Those symptoms have never completely resolved. The symptoms for which Petitioner sought treatment with Dr. Brown were different; they involved a dull, burning and aching pain in the plantar fascia. Those symptoms are located on the inside and down the middle of the right foot.

In February 2008, Petitioner returned to work. In July 2008, Petitioner underwent surgery at the hand of Dr. Brown for his plantar fasciitis. The plantar fasciotomy did not completely resolve Petitioner's foot symptoms, although it did improve his symptoms to the point where he could work full duty without significant pain. Petitioner continued to treat with Dr. Brown post-surgery. Petitioner's post-surgery treatment included physical therapy, injections and use of custom orthotics. After the July 2008 plantar fasciotomy, Petitioner was off work for approximately one and a half years as a result of problems related to his 2006 back injury. Petitioner returned to work again in January 2011.

On March 23, 2011, Petitioner presented to Dr. Brown for right foot pain. Petitioner testified his foot pain had started approximately a month before then. When Petitioner returned to Dr. Brown in March 2011, he thought his symptoms were related to his job duties because he was not suffering significant pain when he returned to work in January, and these symptoms manifested themselves in February. Petitioner believes the new symptoms were caused by his constantly going up and down stairs. Petitioner testified that his job duties involve doing wing checks every 30 minutes. Performing a single wing check involves going up and down six flights of stairs, with each flight containing approximately 16 to 18 steps. Petitioner conducted wing checks

every 30 minutes, or approximately 16 times per work day, although sometimes a second correctional officer would aid in wing checks. On the other hand, Petitioner sometimes went up and down the flights of stairs additional times to feed inmates, pass out laundry, pass out mail, take the nurse around, or take inmates for haircuts.

In March 2011, Dr. Brown referred Petitioner to Dr. John Krause. Dr. Krause advised Petitioner there was nothing he could do, and Petitioner should find another job. Surgery was not an option. Petitioner was not satisfied with Dr. Krause's recommendations, because Petitioner has a wife and four children, and given the economy at the time and the fact he had spent 14 years in his occupation, finding another job would have been difficult.

Dr. Brown later ordered a nerve conduction study. After completion of the nerve conduction study, Dr. Brown advised Petitioner that his symptoms may be due to tarsal tunnel syndrome instead of plantar fasciitis. Dr. Brown then referred Petitioner to Dr. C. David Wood, who advised Petitioner surgery was an option, and Dr. Wood thought there was a 70% chance he could take away 50% of Petitioner's pain. Petitioner did not like those odds and sought another opinion from a surgeon. After Petitioner was unable to see Dr. Schmidt, whom Dr. Brown also referred, Dr. Brown referred Petitioner to Dr. Robert Hagan. Dr. Hagan diagnosed Petitioner with tarsal tunnel syndrome and told Petitioner he could repair it.

Petitioner testified on direct examination that while he sought treatment from these multiple physicians, he asked them whether or not his right foot conditions were related to his work duties. Petitioner knew that if he were to miss work for surgery and his injury was work-related, he would be entitled to benefits to help him provide for his large family while off work. Petitioner was off work approximately three months after Dr. Hagan performed surgery. Although Dr. Hagan's surgery did not take away one hundred percent of Petitioner's symptoms, Petitioner deemed the surgery successful as he was ultimately able to return to work full duty. Petitioner continues to suffer some foot pain anytime he does a lot of walking or prolonged standing.

On cross-examination, Petitioner testified his plantar fasciitis was a lot better after the 2008 surgery by Dr. Brown and before Petitioner returned to work in 2011. Petitioner admitted he initially had problems with his right foot in 2006. Petitioner believes a different condition developed in his right foot from the one that existed in 2006. Petitioner testified the pain is now different. The plantar fasciitis hurts on the bottom of his foot, and his current pain radiates over the inside of the ankle joint. Petitioner admitted the plantar fasciitis symptoms did not completely resolve, but resolved enough to allow Petitioner to do his duty. Petitioner did not have pain into his ankle before this claim.

Petitioner testified on cross-examination that he sometimes worked in the pod control room, sometimes rotated job duties, and sometimes split shifts in half, spending only half of a shift down in the wings. Petitioner testified that he has been transferred to Respondent's Vienna facility, where there are fewer steps and the work is less foot intensive. Petitioner testified he can currently wear any kind of shoes he wants. One of Petitioner's hobbies is hunting, but he does not do a significant amount of hiking or walking when he hunts, as he drives a four-wheeler and parks it within 100 yards of his destination. Petitioner is currently able to walk up and down stairs in the course of his average daily life.

During cross-examination, Petitioner was questioned at length regarding a note written by Dr. David Dickinson, a partner of Dr. Brown. Petitioner disagreed with some, but not all of the comments Dr. Dickinson wrote in the note. On re-direct examination, Petitioner testified he disagreed with Dr. Dickinson's statement that Petitioner did not ask about any form of treatment. Petitioner did not disagree with Dr. Dickinson's diagnosis.

Records of Dr. Daniel Brown

Petitioner began treating with Dr. Brown in 2006 for his right foot pain. On July 26, 2008, Dr. Brown operated on Petitioner by performing an instep plantar fasciotomy to the right heel. The operation included a two centimeter incision to the medial aspect of the right heel. The medial band and a small amount of the central band of the plantar fascia were released. Petitioner treated regularly with Dr. Brown for his right foot plantar fasciitis between the July 26, 2008 surgery and the date of accident in this case (March 23, 2011). Petitioner's treatment during this period included stretching exercises, physical therapy, use of orthotics, pain medication and injections to the foot. On September 16, 2010, Dr. Brown discussed a possible more aggressive plantar fasciotomy to decrease Petitioner's symptoms. The note concluded that Petitioner would consider this and schedule to his convenience, to return on an "as-needed" basis. Petitioner's last visit with Dr. Brown before the date of accident was on December 14, 2010, for casting of custom orthotics. During that visit of December 14, 2010, Dr. Brown noted excellent improvement with resolution of edema to the right heel as compared to prior visits. Petitioner's bilateral heel pain was mild in nature, though worse in the right foot. (Respondent's Exhibit (RX) 4).

On March 23, 2011, Petitioner returned to Dr. Brown with a new complaint of pain on the lateral right ankle. The duration of Petitioner's ankle pain had been one month. (RX 4; PX 2, p. "WBCS-KOEHLER 50"). Dr. Brown recommended Petitioner decrease walking on hard surfaces at work and do a desk job. On April 7, 2011, Dr. Brown referred Petitioner to Dr. Krause for a second opinion, and he ordered an MRI. (RX 4). On April 13, 2011, Petitioner saw Dr. Krause, who recommended an aggressive stretching program and did not recommend a revision of what he perceived to be a failed plantar fascia surgery. (PX 3, p. "WBCS-KOEHLER-0067").

On April 27, 2011, Dr. Brown took note of Petitioner's statement that Dr. Krause advised Petitioner to change his occupation. Dr. Brown noted Petitioner's pain over his tarsal tunnel area on the right ankle. Dr. Brown elicited positive Valleix and Tinel signs with percussion. Dr. Brown ordered a nerve conduction study. (PX 2, p. "WBCS-KOEHLER-0029"). On May 26, 2011, the nerve conduction study was performed by Dr. Terrence Glennon. (PX 5). Dr. Glennon's impressions were that the exam revealed evidence of denervation in the right ADQP muscle, which was most likely suggestive of a peripheral axonal nerve damage such as tarsal tunnel syndrome or lateral plantar neuropathy. Clinical correlation was advised. (PX 5, p. "WBCS-KOEHLER-0080").

On June 1, 2011, Petitioner returned to Dr. Brown, who diagnosed Petitioner with "new onset" of tarsal tunnel syndrome and plantar fibroma on the medial band of the plantar fascia. Dr. Brown stated that he would like to get several opinions prior to any surgical intervention, and that Petitioner agreed to see Dr. Wood for a second opinion. Dr. Dickinson was also present during the examination that day and offered his opinion as well. (PX 2, p. "WBCS-KOEHLER-0028"). Dr. Dickinson completed a separate note for the same visit on June 1, 2011. Dr. Dickinson referred to Petitioner as a "highly litiginous" patient and stated Petitioner questioned whether his foot problems were work-related and whether he could get on disability. Dr. Dickinson stated Petitioner expressed anger and frustration at Dr. Krause's recommendation. Dr. Dickinson agreed with Dr. Krause that if Petitioner has increased pain with standing for long periods of time, Petitioner should seek work at a desk job. (PX 2, p. "WBCS-KOEHLER-0049").

During a follow-up visit on October 5, 2011, Dr. Brown noted Petitioner had seen Dr. Wood, who told Petitioner he was "70% sure that he could reduce the patient's symptoms by 50% if he did undergo surgery which involve tarsal tunnel decompression as well as removal of the plantar fibroma." Dr. Brown wrote that he

felt comfortable stating that Petitioner's plantar fasciitis was due to his workplace, and that there appeared to be a pattern that when Petitioner returned to work, the pain returned, and when he was off work to recover, the pain seemed to dissipate. Dr. Brown saw less of a causal relationship with the tarsal tunnel syndrome, but noted it could be caused by work. Dr. Brown discussed referring Petitioner to Dr. Gary Schmidt. (PX 2, p. "WBCS-KOEHLER 26"). During a visit on November 9, 2011, Dr. Brown noted Petitioner wanted a third opinion given Dr. Wood's relatively poor odds of success via surgery. (PX 2, p. "WBCS-KOEHLER 25"). On January 25, 2012, Dr. Brown referred Petitioner to Dr. Hagan, a surgeon who specializes in peripheral nerves. (PX 2, p. "WBCS-KOEHLER 23").

Dr. Hagan wrote to Dr. Brown on March 8, 2012, advising of his diagnosis of tarsal tunnel syndrome, and that Petitioner was a candidate for a tarsal tunnel release and exploration of the plantar nerves. (PX 2, p. "WBCS-KOEHLER 22"). On January 7, 2013, Dr. Brown thought Petitioner would benefit from tarsal tunnel surgery and neurolysis of the lateral plantar nerve. (PX 2, pp. "WBCS-KOEHLER 12-13"). On February 4, 2013, Dr. Brown wrote the following: "If [Petitioner's] current pain was from the prior plantar fascial release I would have expected complaints earlier in the postoperative period. [Petitioner] was doing fine for 1-2 years and later presented complaining of right ankle pain both medially an [sic] laterally." (PX 2, p. "WBCS-KOEHLER 10").

Records of Dr. C. David Wood

On August 29, 2011, Dr. Wood saw Petitioner pursuant to a referral from Dr. Brown. Dr. Wood noted that Dr. Krause suggested nothing could be done surgically, and that Petitioner should change jobs. Dr. Wood noted the results of the nerve conduction study. Dr. Wood noted a probable positive Tinel's sign. (PX 6, p. "WBCS-KOEHLER 92"). Dr. Wood concluded Petitioner very possibly had tarsal tunnel syndrome and recurrent plantar fasciitis. Dr. Wood thought surgery could be considered in the form of a tarsal tunnel decompression as well as a more aggressive plantar fasciotomy, although the success of such a procedure was unpredictable. (PX 6, p. "WBCS-KOEHLER 93"). On July 17, 2012, Dr. Wood wrote, "[w]ithin a reasonable degree of medical certainty considering the results of my examination of the patient previously as well as complaints in regards to exacerbation with work activities, I feel that his foot condition is at least exacerbated by work activities. The true causality of the disorder would certainly be very difficult to determine with any great certainty." (PX 6, p. "WBCS-KOEHLER 91").

Records and Testimony of Dr. Robert R. Hagan

On March 8, 2012, Dr. Hagan saw Petitioner and deemed him a candidate for tarsal tunnel release and exploration of the plantar nerves. (PX 7, p. "WBCS-KOEHLER 161"). Dr. Hagan's exam was consistent with previous findings from Dr. Brown, including a positive Tinel's over the tarsal tunnel. Dr. Hagan diagnosed Petitioner with tarsal tunnel and plantar nerve compression. (PX 10, p. 6). Dr. Hagan recommended surgery on March 8, 2012. (PX 10, p. 8). Dr. Hagan next saw Petitioner on May 2, 2013. (PX 10, pp. 7-8). There was no change in the overall diagnosis, but there was progressive worsening of the symptoms. (PX 10, p. 8). Petitioner elected to proceed with surgery. (PX 10, p. 9). The operative report of May 22, 2013 states that the first incision was vertical over the area of the tarsal tunnel and into the distal portion of the leg. (PX 8, p. "WBCS-KOEHLER 168"). After the tarsal tunnel release, a second, contiguous incision was made at a 45 degree angle to decompress the plantar nerves. (PX 8, pp. "WBCS-KOEHLER 168-169"). The procedures performed were a tarsal tunnel release and a decompression of the medial plantar, lateral plantar, and calcaneal nerves of the foot. (PX 8, p. "WBCS-KOEHLER 168").

Dr. Hagan took Petitioner off work following surgery. (PX 10, p. 10). On the first post-surgical visit, Petitioner had significantly reduced neuropathy type pain. He was kept off work at the time. (PX 10, p. 11). After undergoing physical therapy, Petitioner canceled his follow-up appointment that was scheduled for August 8, 2013. (PX 10, pp. 11-12). Petitioner said he was doing well, and Dr. Hagan cleared him for return to work full duty on August 8, 2013. (PX 10, p. 12).

Dr. Hagan was aware Petitioner had undergone a previous plantar fasciotomy with Dr. Brown. (PX 10, p. 12). As to causation, Dr. Hagan testified that "someone who does a significant amount of climbing, whether it be stairs and/or ladders, can certainly be predisposed to having a tarsal tunnel syndrome like [Petitioner's] clinical scenario." (PX 10, p. 14). Dr. Hagan had an independent memory of Petitioner describing his job duties as involving walking up and down a significant number of stairs. (PX 10, p. 24). Dr. Hagan was asked to assume Petitioner had to go either up or down 96 steps approximately every 30 minutes throughout his workday. (PX 10, pp. 14-15). Dr. Hagan responded, "I would consider that a large volume of stairs. Doing that over periods of time, shift after shift, that that would easily be an aggravating factor and hard to determine, but certainly could be a causing factor as well." (PX 10, p. 15). As to climbing stairs or ladders causing or contributing to these conditions, Dr. Hagan explained as follows:

> [W]hen one is walking stairs or climbing a ladder, there is a repetitive dorsiflexion, plantar flexion, repetitive motion in that – in the ankle. Much like somebody could have the carpel [sic] tunnel or cubital tunnel. That repeating—repeated motion can certainly inflame the tissues in and around the nerves. The nerves need a gliding surface, too. And once a certain amount of inflammation starts and that—even just a little bit of fibrosis around that nerve, then the slippery slope starts to happen. So whether it be tethering of the nerve or compression of the nerve, that repetitive motion can lead to this condition.

(PX 10, pp. 15-16).

Examination Report and Deposition of Dr. Gary Schmidt

On November 29, 2012, Petitioner saw Dr. Schmidt at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). Dr. Schmidt was unable to elicit a true Tinel's sign. Dr. Schmidt did not feel that this was true tarsal tunnel syndrome. Dr. Schmidt thought the nerve conduction study showed compression of the nerve directly in the area where the previous plantar fasciotomy occurred. Dr. Schmidt's diagnosis was impingement of the nerves of the digiti quinti secondary to the first plantar fascia release. Dr. Schmidt felt that tarsal tunnel release or release of the nerve of the digiti quinti would not relieve Petitioner of his symptoms, and it would not satisfy Petitioner's desire to be rid of his pain. (RX 2, Dep. Exh. 2). Dr. Schmidt testified that he was not aware whether Petitioner underwent surgery after Dr. Schmidt's examination of Petitioner. (RX 2, p. 16).

Records of Dr. Matthew F. Gornet

Petitioner saw Dr. Matthew Gornet on November 18, 2010, and again on January 6, 2011, for follow-up visits related to his 2006 back injury. On November 8, 2010, Dr. Gornet noted he had not seen Petitioner in three years, and that "[Petitioner's] symptoms now are again increasing numbness into his right lateral foot." On January 6, 2011, Dr. Gornet noted that "[Petitioner] is still having some numbness in his right lateral foot. This has been treated with Clonazepam with good benefit." (RX 5).

CONCLUSIONS OF LAW

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

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

Petitioner bears the burden of proving he suffered an injury arising out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203-204, 797 N.E.2d 665 (2003). "In the course of employment" refers to the time, place and circumstances surrounding the injury, essentially meaning that the injury must occur within the time and space boundaries of the job. *Id.* For the injury to "arise out of" the employment, it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.* The risk is incidental to the employment where it is connected to what an employee must do to fulfill his duties. *Id.* An injury may be said to arise out of the employment if the conditions or nature of the employment increases the employee's risk of harm beyond that to which the general public is exposed. *Brady v. Louis Ruffolo & Sons Constr. Co.*, 143 Ill.2d 542, 548, 578 N.E.2d 921 (1991).

There are three categories of risk an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Ill. Inst. of Tech. Research Inst. v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795 (1st Dist. 2000). Neutral risks generally do not arise out of the employment. *Ill. Consolidated Tel. Co. v. Industrial Comm'n*, 314 Ill. App. 3d 347, 353, 732 N.E.2d 49 (5th Dist. 2000). Injuries caused by a personal weakness of the employee, such as an idiopathic fall due to a weak knee, are not compensable unless the employment significantly contributed to the injury by putting the employee in a position of a greater risk of falling. *Stapleton v. Industrial Comm'n*, 282 Ill. App. 3d 12, 16, 668 N.E.2d 15 (5th Dist. 1996). In a personal risk scenario, the increased risk which renders the claim compensable may be either qualitative or quantitative. *Ill. Consolidated Tel. Co.*, 314 Ill. App. 3d at 353.

The Appellate Court has recently rendered a decision that specifically addresses the issue of risk as a result of repetitive use of stairs. *Village of Villa Park v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 130038WC, 3 N.E.3d 885 (2d Dist. 2013). In *Village of Villa Park*, the claimant testified a stairwell he used on every shift consisted of 10 steps, a landing, and then another 10 steps. *Id.* at ¶ 4. The claimant started walking down the stairwell when his right knee "gave out," causing him to fall down about seven stairs and injure his right knee and lower back. *Id.* at ¶ 3. The evidence at trial established that the claimant was required to traverse the stairs a minimum of six times per day (i.e. traversing 120 steps per day). *Id.* at ¶ 21. The arbitrator in that case found that the act of walking down stairs by itself did not establish a risk greater than those faced outside the work place, thus, the arbitrator concluded that the claimant failed to prove that his injuries arose out of and in the course of his employment. *Id.* at ¶ 12. The Commission reversed, holding that the claimant's use of the stairs fell within the "personal comfort doctrine" and thus arose out of and in the course of his employment. *Id.* at ¶ 13. Focusing on the claimant's testimony that he used the stairs "numerous" times per day, ***"the Commission concluded that the claimant's necessary and repeated use [of] the stairs for his employment exposed him to a greater risk than the general public."*** *Id.* (emphasis added).

In affirming the Commission, the Appellate Court noted that falling while traversing stairs is generally a non-compensable neutral risk. *Id.* at ¶ 20; citing *Ill. Consolidated Tel. Co.* at 353. As with personal risks, however, an exception to non-compensability exists where the requirements of the employment create a risk to

which the general public is not exposed. *Id.* "The increased risk may be qualitative or quantitative, such as where the [claimant] is exposed to a common risk more frequently than the general public." *Id.*; quoting *Ill. Consolidated Tel. Co.*, 314 Ill. App. 3d at 353. The Court stated that not only did the claimant's repeated use of the stairs place him in a position of greater risk of falling, satisfying the exception to the rule of non-compensability for injuries resulting from a personal risk, but "the frequency with which the claimant was required to traverse the stairs constituted an increased risk on a quantitative basis from that to which the general public is not exposed." *Id.* at ¶ 21.

In the case at bar, Petitioner's un-refuted testimony is that he traveled both up and down 96-108 stairs (16-18 steps per flight) 16 times per day, although the exact figure could be more or less than that depending on a variety of factors. This means Petitioner traveled both up and down 1,536 to 1,728 steps on a typical work day, depending on whether there are 16 or 18 steps per flight of stairs. Consistent with the court's decision in *Village of Villa Park* (cited *supra*), this figure is clearly a quantity that placed Petitioner at a greater risk than the general public of either developing or aggravating his conditions of ill-being in his right foot.

Dr. Hagan's causation opinion was based on the assumption Petitioner traveled up "or" down approximately 96 steps every 30 minutes. Petitioner testified he goes up "and" down six flights of stairs for every wing check, each flight containing approximately 16-18 steps. Dr. Hagan's testimony may be interpreted as indicating that even one-half of the amount of stair climbing performed by Petitioner is sufficient to at least exacerbate plantar fasciitis and tarsal tunnel syndrome. Dr. Hagan thoroughly explained the causal relationship between repetitive stair climbing and Petitioner's conditions.

Dr. Schmidt's opinions are less persuasive in this case. Dr. Schmidt only examined Petitioner prior to the surgery in May 2013. Dr. Schmidt disagreed with the diagnosis of tarsal tunnel syndrome, which was suggested by Dr. Glennon's nerve conduction study, confirmed by Dr. Brown and Dr. Wood, and confirmed by Dr. Hagan intra-operatively. Dr. Brown, Dr. Wood, and Dr. Hagan were all able to elicit a Tinel's sign, while Dr. Schmidt was not. Dr. Schmidt felt Petitioner's injuries were confined closer to the medial band of the plantar fascia, while Dr. Hagan's operative report shows he released several nerves ("medial plantar, lateral plantar, and calcaneal nerves of the foot"—*supra*) and his approach was much broader and more aggressive than the plantar fasciotomy previously performed by Dr. Brown in 2008. Further, Dr. Schmidt felt surgery was not warranted, as he believed it would not relieve Petitioner's symptoms. Petitioner's testimony that his symptoms are greatly improved and he is back to work full duty tends to refute Dr. Schmidt's pre-surgery diagnosis and recommendations for treatment.

Although Petitioner admitted that he previously had plantar fasciitis unrelated to his work duties, the timeline of his treatment as evidenced by the medical records supports Petitioner's position in this claim. In December 2010, Dr. Brown noted Petitioner's right heel had greatly improved, and he objectively observed that the edema was reduced. Shortly after Petitioner returned to work in January 2011, Petitioner canceled a visit that was scheduled with Dr. Brown, which supports Petitioner's testimony that he was not in pain until February 2011. After dealing with increasing foot pain for approximately one month, Petitioner returned to Dr. Brown on March 23, 2011. Petitioner testified the specific nature of his symptoms was different. Dr. Brown's records support Petitioner's testimony and reflect new complaints of ankle pain.

As to Petitioner's treatment with Dr. Gornet in November 2010 and January 2011, Petitioner was following up with Dr. Gornet for his previous unrelated back injury. Dr. Gornet noted the symptoms in his right foot were numbness. Petitioner testified at trial that he still has numbness into his right foot and little toe. These symptoms are unrelated to the plantar fasciitis or tarsal tunnel syndrome.

Dr. Brown's notes show he is of the opinion Petitioner's plantar fasciitis was aggravated by his work duties. He also feels Petitioner did not have a failed plantar fasciotomy, or Petitioner would have had earlier post-operative complaints. Although Dr. Brown was initially unsure regarding a causal connection with regard to the tarsal tunnel syndrome, Dr. Brown diagnosed the tarsal tunnel syndrome as a "new onset" condition after Petitioner returned to work and complained of the new symptoms into the ankle, which were later confirmed by the nerve conduction study. Dr. Wood's records show he clearly believes Petitioner's work duties exacerbated Petitioner's conditions in his right foot. Dr. Hagan's opinion makes three separate physicians who believe there is at least an aggravation of Petitioner's plantar fasciitis as a result of his work activities, and Petitioner had no documented tarsal tunnel-type complaints prior to the date of accident.

The Arbitrator notes that despite the fact Dr. Dickinson's note of June 1, 2011, was noteworthy for its description of Petitioner as "highly litiginous" and seeking disability benefits, Petitioner appeared credible during his testimony. Petitioner's testimony regarding the date of onset of his symptoms, the nature of his symptoms, statements made to him by various treating physicians, etc., was corroborated by the medical records in evidence. Further, Respondent's representative opted not to testify in any attempt to discredit Petitioner. The Arbitrator takes judicial notice that a uniformed officer of the Illinois Department of Corrections was present during trial with Respondent's counsel, and Respondent offered no testimony to refute any of Petitioner's testimony.

Although the general public may be exposed to similar risks involved in climbing up and down stairs, the astounding amount of stair climbing Petitioner's job duties required him to perform far outweighs the risk to which the general public is exposed by stairs. Even if this were considered a personal risk to Petitioner due to his pre-existing plantar fasciitis, the quantity of additional stress Petitioner was required to place on his right foot renders the injury one that arises out of the employment. The Arbitrator concludes that Petitioner's repetitive stair climbing aggravated his pre-existing plantar fasciitis and caused, contributed to, or aggravated Petitioner's tarsal tunnel syndrome.

For the foregoing reasons, the Arbitrator finds that the March 23, 2011 injury to Petitioner arose out of and in the course of the employment for Respondent.

In analyzing the "arising out of" component of the accident, the primary concern is with a causal connection. *Certified Testing v. Industrial Comm'n*, 367 Ill. App. 3d 938, 944, 856 N.E.2d 602 (4th Dist. 2006). A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro,* 207 Ill.2d at 205. Because the Arbitrator finds Petitioner's March 23, 2011 accident arose out of and in the course of the employment for Respondent, the Arbitrator also finds Petitioner's conditions of ill-being, both the recurrent plantar fasciitis and tarsal tunnel syndrome to his right foot, are causally related to repetitive stair climbing at work.

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?

Although Dr. Schmidt testified surgery was not warranted, it is apparent from the medical records of Dr. Brown and the testimony of Dr. Hagan that both physicians felt surgery was reasonable and necessary. Petitioner's testimony that he feels the surgery was successful and has improved his symptoms supports that finding. There is no evidence in the record to suggest Petitioner's treatment outside of surgery was not reasonable and necessary. The following medical bills are awarded to Petitioner:

1. Southern Illinois Podiatry (PX 2, pp. "WBCS-Koehler 003 to 007")
2. Orthopedic Center of St Louis (PX 3, pp. "WBCS-Koehler-0063 to 0065")
3. RIC-SIH, SPI-Healthcare (PX 5, pp. "WBCS-Koehler-0074 to 0075")
4. Southern Orthopedic Associates (PX 6, p. "WBCS-Koehler-0089")
5. St Louis Plastic & Hand Surgery, Robert Hagan, M.D. (PX 7, p. "WBCS-Koehler-00144")
6. Mason Ridge Surgery Center (PX 8, p. "WBCS-Koehler-00166")
7. St Luke's Hospital (PX 9, p. "WBCS-Koehler-00195")

Pursuant to Section 8(j) of the Act, Respondent is entitled to a credit for any parts of the above-listed medical bills previously paid through its group medical plan.

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

Petitioner was taken off work by Dr. Hagan on the date of surgery, May 22, 2013, and he was released back to work on August 8, 2013, representing 11 2/7 weeks. Respondent is hereby ordered to pay Petitioner temporary total disability benefits for this period.

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

As a result of the work injury, Petitioner underwent a tarsal tunnel release and a decompression of the medial plantar, lateral plantar, and calcaneal nerves of the foot. The post-operative diagnoses were polyneuropathy, tarsal tunnel syndrome, and compression neuropathy of the medial plantar, lateral plantar, and calcaneal nerves of the foot. Petitioner testified that he continues to suffer some foot pain with prolonged standing or walking. Petitioner is able to continue his hobby of hunting, although it requires minimal walking on his part. Petitioner is able to climb stairs as part of his daily life, and he has been able to return to his employment full-time without restrictions. Given the foregoing, the Arbitrator finds Petitioner has sustained permanent partial disability to the extent of 25% loss of use to the right foot, as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF Mc LEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Barnhill,
Petitioner,

vs.

NO: 11 WC 24807
11 WC 37386

Mitsubishi Motors North America, Inc.,
Respondent.

15IWCC0326

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and timely notice given to all parties, the Commission, after considering the issues of benefit rate, medical expenses, temporary disability, permanent disability, and credit, and being advised of the facts and law, modifies the April 8, 2014 decision of Arbitrator Kelmanson, as stated below and otherwise affirms and adopts the decision of the Arbitrator, which is attached hereto and made a part hereof.

Case number 11 WC 24807 and case number 11 WC 37386 were consolidated for hearing on November 13, 2013 before then-Arbitrator Mathis. In both claims, Petitioner alleged injury to his back and legs arising out of and in the course of employment with Respondent. Shortly after the hearing, Arbitrator Mathis was appointed as Commissioner, and the matter was reassigned to then Arbitrator Kelmanson for decision.

After considering the entire record, including surveillance video, the Commission affirms and adopts the Arbitrator's findings regarding causal connection, average weekly wage and benefit rate, medical expenses and permanent partial disability. With regard to temporary disability and credit, the Commission makes the following findings of fact and conclusions of law:

The Arbitrator found Petitioner was not entitled to temporary total disability benefits, based on the credible evidence showing significant symptom magnification and a growing intent by Petitioner to leave the workforce. The Arbitrator further found that between February 16, 2011 and August 4, 2011, Petitioner was working within his restrictions.

The Commission affirms the Arbitrator's finding that Petitioner's related condition of ill-being extends from the February 16, 2011 injury through August 28, 2011. Petitioner continued to work through the August 4, 2011 accident date. After the August 4, 2011 accident, Petitioner was taken off work by Dr. Pace, a physician at the Mitsubishi Motors Plant Medical Clinic due to a flare-up of his work related low back pain. Petitioner was not released to work between August 4, 2011 and August 28, 2011, and as such, the Commission finds Petitioner was temporarily totally disabled from work for the period August 4, 2011 through August 28, 2011 under Section 8(b) of the Act.

15IWCC0326

In accordance with the above findings, the Respondent shall accordingly pay the Petitioner $519.22 per week in temporary total disability benefits for a period of 3 & 4/7 weeks, or a total of $1,854.36. The Commission observes that the parties stipulated at hearing that Respondent had paid $13,133.36 in disability benefits as well as $1,110.89 in other disability benefits for which credit may be allowed under Section 8(j) of the Act. The overpayment of such disability benefits shall be applied against the finding of permanent disability benefits as otherwise discussed herein.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 8, 2014, is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $519.22 per week for a period of 3 & 4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit of $13,133.36 for disability benefits paid through the date of the hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner related medical bills through August 28, 2011 contained in Petitioner's Exhibit 25 pursuant §8(a) and 8.2 of the Act. Respondent shall be given credit for medical benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $467.30 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 the person as a whole. In addition to credit against this sum for the overpayment of disability benefits heretofore paid as referenced above, Respondent shall be given a credit of $1,110.89 for other benefits paid, subject to the hold harmless requirements of Section 8(j) of the Act.

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

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

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: MAY 4 - 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/04/15
jdl/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARNHILL, STEVEN
Employee/Petitioner

Case# **11WC024807**
11WC037386

MITSUBISHI MOTORS NORTH AMERICA INC
Employer/Respondent

15IWCC0326

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0564 WILLIAMS & SWEE LTD
JEAN SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER VOELKER & ALLEN
BRAD INGRAM
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

Steven Barnhill
Employee/Petitioner

v.

Mitsubishi Motors North America, Inc.
Employer/Respondent

Case # **11** WC **24807**

Consolidated cases: **11 WC 37386**

15IWCC0326

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Mathis**, Arbitrator of the Commission, in the city of **Bloomington**, on **November 13, 2013**. The matter was subsequently reassigned to Arbitrator **Svetlana Kelmanson** for disposition. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/16/2011 and 8/4/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the average weekly wage was **$753.82 and $778.83**, respectively.

On the dates of accident, Petitioner was **54 and 55** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$13,133.36** for TTD benefits, for a total credit of **$13,133.36**.

Respondent is entitled to a credit of **$1,110.89** under Section 8(j) of the Act.

ORDER

Respondent shall pay related medical bills in Petitioner's Exhibit 25 that Petitioner incurred until August 28, 2011, pursuant to sections 8(a) and 8.2 of the Act. Respondent shall be given appropriate credit for the medical benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$467.30**/week for **25** weeks, because the injuries sustained caused the **5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

4/8/2014
Date

APR 8 - 2014

15IWCC0326

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On June 29, 2011, Petitioner filed an application for adjustment of claim, alleging that on February 16, 2011, he sustained accidental injuries to his back and legs while working. On September 28, 2011, Petitioner filed another application for adjustment of claim, alleging that on August 4, 2011, he sustained accidental injuries to his back and legs while working. The two applications for adjustment of claim were assigned case numbers 11WC24807 and 11WC37386, respectively, and subsequently consolidated. On November 13, 2013, the matter proceeded to trial before Arbitrator Mathis, and a record was made. Shortly thereafter, Arbitrator Mathis was appointed Commissioner, and the matter was reassigned to Arbitrator Kelmanson for disposition.

Petitioner testified that he worked for Respondent since 1988. On February 16, 2011, he felt a "pull" in his back while he was bent over, reaching down to lift a plastic "side air dam" out of a shipping container. As he was pulling, the air dam became "hung up" in packing foam. Petitioner stated he felt very sharp pain in his back, "almost breathtaking." However, he continued to work. As he was working, his back felt stiffer, and he developed pain down the back of the right leg and into the groin. Later in the day, Petitioner saw Dr. Pace at Respondent's company clinic.

The parties introduced into evidence prior medical records going back to 1988. The records document periodic complaints of low back pain and stiffness since 1989, due to work and non-work related injuries and aggravations. On March 28, 2000, Petitioner underwent an MRI of the lumbar spine, which showed: moderate to severe left posterior paracentral disc herniation at L1-L2; mild to moderate disc bulging with a moderate right-sided herniation at L4-L5; and mild to moderate right-sided disc herniation at L5-S1. On April 13, 2000, Petitioner consulted Dr. Atwater at McLean County Orthopedics, complaining of low back pain with some left-sided radiation. Dr. Atwater prescribed anti-inflammatory medication and imposed a temporary no overtime restriction. Thereafter, Petitioner regularly followed up with Dr. Atwater through December of 2000, reporting improvement. Dr. Atwater continued the no overtime restriction. Next, Petitioner followed up with Dr. Atwater on October 25, 2001, complaining of some low back pain radiating to the groin. Dr. Atwater continued the no overtime restriction. On July 16, 2002, Petitioner followed up with Dr. Atwater, asking for clarification of his restriction and reporting some recurrent flare-ups. Dr. Atwater continued the no overtime restriction. On July 7, 2003, Petitioner followed up with Dr. Atwater, reporting doing fairly well. Dr. Atwater continued the no overtime restriction and instructed Petitioner to follow up as needed. On September 15, 2004, Petitioner returned to Dr. Atwater, complaining that his back pain worsened with increased activity. Once again, Dr. Atwater continued the no overtime restriction.

On August 29, 2005, Petitioner returned to Dr. Atwater, complaining that the pain radiated down the right leg to the ankle. Dr. Atwater ordered an MRI. The MRI, performed September 23, 2005, showed: moderate degenerative changes at L4-L5, with a central disc protrusion, facet changes and mild central stenosis; and anterior spondylotic changes and a small paracentral disc bulge at L5-S1. On October 12, 2005, Dr. Atwater referred Petitioner for an EMG/NCV to evaluate for right-sided radiculopathy. The EMG/NCV, performed October 26, 2005, showed a right L5 radiculopathy with evidence of ongoing denervation. On December 5,

2005, Petitioner followed up with Dr. Atwater, complaining of ongoing low back pain with leg pain, primarily on the right. Dr. Atwater diagnosed degenerative disc disease at L4-L5 and L5-S1, with L5 radiculopathy. On December 9, 2005, Dr. Atwater performed an epidural steroid injection on the right at L4-L5. On December 21, 2005, and January 25, 2006, Petitioner reported significant relief after the injection, and Dr. Atwater instructed him to follow up as needed.

Petitioner testified he last saw Dr. Atwater on January 25, 2006, and has not treated for his low back condition until February 16, 2011. The medical records from the company clinic show that before the work accidents at issue, Petitioner was working under permanent restrictions due to a number of work-related conditions. The medical records in evidence do not document any low back complaints or treatment between 2006 and 2011. Petitioner testified that in 2011, he worked with a 20 pound lifting restriction.

The medical records in evidence further show that on February 17, 2011, Petitioner complained to Dr. Pace of sharp low back pain and stiffness, which he attributed to pulling to remove a side air dam. The pain radiated to the groin. Straight leg raise test was negative. Dr. Pace diagnosed an exacerbation of chronic back pain, released Petitioner to return to work, and instructed him to follow up as needed. On February 24, 2011, Petitioner followed up with Dr. Pace, reporting no improvement. On physical examination, Dr. Pace noted poor flexion, with negative straight leg raise test. He prescribed physical therapy. Petitioner briefly attempted physical therapy in March of 2011, reporting no improvement. On March 14, 2011, Dr. Pace ordered an MRI. The MRI, performed March 21, 2011, showed degenerative disc disease with varying degrees of disc herniation, most pronounced at L4-L5, where there was moderate to severe stenosis, and smaller disc herniations at L1-L2 and L5-S1. On April 4, 2011, Dr. Pace referred Petitioner to Dr. Nardone, a neurosurgeon.

On April 18, 2011, Petitioner consulted Dr. Nardone, complaining of low back pain radiating to the right buttock and groin, giving a history of developing the back pain when he bent over at work in February to pull plastic parts out of Styrofoam. Neurologic examination was grossly normal. Dr. Nardone recommended an epidural steroid injection. On May 9, 2011, Petitioner followed up with Dr. Pace and reported awaiting approval of the injection. On June 10, 2011, Dr. Li performed epidural steroid injections at L1-L2 and L4-L5. On June 20, 2011, Petitioner followed up with Dr. Li, reporting no lasting relief. Dr. Li recommended repeat injections.

Petitioner testified that on or about June 20, 2011, he went on vacation, driving to California and back. He took a trailer with his motorcycle. When asked how much he rode the motorcycle during the vacation, Petitioner responded: "The most a half hour one time." The medical records show that on July 13, 2011, Petitioner followed up with Dr. Pace, reporting no improvement. Dr. Pace recommended repeat injections.

Petitioner testified that on August 4, 2011, he felt severe pain in his back when he bent over and picked up a crate of plastic parts from a pallet on the ground. The pain radiated to the left leg. The medical records show that on August 4, 2011, Petitioner saw Dr. Pace, complaining of worsening back pain after lifting a box of parts. Dr. Pace took Petitioner off work and advised

him to contact Dr. Li or Dr. Nardone. On August 5, 2011, Petitioner saw Dr. Li, who took him off work. On August 16, 2011, Dr. Li performed epidural steroid injections at L1-L2, L4-L5 and L5-S1.

Respondent introduced into evidence surveillance videos showing that on August 28, 2011, Petitioner cleaned a motorcycle, including the wheels, using a cleaning cloth and a hose. He bent down multiple times while cleaning, almost touching the ground with his hands several times. Part of the time when he was cleaning the motorcycle, he sat on a stool. Then, Petitioner briefly rode the motorcycle. Approximately two hours later, Petitioner smoothed the ground with a small shovel along the edge of a path on his property while his wife laid paving bricks there. Next, Petitioner used the shovel to press dirt against the bricks. Lastly, the surveillance videos show Petitioner in the garden, bending down to pick tomatoes. The surveillance footage from September 2, 2011, shows Petitioner and another individual lift a small go cart and move it approximately one foot. Then, Petitioner bent down to pull a cord to start the go cart, and the other individual drove off in the go cart. Lastly, Petitioner pushed and pulled a large wheeled trash can from the curb to the side of the house, and pushed two other trash cans approximately two feet. Petitioner did not appear to be in pain while performing these activities on August 28, 2011, and September 2, 2011, although he moved somewhat stiffly at times.

The medical records show that on September 7, 2011, Petitioner followed up with Dr. Li, reporting some improvement on the right side. On September 19, 2011, Petitioner complained of persistent pain in the low back with radiation to the groin and legs. Dr. Li referred Petitioner back to Dr. Nardone and kept him off work.

On September 28, 2011, Petitioner saw Dr. Nardone, complaining of low back pain with radiation to the groin and legs, the right worse than the left. On physical examination, Dr. Nardone noted a positive straight leg raise test and ordered a repeat MRI. The MRI, performed October 5, 2011, showed essentially the same findings as the MRI from March 21, 2011.

Petitioner testified that in October of 2011, Respondent terminated his employment because of the surveillance videos. Petitioner admitted Respondent paid temporary total disability benefits from August of 2011 through part of January of 2012.

On December 19, 2011, Dr. Levin, a general orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner complained of low back pain with radiation to the groin and legs, the right worse than the left, and gave a history consistent with his testimony. He described significant limitations in his activities of daily living and felt he could not work. Regarding prior back problems, Petitioner reported a back strain in the 1990s that had completely resolved. He denied receiving any treatment for back or leg complaints between 1990s and February of 2011. Dr. Levin noted that Petitioner walked with a non-physiologic antalgic gait and had give way strength. Petitioner was able to walk on his toes, but not his heels. Petitioner's gait changed as he was exiting the exam room and in the parking lot. Dr. Levin reviewed medical records from Dr. Nardone and Dr. Li, and surveillance videos. Dr. Levin noted that Petitioner's subjective complaints and physical examination findings were inconsistent with the video surveillance, and suspected Petitioner was more functional than he reported.

On January 12, 2012, Dr. Nardone performed a bilateral decompressive laminectomy and left-sided microdiscectomy at L4-L5. Postoperatively, Petitioner reported significant improvement. Petitioner last saw Dr. Nardone on March 27, 2012, reporting occasional back pain after prolonged standing. Dr. Nardone imposed no restrictions and instructed Petitioner to follow up as needed.

On March 5, 2012, Dr. Levin issued an addendum after reviewing additional records, stating:

> "[I]t would appear that this patient's activities after his reported alleged work injury have been significantly greater than one would expect from the symptoms of the work injury alone. The patient's need for surgical intervention is based on his subjective report of symptoms, where based on his objective findings it would appear that the activities seen on the video surveillance tapes in and by themselves would be consistent with making this patient symptomatic.
>
> Based on the information I have, the mechanism of injury that would be related to his reported work activities and pain is less than the stress put on his lumbar spine from the activities seen in the video surveillance. It would appear that the activities seen on the video surveillance in and by themselves could be a causative agent making him symptomatic and requiring surgical intervention."

On August 15, 2012, Dr. Nord, a family practitioner and occupational medicine specialist, examined Petitioner at the request of his attorney. In his evidence deposition, taken September 9, 2013, Dr. Nord testified that Petitioner described the work accidents consistently with his testimony and gave a history of prior low back problems. Dr. Nord reviewed Petitioner's medical records and the surveillance videos and opined that the work accidents exacerbated and aggravated Petitioner's preexisting low back condition, ultimately necessitating surgery. Regarding the surveillance footage, Dr. Nord stated: "I felt those movements that [Petitioner] was doing were not unusual for somebody who had a current disk problem, that they more likely than not would be able to do those activities." Dr. Nord further opined that Petitioner "should be basically limited from doing any more than sedentary type duties, which would limit him to no more than ten pounds of weight restriction," explaining that he was concerned about a reinjury or another aggravation.

On cross-examination, Dr. Nord admitted he did not know whether Petitioner had been diagnosed with a disc herniation at L4-L5 prior to 2011, qualifying that he was aware Petitioner previously had been symptomatic at L4-L5. Regarding the surveillance footage, Dr. Nord opined the activities were unlikely to aggravate a back condition, although they could have. On redirect examination, Dr. Nord testified the surveillance footage did not indicate Petitioner had aggravated his back condition while performing those activities.

Dr. Nardone testified via evidence deposition on October 23, 2012, that intraoperatively he confirmed a disc herniation at L4-L5. Regarding causal connection, Dr. Nardone opined the work accident on February 16, 2011, "caused an aggravation of the work injury [*sic*] that required the surgery." Upon further questioning, Dr. Nardone stated the lifting and pulling on

February 16, 2011, aggravated the symptoms of back and leg pain. However, Dr. Nardone conceded he did not know whether Petitioner had prior low back problems.

On cross-examination, Dr. Nardone testified Petitioner did not mention a work accident on August 4, 2011. Dr. Nardone confirmed there was not much difference between the MRI from March 21, 2011, and the MRI from October 5, 2011. Dr. Nardone explained that he recommended surgery because Petitioner failed to improve with conservative treatment. Regarding causal connection, Dr. Nardone agreed that pushing and riding a motorcycle, cleaning a motorcycle, lifting a go cart and performing gardening activities on August 28, 2011, and September 2, 2011, could have aggravated Petitioner's condition, causing the need for surgery. Dr. Nardone added that any activity of daily living can cause a disc herniation or aggravate the symptoms. On redirect examination, Dr. Nardone testified that Petitioner's complaints in September of 2011 were the same as his complaints in April of 2011. Lastly, Dr. Nardone testified that Petitioner had an excellent outcome with the surgery.

Dr. Levin testified via evidence deposition on November 14, 2012, that in his opinion "there is no evidence objectively that there was any work injury dating back to February 16th, 2011 that caused or aggravated [Petitioner's] condition which required treatment as of December 19th, 2011." Dr. Levin explained that: Petitioner's history did not correspond to the findings in the records; Petitioner exhibited non-physiologic behaviors that did not fit with the objective findings; and the surveillance video was inconsistent with the history Petitioner provided. Dr. Levin thought it was much more likely Petitioner's symptoms in December of 2011 were the result of the activities depicted in the surveillance video, than the work accidents.

Regarding his current condition, Petitioner testified that his back pain is much better, although the back is stiff some days. He no longer has pain in the legs. He has retired and is not looking for work.

Regarding his earnings during the year preceding the injuries, Petitioner testified that after treating for an extended period of time for a work injury to his left shoulder and cervical spine, he returned to work in the fall of 2010. At that time, he earned a union hourly wage of approximately $24.00. However, during the remainder of 2010 and until the accident on August 4, 2011, he regularly participated in voluntary layoffs.

On cross-examination, Petitioner described the weight of the plastic part he lifted on February 16, 2011, as "[p]retty light," and the weight of the parts he lifted on August 4, 2011, as heavier because there was a number of them in a crate. Regarding voluntary layoffs, Petitioner explained that he was paid 75 percent of his regular wages if he took a three week long voluntary furlough, and 50 percent for his regular wages for a one week furlough, even though he did not work. Petitioner affirmed that he often volunteered for furloughs. Petitioner further testified that he had sustained a number of work injuries during his employment with Respondent, and Respondent had accommodated his restrictions. After the work accident on February 16, 2011, Petitioner missed no time from work until the accident on August 4, 2011, not counting voluntary furloughs and vacation. The following colloquy then occurred:

"Q. [B]etween February 16th you had no real change in your activities away from work or at work?

A. You know, I just took it a little easier.

Q. But no real, I mean you were able to take vacation, you were able to work, you were able to ride your bike on occasion?

A. Occasionally. Not like I would like to, but occasionally.

Q. And you were able to function in that manner before February 16th as well, right, other than with your restrictions?

A. Yeah.

Q. So, your activities did not change much considering restrictions that you had for the shoulder and neck and all the other injuries much either before February 16, 2011 or afterwards?

A. No.

Q. And your activities after August 4 you were able to do what you were observed doing on the videos, right?

A. Right.

Q. So *** you had a pretty normal active life outside of work after August 4th?

A. Not really."

Petitioner admitted some non-work activities he performed in 2010 and 2011 aggravated his low back symptoms. When that happened, he stopped the non-work activity. However, he did not feel he could just stop and quit when it happened at work, except on February 16, 2011. Upon further questioning, Petitioner admitted in 2010 and 2011, normal daily activities produced symptoms in his back.

On redirect examination, Petitioner testified the back and leg pain he felt on February 16, 2011, and August 4, 2011, was very different from the pain he felt before.

Mel Hall, Respondent's general manager of human resources, testified that Respondent paid temporary total disability benefits from August of 2011 through early January of 2012. Mr. Hall confirmed that Respondent accommodated Petitioner's restrictions. Had Petitioner tried to return to work on restricted duty in August of 2011, Respondent would have tried to accommodate his restrictions.

Mr. Hall further testified that on October 8, 2011, he attended a concert at the US Coliseum and saw Petitioner there. Mr. Hall observed Petitioner walk up and down the stairs in a normal manner, without using a guardrail for support, and even "skipping down the steps *** taking more fast pace." Respondent ultimately investigated the extent of Petitioner's disability, and Mr. Hall viewed the surveillance videos as part of the investigation. At the conclusion of the investigation, Mr. Hall decided to terminate Petitioner's employment because Petitioner claimed temporary total disability status in bad faith.

Regarding Petitioner's earnings, Mr. Hall reviewed Respondent's Exhibit 14 and testified that from February 17, 2010, through February 16, 2011, Petitioner earned $18,091.68 during 24 weeks, corresponding to an average weekly wage of $753.82. From August 5, 2010, through August 4, 2011, Petitioner earned $38,941.51 during 50 weeks, corresponding to an average weekly wage of $778.83. These figures include furlough pay for the weeks and parts thereof Petitioner took voluntary furlough. Mr. Hall explained: "[I]t's a form of pay in lieu of working. We would do the same process [as regular wages]."

On cross-examination, Mr. Hall testified that the Monday after the concert, he went to the waiting area of Respondent's company clinic to observe Petitioner. Mr. Hall observed Petitioner ask a nurse for assistance in sitting down. However, Petitioner exhibited no such disability at the concert. On redirect examination, Mr. Hall testified that he also observed Petitioner in the parking lot. Petitioner walked slowly, in a guarded manner.

During cross-examination of Petitioner, he was asked about the concert at the US Coliseum on October 8, 2011. Petitioner's testimony was evasive, but he admitted to "[p]ossibly" being at the concert.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator does not find Petitioner credible. The record shows Petitioner magnified his symptoms after the accidents on February 16, 2011, and August 4, 2011. The record further shows significant preexisting low back problems. During the section 12 examination by Dr. Levin, Petitioner minimized his preexisting low back problems, telling Dr. Levin he had only sustained a back strain in the 1990s that had completely resolved and denying any other complaints or treatment. Likewise, Dr. Nardone testified he did not know Petitioner had prior low back problems.

Having carefully considered the entire record, the Arbitrator finds the accidents on February 16, 2011, and August 4, 2011, caused mild aggravations of Petitioner's longstanding degenerative low back condition. The Arbitrator compares the mechanisms of injury to the surveillance videos and notes the activities depicted in the surveillance videos were much more strenuous. The Arbitrator also gives substantial weight to the testimony of Mr. Hall that during a concert on October 8, 2011, he observed Petitioner walk up and down the stairs in a normal manner, without using a guardrail for support, and even "skipping down the steps *** taking

more fast pace." The Arbitrator finds Petitioner reached maximum medical improvement from the injuries by August 28, 2011.

In support of the Arbitrator's decision regarding (G), what were Petitioner's earnings, the Arbitrator finds as follows:

Section 10 of the Workers' Compensation Act (the Act) provides, in pertinent part:

> "The basis for computing the compensation provided for in Sections 7 and 8 of the Act shall be as follows:
>
> The compensation shall be computed on the basis of the 'Average weekly wage' which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted." 820 ILCS 305/10 (West 2010).

Petitioner claims an average weekly wage of $960.00, based on the union hourly wage of $24.00 and a 40 hour workweek. Respondent claims an average weekly wage of $753.82 in connection with the accident on February 16, 2011, and an average weekly wage of $778.83 in connection with the accident on August 4, 2011. Respondent bases its calculations on Petitioner's actual earnings, including furlough pay. Petitioner contends his furlough pay should not factor into the average weekly wage calculations because he did not work during those weeks. Thus, Petitioner maintains his average weekly wage should be based only on the weeks and parts thereof he worked during the year preceding the injury.

The Arbitrator finds Petitioner's average weekly wage should be based on his actual earnings, including furlough pay. See Kelly v. Workers' Compensation Appeal Board, 605 Pa. 568, 582, 992 A.2d 845, 854 (2010) ("We view the furlough benefit here as analogous to vacation and sick leave, and as 'otherwise earned income' "); Pluto v. Industrial Comm'n, 272 Ill. App. 3d 722, 729 (1995) ("[V]acation pay is included as earnings or income where an employee is paid his regular earnings during the time he takes time off for vacation"). The Arbitrator is not unmindful that Petitioner was paid only a percentage of his regular earnings as furlough pay. However, Petitioner voluntarily chose to go on paid furlough, which, in terms of pay, is akin to voluntarily deciding to work part-time, rather than full-time.

With regard to calculating the average weekly wage of part-time workers, the appellate court has noted:

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

Robert Kancilja,

Petitioner,

vs. NO: 12 WC 40231

Pace Bus,

15IWCC0327

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, 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 9, 2014, is hereby affirmed and adopted.

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

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

DATED: MAY 7 - 2015
TJT:yl
o 4/6/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KANCILJA, ROBERT
Employee/Petitioner

Case# **12WC040231**

PACE BUS
Employer/Respondent

15IWCC0327

On 5/9/2014, 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 0.45% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
SSANTIAGO ECHEVESTE
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1505 SLAVIN & SLAVIN
PAUL R POPVIC
20 S CLARK ST SUITE 510
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

Robert Kancilja
Employee/Petitioner
v.
Pace Bus
Employer/Respondent

Case # **12 WC 40231**

15IWCC0327

An *Application for Adjustment 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, Illinois**, on **January 31, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 1, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$45,990.43**; the average weekly wage was **$884.43**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **no** dependent children.

ORDER

No benefits are awarded, because Petitioner has not proved by a preponderance of the credible evidence that an accident occurred that arose out of and in the course of his employment.

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

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

Milton Black

Signature of Arbitrator

May 9, 2014
Date

MAY - 9 2014

FACTS

Petitioner testified on direct examination that he is employed by Respondent as a bus operator. Petitioner testified that on November 1, 2012, he was performing a pre-trip bus inspection when he noticed a brown paper bag on the floor under a seat. Petitioner testified that he tried to reach under the seat to get the paper bag but was physically unable to do so. Petitioner testified that he then got down on the floor, extended his left leg flat on the ground in a splits position, and felt a sharp left knee pain. Petitioner testified that he had 4½ hours left on his shift and that for 3 of those hours his knee felt fine in

a sitting position. Petitioner testified that his pain was excruciating when he stood up. Petitioner testified that he had no prior left knee injuries.

Petitioner testified that thereafter he could not walk, that he hopped off the bus, and that he limped. Petitioner testified that he reported the accident as soon as he hobbled off the bus and that he was sent to Vista Corporate Health. Petitioner testified that he was taken off work and referred to an orthopedic physician, Dr. Summerville, Petitioner testified that he did not see Dr. Summerville at that time. Petitioner testified that he went to Dr. Engstrom, his primary care physician, 5 weeks after the accident. Petitioner testified that Dr. Engstrom also referred him to Dr. Summerville.

Petitioner testified that after reviewing an MRI, Dr. Summerville recommended and performed meniscal tear surgery. Petitioner testified that compensation was denied and that medical benefits were paid through his group insurance carrier. Petitioner testified that he returned to work two weeks after surgery. Petitioner testified that he was never examined by Dr. Mercier, Respondent's medical reviewing physician.

Petitioner testified that he has returned to work operating a bus. Petitioner testified that his knee is not the same and that now he has dull, sharp, throbbing, and burning pain in the knee.

On cross examination, Petitioner testified that he had never been unable to reach a package before the date of accident and that he had never been in a position before where his left leg was flat on the ground. Petitioner testified that he told the Vista physician's assistant and Dr. Engstrom that he felt pain when he was standing up.

On redirect examination, Petitioner testified that he first noticed the pain when his leg was fully extended. Petitioner testified that when he was on the ground with his leg extended the pain continued until he stood up. Petitioner testified that he was in pain until he got up. Petitioner testified that when he got up on his knee, it seemed like he pulled a muscle. Petitioner testified that he felt fine when he was driving the bus. Petitioner testified that he could not straighten out his leg.

On recross examination, Petitioner testified that after the accident he could not stand without excruciating pain. Petitioner testified that he did not know whether or not he worked 3 hours after the accident.

The November 1, 2012 Vista chart note recites that Petitioner leaned down to pick up some trash and when he tried to stand up he felt pain in the left knee, that his left leg stretched out behind him, and that he feels he stressed the leg (RX3).

A written accident report dated November 18, 2012 recites that Petitioner stretched out on the floor of a bus to retrieve trash located behind a passenger seat and injured his knee (PX1).

Dr. Engstrom's chart note dated December 12, 2012 recites that Petitioner stood up and had left knee pain (RX1).

Dr. Mercier reviewed medical records for Respondent and opined that there was no accident and no causation (RX1, RX2).

ACCIDENT

Petitioner initially testified that when he extended his left leg flat on the ground in a splits position he felt knee pain.

Then on cross examination, Petitioner testified that he had never been unable to reach a package before the date of accident, something highly unlikely in the real world. He also testified that he told the Vista physician's assistant and Dr. Engstrom that he felt pain when he was standing up.

Then on redirect examination, Petitioner testified that he first noticed the pain when his leg was fully extended, which is not what he said at Vista on November 1, 2012, the alleged accident date. At Vista he said he felt pain when he was standing up. On December 12, 2012 Petitioner told Dr. Engstrom that he had knee pain when he stood up.

Then on redirect examination, Petitioner testified that he first noticed pain when his leg was fully extended and that it continued until he stood up. He also testified that he got up on his knee and could not straighten out his leg.

In between the history he gave at Vista and the history he gave to Dr. Engstrom, Petitioner signed a written accident report dated November 18, 2012, which recited that he stretched out on the floor of a bus to retrieve trash located behind a passenger seat and injured his knee. But that is not consistent with the medical histories of Vista and Dr. Engstrom, which state that he first noticed pain when he was standing up or stood up.

Dr. Mercier's opinion on accident is given no weight, because he has not been qualified as an accident reconstruction expert.

The Arbitrator closely observed Petitioner from direct examination through recross examination. The Arbitrator finds Petitioner's testimony to be unpersuasive and not corroborated by the medical treatment records.

Based upon the foregoing, the Arbitrator finds that Petitioner has not proved by a preponderance of the credible evidence that an accident occurred that arose out of and in the course of his employment.

The remaining issues are moot.

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

Karen Harms,

Petitioner,

vs.

NO: 12 WC 14698

State of Illinois Department of Corrections,

15IWCC0328

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 17, 2014, is hereby affirmed and adopted.

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

15IWCC0328

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: MAY 7 - 2015
TJT:yl
o 3/23/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

HARMS, KAREN
Employee/Petitioner

Case# **12WC014698**

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

15IWCC0328

On 7/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0136 COPELAND FINN & FIERI LTD
SHELDON COPELAND
180 N LASALLE ST SUITE 2507
CHICAGO, IL 60601

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

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 17 2014

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

15IWCC0328

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)

Karen Harms
Employee/Petitioner

v.

Illinois Department of Corrections
Employer/Respondent

Case # 12 WC 14698

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 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. ☐ 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 5, 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 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 **$81,878.16**; the average weekly wage was **$1,574.58**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **no** dependent children.

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

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 **$0** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner established that she sustained a compensable accident at work and causal connection between her current right leg condition of ill being and her injury on April 5, 2012.

Temporary Total Disability

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner temporary total disability benefits of $1,049.72/week for 87 & 6/7th weeks, commencing April 6, 2012 through December 11, 2013 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from April 6, 2012 through June 11, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay reasonable and necessary medical bills totaling $92,734.28 as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

July 14, 2014
Date

ICArbDec19(b) p.3

JUL 17 2014

15IWCC0328

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b)

Karen Harms
Employee/Petitioner

v.

Illinois Department of Corrections
Employer/Respondent

Case # **12** WC **14698**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include accident, causal connection, Respondent's liability for payment of certain medical bills, as well as Petitioner's entitlement to a period of temporary total disability benefits. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

On April 5, 2012, Petitioner was employed by Respondent as an educator and had been employed by Respondent since 1999. Petitioner testified that she was never treated for right leg or hamstring issues and that she has never filed a workers' compensation claim before this one.

She worked in the library/law library in a crowded area. Petitioner explained that one half of the room was dedicated to rows of shelves with books; the library. The other side of the room had seven round tables with 21 chairs, 5-6 teachers' desks, and a copier. One of the round tables had two typewriters placed opposite each other.

On the date of accident, Petitioner testified that she was in the library typing up a certificate for a student that had completed a book. She explained that the other round tables and chairs were located around her, and a teacher's desk was located to her right. When she got up to go to the principal's office, her foot entangled with chair. Her right leg hyper-extended and she heard ripping and cracking. Petitioner testified that she does not know which foot got caught to cause the fall, but that the pressure exerted on her right leg was immense. She also did not know what was immediately behind the chair. Petitioner also testified that the area in which she was located at the time of her incident was "crowded."

Petitioner offered photographs into evidence of the broken chair that were taken after her injury. PX6. These photographs show that the front legs of the chair are not bent and that the back right leg is skewed. *Id.* Petitioner acknowledged that the chair was not rocking back and forth when she sat down and that she did not report the chair as defective before her injury.

Petitioner completed an incident report dated April 6, 2012 in which she states that she was typing a certificate for a student at the time of her injury and "when finished I pushed the orange vinyl chair back and stood up to walk to the office. Either my right foot or left foot became entangled with the chair leg, which protrudes out to

[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 or agreed exhibits are denominated "JX" with a corresponding number or letter as indentified by the parties.

the front of the chair, and my right leg went out in from of me hyperextending to the point that my left knee was almost touching the floor. I heard cracks and felt ripping in my right leg. I could feel the blood rush from my head. I had to fall to my right with my right arm and shoulder cushioning my fall. I remember saying, 'this isn't good.' Bea Stanley and Jenni Robison were asking me what happened." PX9.

Medical Treatment 15IWCC0328

Petitioner testified that her husband came to get her and took her to the hospital. Petitioner testified that she mentioned her knee at the emergency room at this initial visit. The medical records reflect that Petitioner then received medical attention at Provena St. Mary's Hospital the same day. PX1. At that time, Petitioner reported right knee and right hip pain after a fall after tripping on a chair at work. *Id.* She reported pain at a level of 10/10 that increased with movement. *Id.* She underwent right knee x-rays, which showed mild degenerative changes and a small suprapatellar effusion with no acute fracture and right hip x-rays which showed mild degenerative changes and no acute fracture. *Id.* She was diagnosed with a hamstring strain, given crutches, and placed off work. *Id.*

Petitioner returned to see Dr. Panuska at St. Mary's the following day. PX1; PX8. Petitioner reported that she injured her right hip and knee when she was getting up from her chair and her foot got caught. *Id.* On examination, Dr. Panuska noted that Petitioner ambulated very carefully with crutches from the chair to examining table. *Id.* She was able to flex at the hip to about 60 degrees and abduct to about 30 degrees. *Id.* Petitioner testified that he could not examine her knee or foot at that point because she was in a lot of pain. Dr. Panuska noted on examination that extension of the knee was painful. *Id.* He diagnosed Petitioner with a right hip strain and right knee strain and kept her off work. *Id.*

On April 9, 2012, Petitioner returned to Dr. Panuska reporting that the back of her right thigh was very bruised and swollen, and worsened pain when she sits for too long. PX1. She also reported pain in the elbow. *Id.* Dr. Panuska diagnosed Petitioner with a right hip strain and contusion, and he kept her off work. *Id.*

Petitioner completed a Workers' Compensation Employee's Notice of Injury Form[2] on April 11, 2012. RX1. She reported that she was typing a certificate for a student when she "pushed the chair back and stood up. Either foot could have become entangled with the chair leg which does protrude out. The next thing I realized was that my right leg was hyperextended out in from of my with my left knee almost touching the floor. I heard cracking and felt ripping …." *Id.* Petitioner also reported that Bea Stanley was there and she was unsure if she saw anything. *Id.*

Petitioner also testified that she saw Dr. Moss on April 11, 2012 and he said drop your pants I want to see it after which he called Dr. Corcoran at Oak Orthopedics. She testified that she saw Dr. Corcoran and his physician's assistant on the same day, but she still needed to see Dr. Panuska because she was still under his care. The medical records reflect that Petitioner reported a history that "she was in the library at the prison when she stood up from a chair and she just had a sudden feeling of cracks and rips in her leg. She states that she fell down to the ground and that was the only thing she could do because she felt her leg was locked and she could not move." PX2. On examination, Dr. Corcoran noted that she had excessive black ecchymosis from basically her upper posterior thigh all the way down her posterior leg to about mid-calf. *Id.* She has exquisite tenderness to palpation over the ischial tuberosity that worsened down the posterior thigh and over the hamstring insertions at the knee. *Id.* On palpation, it caused Petitioner to cry. *Id.* He also noted that it was

[2] The second page of this form, which appears to be from a double-sided document, was not submitted into evidence. RX1.

extremely painful for Petitioner to undergo a knee examination. *Id.* Dr. Corcoran believed that Petitioner sustained a hamstring tear and he ordered an MRI. *Id.* He also kept her off work. *Id.*

On April 13, 2012, Petitioner reported to Dr. Panuska that she saw Dr. Corcoran and he kept her off work until she underwent the recommended MRI. PX1. She underwent the MRI on the same date, which the interpreting radiologist noted showed a full-thickness tear with complete disruption of the right hamstring complex proximal to the conjoined tendon retracted approximately 3.6 cm and an adjacent hemorrhage and edema. *Id.*

On April 16, 2012, Dr. Panuska concurred with the interpreting radiologist's findings, noting that Petitioner's MRI revealed a full-thickness tear with complete disruption of the right hamstring complex proximal to the conjoined tendon retracted approximately 3.6 cm. PX1. He referred Petitioner back to Dr. Corcoran, discharged her from the clinic, and kept her off work. *Id.* Petitioner also saw Dr. Corcoran on this date and he recommended a right proximal hamstring repair. PX2.

On April 18, 2012, Petitioner saw Dr. Moss at St. Mary's for pre-operative clearance. PX1. She provided a history that "she was typing a certificate for a student, scooted back in her chair, stood up and feels she caught something on her right lower extremity which hyperextended. She then felt a ripping sensation and fell to the right. She feels she might have tripped over a chair and got her foot hooked over a chair with wheels. She could not put any pressure on the back of her right lower extremity when we saw her." *Id.* He noted that Petitioner saw Dr. Corcoran who recommended a right hamstring tear repair surgery and that she was undergoing that day. *Id.*

Petitioner also underwent surgery on April 18, 2012. PX1-PX2. Pre- and post-operatively, Dr. Corcoran diagnosed Petitioner with a right proximal hamstring disruption. *Id.* He performed a right proximal hamstring repair. *Id.*

Petitioner returned to Dr. Corcoran post-operatively from April 25, 2012 through May 2, 2012. PX2. He kept her off work. *Id.* On May 16, 2012, Dr. Corcoran ordered physical therapy three times a week. *Id.* Petitioner testified that she underwent the recommended physical therapy. *See also* PX3-PX4.

When Petitioner returned to Dr. Corcoran on June 13, 2012, he noted that she "actually fell and actually had an acute pop in her right knee." PX2. He reviewed knee x-rays which showed moderate-to-severe medial joint space disease. *Id.* Dr. Corcoran ordered a repeat MRI to rule out ACL disruption. *Id.*

On July 11, 2012, Dr. Corcoran noted that Petitioner had intermittent right knee pain. PX2. He noted that Petitioner likely had some patellofemoral arthralgia and he administered a Kenalog and Marcaine injection to the right knee. *Id.* He ordered continued physical therapy and kept her off work. *Id.* By August 8, 2012, Petitioner reported dramatic improvement in her right knee symptoms after her injection. *Id.* He decreased physical therapy to twice per week and kept her off work. *Id.* As of September 5, 2012, Petitioner reported continued weakness on the right side. *Id.* Dr. Corcoran ordered a gradual decrease in physical therapy to a home exercise program over the next several weeks and kept her off work. *Id.*

On September 26, 2012, Petitioner saw Dr. Corcoran reporting left knee pain. PX2. He reviewed x-rays of the same day which showed primary osteoarthritis of the left knee. *Id.* He administered an injection into the left knee. *Id.*

On October 29, 2012, Petitioner reported a right knee re-injury. PX2. Dr. Corcoran administered another injection into the right knee. *Id.* Petitioner returned to Dr. Corcoran a couple of days later on October 31, 2012. *Id.* Dr. Corcoran diagnosed Petitioner with a complete tear of the right ACL. *Id.* He noted that she had an injury where she had an acute pop, increased pain, and swelling of the right knee. *Id.* He recommended a right knee tibialis anterior allograft ACL reconstruction. *Id.* He kept her off work. *Id.*

On December 6, 2012, Petitioner underwent the recommended right knee surgery with Dr. Corcoran. PX2. Pre- and post-operatively, he diagnosed her with the following: (1) right anterior cruciate ligament disruption grade 3; (2) small areas of great for chondromalacia, medial femoral condyle; (3) grade 3 chondromalacia of the lateral for moral condyle; (4) grade 3 chondromalacia patella and trochlea; and (5) complete tear involving the posterior horn and body of the medial meniscus with an anterior cruciate ligament destruction. *Id.* Dr. Corcoran performed the following procedures: (1) right knee arthroscopy with anterior cruciate ligament reconstruction and tibialis anterior allograft using an all one side technique; (2) partial medial meniscectomy; (3) partial lateral meniscectomy; (4) chondroplasty of medial and for moral condyles; (5) chondroplasty of lateral femoral condyle; and (6) chondroplasty of the patella and trochlea. *Id.*

Petitioner followed up with Dr. Corcoran post-operatively from December 17, 2012. PX2. He ordered physical therapy three times per week and kept her off work. *Id.* On January 3, 2013, Dr. Corcoran aspirated some fluid under the right knee cap and encouraged Petitioner to wean off use of the crutches. *Id.*

On January 31, 2013, Petitioner reported right shoulder pain. PX2. Dr. Corcoran diagnosed Petitioner with right shoulder impingement. *Id.*

As of March 15, 2013, Petitioner reported that her knee had given out recently and some increased pain with popping and pinching. *Id.* She also reported continued right shoulder symptoms. *Id.* Dr. Corcoran ordered a right shoulder MRI to rule out a rotator cuff tear and kept Petitioner off work and in continued physical therapy in relation to her right knee. *Id.* Dr. Corcoran discontinued physical therapy recommending a home exercise program, but kept her off work. *Id.* The physical therapy records from ATI show that Petitioner was discharged effective March 21, 2013. PX4.

On April 12, 2013, Petitioner saw Dr. Corcoran for her right shoulder. PX2. He noted that her MRI showed some tendonitis and administered an injection into the shoulder. *Id.* He did not address Petitioner's right knee at this visit. *Id.*

On May 15, 2013, Petitioner reported aching and stiffness with both good and bad days, and particular tightness over the iliotibial band. PX2. On examination of the right hip, he noted good range of motion. *Id.* He also noted tenderness over the ischial tuberosity, some tenderness with extension of the right hamstring and over the iliotibial band, a stable right knee, a trace to +1 Lachman sign, and stability on valgus and varus testing. *Id.* He recommended continued conservative treatment of the right shoulder and scheduled a follow up visit in four months. *Id.*

In a narrative letter dated January 23, 2014, Dr. Corcoran summarized his treatment of Petitioner in detail and noted his review of her initial treating medical records from St. Mary's. PX5. He opined that Petitioner's ACL tear would have been caused by her fall at work on April 5, 2012 when she suffered a hamstring tear. *Id.* He indicated that her right knee tear was at that time either a partial or a complete tear. *Id.* Dr. Corcoran further noted that after Petitioner's hamstring disruption she had an acute injury with a twisting injury to her right knee which most definitively could have caused injury to her ACL at that time. *Id.* Of note, Dr. Corcoran detailed

additional medical treatment that included a series of three Supartz injections through December 11, 2013, the last date that he saw her. *Id.* Ultimately, Dr. Corcoran indicated that Petitioner could return to work in a sedentary position with limited walking (recommending that she ambulate for 10 minutes every hour), ground level work only, and minimal stair climbing. *Id.*

Additional Information

Petitioner testified that she remains under Dr. Corcoran's care and that when she last saw Dr. Corcoran he restricted her to light duty. Petitioner testified that Respondent has not placed her in any light duty job. However, Petitioner also testified that she now receives 50% of her salary since June of 2012 when she retired through her SRS retirement.

Petitioner submitted her Application for Temporary Disability Benefits[3] into evidence. PX7. The application reflects her indication that she was in the library at the Dwight Correctional Center "typing, stood up to go to office, foot became entangled with chair leg protruding out and right leg hyperextended in front of me causing hamstring tears and hematoma." *Id.* Dr. Corcoran completed his disability medical report on January 21, 2014 and it indicates that Petitioner's condition was at that time right knee osteoarthritis and right knee pain. *Id.*

Petitioner testified that her case was not handled as a workers' compensation case and that she was advised to submit bills to her group health insurance, but some bills remain unpaid.

Regarding her current condition, Petitioner testified that she experiences numbness and spasms, and that she cannot kneel on her right knee. She also testified that she modifies activities such as taking the stairs. She used to climb stairs normally, but now she goes sideways to ascend or descend.

[3] The second page of this application, which appears to be from a double-sided document, was not submitted into evidence. PX7.

15IWCC0328

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:

The crux of the parties' dispute is whether she was placed at an increased risk when she fell so as to create a causal relationship between her employment and the fall causing her right leg condition. The Arbitrator finds that Petitioner was exposed to an increased risk by reason of her employment and that she sustained a compensable accident at work on April 5, 2012 as claimed.

"An employee's injury is compensable under the Act only if it arises out of and in the course of the employment." *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006). After careful consideration of the record as a whole, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent as claimed on April 5, 2012. In so concluding, the Arbitrator notes that Petitioner was located on Respondent's premises at the Dwight Correctional Center while completing a certificate for a student at one of two typewriters moments before she fell. *See Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011) (holding that the "in the course of employment" element is satisfied by "[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....")

The crux of the parties' dispute, however, is whether she was placed at an increased risk when she fell so as to create a causal relationship between her employment and the fall causing her right leg condition. 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, 541 N.E.2d 665 (1989)). Where an "employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment." *Id.* That is, a claimant must demonstrate that the risk of injury was peculiar to or increased by his work duties and the "increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1014 (*citations* omitted). 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*, 365 Ill. App. 3d at 910.

With regard to the second prong necessary to establish a compensable accident at work, the record reflects Petitioner's testimony about the occurrence at work which is specifically and repeatedly corroborated by the medical records of physicians at St. Mary's and Oak Orthopedics as well as her incident report, workers' compensation report of injury, and application for temporary disability benefits through SRS. Petitioner's testimony about the mechanism of injury and her description of the space in which she was working at the time of her injury is also un-rebutted. Petitioner was getting up from a chair in a "crowded" area of the correctional facility's library surrounded by several other round tables and chairs as well as a teacher's desk located to her

right. No evidence was offered that this library space was accessible to members of the general public, but rather the evidence establishes that it was only accessible to inmates and correctional facility staff. Based on the foregoing, the Arbitrator finds that Petitioner's risk of injury was increased as a result of her employment placing her at a greater risk than members of the general public and, thus, that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent as claimed on April 5, 2012.

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 above, the Arbitrator finds that Petitioner sustained a compensable injury as claimed. Again, the Arbitrator finds that Petitioner's testimony at trial was corroborated by documentary evidence submitted at trial and was un-rebutted and, thus, finds that it was credible. Moreover, Dr. Corcoran reasonably opined that Petitioner either partially or completely tore her ACL as a result of her fall at work and the record establishes that Petitioner had only mild degeneration in the right knee on the date of accident and, notwithstanding, no medical treatment or problems with her right leg or knee prior to April 5, 2012. In addition, no contrary medical opinion was offered to suggest that Petitioner's right leg condition was unrelated, in whole or in part, to her fall at work. Thus, the Arbitrator finds that Petitioner has established a causal connection between her current right leg condition of ill being and accident at work.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits for the period beginning April 6, 2012 through June 11, 2014. Based on the record as a whole, the Arbitrator finds that Petitioner is entitled to such benefits for a lesser period of time commencing April 6, 2012 through December 11, 2013.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

In this case, the record reflects that Petitioner was undergoing active medical treatment including two surgeries to her right leg, one to the hamstring and one to the right knee, during which time she was placed off work by her treating doctors through April 12, 2013. As of that date, Dr. Corcoran's records reflect that he was addressing an unrelated right shoulder condition only and no recommendations were made related to the right leg any longer. However, Dr. Corcoran authored a narrative report in which he detailed continued medical treatment of Petitioner's right knee which included a series of three Supartz injections through December 11, 2013, when he released her from his care. Again, no contrary medical opinion was offered.

Thus, the Arbitrator finds that Petitioner has established that her right leg condition had not stabilized through December 11, 2013 during which time she did not work and she was unable to work as opined by her treating

physician, Dr. Corcoran. Petitioner's claim for temporary total disability benefits after that date is denied.

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:

In the parties' request for hearing form, Respondent disputes its liability to pay the medical bills. As explained in detail above, the issues of accident and causal connection have been resolved in Petitioner's favor. In addition, the Arbitrator finds Dr. Corcoran's opinions, which are un-rebutted, to be persuasive and inclusive of appropriate treatment of the right leg to alleviate Petitioner of the effects of her April 5, 2012 injury at work.

Petitioner submitted the itemized bills from Provena St. Mary's Hospital which total $32,913.43, the itemized bills from Oak Orthopedics which total $20,060.00, the itemized bills from ATI Physical Therapy regarding treatment on Petitioner's right hamstring, which total $22,383.59 and the itemized bills from ATI Physical Therapy regarding treatment on Petitioner's right knee, which total $17,377.26. Thus, the Arbitrator awards the reasonable and necessary medical bills incurred by Petitioner totaling $92,734.28 for treatment of the right leg to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

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

Irene Kulas,

Petitioner,

vs. NO: 11 WC 35656

Sherman Hospital,

15IWCC0329

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 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: MAY 7 – 2015
TJT:yl
o 5/5/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

KULAS, IRENE
Employee/Petitioner

Case# **11WC035656**

SHERMAN HOSPITAL
Employer/Respondent

15IWCC0329

On 2/21/2014, 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:

2226 GOLDEN LAW OFFICES
LAUREN S GOLDEN
2400 BIG TIMBER RD SUITE 201A
ELGIN, IL 60123

0481 MACIOROWSKI SACKMANN & ULRICH LLP
ROBERT T NEWMAN
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

15IWCC0329

- [ ] 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

Irene Kulas
Employee/Petitioner

v.

Sherman Hospital
Employer/Respondent

Case # **11** WC **35656**

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 **George Andros**, Arbitrator of the Commission, in the city of **Geneva**, on **December 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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 _____

15IWCC0329

FINDINGS

On **July 3, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$11,372.40**; the average weekly wage was **$218.70**.

On the date of accident, Petitioner was **74** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

THE ARBITRATOR FINDS AS A MATTER OF FACT AND LAW THE INCIDENT DID NOT ARISE OUT OF THE EMPLOYMENT.

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

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

Signature of Arbitrator

Feb 14th, 2014
Date

FEB 21 2014

FINDINGS OF FACT 11 WC 35656

The case having been heard on December 18, 2013, the Arbitrator finds facts as follows in support of the Award under the neutral risk category of falls by case law:

The Petitioner Irene Kulas was an employee in the gift shop in Sherman Hospital as of July 3, 2011. On that date, approximately noon, the Petitioner was going to work at the Sherman Hospital gift shop. She worked at Sherman Hospital for three years. The current Hospital building was constructed in 2009. The Petitioner testified that to enter to the building to work at the gift shop, she had to go through the main lobby. The floor surface in the main lobby was what the Petitioner described as a polished marble surface. On July 3, 2011, the Petitioner said she was earning a good quality of sturdy shoes with laces that were tied. The soles of her shoes were crepe soles with grooves and ridges.

The Petitioner testified that she slipped and fell on the floor on the lobby. The Petitioner testified before the Arbitrator that it was her impression that she slipped because the floor is a polished marble.

The Petitioner testified that in her time as a gift shop employee and volunteer at the information desk, she had seen about three or four persons slip and fall in the lobby over the course of time.

The Petitioner was assisted on July 3, 2011 after she had fallen by a security guard. Thomas R. Eaton testified that he was the security guard who assisted the Petitioner. He found the Petitioner at the main entrance of the Hospital near the tree of life sculpture. Eaton testified that the Petitioner did not have any visible wounds. Eaton testified that the Petitioner said that he injured her right thigh.

Eaton testified that the Petitioner admitted that she had fallen on her own. There was no wet spot. There was no object that she had stumbled upon. Eaton testified that he looked on the floor in the area where the Petitioner had fallen. He did not find any wetness. He did not find any obstruction. He testified that Respondent's exhibit 3 and 4 are photographs of the lobby area. These photograph fairly and accurately depict the main lobby at Sherman Hospital as it was on July 3, 2011. Officer Eaton's note of July 3, 2011, said that "Ms. Kulas was walking through the main lobby when she tripped and fell. She said there was nothing wet nor did she trip on anything. She said she just stumbled. She hurt her right hand and right thigh." Eaton admitted having attended to about dozen persons who had fallen in the lobby over the course of four years. None of them had fallen contemporaneously with the Petitioner on July 3, 2011. They had fallen on different occasions for essentially various or different reasons.

Lisa Knight testified that she is a benefits analyst for Sherman Hospital. She talked with Ms. Kulas by telephone on July 12, 2011. Ms. Knight had written the content of the telephone call on a part of the report of the employee injury or illness entitled "human resources review." Ms. Knight wrote, that she "asked the employee if she slipped on anything and she said she didn't know if there was anything." Ms. Knight had initialed and dated that note as of July 12, 2011. Ms. Knight testified that the lobby floor is smooth, but she does not know if it is accurately called marble.

The Arbitrator finds that the Petitioner's accounts of the occurrence as stated to the security officer Eaton and Lisa Knight contemporaneously with the events are more inherently reliable than the Petitioner's testimony for the Arbitrator, two years and five months after the fact. The Arbitrator finds that the Petitioner stumbled as she was walking but did not slip and did not trip over any object.

The medical records shows that the Petitioner was seen at Sherman Hospital's emergency room on July 3, 2011. She did have x-rays. The x-rays initially were inconclusive.

She did have an MRI which showed bruising and a possible fracture. She did undergo percutaneous pinning of the right femoral neck for stress fracture on July 19, 2011.

As of July 22, 2011, Dr. Vento wrote that the Petitioner was doing well. PX 4. As of August 3, 2011, Dr. Stanley wrote that the Petitioner was two weeks out, from her percutaneous pinning of the femoral neck stress fracture. She had no pain whatsoever and was happy with the outcome. She was beginning weight bearing with minimal weight on her toes. She did have the ability to fully bear weight on the right extremity and she had no pain with full weight bearing. She was putting all the weight on the right leg at times if she felt unsteady with the walker. X-rays showed healing with the bones in the proper alignment and in the appropriate position. Px 5. As of August 22, 2011, Ms. Kulas was five weeks after pinning of the femoral neck fracture. At the time she had no pain. She was walking with a walker and things were coming along nicely. As of this time, she is able to put 100% of her weight on right leg without pain. She did have a mild trendelenberg sign suggesting abductor weakness. Px.5.

The x-rays show the fracture appeared to be completely healed. Dr. Stanley was unable to visualize the fracture line anymore. At that time she was allowed to bear full weight as tolerated in the physical therapy since she would not have to use a walker or cane any longer.

The last visit with Dr. Stanley was in January of 2012. Dr. Stanley reports at the last visit in January 2012 she did have bursitis after the femoral neck pinning procedure. He told her that if she was having persistent bursitis, he could take the pins out, a year after the procedure. He reported as of February 15, 2013 that he had not seen the Petitioner since January 2012. He opined she was likely at maximum medical improvement and would not need any further treatment. Rx. 5.

CONCLUSIONS OF LAW

ON THE ISSUE "C" WHETHER THE PETITIONER HAD AN ACCIDENTAL INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT OF THE ARBITRATOR FINDS:

The Petitioner did establish that her accident was in the course of employment but did not establish that her accident arose out of the employment. The Petitioner did not establish that there was a hazard associated with the employment that caused or contributed to the injury. In the accounts given to the security officer Eaton and Ms. Knight in July of 2011, the Petitioner told the officer that she stumbled. She told Eaton that there was nothing wet nor did she trip on anything. Ms. Knight asked the Petitioner if she slipped on anything and Petitioner said she did not know if there was anything. A highly polished floor in the area transverse by workers and the general public at large should not be a risk peculiar to employment, notwithstanding both workers and the public need to enter the hospital through that lobby.

The Arbitrator relies on the precedent case of Cathy Baldwin v. Illinois Workers' Compensation Commission, 409 Ill.App.3d472, 494 N.E.2d 1151, 351 Ill.Dec. 56 and First Cash Financial Services v. Industrial Commission, 367 Ill.App. 3d 102 853 N.E.2d 799, 304 Ill.Dec. 722 and Lourdes Oliver v. Posen-Robbins School District No. 143.5, 13 IWCC 297. In the Baldwin case, the Appellate Court stated that in order to determine whether a claimant's injury arose out of her employment, the court must first categorize the risk to what she was exposed. Risks to employees fall in the three groups

(1) Risks distinctly associated with the employment;
(2) Risks personal to the employee such as idiopathic falls;
(3) Neutral risks that have no particular employment or personal characteristics

In the Baldwin case, the Petitioner was in good health and had no condition that affected her balance or made her dizzy and had no problems walking or using the stairs. In the course of her work, she slipped and fell while she was descending a staircase. The claimant Baldwin testified she did not know what caused her to slip.

The claimant Baldwin's testimony eliminated any notion that the fall was idiopathic. As to whether the fall stemmed from a risk associated with employment, the claimant Baldwin theorized that moisture might have built up on her shoes walking through a freezer but her testimony was pure speculation. The claimant Baldwin did not show more than a mere possibility that moisture which might have built up on her shoes when walking through a freezer and caused her to slip and fall on the stairs. In sum, the claimant Baldwin did not know what caused her to fall on October 8, 2006.

For Ms. Baldwin's injury caused by unexplained fall to arise out of the employment the claimant must have presented evidence which supports a reasonable inference that the fall stemmed from a hazard related to the employment. However, an injury resulting from a neutral risk to which the general public is equally exposed does not arise out of the employment. By itself, the act of walking up or down a staircase does not expose the employee to risk greater than that faced by the general public. Because claimant Baldwin did not present any evidence of a cause of her fall on October 8, 2006 or that she was exposed to risk greater than that faced by the general public, she failed to prove her injury on that date arose out of her employment. The Commission's decision denying her any benefits was not against the manifest weight of the evidence and was sustained.

This case at bar for is inapposite to the recent case, Village of Villa Park v. Illinois Workers' Compensation Commission, William G. Ceas and Company v. The Industrial Commission, 261 Ill. App. 3d 630, 633NE2d 994, 199 Ill.Dec 198., (At bar, Kulas did not testify to having to rush as part on any duty of employment on the day of her occurrence.), Chicago Tribune Company v. Industrial Commission 136 Ill. App. 3d 260, 483NE2d 327, 91 Ill. Dec. 45 (1985). (no inference of rain, quite bizarre inference I might add).

The Petitioner Kulas' contemporaneous comments to Eaton and to Ms. Knight were that she stumbled and that she did not slip on anything. The Petitioner Kulas did not tell Ms. Knight or Mr. Eaton at the time she slipped because the floor was polished. The evidence reflects that there had been other persons who fell in the hospital lobby. The Petitioner said there were three or four that she had observed. She also said she worked at that Hospital for 3 years. Security officer Eaton said that he had been called for about a dozen such occurrences over four years but each had a different reason and none of the other falls occurred contemporaneously with Petitioner. By reasonable inference, as allowed in such cases to wit in the Chicago Tribune case (it must have been raining a d wet), a hospital exists for the purpose of caring for the people who are in all liklihood ill or even infirm. The fact that some persons have fallen in a hospital lobby could reflect a number of reasons given the population who go to the Hospital, not any hazard of the Hospital lobby. On Respondent Exhibit 3 and 4 one can see that the floor is very clean, and shiny but also that persons depicted incidentally were walking and standing, without any apparent difficulty.

In summation, the Arbitrator finds this unfortunate occurrence of Ms. Kulas, a forthright dedicated person, was in a neutral risk area as it was in an area open to the general public, and the general public experiences similar places. The Petitioner has not shown that that she was exposed to a hazard by reason of her employment that was different in character or degree than that to which the general public is exposed. The Arbitrator acknowledges slip and fall cases are subject to various inferences of the facts and application of the law regarding the case defined different types of risks.

For these reasons, the claims for compensation and medical benefits must be 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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARISOL BARRANCO,

Petitioner,

vs. NO: 10 WC 49666

HERITAGE MANOR,

Respondent,

15IWCC0330

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 expenses, and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident and denies benefits related to this claim but attaches the Decision for the purpose of the statement of facts, which is attached hereto and made a part hereof, with the modifications noted below.

The Commission finds that Petitioner has failed to meet her burden of proof that she sustained accidental injuries arising out of and in the course of her employment with Respondent on November 4, 2010. Petitioner testified that she never had pain in her back before November 4, 2010. T.89. She testified that on that date she was bent over cleaning a toilet when she felt "like something popped" in her back. She testified that she wasn't feeling any pain at that moment so she finished her shift and went home. Later at home, she felt a strong pain in her back that started going down her right leg to her toes. Petitioner was scheduled off work on November 5, 6, and 7. She eventually went to the emergency room on November 7th. Petitioner testified that no interpreter was present but her boyfriend told the provider about her pain and what happened. T.84-85.

Petitioner's argument in support of finding accident focuses on the possibility that there *could have been* language barriers that prevented the providers from recording an accurate history. However, we note that Petitioner never testified that the various histories were inaccurate. Although it is true that the triage section of the first emergency room record indicates that the history was provided by "family, patient," another section of the record, "Chief Complaint," *actually does indicate that an interpreter was present*. This undercuts Petitioner's argument about a language barrier because both of these sections indicate similar histories. The triage section

indicates an onset of "10/24/10" and "low back pain for approx. 2 weeks, radiates to R buttock, no known injury." The Chief Complaint section indicates:

> c/o Rt lower back pain radiating Rt buttock and leg **x 2 weeks.** Pain incr. w/ ROM; **states pain improved and then came back when working. Job is house cleaning;** denies known injury, paresthesias
> **Back Injury = "N"**
> **"No apparent mechanism"**
> **Time course = 14 days; "Intermittent"**

Although Petitioner testified that she had a specific incident at work on November 4th, the first treatment record indicates that she denied a specific injury and there was no apparent mechanism of injury. It also shows that Petitioner had been having this pain for two weeks, which would correspond with the date of onset being around October 24, 2010; not November 4th. Furthermore, although this record indicates that Petitioner's pain had improved and then "came back when working," it doesn't specifically state that Petitioner was working for Respondent at the time and doesn't support Petitioner's allegation that it occurred specifically while cleaning a toilet at Respondent.

This is significant because, although Petitioner denied that she ever cleaned houses as a side job (T.121, 128), two of Respondent's witnesses (Magda Munoz and Mario Gonzalez) testified that she told them that she was not willing to pick up extra shifts at Respondent because she cleaned houses. T.139, 149, 164, 165. We find that it is at least as likely that Petitioner was performing some other activity on her days off when she sustained her injury.

On November 9, 2010, Petitioner returned to the emergency room. This record indicates that an interpreter was present and a history of:

> c/o Rt LBP radiating to Rt buttock **x 3 days after cleaning houses**. Seen here 11/7 for same – out of Vicodin; needs note to be off work; states pain has not worsened but has not gone away

Again, there is no mention that it happened at Respondent on November 4th while cleaning a toilet. To the contrary, it indicates that Petitioner was "cleaning houses," which could be referring to a side job. It also explicitly states she was having pain for three days. This would put her date of injury as November 6th or possibly the 7th but these are both dates that Petitioner was not working at Respondent.

Further casting doubt on Petitioner's alleged work accident, she went to Greater Elgin Family Care on November 13, 2010, and gave a history of:

> "Lower back pain **x 3 wks**, radiates down to Rt leg with numbness"
> "Pt works in housekeeping, denies specific trauma"

Although this record indicates that Petitioner works in housekeeping, there was no mention of a specific incident and the duration of Petitioner's complaints was three weeks, which predates Petitioner's alleged date of accident.

None of the initial medical records support Petitioner's claim that she was injured on November 4, 2010 at her job with Respondent while cleaning a toilet. We also note that Petitioner admitted that, despite three separate medical visits, and submitting off work notes to Respondent,

she never informed anyone at Respondent that she had a work injury on November 4th until November 15th. T.125. Mario Gonzalez, Respondent's Maintenance Supervisor, testified that he spoke in Spanish with Petitioner and they had no trouble understanding each other. T.157. He saw Petitioner during her shift on November 4th and before she went home. He did not notice her in any discomfort or having difficulty and she did not report a work accident. T.158. He testified that on November 15th Petitioner came in and asked to work in the business office (light duty) and it was after he told her that there was no work for her in the business office that she told him she had gotten hurt at work on November 4th. Id.

Petitioner's testimony about whether she asked for light duty is also contradictory. On cross-examination, Petitioner testified that she went and spoke to Mario and asked him for a lighter job. T.124. However, on rebuttal cross-examination, Petitioner testified that she did not ask him if there was a lighter job that she could do other than housekeeping. T.229. We find that the evidence shows that Petitioner did not report a work injury until after she was denied light duty, which casts doubt on the veracity of her claim.

We find that all of the histories recorded in Petitioner's medical records after she reported her accident on November 15th to be suspect, including the one given to Dr. Vlahos on November 18th. Petitioner's chiropractor, Dr. Fladland, to whom she was referred by her attorney, testified that Petitioner's lumbar condition is causally related to her accident on November 4th. T.21. On cross-examination, he testified that he would expect Petitioner to have immediate significant pain but he didn't think it was contradictory that she waited until November 7th to seek treatment. T.36. He agreed that there is "some confusion" regarding Petitioner's conflicting histories in the initial medical records. T.34. He admitted that his causation opinion is based on *speculation* that there was a misunderstanding based on her language in the ER and that if the initial histories were, in fact, accurate then that would change his opinion. T.48-50.

Respondent's Section 12 physician, Dr. Wehner, testified that Petitioner's condition was not causally related based on the initial treating records, which are inconsistent with Petitioner's claim of accident on November 4th.

We find the opinion of Dr. Wehner to be more persuasive than that of Dr. Fladland, which is speculative and not consistent with Petitioner's testimony. She never testified that she had been having some back pain previously but that it became significantly worse after the alleged incident on November 4th. Rather, Petitioner specifically testified that she had no back pain at all prior to that date. This is clearly contradicted by the multiple medical records that reference back pain that pre-dated her alleged accident. Furthermore, Petitioner never testified that these histories were inaccurate. Rather, Petitioner relies on the *possibility* that there were language barriers but the records do not support this allegation.

Based on the medical records, Petitioner's testimony, the timing of her seeking medical treatment, the evidence regarding Petitioner cleaning houses on the side, and our finding that Petitioner did not report a work accident until after she was denied light duty on November 15, 2010, we find it to be more likely than not that Petitioner sustained her back injury outside of her work for Respondent and, in any case, she has failed to prove that she sustained an injury on November 4th while cleaning a toilet at Respondent. Therefore, we reverse the Arbitrator's decision on the issue of accident and deny benefits in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator with respect to accident is reversed and all awards for benefits are vacated.

15IWCC0330

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

DATED: MAY 7 - 2015

Ruth W. White

Joshua D. Luskin

SE/
O: 3/17/15
49

DISSENTING OPINION

I respectfully dissent and would affirm the Arbitrator's decision in this case.

Charles J. DeVriendt

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

BARRANCO, MARISOL
Employee/Petitioner

Case# **10WC049666**

HERITAGE MANOR
Employer/Respondent

15IWCC0330

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:

1293 VITELL & SPITZ LTD
EDWARD SPITZ
155 N MICHIGAN AVE SUITE 600
CHICAGO, IL 60601

2912 HANSON & DONAHUE LLC
PETER DONAHUE
900 WARREN AVE SUITE 3
DOWNERS GROVE, IL 60515

STATE OF ILLINOIS)
)
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
19(b) ARBITRATION DECISION

Marisol Barranco
Employee / Petitioner

v.

Heritage Manor
Employer / Respondent

Case # **10 WC 49666**

15IWCC0330

An *Application for Adjustment 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 **November 13, 2013**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues circled below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was the respondent operating under and subject to the Illinois Worker's Compensation or 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 the petitioner reasonable and necessary?

K. ☒ What amount of compensation is due for Temporary Total Disability?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☐ Other _____

FINDINGS 15IWCC0330

- On **11/04/2010** , the respondent **Heritage Manor** was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship did exist between the petitioner and respondent.
- On this date, the petitioner did sustain 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 $ **16,750.24** ; the average weekly wage was $ **322.12** .
- At the time of the injury the petitioner was, **39** years of age, single with **3** children under 18.
- Necessary medical services have not been provided by the respondent.
- To date, $ **0.00** has been paid by the respondent on account of this injury.

ORDER

- Respondent shall pay Petitioner Temporary Total Disability benefits of $ **319.00** /week for **131-3/7** weeks, from **November 4, 2010** through **May 11, 2013** , as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of Petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

- Respondent shall pay $ **55,351.51** for medical services, as provided in Section 8(a) of the Act. Said medical expenses shall be paid pursuant to the fee schedule.

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

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

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

Signature of arbitrator — Date 2/7/14

ICArbDec19(b) 06/08 p.2

FEB 10 2014

STATEMENT OF FACTS:

On November 4, 2010, Marisol Barranco, hereinafter "Petitioner", was employed by Heritage Manor, hereinafter "Respondent". Petitioner testified with the aid of an interpreter, that she had been employed by Respondent for approximately 2 years and 2 months. Petitioner was in housekeeping which entailed cleaning 25 rooms and the bathrooms in the rooms. Petitioner testified that on November 4, 2010 at around 2:00 PM, she was cleaning a toilet in one of the bathrooms and was bent over when doing so. Petitioner provided that while cleaning a toilet, she felt a pop in her lower back. She finished working that day and went home thinking it would pass. Later that evening the pain got worse. She was scheduled to be off work the next three days. Petitioner stated that on November 5, 2010, the pain got worse and was radiating down to her right leg. She self medicated with Tylenol. On November 6, 2010, the pain was worse and still radiating down her right leg. Again, she self medicated with Tylenol.

Petitioner testified that on November 7, 2010, the pain was so bad that she went to the emergency room at Provena Saint Joseph Hospital in Geneva, Illinois. (Pet. Ex. #1) Records show Petitioner complained of right lower back pain radiating into the right buttocks for two weeks. Also noted was "pain improved then came back when working. Job in housekeeping. Denies known injury." Also noted was no apparent mechanism. (PX 1, p94) The Triage Assessment records reflect that when Petitioner was asked when was the onset of the chief complaint , she indicated that it was on October 24, 2010. These records also reflect that a translator was not present and there was no communication barrier. (PX 1, p92) Petitioner testified and the records show she was accompanied by a friend. Petitioner stated that her friend provided all information to the medical professionals. Petitioner was diagnosed with right sciatica, prescribed medication and restricted to no bending, lifting or twisting. (PX 1, p96) Petitioner testified that her boyfriend took the off work slip to her employer the same day.

Petitioner went back to the same emergency room on November 9, 2010. The records reflect that an interpreter was present during triage and that there was a communication barrier. The records reflect "interpreter used for triage history. Patient states she continues to have pain to her right lower back with radiation of pain down her right leg, also with numbness and tingling. Was seen at PSJH on 11/7/100 but states pain is not getting better..." (PX 1, p72) In another portion of the records it was noted Petitioner "complained of lower back pain radiating to right buttocks X 3 days after cleaning houses. Seen here 11/7 for same...states pain has not worsened but has not gone away." The mechanism of injury was bending. (PX 1, p73)Petitioner was again diagnosed with right sciatica, prescribed medication and restricted to no bending, lifting or twisting. (PX 1, p75)

On November 13, 2010, Petitioner presented to the Greater Elgin Family Care Center with complaints of right low back pain with radiation of pain down the right leg with numbness. She had this problem for 3 weeks. Petitioner was diagnosed with lumbosacral radiculopathy and provided with restrictions of no repetitive bending or stooping for 2 weeks. (PX 2) Petitioner testified that she took this return to work slip with restrictions to her supervisor, Mario Gonzales, on the same day.

Petitioner testified that on November 15, 2010, she received a call from her supervisor, Mario. At that time she informed Mario that she was cleaning toilets when she felt something pop in her back. On November 15, 2010, Mario Gonzalez prepared a form titled "Supervisor's Report of Work Injury Or Illness." Mr. Gonzalez wrote that on November 15, 2010 Petitioner "reported she was cleaning a toilet on November 4th 2010 around 1:00 pm

and felt something crack in her back. She continued to work until her shift was completed at 3:00 pm." (RX 3) On November 17, 2010, Petitioner signed an "Employee's Report of Incident" form indicating she injured herself on November 4, 2010 while bending and cleaning a toilet. (RX 4)

Petitioner testified that Respondent told her to go to the Occupational Health Services, herein after "Occupational Health", at Provena Saint Joseph Hospital. On November 18, 2010, Petitioner presented to the Occupational Health where she saw Dr. Maria Vlahos. Records show Petitioner informed the doctor that on November 4, 2010 while at work and frequently bending to clean toilets she heard a pop in the low back. After an examination, Petitioner was assessed with acute lumbar strain with right leg radiculopathy, related to work incident on November 4, 2010. Petitioner prescribed medication, physical therapy and given work restrictions of no lifting over 5 ponds, no bending or stooping and no activities involving body bouncing, jerking or twisting. (PX 1, p16-17) Petitioner provided that Respondent did not accommodate her restrictions.

Petitioner attended physical therapy and continued to treat at Occupational Health. On December 6, 2010 a MRI was prescribed. On December 20, 2010, Dr. Vlahos noted that despite therapy, Petitioner's symptoms were not improving. The doctor also noted the MRI was not authorized by Respondent. Dr. Vlahos advised a consultation with an orthopedic physician for further evaluation and treatment. The doctor continued Petitioner's work restrictions and discharged her from Occupational Health. The diagnosis that day was subacute lumbar strain with right leg radiculopathy. (PX 1, p4)

On December 22, 2010, Dr. Vlahos authored a note indicating:

> "Ms. Marisol Barranco, (DOB 09/27/71), was treated at St. Joseph's Hospital Occupational Health Clinic for work related low back and right leg symptoms. The work incident at Heritage Manor reportedly occurred on 11/04/10. Her dates of treatment here were: 11/18/10, 11/26/10, 12/6/10, 12/13/10, and 12/20/10. She also attended six sessions of physical therapy during this time. She was advised to work with restrictions while under my care. She was discharged from Occupational Health on 12/20/10, and advised to follow up with an Orthopedic Specialist for her continued symptoms…"

Petitioner testified that she then sought the services of an attorney who referred her to Dr. Scott Fladland, a chiropractor. Dr. Fladland testified that he first met Petitioner on December 27, 2010. Petitioner told Dr. Fladland that she was cleaning a toilet at work and was bent over and twisting and she felt and heard a pop in right lower back. Dr. Fladland obtained an MRI for Petitioner the same day, December 27, 2010. The MRI was read to show 1.) moderate right paracentral disc extrusion at L4-L5 with 7mm of inferior migration of discal materialindicated; 2.) moderate advanced degenerative disc disease at L4-L5 and L5-S1; mild to moderate degenerative disc disease at L3-L4; 3.) high intensity zone involving the posterior annular fibers of the L3-L4 intervertebral disc; 4.) mild facet arthrosis at L4-L5 and L5-S1; and 5.) mild to moderate central canal and lateral recess stenosis, due to the combination of degenerative changes described above, with severe stenosis of the right L4-L5 lateral recess. (PX 4, p56) Dr. Fladland referred Petitioner to Dr. Kern Singh, an orthopaedic spine surgeon, and to Dr. Renlin Xia, a pain management doctor. (PX 4, p181)

Petitioner presented to Dr. Singh on January 3, 2011with complaints of right low back pain with radiation of pain down the right leg pain. Petitioner informed the doctor that she was cleaning around a toilet when she experienced increasing pain in her back. Dr. Singh reviewed the December 27th MRI indicating same revealed a large, right sided L5-L5 disc herniation with significant spinal stenosis. After an examination, Petitioner was diagnosed with L4-L5 herniated nucleus pulpous, right sided which the doctor felt was directly related to her work injury. Dr. Singh recommended a series of epidural injections. An off work note was also provided. (PX 4)

Petitioner presented to Dr. Xia who administered a series of 3 epidural shots/nerve bocks with the first one January 13, 2011 followed by 2 more on January 20, 2011 and January 27, 2011. (PX 5) Petitioner was then referred to ATI for physical therapy by Dr. Fladland and started on February 4, 2011 through March 25, 2011. (PX 6)

Petitioner returned to Dr. Singh on April 4, 2011. The doctor noted that the epidural injections provided only transient relief. Dr. Singh recommended surgery in the form of a right sided L4-L5 microscopic discectomy. (PX 4) Petitioner testified that as of the day of trial Respondent has not authorized the surgery.

Petitioner testified that she was terminated from her employment with Respondent on January 27, 2011. Petitioner testified that she applied for unemployment benefits and was approved beginning February 27, 2011 and received these benefits through September of 2012. She also testified that she looked for work during this time period and was finally able to find work at a McDonalds on May 11, 2013. She was still working there on the day of trial. Petitioner testified that prior to this injury she never had any treatment to her back and that she still wants to have the surgery prescribed by Dr. Singh. She also provided that she does not clean houses for other people.

Petitioner testified that none of the medical bills introduced into evidence by Petitioner have been paid by Respondent. (PX 5-17)

Respondent called 3 witnesses on its behalf. The first witness was Magda Nunez. She testified that she spoke Spanish and was employed by Respondent for the last 2years. She also testified that Petitioner did not understand English. She testified that Petitioner gave notice of the accident on November 15, 2010 and that the accident occurred on November 4, 2010. Furthermore, she testified that she heard a comment that Petitioner cleaned houses. Ms. Munoz testified that she did not have knowledge of her own whether Petitioner cleansed houses.

Respondent's 2nd witness was Mario Gonzales. He is the maintenance supervisor for Respondent and in charge of housekeeping, which includes cleaning the rooms. He testified that Petitioner had a duty to report her accident immediately after it happened. During cross examination he admitted that rule is not always followed as the injured party may think the injury is minor and not report it right away. He admitted that he has even done that. He also testified that he didn't learn of a claimed accident until he spoke with Petitioner on November 15, 2010. He testified that he heard that Petitioner was doing housecleaning and that is why she turned down overtime work. He heard that from another worker for Respondent but had no independent knowledge of his own. Furthermore, he testified that when Petitioner advised him of the accident and her work restrictions, Petitioner demanded an office job which requires the person to speak and understand English which was established by Respondent's 3rd witness.

Respondent's 3rd witness was Linda Hartmann. She testified that Petitioner could not communicate in English. Ms. Hartmann stated that she filled out "Employee's Report of Incident" on behalf of Petitioner and that she filled out the "Form 45".

Dr. Julie M. Wehner testified on behalf Respondent by deposition on January 11, 2013. Dr. Wehner testified that Petitioner suffers from a large herniated disc, which may need surgery. Dr. Wehner stated that Petitioner's condition was not causally related to the alleged injury. The doctor relied on the initial medical histories of injury prior to November 4, 2010 and Petitioner's denial of a specific trauma. Dr. Wehner testified that a herniated disc is an acute type of problem. It would happen over the course of a day but not over a long period of time. (RX 1, p24,25) Dr.Wehner also testified that the activities performed by Petitioner could cause the

injury she suffered. (Rx 1, p41,42) Dr. Wehner also testified that the activities at work could cause back pain. (RX 1, p32)

In regards 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:

On November 4, 2010, Petitioner had been employed for approximately 2 ½ years in housekeeping. Petitioner duties included cleaning 25 rooms and the bathrooms in the rooms. The activities involved in cleaning the bathrooms and the toilets therein. Petitioner testimony show that on November 4, 2012, she was bent over cleaning a toiled when she felt a "pop" in her lower back and had pain. She finished working that day and went home. The pain got worse over the next couple of days to the point she went to the emergency room at Provena Saint Joseph Hospital (The records reflect that there was no translator available at that time). The records indicate that the "Onset of chief complaint" was on October 24, 2010. The records also reflect that Petitioner had an "Accidental Injury." The records also reflect that she had pain radiating down her buttock but no mention of numbness. Petitioner returned to the same emergency room 2 days later on November 9, 2010. At this time an interpreter was used during triage and Petitioner's complains now included "pain in her right lower back with radiation of pain down her right leg: also with numbness and tingling" Petitioner by her own admission states that she had lower back pain prior to November 4, 2010 but the pain after November 4, 2010 forced her to seek medical care. On November 13, 2010, Petitioner went to Greater Elgin family Care Center for more medical treatment. Petitioner told them that she has lower back pain for 3 weeks, no know trauma and it radiated down her right leg with numbness.

Petitioner is Spanish speaking and testified through an interpreter. Her coworkers testified that she did not understand English. When she stated she had no trauma she misunderstood. Even Dr. Wehner, Respondent's Sec. 12 examining doctor, on page 33 and 34, admitted that the word trauma can interpreted differently by medical people versus laypeople. (RX 1) Dr. Wehner testified that a herniated disc is an acute type of problem. It would happen over the course of a day but not over a long period of time. (RX 1, p24,25) Dr.Wehner also testified that the activities performed by Petitioner could cause the injury she suffered. (Rx 1, p41,42) Dr. Wehner also testified that the activities at work could cause back pain. (RX 1, p32)

In the case at hand, Petitioner testified that she felt a "pop" in her right lower back on November 4, 2010 and that the pain continued to worsen to the point that she had to go to the emergency room for medical treatment on November 7, 2010, 3 days later. Dr. Wehner testified that a herniated disc is an acute type of problem. It would happen over the course of a day but not over a long period of time. This confirms her position that she may have had back pain prior to November 4, 2010 but the acute event occurred on November 4, 2010.

Here, Petitioner had back pain prior to November 4, 2010 and continued to work thereafter. On November 4, 2010, the acute injury she suffered, as described by Dr. Wehner, prevented her from doing her job. It became plainly apparent to her then. Her language issues may have led to some confusion, but there was no evidence introduced that refuted her testimony regarding the events of November 4, 2010.

Therefore, based on the foregoing, the Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent on November 4, 2010.

In regards to issue "F", Is the petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds as follows:

In light of the fact that the Arbitrator has found that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent on November 4, 2010, this finding obviates the opinion of Dr. Wehner. Dr. Wehner based her opinion that Petitioner's condition of ill-being is not causally related to her injury primarily on the histories given to the medical providers by Petitioner. Dr. Wehner, in her deposition, readily admitted that bending over and cleaning a toilet can cause a herniated disc. (See Res. Ex. #1, Pages 41,42) Dr. Scott Fladland and Dr. Singh provided opinions that Petitioner current condition of ill-being was casually related to her injury of November 4, 2010. Also, Dr. Maria Vlahos of St. Joseph Occupational Health stated Petitioner was treated for work related low back and right leg symptoms.

Therefore, based on the foregoing, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to her injury of November 4. 2010.

In regards to issue "J", Were the medical services that were provided to the petitioner reasonable and necessary, the Arbitrator finds as follows:

Dr. Wehner, Respondent's Sec. 12 examining doctor, testified that with the exception of Dr. Fladland's treatment, the other treatment was reasonable and necessary. In regards to Dr. Fladland's treatment, he testified that he coordinated all the treatment of the other doctor's and the treatment he rendered was different than that which was rendered in physical therapy.

Petitioner's initial treatment, with the exception of the emergency room visits at Provena Saint Joseph Hospital, was at Greater Elgin Family Care Center. This was her first choice of doctors. Petitioner's 2nd choice was Dr. Fladland and he referred Petitioner to all other treating doctors. Therefore, Petitioner did not violate the two doctor choice rule.

Petitioner testified that her recommended surgery was never authorized. Dr. Wehner testified, that if a current MRI was similar to the prior MRI, Petitioner would still be a candidate for surgery.

Petitioner submitted the following medical bills:

RX Pain Management (Renlin Xia(Shaw) MD)	$8,085.00
Fullerton Kimball Medical & Surgical Center	$27,160.00
ATI Physical Therapy	$8,780.00
Provena Saint Joseph Hospital	$680.00
Provena Saint Joseph Hospital	$366.00
MEA-SJMC – Dr. Shenfeld	$768.00
PSJH-Elgin Occupational Health Services	$2,524.77
Scott R. Fladland D.C	$1,515.00
Advanced Medical Imaging Center	$1,587.00
Fullerton – Kimball Medical Group	$2,945.00
Midwest Orthopaedics At Rush, LLC	$345.90
Midwest Orthopaedics At Rush, LLC	$109.20
Rush University Medical Center	$389.64
University Pathologist	$87.00

Based on the foregoing, the Arbitrator finds that all medical services rendered to Petitioner were reasonable and necessary. The Arbitrator orders Respondent to pay the aforementioned listed medical bills pursuant to the fee schedule. Furthermore, the Arbitrator orders Respondent to authorize and pay for prospective medical care that is necessary and reasonable to cure Petitioner's condition of ill-being.

In regards to issue "K", What amount of compensation is due for Temporary Total Disability, the Arbitrator finds as follows:

Petitioner was returned to work with restrictions after her visits to the emergency room but Respondent refused to accommodate her. Respondent never accommodated Petitioner. On January 27, 2011, Respondent terminated Petitioner as an employee at their facility. Petitioner testified that thereafter she applied for and received unemployment benefits from the State of Illinois. Petitioner looked for work while receiving these benefits as required. Petitioner was unable to find work while receiving unemployment benefits. Petitioner testified that she continued to look for work and that on May 11, 2013 she found a new job at a McDonalds in Geneva, Illinois within her restrictions. Petitioner testified that at the time of trial, she was still employed at that McDonalds.

Respondent did not refute any of this testimony. In fact, Respondent's Sec.12 examiner, recommended light duty for Petitioner, which Respondent never accommodated. (RX 1, p13,14)

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to Temporary Total Disability benefits from November 4, 2010 though May11, 2013 a period of 131-3/7 weeks.

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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EMILY WILLIS,

Petitioner,

15IWCC0331

vs.

NO: 11 WC 30593

STATE OF ILLINOIS – SHERIDAN CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner worked as a correctional officer at Respondent's facility. On June 12, 2011, she was being transported from her scheduled break in a Department of Corrections van from the front gate of the facility to her assigned work location. She was injured when the van took a fast turn and she struck her left knee on the console of the van. The Arbitrator found that Petitioner proved accident even though she had not yet returned from her break based on the personal comfort doctrine. *See, Eagle Discount Supermarket v. Industrial Commission,* 82 Ill. 2d 331 (1980). The Arbitrator awarded her $387.00 in medical expenses subject to the medical fee schedule. The Commission agrees with the legal conclusion of the Arbitrator and affirms and adopts those portions of the Decision of the Arbitrator.

The Arbitrator also awarded Petitioner 1.075 weeks of Permanent partial disability benefits representing permanent loss of .5% of the use of the left leg. The Commission notes that Petitioner suffered a contusion. She was restricted to working with a minimum of walking and standing. The medical records show her condition resolved within eight days and she was released to full duty.

Petitioner testified she had a "little bit" of pain in her knee at the time of hearing because she had a long drive and "kind of cramped up in the car." Her knee was not currently swollen. She takes Tylenol two or three times a month. She saw her general practitioner after she was released to full duty and he said the only thing he could recommend was physical therapy, but she was not going to pay for it out of her pocket. She has not asked that any physical therapy be covered under workers' compensation.

The Commission concludes that Petitioner has not sustained her burden of proving she suffered any permanent disability from her work-related injury. Therefore, the Commission vacates the Arbitrator's permanent partial disability award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $387.00 for medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule pursuant to §8.2 of the Act.

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

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

DATED: MAY 7 - 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-4/21/15
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIS, EMILY
Employee/Petitioner

Case# **11WC030593**

SHERIDAN CORRECTIONAL CENTER
Employer/Respondent

15IWCC0331

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:

0190 LAW OFFICES OF PETER F FERRACUTI PC
JENNIFER L KIESEWETTER
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OTTAWA, IL 61350

5048 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
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0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

SEP 17 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

15IWCC0331

☐ 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

Emily Willis
Employee/Petitioner

v.

Sheridan Correctional Center
Employer/Respondent

Case # **11** WC **30593**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **8/27/2014**. 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

On **6/12/2011**, 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 **$44,050.24**; the average weekly wage was **$847.12**.

On the date of accident, Petitioner was **25** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$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 $387.00, subject to the fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $508.27/week for 1.075 weeks, because the injuries sustained caused the 0.5% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

9/9/14
Date

SEP 17 2014

15IWCC0331

FINDINGS OF FACT

Petitioner testified that on June 12, 2011 she was a correctional officer at Sheridan Correctional Center. This would require her to monitor the buildings and the position did allow for one 30 minute break per shift. Ms. Willis testified that the officers would take a break either in the dietary area for food or if they were smokers they may take their break outside at the main gate because smoking was not allowed inside the gates. She further testified that it was common for an officer to pick up smokers in a corrections van on the way back to the buildings from the main gate after their break. She testified that the officers were allowed to ride in the van. The van was also used for rides to different places with the inmates or also to pick up and drop off paperwork.

On June 12, 2011, Petitioner had taken her allowed break outside at the main gate. She stated that on the way back to the building she was picked up by Officer Zulfic who was driving the 106 van back to the building. He was driving fast and when he turned it threw her and she hit her left knee on the center console of the van. They were inside the gates at the time this occurred. She testified that she had immediate swelling and reported to Lieutenant Allen who sent her to the medical department.

An Initial Workers' Compensation Medical Report dated June 12, 2011 was created by the Sheridan Correctional Center nurse. She noted a history that Petitioner bumped her left knee on the center council in #106 van and hit her thigh on the radio. She noted left knee mild swelling and bruising. She also noted that Petitioner complained of tenderness with palpation, no redness, swelling or bruising into the left thigh. Mild limping was noted. She was issued an ice pack and referred to her personal doctor as needed. (PX 3)

On June 13, 2011, Petitioner reported to St. Margaret's Hospital Occupational Health Clinic. She had complaints of pain in her left knee. The doctor noted a history that she was a passenger in a vehicle driven by another correctional officer and that he turned a corner fast and he was thrown around in the vehicle and struck her left thigh and knee on the console of the vehicle. He further noted pain on walking and straightening the leg. He diagnosed left knee pain, probably a contusion and recommended Tramadol and work restrictions. (PX 2, p.11)

Petitioner testified that she received service connected sick leave for the days she missed but then she received a workers' compensation packet that her case was denied and her paycheck was docked for the sick leave. She missed a couple of days with this sick leave, then came back to work light duty, then missed work again due to irritation and pain prior to her release to full duty work.

Petitioner returned to St. Margaret's Occupational Health on June 20, 2011. The doctor noted that her pain had subsided about three days ago and that she had some swelling in the knee the night prior but it had subsided as well. He recommended that she return to work without restrictions. On physical examination, he did note a minimal area of tenderness at the lateral aspect of the knee just below the joint. (PX 2, p.6)

Petitioner testified that at the time she injured her knee she was pregnant and did not seek any further diagnostic studies or treatment. She stated that currently if she does a lot of walking the knee will still act up and that she will take Tylenol for it occasionally, maybe 2 to 3 times per month.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met her burden of proof. This finding is supported by the Petitioner's unrebutted testimony as to the events of June 12, 2011 wherein she struck her knee against the center console of the corrections van while returning from a break. She was further

15IWCC0331

unrebutted that this was an allowed and accepted policy for officers to pick up other officers in the corrections van from the main gate at the completion of their break to return to the work buildings. The Petitioner was participating in and returning from a scheduled and allowed personal break at the time of her injury and her injury arose out of and in the course of her employment under the personal comfort doctrine. The leading authority on this doctrine is still Eagle Discount Supermarket v. Industrial Commission, 82 Ill.2d 331 (1980) which clarified that when the person is participating in an activity for personal comfort, such as an allowed break, it is not significant to the determination of accident whether or not the injury is caused by a hazard of the employment. The doctrine allows for recovery for certain acts related to the personal comfort of the employee. Further, the Court in Eagle found it significant when such personal comfort acts occur on the premises of the employer and when the injury occurs during acts which were acquiesced to by the employer or the employer had knowledge that the actions were common.

In this particular case, the Petitioner was returning from, but still partaking in, her scheduled and allowed break. She was on the premises of the employer, inside the gates of the correctional center. She was further inside a correctional van which she testified was commonly used by officers to retrieve other officers from the main gates at the end of their break time. She further testified that she was allowed to ride in the van to return to the buildings. There was no evidence presented at hearing to counter her testimony that this was a common practice and that the employer had knowledge that this was a common practice. This is further supported by her own admissions to the medical department on that date immediately following the incident that she was in the van returning from the break when she hit her knee.

Based on the above, the Arbitrator finds that the Petitioner had an accident on June 12, 2011 that arose out of and in the course of her employment with the Respondent.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the medical evidence, indicating Petitioner sought medical attention on the date of accident and was subsequently diagnosed with a contusion to her knee. There was no evidence presented to rebut these facts. Accordingly, the Arbitrator concludes that the Petitioner sustained a contusion to her knee that was causally connected to her accident from June 12, 2011.

3. The Arbitrator finds that the Petitioner was married and had two dependents at the time of her injury. This finding is based on the Petitioner's unrebutted testimony in this regard.

4. Based on the findings above, the Arbitrator finds that the Petitioner's medical expenses related to the treatment of her knee contusion was both reasonable and necessary. Accordingly, the Arbitrator awards the Petitioner medical expenses as set forth in Petitioner's Exhibit 1 in the amount of $387.00, subject to the fee schedule.

5. With regard to the issue of the nature and extent of the Petitioner's injuries, the Arbitrator finds that the Petitioner sustained a contusion to her left knee that has resulted in 0.5% loss of use of the left leg. In support of this finding, the Arbitrator relies on the treating medical records showing the Petitioner experienced swelling and had very minimal treatment following her injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CASEY FLETCHER,

Petitioner,

vs. NO: 11 WC 44029

ASPLUNDH TREE EXPERT CO.,

Respondent.

15IWCC0332

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, permanent partial disability, wage differential, vocational rehabilitation, medical expenses both current and prospective, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of fact and Conclusions of Law

1. Petitioner testified he lives in Aurora. He was currently unemployed and he was last employed with Respondent until June 21, 2012. He was initially hired by Respondent on October 29, 2002. Respondent prunes trees as a contractor for Naperville Electric. Petitioner's employment was exclusively within Naperville. Respondent did not have an office there and Petitioner operated out of a car dealership where Respondent parked its trucks. Every morning he would be given his assignment of where to trim trees. Besides climbing and trimming trees, he also controlled traffic and cleaned debris. He had been foreman for six years, which entails the same activities but also includes delegation of duties and paperwork.

2. Petitioner further testified that on October 13, 2011, he was "cutting a tree down in an alleyway and part of the tree had fell into the resident's yard." The gate to the yard was locked and nobody was at home. Petitioner tried to retrieve the branch, which he estimated was 10-15,' and about 4" around, with a 10-12' pole pruner. As he was retrieving the branch he felt pain in his right wrist. He told the general foreman, Loren Peterson, that he "just tweaked the 'S' out of" his wrist. The injury occurred between 11 am and noon. He continued to work despite the pain. However, the general foreman excused him from performing his regular duties.

3. Petitioner reported to work the next day, but was unable to perform his regular duties because of the continued pain in his wrist. He was still able to delegate jobs and fill out the necessary paperwork. Petitioner continued to have pain in his wrist when he reported to work on October 21, 2011. He tried to resume his normal work activities. He had to yank the pole pruner pretty hard and he reinjured his wrist. He could not complete his task and came back to the ground. He called Mr. Peterson by radio telling him he injured his wrist again. Mr. Peterson told him to shut the crew down for the day and to rest over the weekend. He also stated he would take Petitioner to a doctor if it did not improve. On neither occasion did Mr. Peterson give him an accident report to fill out.

4. The following Monday, Mr. Peterson took Petitioner to Concentra Urgent Care. Petitioner reported the mechanisms of injury. Petitioner's hand and wrist were examined and x-rays were taken. The Concentra doctor provided Petitioner a brace and placed a 10-lb restriction on him. Respondent accommodated his restrictions. Later, Petitioner was restricted to no use of the right hand and Respondent was able to accommodate that restriction as well.

5. Petitioner also testified he had physical therapy which did not help his condition. An MRI was ordered but not authorized. He had the MRI on December 19, 2011, but through his personal insurance and not through workers' compensation. According to Dr. Giannoulias, the MRI did not show a tear and he was stumped. He raised Petitioner's weight limit to 40 lbs.

6. Petitioner saw Dr. Velagapudi, at Castle Orthopedics, on April 26, 2012. He administered an injection, reduced Petitioner's restrictions from 40 lbs to 20 lbs, and recommended a bone scan. The parties stipulated that the results of the bone scan were consistent with ulnar lunate impingement. Petitioner continued to work with whatever restrictions were imposed on him up to June 21, 2012. However, he "definitely" continued to experience pain in his wrist.

7. Dr. Velagapudi performed surgery on June 25, 2012. He released Petitioner to work with the restriction of one-handed work on July 3, 2012. Petitioner reported to Respondent, but was not allowed to work. After the surgery all benefits stopped. The parties stipulated that Respondent eventually paid temporary total disability benefits in the amount of $29,557.89 representing the period from June 25, 2012 to August 19, 2013. He received that payment about a year after the surgery.

8. Petitioner had a Functional Capacity Evaluation ("FCE") and Dr. Velagapudi released him from care with permanent restrictions based on the results. He recommended that Petitioner have the hardware removed, but that would have necessitated him being off work for about another month. Petitioner testified that Respondent informed him that he could return to work as a "ground person" as of April 15th. He filled out the necessary paperwork and had required the drug testing. However, he was then told that the ground job in Naperville had been eliminated. Petitioner believed he was offered a position as a work planner and flagger in Gary and Valparaiso Indiana, respectively.

9. Petitioner indicated that initially he did not take those offers because one was not union, he would lose seniority, there would be a cut in pay, and the distance required for travel; "it was like 84 miles one way from his home to Valparaiso." Later he tried to accept the work planner job in Gary after the deadline Respondent imposed, but his four phone calls were not returned. Petitioner has not returned to work with Respondent or anyone else within his restrictions. He was currently working with Vocamotive and wanted to continue. He has applied for "numerous" jobs through the agency and on his own.

10. Petitioner also testified that his wrist was "unfortunately" "pretty much the same way as before the surgery to a point. It's just that the steady pressure is relieved off the bone, but certain movements still cause it pain." He has a little limited range of motion. He takes over-the-counter Aleve "pretty much almost every day." His right hand has ¼ strength of the left. He writes with his left hand, but his right hand is his "power;" he is somewhat ambidextrous.

11. On cross examination, Petitioner testified as foreman he supervised the crew and delegated tasks. As foreman he was require to have a Class B CDL. He operated a boom on the truck which involved using hand levers about once a week or so. He used a computer in supervisory jobs. He did "not really" recall Dr. Giannoulias telling him his lunate capitate condition was degenerative in nature. Petitioner agreed he was able to work for a week after the first accident. He did not seek medical attention during that period and had no treatment between 1/19/12 and 4/26/12. He was able to work with restrictions up to his surgery and Respondent accommodated his restrictions.

12. Petitioner agreed that the FCE rated him capable of working at a medium physical demand level. Petitioner filed a grievance through the union to get his job back with Respondent. He did not look for work with any other employer for four months. He agreed that he was offered a job in Gary on August 5th @ $19.71 an hour and had until August 19th to accept it. He did not contact the person about accepting the job within that time period. He did not contact him until September 17th to accept the job. He was also offered a job as a flagger at the same rate of pay previously and turned down that job.

13. Petitioner worked his entire career with Respondent in Naperville. He applied for the job in Naperville and got it. However, he knew that other Respondent's employees were sent to different locations, but "pretty much within their region."

14. Petitioner became aware that Naperville was within the Indiana region, but he did not know why. Petitioner disagreed that he worked for another tree company in the summer of 2013. Getting a Class A CDL was not part of his vocational plan. Petitioner agreed that he previously worked in collections, as a forklift driver, a warehouse worker, and for Caterpillar as a supervisor for about two years.

15. Petitioner agreed he was referred to Vocamotive by his lawyer. He told the counselor that he had full range of motion in both wrists at the initial interview. Petitioner agreed that he was not unemployable and would "love to find a job." He disagreed that the jobs Respondent offered in Indiana were within 70 miles of his home.

16. On redirect examination, Petitioner testified that the FCE indicated he could lift 40 lbs occasionally; medium physical demand level requires a 50 lbs lifting capability. There are some medium level jobs he cannot perform. While he was at work after the first accident, he was told not to strain his right hand. He was able to climb the smaller trees but not the larger ones. He was not required to lift anything. Dr. Giannoulias imposed a 40-lb restriction when he released Petitioner from his care on January 19, 2012. Respondent accommodated that restriction through April of 2012. He was still having pain in his wrist which was why he sought treatment from Dr. Velagapudi.

17. Petitioner also testified that there were negotiations about his returning to his job in Naperville before he was offered the first job in Indiana. He would have accepted a job in Indiana if it included reimbursement for mileage. He agreed to accept the job in Gary after a pretrial conference. However, Respondent's representative never returned his calls.

18. Petitioner stated that every once in a while he has some pain in his wrist when turning a steering wheel. He has gripping restrictions and all tractor-trailers have manual transmissions. He has not tried to drive a manual transmission "up to this point." Respondent's employees are transferred temporarily to address storm damage.

19. On re-cross examination, Petitioner agreed he might have indicated on his job application that he was willing to travel; he said "anything to get the job, man." On re-redirect, Petitioner testified he was still willing to travel.

20. On questioning from the Arbitrator Petitioner testified he believed he was terminated by Respondent because he did not return to work after his FMLA leave. He was sent material for COBRA insurance. He applied for, and received, unemployment benefits. He no longer received unemployment benefits after he "received his back pay." As foreman for Respondent, he did the same job activities as other members of the crew. He has a plate and seven screws in his forearm.

21. Sergio Benavidez was called by Petitioner pursuant to subpoena. He was employed by Respondent on October 13 and October 21, 2011 in Naperville. He worked with Petitioner, who was his foreman. On October 13th, Petitioner's "boss," the general foreman, told Petitioner to get a branch out from a yard with a pruner; it was heavy.

22. After Petitioner started lifting the branch, Mr. Benavidez and the general foreman, Mr. Peterson, raised it over the 6' fence. Petitioner told the general foreman that his wrist hurt and "he [jokingly] told him to stop jagging off." Mr. Peterson then told Petitioner to take it easy. On October 21, 2011, Mr. Peterson told Petitioner to cut a branch of an oak tree. Petitioner tried but could not complete the task "because his hand was hurting." Thereafter, Petitioner continued to complain about pain in his wrist. He saw Petitioner come to work with a cast on his arm.

23. Lisa Helma testified she works for Vocamotive. She was referred to Petitioner by his lawyer. She interviewed Petitioner and evaluated his medical records including his FCE. Dr. Velagapudi agreed with the assessment in the FCE. Petitioner reported pain associated with raising his arms, gripping, twisting, and torquing motions, as well as driving. He reported decreased grip strength and a grinding and popping sensation over the hardware in his wrist. Petitioner did not complete high school but did later obtain a GED. Petitioner indicated he was not keyboard proficient and did not have any software skills. He used a computer at Caterpillar but simply to look up parts. He did not have any skills in mechanical repair.

24. Ms. Helma also testified a Class B CDL license can be valuable depending on the physical capabilities of the holder. Most jobs associated with the license involved medium physical demand capacity. Petitioner's restrictions do not qualify him for all medium physical demand jobs. Medium physical demand required up to 50 lbs occasional lifting and 25 lb frequent lifting, while Petitioner's maximum occasional and frequent lifting was rated at 40 and 20 lbs respectively. In addition, in the experience of the witness a lot of the jobs actually involve greater than medium physical demand. Petitioner also worked as a debt collector and forklift operator, which is also classified as at least medium physical demand job if not higher.

25. Ms. Helma prepared an initial assessment and recommended "testing by a certified vocational evaluator." However, that testing was not done because no rehabilitation plan was authorized. Vocamotive does not do such testing in house; it is outsourced. Petitioner's job as tree trimmer was classified as a semi-skilled heavy demand level job.

26. Ms. Helma concluded Petitioner did not have any transferable skills. She also concluded that the jobs Respondent offered Petitioner did not provide him a stable labor market. 59.3% of flaggers in Illinois work only part time and the mean hourly wage was $9.93. The only posting for such a job she found within 75 miles of Naperville was in Michigan City Indiana and that required the candidate to lift 50 lbs. In addition, in her experience, flaggers often also work as laborers, which require a very heavy physical demand capability. She could not find any reference to "job planner" positions.

27. Ms. Helma opined that based on her labor market survey, Petitioner would be qualified to work jobs that would pay between minimum wage and $10 an hour. He would benefit from vocational rehabilitation services. Besides the testing, she recommended computer training and "job seeking skills instruction and placement activities."

28. Petitioner has provided Ms. Helma job search reports. Petitioner is conducting a job search based on her targets as well as those identified in a job analysis report by Mr. Minnick, a vocational rehabilitation counselor retained by Respondent. He identified target jobs including bus driver and truck driver. Mr. Minnick simply identified available jobs without noting their requirements. She also thought other bus/truck driving jobs would exceed his 40-lb restriction. Some truck driving jobs required a Class A CDL, which requires a DOT physical and some required previous driving experience, which Petitioner did not have. Petitioner also did not have retail experience which would disqualify him for some jobs targeted by Mr. Minnick. She disagreed with Mr. Minnick's assessment of Petitioner's transferable skills.

29. On cross examination, Ms. Helma agreed that the first goal of vocational rehabilitation would be to return a client to his previous employment. Alternative employment from the employer within a client's restrictions would only eliminate the need for vocational rehabilitation as long as it represented a stable job market. She did not review an official job description of flagger for Respondent. She was not aware of the pay Respondent was going to pay Petitioner to work as a flagger. She did not contact Respondent to determine the job duties of a job planner. She agreed that Petitioner's jobs included supervising and interacting with customers; those are skills. Ms. Helma had no knowledge of Petitioner seeking employment other than with Respondent prior to her initial evaluation. She was not familiar with any "tree companies" and did not contact any about work planning positions. She was unaware that Respondent had 1,200 work planners on staff.

30. On redirect examination, Ms. Helma testified she believed Respondent was a national company and would not know where the work planning positions were located. A salary of $19.71 an hour would exceed the normal pay for work only as a flagger without a connection to other labor. His pay would be less if he lost that job with Respondent. Petitioner worked for Rent-A-Center for two months in which he had interaction with customers; "it takes a minimum of three months to develop a skill." She still opined that Petitioner would benefit from vocational rehabilitation training/counseling to obtain suitable employment within his restrictions.

31. On re-cross examination, Ms. Helma testified she did not contact Respondent about activities involved in work planning positions and did not know the internal stability of that position or the position of flagger in Respondent's company. She did not inquire about such positions at other tree trimming companies, but did an internet job search.

32. On re-redirect examination, Ms. Helma testified she did not find any work planning positions in her internet search. It would not be customary in her profession to contact tree companies through the yellow pages. Petitioner informed her that the jobs offered were no longer available, which was why he came to Vocamotive.

33. On re-re-cross examination, Ms. Helma testified she was not aware that Petitioner turned those jobs down.

34. Stephen Williams testified he worked for Respondent for 10 years, seven as a general foreman and the last three as regional manager. Respondent is a billion dollar company with 38,000 employees. He testified he puts 9,000 miles a month on his vehicle working for Respondent. He has employees who travel 80 one way to work every day. They do large circuits in Indiana on a contract with NIPSCO. "Once the circuit is complete" his "job is actually to bid more work," which is why he has his "work planners go out there and actually measure the trees, shoot the footage of the pole spans. They document exactly what" the witness needs to price a job. If an employee specifies a travel limit, Respondent tries to accommodate it. Petitioner's job application indicated he was willing to travel and in the question as to how far, he answered "open." Mr. Williams interpreted that answer to indicate "he'd go wherever we want him to go within the region or if there's a storm emergency."

35. Mr. Williams related that Respondent had only two contracts in which the trimmers are based in a single location; one in Naperville and one in Monticello Indiana. Those crews can be sent all over the US for storm duty. Last year they sent crews from Naperville to New York for storm duty. Such duty usually lasts two-four weeks, working seven days a week. Mr. Williams thought Petitioner probably had the opportunity to work storm duty, but he never was on it. Mr. Williams testified that a foreman had to know the business, deal with customers, utilities, and homeowners, and manage the crew. To the best of his knowledge Petitioner satisfies all the requirements needed to be a foreman.

36. Mr. Williams also testified it is not unusual for employees to drive 60-70 miles each way to a job. A job can take a couple of days or a couple of months. The employees would have to drive back and forth each day. Respondent does not reimburse for mileage; it is the nature of the business. Employees can carpool and they accept the travel because they can work overtime.

37. Mr. Williams further testified that if Respondent lost the Naperville contract, the workers would be offered jobs in Indiana because Naperville and Indiana is his region. Since the alleged injury, the witness has offered Petitioner three jobs. By letter dated May 21, 2013, he offered Petitioner a job as flagger in Valparaiso. It is cheaper to have his employees flag rather than outsourcing. Petitioner refused that job. He believed Petitioner had a week to respond to that offer. He was notified about the issue of mileage, but he had guys that travel that mileage all the time, and it was all highway miles. Petitioner turned down the job citing the length of commute.

38. By letter dated June 3, 2013, he offered Petitioner another flagger job in Valparaiso. Petitioner was given two weeks to respond, and he again rejected it. He uses flaggers every day somewhere in his region. It is actually a very skilled position because he has to know "proper radio communication," the laws of each state, where to stand, and that no one is allowed in the work zone when he is flagging. The flagger position with Respondent is "very stable." The duties of a flagger definitely comply with Petitioner's restrictions. There is no heavy labor involved in flagging for Respondent. The flagger job paid $1.32 cents an hour less that Petitioner's previous job.

39. By letter dated August 5, 2013, he offered Petitioner a job as work planner stationed out of Gary also at $19.71 an hour. He had to respond by August 19th. He would report there and go where he needed work planning. He could have to drive 10 minutes to a site or up to two hours, but he would get paid for it. It was not unusual for work planners to travel such distances. Petitioner would work four, 10-hour days a week. He offered Petitioner the job because he knew the business and requirements of various trimming jobs.

40. After Petitioner failed to respond, Mr. Williams hired someone else on August 26th at a rate of $16 an hour. He received a voicemail from Petitioner on September 17th indicating he would accept the job and to return the call if it was still available. He did not return the call because the job was no longer available. The job of work planner with Respondent is very stable. No job as work planner was currently available, but if one opened up he would offer it to Petitioner. To the best of Mr. Williams' knowledge Petitioner has not been terminated and the witness filled out no such paperwork.

41. In his 10 years with Respondent, Mr. Williams has never known of an employee failing the Class B CDL medical test. It took the witness three days to obtain a Class A CDL after having a Class B. The physical exam for a Class A license is exactly the same as that for a Class B. To the best of his knowledge Petitioner had never applied for a Class A CDL.

42. Mr. Williams explained that all competing tree companies employ flaggers and work planners. Respondent is much larger than its competitors; it is "the largest of all tree companies." The bigger companies would employ full time flaggers with no additional work requirements. It takes between three and six weeks to be certified as a flagger. It would only take a couple of hours training for Petitioner to be a work planner because of his experience. One does not have to be certified to be a planner but he has to be trusted.

43. On cross examination, Mr. Williams testified that each employee in Naperville was trained as a flagger "because they have to be self-regulated." They did not hire full time flaggers in Naperville. The foremen would handle trees that the less experienced trimmers felt uncomfortable trimming. There were other foremen other than Petitioner in Naperville. If one was not working with Petitioner, he would have to handle the difficult trees. The witness did not designate crews, the general foremen did; they come from the utility. There is one general foreman in Naperville and three crews consisting of two to three people. Petitioner could not be employed as a foreman because he would have to trim trees. There are no planners assigned to Naperville. The witness would bring one in from Indiana if he needed planning work done, but the general foreman pretty much does all the planning there.

44. Mr. Williams understood that Petitioner voluntarily terminated his employment when he did not return from FMLA leave in September 2012. Mr. Williams was transferred to his current region in 2011. In that period he had not transferred any employee from Naperville to Indiana. He did not specifically tell Petitioner the duties of a work planner, "because people with experience in trees should know what a work planner position is."

45. Mr. Williams explained that in the work planning job, Petitioner would have parked his car in Gary and then taken a company truck to his job location, as he did every day in Naperville. He would be paid for the time he was driving to his job but not driving to Gary. Petitioner never called and asked about the duties of a work planner or whether he would be working four-day weeks. Respondent has work planners in the ComEd area of Illinois, but that is not in Mr. Williams' region. If Petitioner wanted to be transferred to another region he would have to contact that region and ask them. He did not know if there were openings out of his region. There is not a high turnover rate for work planners and flaggers.

46. Mr. Williams also testified that Petitioner was not returned to work in Naperville because he could no longer climb trees and they did not want another ground person in Naperville. There was already one and the position was to be eliminated after her retirement.

47. Mr. Williams agreed the fact that Petitioner filled out paperwork to apply for work with Respondent and took a drug test indicated he wanted to return to work. He would have had to take a drug test for the jobs of flagger and work planner. Those offers were conditional on his passing the drug test. Flagger and work planner are not union positions. Naperville is the only place in his region that has union employees. Those jobs include retirement and health benefits, but that was not mentioned in the offer letters.

48. On redirect examination, Mr. Williams testified that no employee is guaranteed a job for life in Naperville and there is no union agreement about such a right. Respondent has no control of the number of people employed in Naperville; the utility determines the number of workers and the distribution of jobs. The witness is not in human resources, is not expected to explain job duty information in a job offer, and has never provided such information. Mr. Williams can hire within his region outside of Naperville, but he has no authority to hire somebody in any other region. Some employees in the ComEd region have to drive an hour and a half each way to and from work.

49. On re-cross examination, Mr. Williams agreed that while union membership does not provide any job guarantees, there were different termination procedures for union and nonunion employees; "union boys get more protection." There was a union grievance regarding Petitioner's termination. He has not worked in the ComEd region and the general foreman generally takes care of Naperville. He was not personally familiar with the ComEd region but they had more than 400 employees there. He has not had any discussion with human resources about Petitioner.

50. On re-redirect examination, Mr. Williams testified Petitioner's local union is based in Illinois and not Indiana. He was sure it was possible for Petitioner to seek employment in Illinois through his union. He could have applied for jobs with Respondent within Illinois. The witness has no say in the actions of the union and it would be Petitioner's responsibility to seek help from his union to obtain employment in Illinois. He had no knowledge of Petitioner seeking such help.

51. The medical records indicate that Petitioner treated at Concentra, on Respondent's referral, from October 31, 2011 through January 19. 2012. An MRI taken on 12/11/11, showed mild to moderate joint effusion and ulnar lunate degeneration. Dr. Giannoulias noted that Petitioner's symptoms had not improved with six physical therapy sessions and an injection.

52. On January 19, 2012, Dr. Giannoulias diagnosed lunate-capitate degenerative changes and noted that most of the symptoms were degenerative in nature. He had no pain over the TFCC. Dr. Giannoulias informed Petitioner that the condition would ultimately bother him with heavier activities. He recommended a 40-lb lifting/pushing/pulling restriction with no repetitive squeezing. Petitioner indicated that restriction could be accommodated at work. Dr. Giannoulias released him from care prn.

53. Thereafter, Petitioner sought treatment from Dr. Velagapudi at Castle Orthopedics. He ordered a bone scan and imposed a 20-lb lifting restriction. The bone scan was "compatible with provided history of right lunate impingement." On June 25, 2012, Dr. Velagapudi performed right ulnar shortening osteotomy for ulnar lunate abutment.

54. On November 19, 2012, Dr. Vender, a board certified orthopedic surgeon, testified by deposition. He performed a review of Petitioner's medical records at Respondent's request and later physically examined him. He noted the MRI showed changes in the lunate bone, which is associated with end-stage ulnar abutment indicative of a long developing degenerative process. "When you have a condition that is already present, use will change the level of symptomology. You'll have symptomology variance. You'll have ups and downs, temporary changes in the level of symptoms depending on how you use it." Dr. Vender opined that it had nothing to do with work, but anything he did with his hands.

55. Dr. Vender opined that Petitioner did not really suffer a sprain which represents a true acute injury. Rather he experienced TFCC wore out due to the chronic pressure of the underlying ulnar abutment syndrome. That is "the first thing that gets worn out" from the long-term pressure.

56. On cross examination, Dr. Vender disagreed that ulnar deviation can cause ulnar abutment; it is a degenerative condition. However, anything of sufficient force can aggravate it. Lifting something heavy is a normal activity and not an injury. He agreed that if somebody "were to rotate in a supinated, beyond what was normal" that could cause injury. A healthy joint can withstand normal repetitive stress indefinitely. A trauma "of sufficient magnitude that causes separate tissue damage to the wrist, aside from the underlying condition" could aggravate the condition.

57. On redirect examination, Dr. Vender testified he did not believe the medical records showed that Petitioner sustained any separate tissue damage. One would expect significant swelling from a sprain and some swelling would be present from the underlying condition. Knowledge of the height of the fence or that Petitioner used a utensil would not change his opinion he did not sustain a separate injury.

58. On re-cross examination, Dr. Vender did not remember whether the medical records identified swelling. He reviewed the MRI which showed some effusion. However, that may not be considered swelling if it were simply from his underlying condition. Dr. Vender agreed that Petitioner could not return to his job as tree trimmer after his physical examination, which was conducted after the surgery.

59. Petitioner's surgeon, Dr. Velagapudi testified by deposition on November 29, 2012, prior to Petitioner's FCE and prior to his last visit. Dr. Velagapudi is a certified orthopedic surgeon; over 50% of whose practice involves injury to the arm and mainly hand, wrist, and fingers. After his examination of Petitioner and a bone scan, he recommended an ulnar shortening osteotomy to take away about four mm sliver of bone from the ulna in order to eliminate the ulnar lunate from abutting against each other. The surgery was performed on June 25, 2012.

60. Dr. Velagapudi opined that in his work-related accidents Petitioner suffered an acute aggravation of the preexisting lunate impingement condition making it symptomatic. He based that opinion on the fact that apparently he was asymptomatic prior to his work incident. Dr. Velagapudi did not believe Petitioner would need prospective treatment. His permanent restrictions and ability to return to work in his previous job would be based on the results of the FCE.

61. On cross examination, Dr. Velagapudi agreed that edema should resolve within a year. However, he disagreed that Petitioner suffered only a temporary exacerbation because he complained of continued symptoms. Dr. Velagapudi explained that "bones together" which is the characteristic of the ulnar laminate abutment, generally "might do fine," but "if you have a sudden force between the two of them you now have an aggravation." He ordered the bone scan to determine "what the activity level is."

62. On October 31, 2013, in his last treating note, Dr. Velagapudi indicated Petitioner had an FCE on October 29, 2013 which was considered valid. "His strength testing really not anywhere as most appropriate to evaluate and that is that of 10 lbs on the affected side and 40 lbs on the opposite side." The deficit of strength on the affected side was ¼ of the other. The FCE concluded Petitioner could not return to work as a tree trimmer which was heavy labor. Petitioner was at maximum medical improvement but could consider removal of the hardware which would require him to off work for a couple of months.

63. On December 10, 2013, a vocational rehabilitation counselor, Mr. Minnick prepared a vocational assessment of Petitioner at Respondent's request. He criticized the evaluation of Ms. Helma and found Petitioner had transferable skills in management, customer service, and truck driving. He thought there was no basis for vocational testing or computer training because he already has transferrable skills. Rather he thought that Petitioner should convert his Class B CDL to a Class A which would increase his employability and earning potential. Mr. Minnick then included a Labor Market Survey. He concluded that as a Class B truck driver he could earn between $16.78 and $22.81 an hour.

In finding Petitioner sustained his burden of proving accident and causation, the Arbitrator based his decision on the weight of the testimonial evidence and medical records. He specifically found the causation testimony of Dr. Velagapudi more persuasive than that of Dr. Vender, whom he characterizes as not sufficiently familiar with Petitioner's work activity to make a causal opinion. In addition, Dr. Vender actually acknowledged that a significant trauma could aggravate his underlying condition.

Respondent argues the Arbitrator erred and that the testimony of Dr. Vender **"proved that an accident did not occur despite Petitioner's pain"** (emphasis in original). The condition was not work related because ***"anything Petitioner does with his hands could cause symptoms"*** (emphasis in original). Respondent also asserts that Petitioner's testimony was not credible. On causation, Respondent argues that Petitioner simply experienced the symptoms from his underlying condition in October of 2011, which does not connote causation.

The Commission agrees with the analysis of the Arbitrator regarding the issues of accident and causation. We note that Petitioner's report of accident was corroborated by Mr. Benavidez and Dr. Vender's opinion testimony was more persuasive than Dr. Vender. Dr. Vender seemed unclear that Petitioner had swelling soon after the accident, which would connote a traumatic injury causing tissue damage which he acknowledged could aggravate Petitioner's preexisting condition. The Commission also notes that Petitioner apparently worked in the heavy physical demand level occupation of tree trimmer for a period of nine years with the underlying condition without symptomology. It was only after the accidents that he had persistent symptoms leading up to his surgery. The Commission also agrees with the analysis of the Arbitrator that the medical treatment Petitioner received was necessary and reasonable. Therefore, the Commission affirms and adopts those portions of the Decision of the Arbitrator.

The Arbitrator awarded Petitioner 78 and 2/7 weeks of temporary total disability/maintenance benefits, representing the period between June 21, 2012, the date Respondent no longer would accommodate his restrictions after his surgery and the date of arbitration. The Arbitrator indicated that the job offers provided to Petitioner were basically sham offers which were made only in an attempt to limit Respondent's liability. The Commission disagrees with that characterization. Mr. Williams testified persuasively about the need of tree trimming companies to hire flaggers and work planners in their operations. These are real jobs fulfilling a real need on the part of Respondent. While the offers did require considerable travel on the part of Petitioner he had indicated that he was willing to travel and the distance he was prepared to travel was "open." In addition, long-distance travel appears to be endemic in the jobs associated with the business of trimming trees and it is evident that all of the jobs Respondent offered Petitioner were well within his restrictions. Finally, although the jobs offered Petitioner involved slightly less compensation than his previous job, ($1.32 an hour), that diminishment of income is relatively minor and Petitioner did not even make a demand that he be paid his previous salary in his new job. Rather by letter from his lawyer, he declined the job offers citing only the length of commute. The Commission finds that all three jobs Respondent offered Petitioner were reasonable within Respondent's industry. Therefore, the Commission modifies the Decision of the Arbitrator terminating temporary total disability benefits as of May 28, 2012, the date by which Petitioner had to accept the first offer of work within his restrictions.

The Arbitrator also awarded Petitioner a wage differential award of $317.47 a week. He based that award on his conclusion that the jobs Respondent offered Petitioner were sham offers and on the vocational assessment of Ms. Helma from Vocamotive. As we noted above the Commission disagrees with the characterization that the jobs Respondent offered Petitioner were sham offers. On the contrary, we believe they were reasonable in the context of Respondent's industry. In addition, we do not find the vocational assessment of Ms. Helma to be persuasive. Ms. Helma was not familiar with the tree trimming industry and the job classifications applicable to the industry.

Again, Mr. Williams testified that the jobs of flagger and work planner within Respondent's operation were "very stable," and they experienced very little attrition. In order to be entitled to a wage differential award, the claimant must show inability to return to his customary employment and a diminution of earning capacity. In the case now before the Commission, Petitioner has established that he cannot return to his previous job of tree trimmer. However, he has been offered employment within the field of his previous occupation at virtually the same rate of pay. The Commission concludes that the actual offers were more relevant than Ms. Helma's vocational assessment. Therefore, the Commission finds that Petitioner has not sustained his burden of proving that he is entitled to a wage differential award and vacates that award.

Petitioner appears to have had a good result from his surgery. Dr. Velagapudi noted excellent range of motion, no impingement, and declared Petitioner at maximum medical improvement four months after surgery. The FCE rated Petitioner to be able to work at a medium level of physical demand. Petitioner did not testify persuasively about any substantial persistent ongoing impairment. In looking at the record as a whole and taking into consideration Petitioner's age, occupation, medical records, and potential future earnings, the Commission concludes that Petitioner suffered the permanent loss of 30% use of his left hand.

In awarding more than $44,000 in penalties, the Arbitrator found that Respondent had not met its burden of proving it had reasonable belief to justify the non-payment of temporary total disability benefits of 16 and 3/7 weeks or outstanding medical bills of $8,954.17. The Commission does not believe the imposition of penalties is justified here. It is clear that Petitioner had a significant preexisting condition that arguably caused his impairment. In addition, Respondent had the accident/causation opinion of Dr. Vender, who is a respected hand surgeon, even if he may have an inaccurate conception of the legal standards for determining causation under the Act. Finally, Respondent paid more than $29,000.00 in medical expenses, and more than $29,500.00 in temporary total disability benefits some of which were incurred after Petitioner refused the first offer to return to work. Therefore, the Commission concludes that Respondent's actions were neither unreasonable nor vexatious in this case and vacates the award of penalties.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $487.23 per week for a period of 48&6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

15IWCC0332

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $431.51 per week for a period of 61.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 30% of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $$45,005.96 for medical expenses and $813.28 in vocational rehabilitation services subject to the applicable medical fee schedule under §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award for wage differential pursuant to §8(d)1 of the Act is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of penalties of $20,903.70 and $23,450.00 pursuant to §§19(k) and 19(l) of the Act, respectively are 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.

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

DATED: MAY 7 - 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-4/22/15
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLETCHER, CASEY
Employee/Petitioner

Case# **11WC044029**

12WC013097

ASPLUNDH TREE EXPERT COMPANY
Employer/Respondent

15IWCC0332

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:

0019 FAY FARROW & ASSOC
DONALD M PHELAN
1730 PARK ST SUITE 109
NAPERVILLE, IL 60563

4866 KNELL O'CONNOR DANIELEWICZ PC
BRADLEY C KNELL
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

15IWCC0332

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CASEY FLETCHER
Employee/Petitioner

v.

ASPLUNDH TREE EXPERT COMPANY
Employer/Respondent

Case # 11 WC 44029

Consolidated cases: 12 WC 13097

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of Wheaton and Chicago, on December 12, 2013, January 8, 2014, and 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Vocational rehabilitation.**

FINDINGS

On **October 13, 2011 and October 21, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**38,004.05**; the average weekly wage was $**730.85**.

On the date of accident, Petitioner was **36** 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 $**29,557.89** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**29,557.89**.

Respondent is entitled to a credit of $**29,024.42** under Section 8(j) of the Act.

ORDER

TEMPORARY TOTAL DISABILITY

Respondent shall pay Petitioner temporary total disability benefits of $487.23/week for 78 2/7 weeks, commencing June 21, 2012 to December 12, 2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $29,557.89 for temporary total disability benefits that have been paid from June 21, 2012 to August 19, 2013.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $45,005.96 and reasonable and necessary vocational services of $813.28, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $29,024.42 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: Wage differential

Respondent shall pay Petitioner permanent partial disability benefits, commencing December 13, 2013, of $317.47/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Penalties

Respondent shall pay to Petitioner penalties of $20,903.70, as provided in Section 19(k) of the Act, and $23,450.00, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

04-22-14
Date

APR 22 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CASEY FLETCHER, Petitioner,	)	
v.	)	11 WC 44029 12 WC 13097
ASPLUNDH TREE EXPERT CO., Respondent.	)	

I. FACTS

Petitioner was hired by Respondent on October 29, 2002 as a tree trimmer, corroborated in the Schedule Of Weekly Earnings (PX #1). Respondent is in the business of clearing tree limbs from power lines. Petitioner worked for Respondent exclusively in the City of Naperville from the date of hire until September 12, 2012, the date Respondent terminated Petitioner for not returning to full duty work on expiration of Family Medical Leave Act (FMLA) (PX #24) following surgery on his right arm after the injury he sustained at work.

Respondent did not maintain an office in the City of Naperville where Petitioner would report to work. Petitioner reported to work at an automobile dealer's parking lot in the City of Naperville where Respondent parked its trucks. Petitioner would drive one of Respondent's trucks to an area of Naperville where his work was assigned that day and he returned to the automobile dealer's parking lot at the end of the work day.

Petitioner and Respondent stipulate on the dates of October 13, 2011 and October 21, 2011, Petitioner and Respondent had an employee-employer relationship. Petitioner was working for Respondent as a Foreman and his duties included climbing trees, cutting branches, cleaning debris, roadside set up, supervising crew and preparing paperwork.

Petitioner testified on October 13, 2011 he reported to work, without right arm pain, and was assigned to work at an area of Ogden Avenue in Naperville, Illinois. At approximately 11:00 a.m. on that date, Petitioner sustained a work accident injury his right wrist and arm while using a pole pruner tool to lift a heavy branch, approximately 10 to 15 feet in length and 4 inch in diameter. At the time of the accident, Petitioner was standing in a tree 7 feet off the ground on one side of a fence and the branch he was lifting was on the other side of the fence on the ground. Petitioner reached over the 6 foot fence with the 10 foot pole pruner, lifted the branch off the ground to pull it over the fence and felt a pop and immediate pain in his right wrist and arm. Petitioner's general foreman, Loren Peterson and co-worker, Sergio Benavitez, were assisting Petitioner pull the heavy branch over the fence. Mr. Peterson and Sergio Benavitez witnessed Petitioner's work accident and injury to his right wrist and arm. Mr. Benavitez testified corroborating Petitioner's testimony describing the accident and injury. Mr. Peterson did not testify. After the accident, Mr. Peterson, told Petitioner to take it easy until his right arm felt better. Mr. Peterson did not offer Petitioner an accident report and Petitioner did not seek medical attention that day.

Petitioner testified he worked on easy tasks for Respondent until October 21, 2011. On this date, Petitioner attempted to cut tree branches off a tree using the 10 foot pole pruner for the first time since the October 13, 2011 injury. Petitioner was standing in an Oak tree gripping the pole pruner with his left hand and yanked the pruner cord with his right hand to cut a branch and felt immediate and severe pain in his right wrist and arm. Petitioner was unable to cut the branch and climbed down from the tree. Petitioner immediately reported the accident to the General Foreman, Loren Peterson, and Mr. Peterson told Petitioner he did not have to cut tree branches

but continue to work on his other Foreman duties. Again, Mr. Peterson did not offer Petitioner an accident report and Petitioner did not seek medical attention that day.

Petitioner testified his right wrist and arm pain failed to resolve and he sought medical attention on October 31, 2011 at Concentra Urgent Care (PX #2 p.5-16). Mr. Peterson drove Petitioner to Concentra Urgent Care for the medical evaluation. Petitioner saw Dr. Sonal Bhatt at Concentra Urgent Care that day and he reported the history of right wrist and arm injury at work on October 13, 2011. Dr. Bhatt ordered an x-ray as part of her examination which "demonstrated some angulation in the distal ulna." Dr. Bhatt assessed Petitioner's injury as "a right wrist sprain" and prescribed physical therapy at Concentra for two weeks and restrictions of "no lifting over 10 pounds, no pushing/pulling over 10 pounds of force and use of a wrist brace." (PX #2 p.6 and 14). Concentra records report Mr. Peterson was present and informed of Petitioner's diagnosis and restrictions. (PX #2 p.7-8). Petitioner returned to work with those modified activity restrictions.

On November 2, 2011, Petitioner returned to Concentra Urgent Care for follow up care and was examined by Dr. Julia Dyer. Dr. Dyer examined Petitioner, assessed "right wrist sprain" and continued physical therapy and work restrictions prescribed by Dr. Bhatt (PX #2 p.17). On November 10, 2011, Petitioner returned to Concentra Urgent Care reporting "no improvement with physical therapy" (PX #2 p.27). Dr. Mahmuda Mohsin examined Petitioner that day and his findings were "decreased grip strength, mild pain with motion and tenderness over the 2nd, 3rd and 4th metacarpal area and over the wrist joint." (PX #2 p.27) Dr. Mohsin modified Petitioner's work restrictions to "no use of right hand" (PX #2 P.31) and continued physical therapy (PX #2 p.27). On November 14, 2011, Petitioner returned to Concentra Urgent Care reporting "No improvement in right wrist/hand pain" (PX #2 p.35). On examination, Dr.

Bhatt reports "pain increases with twisting, lifting and direct pressure on medial part of right wrist." (PX #2 p.35). On this date Dr. Bhatt ordered an MRI of the right wrist and right hand, continued physical therapy and activity status to "no use of right hand" and "must wear brace." (PX #2 p.35-36). On November 23, 2011, Petitioner returned to Concentra Urgent Care reporting "physical therapy sessions have made the pain worse" (PX #2 p.45). Dr. Julia Dyer examined Petitioner on this date reporting "decreased active and passive range of motion all directions." Dr. Dyer discontinued physical therapy and Dyer continued work restrictions until MRI results (PX #2 p.45).

Petitioner testified on December 19, 2011 he obtained an MRI Scan of his right wrist and right hand at Fox Valley Imaging (PX #3) using his group health insurance plan. Petitioner returned to Concentra Urgent Care on December 23, 2011 with the MRI. The MRI findings report: "There is joint A effusion. There is degenerative change in the lunate with edema and cyst formation near the volar aspect. There is degenerative change of the capitate with edema and cyst formation" (PX #3). Dr. Bhatt referred Petitioner for orthopaedic evaluation after her examination findings and review of the MRI findings and Petitioner's ongoing pain (PX #2 p.58). Dr. Bhatt restricted Petitioner's activity status to "no use of right hand" (PX #2 p.59, 61 and 63) until orthopaedic evaluation.

On December 29, 2011, Petitioner saw Dr. Giannoulias at Occupational Specialists for an orthopaedic consultation. Dr. Giannoulias examined Petitioner's right wrist finding "tenderness over the Dorsum of the wrist and swelling over the palmer aspect of the ulnar pad of the wrist." (PX #2 p.65). Dr. Giannoulias assessed Petitioner's condition of ill-being as "right wrist pain with some mild metacarpal degenerative joint disease" (PX #2 p.65). Dr. Giannoulias injected Petitioner's lunate-capitate joint with Depo-Nedrol and Lidocaine that day, (PX #2 p.65) and

modified Petitioner's work activities to "no lifting over 5 pounds and no pushing and/or pulling over 5 pounds of force" (PX #2 p. 69 and 70). On January 19, 2012, Petitioner returned for follow up care with Dr. Giannoulias. Dr. Giannoulias' examination findings were consistent with previous findings and he released Petitioner from his care that day with restricted activity of "no lifting over 40 pounds, no pushing/pulling over 40 pounds of force, and no repetitive gripping with right hand" (PX #7).

Petitioner testified he continued to work for Respondent with the restricted activity prescribed by Dr. Giannoulias, however, he continued to feel right wrist pain performing work activities. Petitioner sought medical attention for his right wrist pain from Dr. Velagapudi at Castle Orthopaedics on April 26, 2012. Petitioner reported a history of an accident and injury at work consistent with the history reported to Concentra Urgent Care and complaint of right upper extremity pain, stiffness, numbness and tingling (PX #4 p.6 and 7). Dr. Velagapudi conducted an examination, reviewed the MRI from Fox Valley Imaging (PX #3) and assessed Petitioner's symptoms are "arising from lunate and ulnar impingement." (PX #4 p.7). Dr.Velagapudi recommended a bone scan limited to the right wrist and modified Petitioner's lifting restrictions to "no lifting over 20 pounds" (PX #4 p.7-8).

Petitioner testified he obtained a bone scan at Rush Copley Medical Center on May 18, 2012 (PX #4 p.10) using his group health insurance and returned to Dr. Velagapudi on May 30, 2012 with the bone scan. Dr. Velagapudi's assessment of the bone scan is" consistent with ulnar lunate impingement". Dr. Velagapudi's recommended ulnar shortening osteotomy surgery (PX #4 p.14). A right ulnar shortening osteotomy was performed by Dr. Velagapudi at Rush Copley Medical Center on June 25, 2012 (PX #4 p.15).

Castle Orthopaedics (Dr. Velagapudi), Fox Valley Imaging, Guardian Anesthesiologists and Rush Copley Medical Center submitted their billing to Petitioner's group health insurer, BlueCross/BlueShield, because Respondent denied to authorize and timely pay the medical providers (PX #6).

Prior to surgery on June 25, 2012, Respondent accommodated Petitioner's varied work restrictions and Petitioner testified he was paid wages from the date of his injury on October 13, 2011 until June 20, 2012. However, Petitioner testified Respondent did not accommodate his work restrictions from June 21, 2012 to the Arbitration (PX #4, PX #8, p.9 and p.19), nor timely pay Petitioner temporary total disability from June 21, 2012 to June 14, 2013. On June 28, 2013, Respondent paid Petitioner $24,848.90 for retroactive temporary total disability benefits of $487.23 per week from June 21, 2012 through June 14, 2013 (PX #16 p.1), after Petitioner filed a Section 19(b) Petition for Medical and Temporary Total Disability Benefits. Respondent timely paid Petitioner temporary total disability benefits of $487.23 per week from June 15, 2013 to August 20, 2013 (PX #16 p.2-5), when Respondent, without notice, stopped temporary total disability benefits, based on Petitioner's failure to accept a position of Work Planner at Gary, Indiana by August 19, 2013 (PX #4).

Respondent's Regional Manager, Steve Williams, testified he presented Petitioner a position of Work Planner at Gary, Indiana, in a August 5, 2013 letter (RX #4). Only the position "Work Planner", the location "Gary, Indiana", the rate of pay "$19.71 per hour", and the report date "August 19, 2013", were described in the letter (RX #4). Petitioner responded to Respondent's job offer, his attorney's letter of August 15, 2013 (PX #15), responding the distance to the job in Gary, Indiana from his home in Aurora, Illinois (140 mile round trip) is not a reasonable accommodation and requested a reasonable accommodation job offer in the Aurora,

Illinois geographical area. Mr. Williams did not reply to Petitioner's request for accommodation in Illinois and Respondent terminated temporary total disability benefits on August 20, 2013. Mr. Williams testified he assumed Petitioner voluntarily terminated his employment with Respondent, as stated in his August 5, 2013 letter (RX #14). Mr. Williams admitted in his testimony Petitioner was terminated by Respondent on September 12 2012 after FMLA expired. Petitioner filed a 19(b) Petition on September 3, 2013 for Section 8(a) benefits including, but not limited to temporary total disability, vocational rehabilitation, functional capacity test, medical bills and Section 19(l) penalties. (See file for Petition for Immediate Hearing under Section 19(b) of the Act). Respondent filed a Response to Petition for Immediate Hearing under Section 19(b) of the Act on September 13, 2013 (RX #5), agreeing "the alleged accident or disease arose out of and in the course of employment", and Petitioner's allegations regarding the "nature of the injury", "the medical providers and treatments" and "employer's receipt of a statement from a medical provider indicating employee cannot work" (RX # 5). Respondent disagreed with Petitioner's "description of the accident", "employer's refusal to pay proper compensation and/or medical benefits", "medical bills are in dispute" and "August 19, 2013 is the last payment of temporary total disability benefits" (RX #5).

Prior to a hearing on Petitioner's 19(b) Petition, Petitioner testified on September 17, 2013 he contacted Mr. Williams by telephone and left a voice mail accepting the position of Work Planner. On September 19, 2013, Petitioner's attorney confirmed by letter sent to Stephen Williams, Petitioner accepts the position of Work Planner (PX #17). Mr. Williams acknowledged in his testimony he did not respond to Petitioner's September 17, 2013 telephone call, nor the September 19, 2013 letter from his attorney because he had filled the position of Work Planner from within the company prior to receiving Petitioner's phone call and his

attorney's letter. Mr. Williams testified he filled the position of Work Planner internally at $16.00 per hour.

Petitioner testified after he did not receive a response from Mr. Williams when to report to work in the position of Work Planner, he obtained a Functional Capacity Evaluation (FCE) at Improved Functions on October 29, 2013 (PX #19).

The Functional Capacity Evaluation Reports Summary reports "The Dictionary of Occupational titles places Mr. Fletcher's occupation as a tree trimmer in the heavy strength category. Therefore, Mr. Fletcher does not meet the strength requirements and may not return to work as a tree trimmer," and "based on the strength classifications as established by the Dictionary of Occupational Titles, Mr. Fletcher is capable of assuming a position in the medium strength category. His maximum lifting capacity is 40.0 pounds, and his maximum carrying capacity is 25.0 pounds. According to the Dictionary of Occupational Titles, the medium strength category is defined as having the ability to lift 20 to 50 pounds and carry 10 to 25 pounds."

Petitioner's Job Factor Restrictions state: In order for Mr. Fletcher to successfully return to work in the medium strength category the following job factor restrictions must be met: (1) no crawling, (2) no tip-pinching with the right hand, (3) no palmer pinching with the right hand. Patient strength capacities are: (1) occasional lifting up to 40 pounds, frequent lifting up to 20 pounds and constant lifting up to 8 pounds; (2) occasional carrying up to 25 pounds, frequent carrying up to 13 pounds and constant carrying up to 5 pounds.

Petitioner testified on October 31, 2013 he brought the FCE to Dr. Velagapudi to obtain a medical release. Dr. Velagapudi had recommended a Functional Capacity Evaluation (FCE) to determine permanent restrictions (PX #4 p.28). Dr. Velagapudi reviewed the Functional Capacity Evaluation (FCE) (PX #19) and assessed "Petitioner to be at MMI with permanent deficits in strength based on the findings in the FCE where his strength in the right arm is apparently one-fourth of the opposite side." In addition, Dr.Velagapudi recommended "hardware removal to relieve the crepitis related to the screws or plate in Petitioner's forearm" (PX #4 p.30).

Petitioner testified on November 20, 2013 he met with Lisa Helma, a certified vocational counselor at Vocamotive for an initial interview, vocational evaluation and rehabilitation plan, corroborated by Ms,. Helma in her testimony. On December 2, 2013, Ms. Helma testified she prepared her Initial Evaluation Report (PX #20) and her Section 7110.10 Rehabilitation Plan (PX #21). In her Initial Evaluation Report, Ms. Helma opines "Petitioner has lost access to his usual and customary line of occupation as a tree trimmer as a result of his physical restrictions outlined in the Functional Capacity Evaluation (PX #19), however Petitioner is employable in available job targets of Parts Clerk, Sales Representative, Cashier, along with other similar types of occupations, (PX #20 p.8) based upon Petitioner's age, education, work experience, physical capacity, transferable skills and elements of acquired disability" (PX #20 p.6-8). As part of her Initial Evaluation Report, Ms. Helma conducted a Labor Market Survey for the aforesaid job targets and opines "Petitioner would have a probable wage earning potential of $8.25 to $10.00 per hour" (PX #20 p.8). Ms. Helma testified it is her opinion "vocational rehabilitation services should be offered to Petitioner, including comprehensive vocational testing by a Certified Vocational Evaluator in order to complete the most thorough assessment of aptitude, interest and

temperament." Additional vocational services recommended by Ms. Helma include "onsite development of computer literacy to level of marketable skill, facilitation of on-the-job training opportunities, assistance with letter development, completion of mock interviews and participation in self directed and supervised job search." Ms. Helma testified her Rehabilitation Plan conforms to and is consistent with guidelines articulated in the National Tea Company v The Industrial Commission, 97 Ill. 2d 424; 454 N. E. 2d 672; 1983 Ill. Lexis 440; 73 Ill. Dec. 575 (1983).

Vocamotive charged Petitioner $85.00 per hour for the Initial Evaluation Report and Rehabilitation Plan, a total charge of $813.28 through December 2, 2013. Vocamotive continued to provide Petitioner vocational counseling services at $85.00 per hour after December 2, 2013 through the dates of Arbitration on December 12, 2013, January 7 and January 8, 2014.

Edward Minnich, C.R.C., a rehabilitation Consultant at Select Case Management Services, prepared a Vocational Report for Respondent in response to the Report prepared by Ms. Lisa Helma, C.R.C. (RX #20). In his December 10, 2013 Vocational Report Mr. Minnich agrees Petitioner has lost access to his usual and customary line of work and has been released to medium work per the Functional Capacity Evaluation and the records of Dr. Velagapudi (PX #4), Petitioner's treating physician and the Section 12 Independent Medical Examination of Dr. Michael Vender (RX #19). Mr. Minnich interprets the findings identified in the Functional Capacity Evaluation as being in line with the medium work level, as defined in the Dictionary of Occupational Titles (DOT). He reports the Dictionary of Occupational Titles defines "medium work" to be "exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects." Of note, Mr. Minnich does not address the Functional Capacity Evaluation job factor restriction

stating "Petitioner's maximum lifting capacity at 40 pounds of force occasionally and 20 pounds of force frequently", which is less than the medium level defined in the Dictionary of Occupational Titles (DOT). Mr. Minnich did not meet with Petitioner prior to preparing his Report and he states he relies on Ms. Helma's December 2, 2013 Initial Evaluation Report for an accurate history and compilation of Mr. Fletcher's background for his opinions in the Vocational Report. Mr. Minnich is critical of Ms. Helma's failures to capitalize on Mr. Fletcher's vocational factors of being a Foreman, an Account Manager, a "Lead Person" and having Class B CDL which flaws her Rehabilitation Plan (PX #2 and #3). Mr. Minnich opines "Petitioner has these transferrable skills that allow him to return to work to cover his income loss." Mr. Minnich disagrees Petitioner needs vocational testing or computer skills courses recommended by Vocamotive. The basis for Mr. Minnich's opinion is Petitioner already has transferrable skills of a Class B CDL-Truck Driver (medium level work), or skills as a Foreman that are transferrable to many Bus and Truck Driver jobs and managerial jobs including sales, or skills as a warehouse worker transferable to a warehouseman/forklift operator, or warehouse supervisor or transferable skills as salesman/collections. Mr. Minnich conducted a Labor Market Survey, attached to his Vocational Report as an Addendum, that focused on those afore-described transferable skills from Petitioner's background and opines "Petitioner has sufficient transferable skills to return to work through a direct job placement process, not vocational services or retraining", as recommended by Ms. Helma (RX #20 p.3).

Mr. Minnich prepared a Rule 7110.10 Rehabilitation Plan as part of his Vocational Report (RX #20). Mr. Minnich states his 7110.10 Plan calls for "supported employment when and if the goal of full remuneration is not obtained in the first job." Mr. Minnich opined

"Petitioner will benefit from direct job placement services from Select Case Management Services as outlined in his 7110.10 Plan" (RX #20 p.5).

Ms. Lisa Helma of Vocamotive, in her January 2, 2014 Evaluation Report, states her opinions on the employability of Petitioner following her review of the Labor Market Survey conducted by Mr. Minnich. Ms. Helma's opines "Petitioner would not be qualified for the occupations named in Mr. Minnich's Labor Market Survey, to-wit: Bus Driver, Heavy and Tractor Trailer Driver, Light Truck or Delivery Service, Industrial Truck, First Line Retail Supervisor, Parts Salesperson, Sales Representative and Transportation Storage and District Manager" (PX #22 p.1). The basis of her opinion is her research of the available occupations in Mr. Minnich's Labor Market Survey. The available Bus Driver positions entail transporting children and maintaining vehicle functionality on a regular basis (PX #22 p.2). Ms. Helma reports though the Dictionary of Occupational Titles classifies Bus Driver as semi-skilled at the medium level of physical demand, and most available Bus Driver jobs transport children on a part-time schedule and only "during student attendance days." It was Ms. Helma's experience school Bus Drivers are required to pass a background check, which is a negative socioeconomic factor for Petitioner because of his felony conviction. For the occupation of Bus Driver, Ms. Helma reports wage information obtained from Occupational Employment Statistical Data from the State of Illinois states the starting wage for a bus driver is $8.89 hourly and the average hourly wage is reported at $13.17 hourly (RX #22 p.1), an impairment of earnings for Petitioner, if employed as a bus driver.

The position of Tractor-Trailer Truck Driver is described in the Dictionary of Occupational Titles as semi-skilled at the medium level of physical demand. Wage information obtained by Ms. Helma from Occupational Employment Statistical Data from the State of Illinois

states a starting wage is $12.54 hourly and the average hourly wage is reported as $19.98 hourly (RX #22 p.3), an impairment of earnings for Petitioner, if employed as a Tractor-Trailer Truck Driver. Ms. Helma testified Petitioner does not qualify for available jobs for Tractor-Trail Truck Driver for reasons including, but not limited to the necessity of unloading/delivering boxes of cargo weighing in excess of 40 pounds occasionally or 20 pounds frequently (FCE), the requirement of a valid Class B CDL medical card, passage of a Department of Transportation physical examination and proven commercial driving experience from 6 months to 5 years (PX #22 p.4).

The position of Light Truck Driver is described by the Dictionary of Occupational Titles as semi-skilled at the medium level of physical demand. Wage information obtained by Ms. Helma from Occupational Employment Statistical Data from the State of Illinois indicates a starting wage pay is $9.19 hourly and the average hourly wage is reported as $15.24 hourly (RX #22 p.5), an impairment of earnings for Petitioner, if employed as a Light Truck Driver. Ms. Helma testified it was her opinion Petitioner does not qualify for the available positions in this job category because they require a Class B CDL with a valid medical card and verifiable CDL B driving experience one to four years. Additionally, Ms. Helma testified it is her experience this job category requires passage of pre-employment screening and loading and unloading packages which may exceed Petitioner's restrictions.

The position of Industrial Truck Operator is described by the Dictionary of Occupational Titles as semi-skilled at the medium level of physical demand. Wage information obtained by Ms. Helma from the Occupational Employment Statistical Data from the State of Illinois indicates the starting wage of an Industrial Truck Operator is $9.90 hourly and the average hourly wage is reported as $14.26 hourly (PX #22 p.6), an impairment of earnings for Petitioner,

if employed as an Industrial Truck Operator. Ms. Helma opines Petitioner's lifting restrictions disqualify him from this position which typically requires lifting in excess of 40 pounds occasionally and 20 pounds frequently and requires reach truck and/or motorized pallet jack experience from 6 months to 2 years as well as and the ability to pass a background check (PX #22 p.6-7).

The position of Retail Store Manager is described by the Dictionary of Occupational Titles as skilled at the light level of physical demand. The wage information obtained by Ms. Helma from Occupational Employment Statistical Data from the State of Illinois indicates the starting wage in this category is $11.36 hourly and the average hourly wage is reported as $17.38 hourly (PX #22 p.8), an impairment of earnings for Petitioner, if employed as a Retail Store Manager. Ms. Helma opined, based on upon her research, available jobs in this position require retail management experience in many facets of the operations of a retail store including, but not limited to, execution of business plans, recruitment, training and management of personnel and operations. Additional disqualifying requirements of this position are computer skills and the ability to lift greater than 20 pounds regularly and 40 pounds occasionally (PX #22 p.8-9).

The position of Sales Representative is described by Dictionary of Occupational Titles as skilled at the light level of physical demand. Wage information obtained by Ms. Helma from Occupational Employment Statistical Data from the State of Illinois indicates the starting wage is $13.21 hourly and the average hourly wage is reported as $25.97 hourly ((PX #22 p.9-10). Ms. Helma reported, on the basis of her research, available jobs in this job category require direct selling and servicing of identified customers with the purpose of gaining new customers and expanding existing business. It is Ms. Helma's experience sales positions require a minimum 3 to 5 years of sales experience, strong relationship building skills and require proficiency with

personal computers. Some Sales Representative positions only pay commission or require a Bachelor's Degree (PX #22 p.9-11).

The position of Warehouse Manager is described by the Dictionary of Occupational Titles as highly skilled at the light level of physical demand. Wage information obtained by Ms. Helma from Occupational Employment Statistical Data from the State of Illinois indicates the starting wage in this capacity as $22.98 hourly and the average hourly wage is reported as $38.80 hourly (PX #22 p.11). Ms. Helma testified, based upon her research, that Petitioner is not qualified for the position of Warehouse Manager due to his lack of supervisor or distribution experience, his lack of computer skills in Microsoft Word and Excel, and his inability to move and/or lift in excess of 40 pounds and the preference for candidates with Bachelor degrees (PX #22 p.11-12).

Ms. Helma opines in her January 2, 2014 Evaluation Report (PX #22) "Petitioner has insufficient transferable skills to obtain employment in job targets identified by Mr. Minnich in his Vocational Report (RX #20) without further training and/or education." It is the opinion of Ms. Helma the positions identified by Mr. Minnich were either outside of Mr. Fletcher's physical capabilities, or he would not be a qualified candidate for them based upon his experience, as "Mr. Fletcher's previous position did not provide him with any type of transferability of skills as he had working in a narrow capacity" (PX #22 p.16).

Ms. Helma opines "Petitioner's experience as a Foreman would not be considered a transferable skill because Petitioner was needed to be able to perform the physical requirements of a tree trimmer", contrary to Mr. Minnich's opinion "Petitioner's experience as a Foreman is transferable to many managerial jobs including sales" (PX #22 p.16). Ms. Helma reports "it has been her experience that working as a Foreman is generally industry specific and the supervisory

experience that is developed as a Foreman does not transfer into any other industry and is non-transferable to other job targets without gaining the necessary experience in those job target areas." Ms. Helma also considered various CDL B driving positions identified by Mr. Minnich to be a "transferable skill" and opines based upon her experience "many driving positions would be outside Mr. Fletcher's physical capabilities and not a valid job target" (PX #22 p.16-17). Even if Petitioner would be employed in Mr. Minnich's targeted areas of Bus Driver, Tractor-Trailer Truck Driver, Light Truck Driver, Industrial Truck Driver, Retail Store Manager or Sales Representative/Salesperson, it is apparent he would be employed at starting wages in any other job outside the business of tree trimming, all of which pay less that Petitioner's hourly wage of $21.03 per hour. Mr. Minnich and Ms. Helma concur a rehabilitation plan is necessary for Petitioner to return to work. They differ in their plan for rehabilitation service. Ms. Helma's Plan calls for comprehensive vocational testing to include assessment of aptitude, interest and temperament and training/education to increase Petitioner's wage earning capacity (PX #21), whereas, Mr. Minnich's Plan calls for direct job placement assistance utilizing Petitioners transferable skills to provide him full remuneration (RX #20 – Rehabilitation Plan).

Ms. Helma reports Petitioner's vocational activities to January 2, 2014 (PX #22). Petitioner reports to Vocamotive and her Rehabilitation Plan was reviewed. Petitioner completed the vocational testing interview and reviewed the Client Handbook. Schedules were prepared for Petitioner and he was supplied with training materials. Petitioner completed the keyboard test and was introduced to Word 2010 Fast Track Curriculum. Petitioner prepared his Resume and job leads were identified for Automotive Parts and Warehouse Worker. Petitioner applied for these positions online with assistance. Vocamotive installed Microsoft Word 2007 to Petitioner's personal computer to utilize Microsoft Word documents at home for job search

purposes. Employment opportunities have been identified in target job areas of Forklift Operator and Warehouse Worker and Petitioner applied to these positions with online applications. The Arbitration Hearing commenced December 12, 2013 and continued to January 7, January 8, and February 11, 2014.

II. FINDINGS:

In support of the Arbitrator's Decision relating to (C) whether Petitioner sustained accidental injuries that arose of and in the course of his employment, the Arbitrator finds the following facts:

It is uncontroverted, Petitioner worked for Respondent ten years prior to his work accidents that occurred on October 13, 2011 and on October 21, 2011. Petitioner testified he was working for Respondent on October 13, 2011 in the position of a Foreman-Tree Trimmer and one of his duties was trimming tree branches from electrical lines. On October 13, 2011, Petitioner was standing in a tree to cut a branch, 10 to 15 feet in length and 4 inches in diameter, with a 10-12 foot pole pruner. He cut the branch and it fell to the ground on a different side of a 6 foot fence from the tree he was standing in. Petitioner testified he was told by his General Foreman, Loren Peterson, to reach over the fence with the 10 foot pole pruner and lift the branch and pull it over the fence. Petitioner, while standing in the tree, 7 feet off the ground, reached over the fence with the pole pruner and lifted the heavy branch over the fence and felt a pop in his right wrist and immediate pain. Petitioner testified he was working for Respondent on October 21, 2011, in the position of a Foreman-Tree Trimmer. On this day, he was standing in a tree to cut a branch from an Oak tree. As he gripped the pole pruner with his left hand he yanked on the pole pruner cord with his right hand to cut the branch he felt immediate and severe pain in his right wrist.

On October 13, 2011, and on October 21, 2011, Petitioner notified his General Foreman, Loren Peterson, of the afore described accidents and injuries to his right wrist in the course of his employment. Mr. Peterson and co-worker Sergio Benavitez witnessed Petitioner's work accidents and to his right wrist. Mr. Benavitez testified corroborating Petitioner's history of accident's and injury to his right wrist. Mr. Peterson did not testify to dispute Petitioner's work accident's or the right wrist injury. On October 31, 2011, Loren Peterson drove Petitioner to Concentra Medical Clinic to assess Petitioner's work injury to his right wrist/arm. Petitioner reported a consistent history of work injury on October 13, 2011 resulting in right wrist pain to his medical providers.

Based on the weight of the evidence, the Arbitrator finds Petitioner sustained an accidental injury on October 13, 2011 and an accidental aggravation injury on October 21, 2011, arising out and in the course of his employment with the Respondent.

In support of the Arbitrator's Decision relating to (F) whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator finds the following facts:

Petitioner's treating physician, Dr. Velagapudi of Castle Orthopaedics, testified in his opinion the work accident, as heretofore described in (C), was "an acute aggravation of an asymptomatic pre-existing condition of ulnar lunate impingement" (PX #18 p.37). Based on Petitioner's complaints consistent with the history of work injury, the demonstration and description of the mechanism of the work accident and his findings upon objective medical exams (PX #18 p.7-12 and p.14-19). In addition to the testimony of Dr. Velagapudi, and Petitioner's medical records in evidence from Concentra (PX #2), Fox Valley Imaging (PX #3)

and Castle Orthopaedics (PX #4), the Arbitrator has had the opportunity to consider the testimony of Dr. Michael Vender. Dr. Vender was retained by Respondent to review Petitioner's medical records (PX #2 p.3 and 4) to opine whether Petitioner's condition of ill-being is causally related to the accident's that arose out of and in the course of Petitioner's employment on October 13, 2011 and on October 21, 2011. Dr. Vender reported on August 6, 2012, and testified, to having an opinion "Petitioner did not have an acute sprain injury that would be considered an exasperation of a pre-existing condition, but the onset of symptoms consistent with ulnar abutment" (RX #17 p.15). However, on cross examination Dr. Vender acknowledges "a trauma of sufficient magnitude can cause an aggravation of a pre-existing degenerative condition of ulnar abutment (RX#17 p.27). Of note, Dr. Vender admitted in his testimony he did not meet or examine the Petitioner (RX #17 p.19) nor have an independent recollection of the history of the work activity (RX #17 p.21-22).

The Arbitrator finds Petitioner's current condition of ill-being is causally related to the work injury on October 13, 2011, aggravated at work on October 21, 2011, based upon the opinion of Dr. Velagapudi of Castle Orthopaedics there was an "acute aggravation injury of a pre-existing condition of ulnar abutment caused by the work accidents" described in Petitioner's testimony and the medical records (PX #18 p.18).

The Arbitrator finds it to be significant Dr. Vender did not meet or examine Petitioner, or have sufficient recollection of the history of the work activity to form his opinion Petitioner's condition of ill-being is not causally related to the work injury, but more importantly, his acknowledgment on cross examination "a trauma of significant magnitude can aggravate a pre-

existing condition of ulnar abutment" rendering his opinion Petitioner's condition of ill-being is not causally related to the work accident, unpersuasive in the context of chain of events.

Based upon the opinion of Dr. Velagapudi of Castle Orthopaedics, this Arbitrator finds Petitioner's condition of ill-being to his right arm is causally related to his work accidents on October 13, 2011 and aggravated on October 21, 2011.

In support of the Arbitrator's decision relating to (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, and (N) is Respondent due any credit, this Arbitrator finds the following facts:

The medical services provided to Petitioner were reasonable and necessary to treat the condition of ill-being, and the evidence shows Respondent has not paid all appropriate charges for all reasonable and necessary medical services as provided in Petitioner's Medical Summary including attachments (PX #6).

Respondent shall pay reasonable and necessary medical services of $42,773.22, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit of $29,024.42 for medical benefits that have been paid, as stipulated by the parties, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's Decision at (K), whether temporary and (O) vocational benefits are in dispute, the Arbitrator finds the following facts:

Petitioner's medical providers at Concentra (PX #2) and Castle Orthopaedics (PX #4) restricted his work activities from October 31, 2011 through June 20, 2012 with various and

different restrictions including, but not limited to "no use of right arm", "10 to 40 pound lifting restrictions" and "no forcible grasping or pulling." Petitioner continued to work for Respondent as a Foreman with accommodation after the October 13, 2011 work accident until June 20, 2012. On June 21, 2012, Petitioner's restrictions were "no lifting over 20 pounds" (PX #3 p.8); on July 7, 2012, "may work - no use of right arm" (PX #8); on July 31, 2012 "5 pounds" (PX #8); on October 9, 2012 "no climbing or gripping/grasping" (PX #9); on November 2, 2012, "MMI, FCE (Functional Capacity Evaluation) to base permanent restriction" (PX #3); and on October 31, 2013, MMI with deficit in strength based on FCE (PX #4 p.30). October 29, 2013 Improved Functions FCE job factor restrictions are as follows: now crawling, no tip-pinching with right hand, no palmer-pinching with right hand, no lifting over 40 pounds occasionally, 20 pounds frequently or 8 pounds constantly, no carrying over 25 pounds occasionally, 13 pounds frequently or 5 pounds constantly.

Respondent did not accommodate Petitioner's work restrictions from June 21, 2012 to the date of the date of Arbitration. Respondent did not timely pay temporary total disability benefits from June 21, 2012 to June 14, 2013. Respondent did pay retroactive temporary total disability benefits of $24,848.90 on June 28, 2013, a period of 51 weeks from June 21, 2012 to June 14, 2013. Respondent timely paid Petitioner weekly temporary total disability benefits from June 15, 2013 to August 19, 2013, (PX #16). On August 19, 2013, Respondent stopped paying Petitioner weekly temporary total disability on the basis Petitioner failed to accept work from Respondent by August 19, 2013 as a Work Planner in Gary, Indiana (PX #4). Prior to August 19, 2013, on August 15, 2013, Petitioner responded to Respondent, through his attorney, the Work Planner job in Gary, Indiana was not a reasonable accommodation and requested

accommodation of a job closer to his home in Aurora, Illinois (PX #15). Petitioner testified the Work Planner job was non-union (he is a member of IBEW), the rate of pay ($19.71) was less than the amount he earned at the time of his accident ($21.03) and the location of the job was 70 miles from his home. Respondent's Regional Manager, Stephen Williams, testified he did not respond to Petitioner's August 15, 2013 letter (PX #15) requesting accommodated for work closer to Aurora, Illinois. Petitioner testified he contacted Mr. Williams by telephone on September 17, 2013 and left Mr. Williams a voice mail message he will return to work for Respondent as a Work Planner in Gary, Indiana. On September 19, 2013, Petitioner's attorney notified Mr. Williams by letter Petitioner accepts the position of Work Planner in Gary, Indiana (PX #10). Mr. Williams testified he did not reply to Petitioner's September 17, 2013 telephone message, nor reply to his attorney's September 19, 2013 letter that Petitioner will return to work as a Work Planner because he had filled the Work Planner position internally with an employee in Indiana at the rate of $16.00 per hour after Petitioner failed to report to work on August 19, 2013.

Petitioner obtained a Functional Capacity Evaluation on October 29, 2013, returned to Dr. Velagapudi for a medical release on October 31, 2013 and initiated vocational rehabilitation services at Vocamotive. At Vocamotive Petitioner was provided counseling from Lisa Helma, a certified rehabilitation counselor. Ms. Helma met Petitioner on November 12, 2013 to evaluate Petitioner's capacities to return to work with the knowledge Respondent did not respond to Petitioner's telephone call and letter to return to work for Respondent as a Work Planner. Lisa Helma testified she continues to work with Petitioner to assist him in obtaining employment up

to the day of her testimony. She testified Petitioner has cooperated in all training in her Rehabilitation Plan.

This Arbitrator finds Respondent's job of Work Planner was designed to avoid further liability under Section 8(a) and 8(d)(l) of the Workers' Compensation Act for temporary total disability and vocational rehabilitation benefits per Reliance Elevator Company v Industrial Commission, 309 Ill. App. 3d 987, 243 Ill. Dec. 294, 723 N. E. 2d 326 , 1999 Ill. App. Lexis 890, on the basis the rate of pay of $19.71 offered Petitioner is more than the rate of pay of $16.00 offered to the employee hired for the Work Planner job, and the job location was not in Gary, Indiana, but Gary, Indiana is merely a ruse to lessen the miles Petitioner would commute. Mr. Williams testified Petitioner would drive to Gary, Indiana, park his car, pick up Respondent's truck and drive to other destinations in Northern Indiana and Central Indiana. At the end of the work day, Petitioner would return to Gary, Indiana park the truck and drive 70 miles home to Aurora, Illinois. It is uncontroverted, Respondent has employees working in Illinois, therefore, Petitioner request for return to work accommodation in Illinois was reasonable and the job offer in Gary, Indiana was a sham. The Arbitrator finds Respondent's job offer of Flagger in Valparaiso, Indiana was withdrawn when Respondent commenced paying retroactive and active temporary total disability benefits from June 21, 2012 through August 19, 2013, after the May 21, 2013 and June 3, 2013 job offers.

Respondent shall pay Petitioner temporary total disability benefits of $487.23/week for weeks commencing June 21, 2012 through October 31, 2013, Dr. Velagapudi MMI date with permanent restrictions (PX #4 p.30), as provided in Section 8(b) of the Act. The Arbitrator further finds Respondent shall pay Petitioner maintenance benefits of $487.23/week

commencing November 1, 2013 and ongoing until Petitioner is employed in a stable labor market, or alternatively Petitioner is awarded wage differential benefits under Section 8(d)(l). Respondent shall pay Vocamotive $813.28 for vocational rehabilitation services through provided to Petitioner through December 2, 2013 (PX #23) and ongoing vocational rehabilitation services at Vocamotive until Petitioner becomes employed in a stable labor market under Section 8(a) of the Act, or alternatively until Petitioner is awarded Section 8(d)(1) benefits under the Act.

Respondent shall be given a credit of $29,557.89 for temporary total disability paid commencing June 21, 2012 through June 14, 2013, as stipulated by the parties (ARBX #1).

In support of the Arbitrator's Decision (L) Nature and Extent and (O) is Petitioner entitled to a wage differential pursuant to Section 8(d)(l) of the Act, the Arbitrator finds as follows:

Respondent contends Petitioner is not entitled to wage differential under Section 8(d)(l) of the Act and should receive a permanent partial disability award (Arbitrator's X #1).

In order to be entitled to a wage differential under a Section 8(d)(1), Petitioner must prove (1) partial incapacity which prevents him from pursuing his "usual and customary line of employment", and (2) impairment of earnings. Ricky J. Gallianetti v Industrial Commission of Illinois, 315 Ill. App. 3d 721, 730; 734 N. E. 2d 482; 2000 Ill. App. Lexis 635; 248 Ill. Dec. 554. The Illinois Supreme Court mandated that once a claimant has presented sufficient evidence to demonstrate a loss of earning capacity, an award under Section 8(d)(1) is to be given and not a percentage of a person as a whole. I.d. at 728.

In this case, Petitioner presented undisputed facts of a permanent and disabling injury that prevents him from pursuing his "usual and customary line of employment." Petitioner's

orthopaedic physician, Dr. Velagapudi, on October 31, 2013, assigned permanent restrictions per the FCE (PX #4 p.30). The Functional Capacity Evaluation (FCE) on October 29, 2013 assigns (PX #19 p.4) Petitioner's strength category and job factor restrictions. In the strength category, it reports "Petitioner does not meet the heavy strength category of a tree trimmer based on the strength classifications established by the Dictionary of Occupational Titles (DOT), but Petitioner is capable of assuming a position in the medium strength category." The medium strength category is defined in the Dictionary of Occupational titles as "having the ability to lift 20 to 50 pounds and carry 10 to 25 pounds." The FCE Report Summary Job Factor Restrictions state:

> "in order for Petitioner to successfully return to work in the medium strength category the following job factor restrictions must be met: no crawling, no tip-pinching with the right hand, no palmer-pinching with the right hand, occasional lifting of 40 pounds, frequent lifting of 20 pounds, constant lifting of 8 pounds and occasional carrying of 25 pounds, frequent carrying of 13 pounds and constant carrying of 5 pounds."

Respondent's Section 12 physician, Michael Vender, examined Petitioner on February 20, 2013 opined:

> "Either now, or with further treatment, I do not expect that Mr. Fletcher would be able to return to his previous work activities as a tree trimmer. I would not recommend that he climb to heights, either up a tree or up a ladder. However, he could perform ground work that is more under his direct control." (RX #19).

After Dr. Vender opined Petitioner could perform ground work, Petitioner testified Respondent had him complete an employment application for the position of Grounds Person in Naperville, Illinois at the same rate of pay he earned as a Foreman, $21.03 per hour, and a pre-employment drug test. Petitioner testified he thought he would return to work in Naperville, Illinois on April 15, 2013 (PX #10). Respondent's Regional Manager, Stephen Williams testified the City of Naperville, a third party contractor, rebuked Respondent's request to return Petitioner to work in Naperville, Illinois in the position of Groundsman, stating the City was going to eliminate the position of Groundsman in its next contract. Instead, on May 21, 2013 Respondent offered Petitioner a Flagger job in Valparaiso, Indiana, a distance of approximately 80 miles from his home in Aurora, Illinois at a pay of $19.71 per hour, which was less than Petitioner's rate of pay of $21.03 on the date of accident (PX #1). Petitioner testified the Flagger job did not state the hours of employment or whether Petitioner would retain his 10 year seniority and other union benefits. Petitioner responded in a letter from his attorney (RX #2) expressing the job offer at Valparaiso, Indiana was not a reasonable distance to travel to and from his home in Aurora, Illinois and requested a reasonable accommodation of a job closer to his home. On June 3, 2013, Respondent sent Petitioner a similar offer for the Flagger position at Valparaiso, Indiana and Petitioner filed a 19(b) Petition for Section 8(a) benefits. Prior to a hearing on the 19(b) Petition, Respondent agreed to pay Petitioner retroactive temporary total disability from June 21, 2012 to June 14, 2013 and ongoing temporary total disability benefits while Respondent looked into job opportunities for Petitioner closer to his home in Aurora, Illinois.

On August 5, 2013, Respondent offered Petitioner the position of Work Planner at Gary, Indiana, at the same rate of pay, $19.71 per hour, as the Flagger position at Valparaiso, Indiana, (RX #4), though Petitioner had earned $21.03 per hour as a Foreman in Naperville, Illinois on the date he was injured. Respondent's Regional Manager, Steve Williams testified on cross examination the address at Gary, Indiana stated in his August 5, 2013 letter is a parking lot for Petitioner to park his vehicle and pick up a company truck for work assignments outside the Gary, Indiana area. Mr. Williams testified Petitioner's work assignment as a Work Planner would be most anywhere in Northern and Central Indiana. On August 15, 2013 Petitioner responded through his attorney, by letter Respondent's job offer was an unreasonable accommodation and requested an accommodation in the Aurora, Illinois geographical area (PX #15). Petitioner filed a Section 19 Petition for Section 8(a) benefits on September 3, 2013. Prior to a hearing on Petitioner's 19(b) Petition, Petitioner testified at Arbitration he called Mr. Williams on September 17, 2013 and left a message accepting the Work Planner position. Petitioner testified Mr. Williams did not respond to his telephone call, nor did he respond to his attorney's September 19, 2013 letter accepting the Work Planner position (PX#17). Mr. Williams testified he did not return Petitioner's telephone call, or his attorney's letter, because he had already filled the Work Planner position from within the company in Indiana at the rate of pay of $16.00 per hour.

In Reliance Elevator Company v Illinois Industrial Commission, 309 Ill. App. 3d 987; 243 Ill. Dec. 294; 723 N.E. 2d 326; 199 Ill. App. Lexis 890; 243 Ill. Dec. 294, the Court provided guidance on assessing whether a job offer from a Respondent is bona fide or a sham job offer. In Reliance, Respondent offered a job to claimant after a vocational assessment

determined that he would not be able to find employment. Id. at 329. The position offered by Respondent would pay claimant over $44.00 per hour, when the position usually paid $10.00 per hour. Id. The Court determined that Respondent's job offer to claimant was a sham, in that the job offer was designed to circumvent Reliance's responsibility under the Act. Id. The Court reasoned that "such practice must be strongly discouraged and even condemned. To countenance such practice would severely jeopardize injured workers ability to obtain relief and would undermine the spirit and purpose of the Act." Id. at 331.

After Petitioner indicated his willingness to return to work for Respondent on September 17, 2013 and September 19, 2013 (PX # 17) by accepting the position of Work Planner, Respondent did not contact Petitioner for a position of employment, but instead discontinued temporary total disability benefits after August 20, 2013 (PX # #16 p.5). This is further suggestion Respondent's job offer of Work Planner was a sham under Reliance to avoid paying Section 8(a) temporary benefits and to circumvent Respondent's responsibilities under the Act..

The history of the case shows Respondent accommodated Petitioner's varied restrictions (PX #2 and #3) from the date of Petitioner's right wrist injury on October 13, 2011 to June 20, 2012, as a Foreman-Tree Trimmer. After Petitioner's surgery on his right arm on June 25, 2012, Respondent did not accommodate Petitioner's varied restriction (PX # #4). On September 12, 2012, Respondent terminated Petitioner when he did obtain full duty release after his 12 weeks FMLA absence (PX #24). Respondent waited three (3) months after Respondent's Section 12 physician, Dr. Vender reported on February 20, 2013 that Petitioner could not return to work as a tree trimmer (RX #19) before Respondent offered Petitioner the position of Flagger at

Valparaiso, Indiana (RX #1 and #3) and six (6) months before Respondent offered Petitioner the position of Work Planner at Gary, Indiana (RX #4).

It is apparent Respondent does not dispute the Flagger position at Valparaiso, Indiana was not a bona fide job offer because after the position was offered to Petitioner on May 21, 2013 (RX #1) and June 3, 2013 (RX #3), Respondent withdrew the offers and paid Petitioner $24,848.90 on June 28, 2012 for retroactive temporary total disability benefits from June 21, 2012 o June 14, 2013 and current temporary total disability benefits from June 15, 2013 to August 20, 2013, when Respondent stopped paying Petitioner when Petitioner did not accept the position of Work Planner in Gary, Indiana by August 19, 2013. Even if Respondent's position is believes the Flagger position was a reasonable accommodation, the rate of pay of $19.71 per hour offered is contrary to the opinion expressed by Ms. Helma, Petitioner's Certified Vocational Counselor, who reports the mean hourly wage in the occupation of Flagger is reported to be $9.39 hourly according to the Occupational Employment Survey in the State of Illinois (PX #20 p.7), which suggests per the guidelines in Reliance, the job was a sham designed to circumvent Respondent's responsibility under the Act. Ms. Helma further reported 59.3% of the Flagger positions nationwide work on a part time basis according to the Dictionary of Occupational Titles (PX #20 p.7), and it has been her experience independent Flagger positions are difficult to locate and generally do not exist in a stable labor market, and many are also required to perform the physical demands of a laborer, which is a heavy level of physical demand (PX #20 p.7-8).

The Arbitrator finds Respondent's job offers for Petitioner positions of employment of a Flagger at Valparaiso, Indiana, and a Work Planner at Gary, Indiana were not bona fide job offers but sham offers to avoid both vocational benefits under Section 8(a) and wage differential

benefits under Section 8(d)(1) benefits of the Act. The two positions and titles were clearly different than Petitioner's pre-injury position of Foreman, however both positions paid exactly the same rate of pay, $19.71 per hour, which is less than the rate of pay of $21.03 Petitioner earned as a Foreman, and the two positions were located in Northwest Indiana, more than 70 miles from Petitioner's home in Aurora, Illinois when, in fact, Respondent employs hundreds of employees in Illinois closer to Petitioner's home.

The Arbitrator finds after Petitioner accepted the Work Planner offer on September 17, 2013 and September 19, 2013, and Respondent did not contact Petitioner, or his attorney, these facts more than suggest Respondent's position of Work Planner was not bona fide, but a sham to avoid paying temporary total disability, vocational benefits and maintenance benefits under Section 8(a) of the Act to circumvent paying Petitioner wage differential benefits under Section 8(d)(1) of the Act.

This is the scenario envisioned by the Court in Reliance and condemned as undermining the spirit and purpose of the Act.

Following Respondent's failure or refusal to respond to Petitioner's request for a reasonable work accommodation closer to his home in Aurora, Illinois, Petitioner obtained a Functional Capacity Evaluation (PX #19) on October 29, 2013, previously recommended by Dr. Velagapudi (PX #28), and met with Lisa Helma, a Certified Rehabilitation Counselor at Vocamotive on November 12, 2013 for vocational assessment. Ms. Helma testified she prepared a December 2, 2013 Initial Evaluation Report, including a Labor Market Survey (PX #20) and a Section 7110.10 Rehabilitation Plan (PX #21) for Petitioner. Ms. Helma offers the opinion in her Report that "Mr. Fletcher is employable in the target job areas of Parts Clerk, Sales

Representative and Cashier, along with other similar types of occupations in a pay scale range of $8.25 per hour to $10.00 per hour (PX #20 p.8). It is uncontroverted, Petitioner has proven he sustained a permanent partial incapacity that prevents him from pursuing his usual and customary line of employment as a tree trimmer-foreman. The Arbitrator finds Petitioner has also proven that he has an impairment of earnings.

Though Respondent agrees Petitioner sustained a permanent partial incapacity that prevents him from pursuing his usual and customary line of employment (RX #20 p.1), the controversy is Respondent disagrees Petitioner has an impairment of earnings, on the basis of Petitioner did not timely accept the Work Planner position in Gary, Indiana at the pay rate of $19.71 per hour and Mr. Edward Minnich's Labor Market Survey that states "Petitioner has transferable skills for direct job placement in the job target areas of Truck Driver, Foreman, Warehouseman/Fork Lift Operator, Warehouse Supervisor or Salesman/Collection" (RX #20 LMS p.1). Based on his Labor Market Survey, Mr. Minnich opines "Based upon Mr. Fletcher's transferable skills and medium level restrictions, he is employable at or near his previous income levels", a pay rate of $21.03 per hour at the time of the accidental injury (RX #20, LMS p.2-3).

Although, Mr. Minnich disagrees with the findings in the Vocamotive Labor Market Survey (PX #20), the Arbitrator finds the Vocamotive Labor Market Survey to be thorough and Ms. Helma's findings and opinions to be credible. Lisa Helma testified based upon her findings in her Labor Market Survey, there is a stable labor market for Petitioner's skills, abilities and physical capacities for positions of Parts Clerk, Sales Representative, Cashier and other similar position with wages that range from $8.25 to $10.00 per hour (PX #20 p.8-9). The Arbitrator finds the mean wage is $9.125 per hour, ($8.25 + $10.00 = $18.25 ÷ 2) or $365.00 per week.

Based upon rate of pay of $21.03 on the date of accident, Petitioner's weekly wage differential would be $841.20 per week ($21.03 per hour x 40 hours) minus $365.00 per week = $476.20 x 2 ÷3 = $317.47 per week.

Based upon the weight of the evidence the Arbitrator finds Ms. Helma's January 2, 2014 Report (PX #22) and testimony that Petitioner has an impairment of earnings more credible than the Report and opinion of Mr. Minnich (RX #20) that Petitioner does not have an impairment of earnings.

Respondent shall pay Petitioner permanent wage differential partial disability benefits of $317.47 per week commencing on December 13, 2013 until Petitioner reaches 67 years of age because the injury sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act. Further, Respondent shall pay Petitioner $813.28 for vocational rehabilitation services at Vocamotive from November 1, 2013 through December 2, 2013, the date of arbitration.

Respondent shall be given a credit of $2,000.00 paid to Petitioner for an advance of permanent partial disability, as stipulated by the parties.

In support of this Arbitrator's Decision at (M), should penalties be imposed upon Respondent, the Arbitrator finds:

> If an employer delays paying compensation, the employer has the burden of showing that it has reasonable belief that the delay was justified. Howlett's Tree Service v Industrial Commission, 160 Ill. App. 3d 190, 513 N. E. 2d; 1987 Ill. App. Lexis 3089; 111 Ill. Dec. 836.

Respondent did not meet its burden of showing it had reasonable belief to justify the delay in paying compensation on June 28, 2013 for temporary total disability benefits from June 21, 2012 through June 14, 2013, a total of 51 weeks at the rate of $487.23 per week for the total

amount of $24,848.73. The Arbitrator finds further Respondent has not met its burden of showing it had reasonable belief to justify the non-payment of compensation of temporary total disability benefits from August 20, 2013 through December 12, 2013, a total amount of 16 3/7th weeks at the rate of $487.23 per week for the total amount of $8,004.49 and for the non-payment of medical bills of $8,954.17. As a result, Respondent shall pay Petitioner $12,424.36 for penalties as provided in Section 19(k) and $10,000.000 for penalties as provided in Section 19(l) for the 373 day delay of payment on June 28, 2013 of temporary total disability benefits accrued from June 21, 2012 through June 14, 2013; $4,002.25 for penalties as provided in Section 19(k) and $3,450.00 for penalties as provided in Section 19(l) for 115 day for non-payment of temporary total disability benefits accrued from August 21, 2013 through December 12, 2013, the arbitration date; and, $4,477.09 for penalties as provided in Section 19(k) and $10,000.00 for non-payment of unpaid medical bills of $8,954.17 from June 25, 2012 through December 12, 2013, the arbitration date.

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

Donna Sutherd,

Petitioner,

vs.

NO: 13 WC 10706

State of Illinois/Healthcare and Family Services,

15IWCC0333

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical 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 August 5, 2014 is hereby affirmed and adopted.

No bond or summons for the State of Illinois.

DATED: MAY 7 - 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:3/25/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUTHERD, DONNA
Employee/Petitioner

Case# **13WC010706**

15IWCC0333

SOI/HEALTHCARE & FAMILY SERVICES
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:

0352 LaMARCA LAW OFFICES PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

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

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

AUG - 5 2014

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

15IWCC0333

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

DONNA SUTHERD,
Employee/Petitioner

v.

STATE OF ILLINOIS/HEALTHCARE AND FAMILY SERVICES,
Employer/Respondent

Case # **13** WC **10706**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **7/15/14**. 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 **12/7/12**, 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 not*** sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned **$35,848.50**; the average weekly wage was **$689.39**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 12/7/12. 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

7/30/14
Date

ICArbDec p. 2

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 43 year old clerical employee, alleges she sustained an accidental injury to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 12/7/12.

Petitioner has performed clerical activities since she was 20 years old. Before beginning her work for respondent in 2008 she worked as a web designer for Southern Illinois School of Medicine. Since petitioner began working for respondent in April of 2008, she has worked in different positions and had different job duties.

Petitioner began working in the All Kids Program for respondent in April of 2008. She testified on direct at trial that she worked in this position until July of 2011. Petitioner testified that her duties included a half day of hand writing files and putting cases together, assigning out cases and typing. She testified that the remainder of the day was spent doing mouse work. Petitioner testified that she processed 300-350 applications per day which involved writing with a pencil in her right hand. She testified that she also inserted and sorted paperwork into files. She testified that she operated a keyboard, but not to a heavy degree, but then testified that she operated a keyboard/mouse 50% of the day.

Petitioner further testified that after she left the All Kids Program she became the Office Coordinator in Child Support beginning in July 2011. She testified that her duties included payroll, sorting, scanning, keyboarding, doing spreadsheets, and clerical work. She stated that she talked to clients on the phone. Petitioner testified that her computer use in this job was less than when she worked in the All Kids Program. She stated that she spent about 3 hours a day processing timekeeping. This involved sorting and calculating hours for the office staff. She also did alot of faxing. Petitioner also handled FMLA forms and filed them in the personnel files. She stated that this task involved use of her hands for gripping files. Petitioner was only in this job for 6-7 months.

Petitioner testified that her third, and current job is in the Child Support Call Center. She began working here in March of 2012. She stated that her duties here included taking calls with the use of a headset and then entering case notes in the computer after the call was completed. Petitioner did not perform any filing in this job. Petitioner does some handwriting in this job and uses the mouse and keyboard.

Petitioner testified that she began noticing symptoms in her hands, that included numbness and tingling while under the care of Dr. Gelber. Petitioner was diagnosed with multiple sclerosis in 2009, and treats with Dr. Gelber for this condition.

On 10/27/11 petitioner was seen by Dr. Gelber for follow-up of her multiple sclerosis. She stated that in August she developed optic neuritis on the right, and was treated with intravenous Solu-Medrol an oral prednisone. Dr. Gelber was of the opinion that petitioner had sustained a recent attack of her multiple sclerosis for which she recovered with corticosteroids. Dr. Gelber completed a FMLA report that stated that petitioner may require time off for treatment and recovery of her multiple sclerosis with symptoms that included weakness, severe chronic fatigue, numbness in her extremities, and optic neuritis. He noted that her symptoms might worsen during exacerbations.

On 1/29/12 petitioner underwent an EMG/NCV performed by Dr. Gelber. Petitioner gave a history of having a lot of numbness, tingling and pain in her wrists and hands. The impression was bilateral carpal tunnel syndrome, moderately severe on the left and moderate to severe on the right. There was no evidence of ulnar neuropathy on either side, and no evidence of peripheral neuropathy, brachial plexopathy, or cervical radiculopathy. An addendum to the report states that the results were reviewed with the petitioner. She was told that she had fairly severe carpal tunnel syndrome bilaterally. Petitioner did not feel that she was ready to go forth with surgery. She indicated that she would try some wrist splints at night first, and then consider surgery down the line. She stated that she was strongly considering taking a new job with the state and wanted to get established there before taking time off for an operation.

On 12/7/12 petitioner presented to her primary care physician, Dr. Mirocha, with a chief complaint of right hand pain. Dr. Mirocha noted that petitioner was diagnosed with carpal tunnel syndrome two years ago, and it was confirmed by an EMG one year ago. She noted that a few months ago petitioner's right wrist had gotten worse. Petitioner stated that her pain radiated to her entire hand and up her right arm. She reported numbness and tingling to her fingers. She stated that movements make it worse. Petitioner had tried a splint that did not fit well and was working on getting a better fitting splint. Petitioner reported that she occasionally uses over-the-counter ibuprofen for pain, but it had not helped. Petitioner noted that she is right-handed and has worked in clerical positions since she was 20. Prior to 2008 petitioner was doing computer work for her jobs, and from 2008 to 2011 she worked for All Kids and she was doing a great deal of handwriting. Petitioner stated that this was when her hands started hurting. She reported that in 2011 she changed jobs to a child support call center and does a good amount of typing with that job. Dr. Mirocha ordered a new splint for petitioner, but felt that petitioner would likely need a surgical release. She noted that the EMG done one year ago should be forwarded to the surgeon. She prescribed gabapentin for petitioner's pain and referred her to an orthopedic surgeon. Petitioner also followed up with Dr. Mirocha for other unrelated conditions that included a history of

anxiety/depression, hypertension, and metabolic syndrome. An examination revealed positive Phalen's. Dr. Mirocha referred petitioner to Dr. Maender.

On 12/24/12 petitioner presented to Express Care. She reported continued right wrist pain related to carpal tunnel. She stated that this had been an issue for about a year, and worse over the last six weeks. She complained of severe pain. She was given Tylenol #3, Tramadol, and Neurontin without relief. She stated that she felt like her hand was cold. She complained of numbness in her right thumb and second/third fingers intermittently. Petitioner was diagnosed with carpal tunnel. She was given an new brace and told to wear it as much as possible.

On 12/26/12 petitioner followed up at Dr. Mirocha's office with Dr. Carson. Petitioner complained of severe right wrist and forearm pain. She stated that she was diagnosed with bilateral carpal tunnel almost a year ago, and that the symptoms began to worsen approximately 6 months ago, and in the past few days had become unbearable. She complained of the pain being mostly in her right forearm. She reported it as a burning sensation that feels like a Python was wrapped around her hand. She stated that the pain was so debilitating that she is unable to complete her work. An arterial Doppler of the right upper extremity was performed, and the results were normal.

On 1/4/13 petitioner completed a Worker's Compensation Employees Notice Of Injury. She indicated that on 12/5/12 she reported to Linda Grimble and Nancy Oschwald that she was having problems with her left and right hand due to repetitive motion. She stated that she was diagnosed on 1/27/12 and her last day of work was 1/4/13. She stated the duty she was performing at the time of injury was clerical over time. When asked to detail how the injury occurred she noted that "3 1/2 years of handwriting at all kids, keyboard use/filing."

On 1/4/13 petitioner presented to Dr. Maender for evaluation of her bilateral hands. She complained of constant numbness and tingling in both hands, right much worse than left. She stated that she has significant pain in her right forearm that feels like a snake is wrapped around it. She stated that the pain had been present for about two weeks. She denied any injury causing the severe pain. Petitioner reported that she has chronic fatigue, due to her multiple sclerosis. She related her numbness and tingling to her work for respondent. Petitioner stated that she started working for respondent in 2005 and was currently working at a call center since March of 2012. She stated that she does case notes on an ergonomic desk space. She reported increasing numbness and tingling since then. Prior to the call center petitioner stated that she was at a regional office for seven months. Before that she was at the Bloom Building doing a lot of handwriting. This is where she thinks this all began. Petitioner was examined and x-rays were taken of her left and right wrists. X-rays of the left wrist showed mild to moderate arthritis at the base of the CMC joint of the thumb. X-rays of the right wrist

showed mild arthritis of the CMC joint of the thumb with some impingement laterally. Dr. Maender was of the opinion that petitioner had bilateral hand numbness and tingling, most consistent with carpal tunnel confirmed by her nerve study in January. Dr. Maender was of the opinion that this large increase in severity of her pain was out of proportion to just carpal tunnel. He recommended a repeat EMG nerve conduction velocity. Dr. Maender completed a Worker's Compensation Medical Report. He noted that petitioner has carpal tunnel syndrome related to repetitive writing, typing, and use of hands.

On 1/14/13 petitioner underwent a repeat EMG/NCV studies. The impression was severe bilateral carpal tunnel syndrome with values worse than those a year ago, and no evidence of ulnar or radial neuropathy, brachial plexopathy, peripheral neuropathy, or cervical radiculopathy.

Petitioner offered into evidence the demands of the job for an Office Specialist II. This document was dated 1/16/13 and was completed by Linda Grimble. Use of hands for fine manipulation (typing, good finger dexterity) was reported as 6-8 hours per day.

On 1/30/13 petitioner followed up with Dr. Maender. He noted that the repeat EMG/NCV showed worsening of petitioner's carpal tunnel. He noted that it was severe on both sides. An examination revealed positive Tinel's and Phalen's bilaterally. Dr. Maender assessed bilateral carpal tunnel syndrome, right side more symptomatic than the left, both severe. He offered a right carpal tunnel release. Petitioner indicated that she would like to proceed.

On 2/4/13 petitioner underwent a right carpal tunnel release performed by Dr. Maender. Petitioner followed-up postoperatively with Dr. Maender. On 2/15/13 Dr. Maender noted that petitioner was doing well overall. He recommended some therapy. He released her to return to work on 2/25/13 with 10 minute breaks each hour for the first week, and then a return to work without restrictions. On 2/27/13 Dr. Maender ordered an ergonomic evaluation of petitioner's workplace.

Petitioner underwent physical therapy at Memorial from 3/8/13 through 4/26/13. On 3/8/13 petitioner reported the onset of her symptoms as 2/21/13. She reported an extended history of pain and numbness in both hands, with the right one starting about five years ago, and becoming severe over the past year. She reported a 20 year history of performing clerical work, with one job requiring extensive handwriting. She stated that her current job was primarily computer work which involved using a standard mouse and keyboard. She reported a pain level of 5–6/10 during and after work.

On 3/18/13 Dr. Mirocha referred petitioner to an ophthalmologist. Petitioner was referred for optic neuritis associated with her multiple sclerosis. On 3/25/13 petitioner followed up with Dr. Mirocha for her

anxiety/depression. She reported increased anxiety and depression due to increased stress at work. Petitioner made no mention of her carpal tunnel syndrome complaints.

On 3/19/13 petitioner followed up with Dr. Maender. Petitioner reported that her hand was getting better. She stated that she was progressing with occupational therapy. She stated that her ergonomic smart mouse really aggravates the pain she has across her right hand. Dr. Maender assessed that petitioner was progressing slowly and had fair pain control. His assessment was carpal tunnel syndrome and trigger finger of the right thumb. Dr. Maender injected petitioner's right trigger thumb.

On 4/15/13 Dr. Mirocha drafted a letter to respondent. She stated that she had been petitioner's physician for several years, and that petitioner has had severe hand pain leading her to need surgery this year. She requested that respondent allow petitioner to have just five minutes per hour to rest and massage her hand throughout her workday. Dr. Mirocha stated that this letter was based on a secure message that petitioner had sent her. Petitioner wrote in her secure message that every minute of her job at the call center has to be accounted for. Petitioner told her that codes have to be punched in and constantly kept track of, even her bathroom breaks. Petitioner told Dr. Mirocha that in March she was called in for counseling due to the amount of time she was taking between calls. She noted that she was still in pain, mostly with respect to her thumb and wrist area. She blamed this on respondent not providing her with proper equipment. She also stated that she had problems with her left hand. She stated that there were times in between calls that she would have to massage her hands due to pain, especially the thumb. She also stated that sometimes fatigue is a huge factor, due to her multiple sclerosis. She requested Dr. Mirocha draft her a note regarding the pain she was experiencing which may require some minimal time on a daily basis for resting and general massage. She requested about five minutes per hour.

On 12/23/13 Dr. Mirocha drafted a narrative report to petitioner's attorney, Mr. LaMarca, regarding petitioner's bilateral carpal tunnel syndrome and right trigger thumb. This narrative report was in response to a letter from Mr. LaMarca dated 11/20/13. She stated that the first time petitioner actually presented with upper extremity symptoms was to Dr. Gelber in June 2009. At that time petitioner was treating with Dr. Gelber for her multiple sclerosis, but one of her chief complaints was tingling in the right hand. At that time the focus was on petitioner's multiple sclerosis and related treatment and workup. From that time until January 2012, petitioner's treatment seemed to focus mostly on her blood pressure and multiple sclerosis with multiple visits to Dr. Gelber. She noted that petitioner told her that she worked in clerical positions for many years. She's noted that petitioner stated that prior to 2008 she was doing computer work for her jobs, and then from 2008 to 2011 she worked for All Kids doing a great deal of handwriting, and that is when her right hand really started to hurt.

Dr. Mirocha noted that petitioner stated that in 2011 her job shifted to a child support call center and she started doing a great deal of typing with that job. Dr. Mirocha noted that petitioner already had a diagnosis of carpal tunnel syndrome at that point that was confirmed by an EMG. Dr. Mirocha was of the opinion that carpal tunnel syndrome is usually caused by an occupational hazard, that being excessive use of the hands. It was her opinion that petitioner's work in a clerical position doing job duties such as keyboarding, processing of paperwork, and other office type work caused her carpal tunnel syndrome. As for petitioner's right trigger thumb, Dr. Mirocha could not formulate an opinion with respect to causation.

On 7/1/13 petitioner underwent a Section 12 examination performed by Dr. Patrick Stewart at the request of the respondent. In addition to his examination Dr. Stewart reviewed medical records that included x-ray reports, MRIs, as well as an evaluation and treatment notes by Dr. Gelber, Dr. Mirocha, and Dr. Carson. He also reviewed a patient questionnaire prior to Dr. Maender's examination, a vascular study completed in December 2012, and the occupational therapy notes.

Following his examination and record review Dr. Stewart assessed status post right carpal tunnel release, minimal right thumb CMC arthritis, and left carpal tunnel syndrome. Dr. Stewart was of the opinion that patients can develop numbness and tingling and symptoms secondary to the multiple sclerosis, but petitioner's symptoms had essentially resolved in her right hand with just the carpal tunnel release. He noted that petitioner did have previous treatment and ongoing treatment for her hypertension, and diagnosis of the elevated BMI. Dr. Stewart was of the opinion that petitioner was an excellent candidate for a carpal tunnel release. He also believed that she could continue performing her normal work activities.

With regards to the causal relationship between her work activities and the incident on 1/26/12 (this date was utilized as the date as far as this essentially being reported as being related to the data entry, secretarial and mouse work that petitioner was given the opportunity to describe as far as work activities are concerned), Dr. Stewart noted that the American Neurologic Society and the Mayo Clinic had addressed whether or not these isolated activities, whether being performed at home or in a workplace, have an increased risk of developing compression neuropathy, and they found that they do not. When these activities are stratified for other medical comorbidities or other factors that place an increased risk, he was of the opinion that these independently do not show an increased risk and therefore would not be related to these activities. Dr. Stewart was of the opinion that petitioner had reached maximum medical improvement with respect to her right hand, but had not reached it with regards to her left hand, regardless of whether it's causally related to her work or not.

On 4/28/14 the evidence deposition of Dr. Mirocha was taken on behalf of the petitioner. Dr. Mirocha was trained in osteopathic medicine and is a D.O. Dr. Mirocha was of the opinion that petitioner's pain

developed some when she was involved in the All Kids Program. Dr. Mirocha stated that she did not grill petitioner for the absolute details of her day-to-day job, but gathered that these activities were consistent with being related to carpal tunnel syndrome. Dr. Mirocha was of the opinion that carpal tunnel syndrome comes from a repetitive motion that puts a lot of strain on the nerves and muscles causing inflammation around the median nerve contributing to the symptoms in the hands. She did not think it was necessary to know exactly how many movements an individual makes in their shift in order to render an opinion that an activity may be a contributing factor to carpal tunnel syndrome. Dr. Mirocha agreed that multiple sclerosis can present with nerve dysfunction. However, according to Dr. Gelber's notes to her, and what she knew of presentations of multiple sclerosis, she did not believe that this was consistent with multiple sclerosis. Dr. Mirocha opined that petitioner was doing a great deal of handwriting while working at All Kids and that is when her pain started getting worse. Dr. Mirocha agreed that using a mouse with her right hand, keyboarding, and gripping and handling documents and files, are also activities that can cause or contribute to carpal tunnel syndrome.

On redirect examination Dr. Mirocha testified that she did not ask petitioner how many hours per day she did handwriting, how many pages she would write, or what she was writing with. She also stated that petitioner did not tell her how many hours per day she typed while in the call center, did not estimate what percentage of her day was spent typing, and did not describe her job duty of processing paperwork. Dr. Mirocha did not ask petitioner if she had a computer at home for personal use. Dr. Mirocha stated that petitioner did not demonstrate how she holds her hands and arms at her desk at work. Dr. Mirocha agreed that when petitioner first reported tingling in her right hand she was obese, and obesity is a risk factor for the development of carpal tunnel syndrome. Dr. Mirocha admitted that she did not have an understanding of how petitioner processed her paperwork or performed other office type work.

Dr. Gelber completed at least three FMLA reports for petitioner with respect to her multiple sclerosis. In each of these Dr. Gelber noted that petitioner had weakness and numbness in her extremities since January 2009.

Petitioner offered into evidence a job description for her Call Center position. This position was broken up into 11 different functions/duties that ranged from 5% to 25% of her time.

Petitioner testified that she has had improvement in her right hand since the surgery. She stated that the main problem she still has is with regards to grasping with her right hand. She believed this may be related to the spur on her thumb. Petitioner testified that in April 2013 Dr. Maender filled out a form for an ergonomic mouse and keyboard for petitioner. She stated that the request was granted and she was provided these items 4 to 5 months later. She stated that the ergonomic mouse has helped tremendously since she no longer has to

pivot her hand. With respect to her left hand petitioner complained of numbness, stiffness, tightening, problems sleeping, numbness at night, and wearing a brace at night.

On cross-examination petitioner testified that she typed 50% of the day while working in the All Kids Program. She stated that her duties varied and she did a lot of multitasking in this position. She stated that in the call center position she typed about 30% of the day, and most of her time was spent on the phone. Petitioner testified that while working with the All Kids Program, she could file up to 3600 folders at a time, and this involved grasping and pulling. Petitioner testified that she used 3 to 4 different computer programs in the All Kids Program, 6 to 7 different computer programs in her second job, and 12 different computer programs in the call center.

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.

Petitioner has performed clerical work since she was 20 years old. She began working for respondent in April 2008. She testified that while working for respondent she worked in different positions and had different job duties. Her first job was in All Kids until July of 2011. Next she became an Office Coordinator in Child Support. She was only in this job for 6-7 months. Her third and final job was in the Child Support Call Center where she currently works.

Petitioner testified that the symptom of numbness and tingling began in her hands while under the care of Dr. Gelber. In 2009 Dr. Gelber diagnosed petitioner with multiple sclerosis. On 10/27/11 Dr. Gelber diagnosed petitioner with optic neuritis due to a recent multiple sclerosis attack. Her symptoms at that time included weakness.

On 1/29/12 petitioner underwent an EMG/NCV after she gave Dr. Gelber a history of having a lot of numbness, tingling and pain in her wrists and hands. She was diagnosed with bilateral carpal tunnel syndrome, moderately severe on the left and moderate to severe on the right.

When petitioner presented to Dr. Mirocha on 12/7/12 she reported that she was diagnosed with carpal tunnel syndrome 2 years ago, and it was confirmed by EMG a year ago. Her chief complaint was right hand pain. Petitioner told Dr. Mirocha that she had been performing clerical positions since she was 20. She stated that prior to 2008 she was doing computer work for her jobs, and from 2008-2011 she worked in the All Kids Program and did a great deal of handwriting. She stated that this when her hands started hurting her, She told Dr. Mirocha that when she changed jobs in 2011 to the Child Support Call Center, she started doing a good amount of typing. Petitioner also treated with Dr. Mirocha for anxiety/depression, hypertension and metabolic syndrome. Dr. Mirocha did not have a detailed and accurate understanding of the petitioner's work activities

Contrary to the history she gave Dr. Mirocha that her symptoms stated while she was working in the All Kids Program, she told the doctor at Express Care on 12/24/12 she had right wrist pain for about a year, worse over the last 6 months. On 12/26/12 she told Dr. Carson that her symptoms became unbearable in the past few days. She stated that the pain was so bad she could not complete her work.

On 1/4/13 petitioner completed an accident report claiming that she reported problems with her left and right hand due to repetitive motion on 12/5/12, that she was diagnosed with carpal tunnel on 1/27/12 and that her last day of work was 1/4/13. On the form she stated that the injury occurred as the result of "3 1/2 years of handwriting at all kids, keyboard use/filing."

On 1/4/13 she also presented to Dr. Maender and told him the significant pain in her right forearm had been present for about two weeks. She related her numbness and tingling to her work for respondent. She stated that she does case notes on an ergonomic desk space. She stated that she did alot of handwriting before that, and that is when she believes it all began. Dr. Maender was of the opinion that petitioner's complaints were out of proportion to a diagnosis of carpal tunnel. He assessed carpal tunnel syndrome related to repetitive writing, typing , and use of hands. The arbitrator notes that Dr. Maender did not have a detailed and accurate understanding of the petitioner's work activities.

While in physical therapy petitioner reported the onset of her symptoms as 2/21/13, and an extended history of pain and numbness in both hands with the right starting about five years ago (2008) and becoming severe over the past year (2012-2013). She gave a history of 20 years of performing clerical work, with only one job requiring extensive handwriting.

In a letter dated 12/23/13 Dr. Mirocha stated in a letter that petitioner presented with upper extremity symptoms to Dr. Gelber in June of 2009. Her chief complaint was tingling in the right hand. From June of 2009 until January 2012 petitioner's treatment seemed to focus mostly on her blood pressure and multiple sclerosis with multiple visits to Dr. Gelber. Dr. Mirocha was of the opinion that petitioner's carpal tunnel syndrome was caused by her job duties of keyboarding, processing paperwork, and other office type work in a clerical position. She did not relate petitioner's right trigger thumb to her work.

Dr. Stewart opined that petitioner's work activities of data entry, secretarial and mouse work did not place an increased risk on petitioner and are not related to her carpal tunnel condition.

During her deposition Dr. Mirocha stated that she did not grill petitioner for the absolute details of her day to day job, but gathered that these activities were consistent with being related to carpal tunnel syndrome. She did not think it was necessary to know exactly how many movements an individual makes in their shift in order to render an opinion that an activity may be a contributing factor for carpal tunnel. Although Dr. Mirocha agreed that using a mouse with the right hand, keyboarding, gripping, gripping and handling documents and files, are also activities that can cause or contribute to carpal tunnel syndrome, she admitted that she did not know the details regarding when and how petitioner performed these tasks. She also admitted that she did not ask petitioner how many hours a day she did handwriting, how many pages she would write, or what she was writing with. She also had no idea how many hours petitioner typed a day, how she processed paperwork, or performed other office type work. She also did not ask her how she held her hands and arms at her desk.

Petitioner only offered into evidence a job description for her Call Center position. This position identified up to 11 different functions/duties that were performed in this position from 5-25% of the time. Petitioner testified that she typed 50% of the time while working in All Kids, and 30% while in the Call Center. She testified that most of her time in the Call Center was spent on the phone. She claims that while she was in the All Kids program she would also do a lot of filing. Petitioner, herself, admitted that her duties working for respondent are varied and she does a lot of multitasking.

In order to prove a repetitive trauma claim be compensable it is imperative that the petitioner place into evidence specific detailed information concerning her work activities, including the frequency, duration and

manner of performing. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities. Based on the above, as well as the credible evidence the arbitrator finds the petitioner has failed to place into evidence specific detailed information concerning her work activities, and provide to the medical experts a detailed and accurate understanding of the her work activities.

In the case at bar petitioner testified that she performed clerical work since she was 20 and did alot of computer work. She stated that from 2008 to 2011 she did a lot of handwriting from her symptoms started, but did not provide any other information regarding the frequency, duration and manner of performing. She also stated that since working in the Child Support Call Center she does a lot of typing. Again, she did not provide any other specifics. Petitioner then went on to state that her work duties vary and she did a lot of multitasking. She also entered into evidence the job description for her Call Center position that identified 11 different task she performed from 5-25% of the time. Based on this evidence the arbitrator finds the petitioner has clearly failed to provide specific detailed information concerning her work activities, including the frequency, duration and manner of performing.

With respect to the medical experts having a detailed and accurate understanding of her work activities the arbitrator relies on the testimony of Dr. Mirocha who stated that she did not grill petitioner for the absolute details of her day to day job, but gathered that these activities were consistent with being related to carpal tunnel syndrome. She did not think it was necessary to know exactly how many movements an individual makes in their shift in order to render an opinion that an activity may be a contributing factor for carpal tunnel. Although Dr. Mirocha agreed that using a mouse with the right hand, keyboarding, gripping, gripping and handling documents and files, are also activities that can cause or contribute to carpal tunnel syndrome, she admitted that she did not know the details regarding when and how petitioner performed these tasks. She also admitted that she did not ask petitioner how many hours a she did handwriting, how many pages she would write, or what she was writing with. She also had no idea how many hours petitioner typed a day, how she processed paperwork, or performed other office type work. She also did not ask her how she held her hands and arms at her desk. Given this testimony the arbitrator finds Dr. Mirocha did not have a detailed and accurate understanding of petitioner's work activities.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 12/7/12.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having determined the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her bilateral hands due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 12/7/12, the arbitrator finds these remaining issues 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

Elvis Douglas Ray,

Petitioner,

vs.

NO: 11 WC 20979

Kress Corpration,

15IWCC0334

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 an employer-employee relationship, 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 August 7, 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: MAY 7 - 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:3/25/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAY, ELVIS DOUGLAS
Employee/Petitioner

Case# **11WC020979**

15IWCC0334

KRESS CORPORATION
Employer/Respondent

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:

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

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

15IWCC0334

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elvis Douglas Ray
Employee/Petitioner

v.

Kress Corporation
Employer/Respondent

Case # 11WC 20979

An *Application for Adjustment 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 **Peoria, Illinois on June 19, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 15IWCC0334

On May 5, 2011, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned $0; the average weekly wage was $0.

On the date of accident, Petitioner was **49** years of age, ***married*** with **four (4)** dependent children.

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

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

ORDER

Having failed to prove that an employee- employer relationship exisited with Respondent on May 5, 2011, Petitioner's 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

8/4/14
Date

ICArbDec p.2

AUG – 7 2014

Attachment to Arbitrator Decision
(11 WC 20979)

STATEMENT OF FACTS

15IWCC0334

Petitioner testified that he applied for employment with Respondent, Kress Corporation, in April of 2011. Petitioner testified that he completed an application for employment on April 21, 2011 (RX 2) and then interviewed with Respondent on April 25, 2011. Petitioner testified that he interviewed with Respondent's Human Resource Manager, Gordon Henderson. Petitioner provided that during the interview, he was asked to take a painting test. Petitioner testified that he successfully completed the painting test and the interview continued. Thereafter, Petitioner was provided with documents which outlined the physical requirements for a painter with Kress Corporation as well as an "Acknowledgement" that an offer of employment had been made by Kress Corporation. These documents were signed and dated April 25, 2011. (PX 6 and RX 1)

Petitioner testified that it was his understanding that he was offered employment on April 25, 2011. Petitioner testified that wages were discussed in that he would be paid approximately $14.79 per hour. Petitioner testified that there was a discussion between himself and Mr. Henderson regarding his ability to start employment as a painter. Petitioner testified that he understood that he would have to complete a drug test and a physical examination. Petitioner testified that he was not made aware that the offer of employment made to himwas contingent upon his completion of the physical examination and drug testing procedure. Petitioner believed that this was all part of the employment process.

Petitioner initially was sent for the drug testing at the IWIRC medical facility in Peoria, Illinois on April 28, 2011. Petitioner testified that he was unable to complete the drug testing that day due to the fact that he had to leave in order to pick up his son and prepare for an out of country visit. Petitioner also testified that he made the medical facility aware of the prescription medications that he had taken that might be identified in the drug testing results.

Petitioner returned for the drug test and physical examination on May 3, 2011. The drug testing was completed; however, the physical examination portion was rescheduled to May 5, 2011 due to the drug testing results were not readily available.

On May 5, 2011, Petitioner returned to IWIRC for completion of the physical examination. Petitioner testified that the first activity that he was asked to perform was to move a milk crate full of materials from one shelf at his shoulder height to a lower shelf and then back up to the shoulder height shelf. Petitioner estimated that the crate with material weighed approximately 75 lbs. Petitioner testified that while he was performing this particular activity, he felt a pop and immediate pain in his left shoulder. Thereafter, the physical examination was stopped. Petitioner was unable to complete the physical examination on that date.

Following the failed completion of the physical examination, IWIRC notified Gordon Henderson, the human resource manager for Kress Corporation, that Petitioner had failed the physical examination test.

Petitioner testified and the records show that he sought medical treatment with Proctor First Care. (PX 4) Petitioner was then referred to Great Plains Orthopedics. The medical records of Great Plains Orthopedics (PX 3) show Petitioner first saw Great Plains Orthopedic doctors on May 25, 2011 with a history that he was lifting a milk crate weighing approximately 70 to 75 lbs. from shoulder height shelf to a lower shelf when he felt and heard a tearing in his left shoulder that was a result of the screening process for a work interview that he

did on May 5, 2011. Petitioner was assessed with left shoulder pain with possible rotator cuff tear. A MRI was recommended. (PX 3)

Petitioner was referred to Dr. Stephen Orlevitch, another orthopedic surgeon within Great Plains Orthopedics. Petitioner saw the surgeon on July 1, 2011. The doctor noted the MRI performed showed a full thickness supraspinatus tear and degenerative changes of the AC joint. Surgery was recommended. (PX 3)

Petitioner underwent surgery on July 27, 2011 consisting of a left shoulder arthroscopic sub acromial decompression with an acromioplasy excision distal clavicle mini-incision rotator cuff repair. (PX 3) Petitioner testified that he followed up with the orthopedic surgeon post operatively through October 21, 2011. Progress Notes from that date show Petitioner reported that he was doing well. The doctor issued restrictions of no lifting over 10 pounds. Petitioner was to return in six (6) weeks. (PX 3)

Respondent offered the testimony of Human Resource Manager Mr. Gordon Henderson. Mr. Henderson testified that Respondent placed an ad indicating that it was looking for painters. Petitioner submitted a resume that he received. Subsequent thereto, he contacted Petitioner to schedule an interview for April 25, 2011. Petitioner also filled out a job application. Petitioner submitted for the interview. As part of the interview, Petitioner was given a painting test which Petitioner successfully completed. Mr. Henderson stated that after Petitioner passed the painting test, he was given a provisional job offer that was subject to Petitioner passing a drug test, a physical and a background check.

Mr. Henderson testified Petitioner appeared for the drug test, but same was not completed. Mr. Henderson stated Petitioner subsequently contacted him and asked if he could take the drug test again. He was allowed to do so on May 3, 2011. On May 5, 2011, Petitioner underwent a physical at IWIRC. Mr. Henderson indicated Petitioner failed the lift test.

Mr. Henderson testified that while a conditional offer was made to Petitioner, said offer was subject to Petitioner passing a drug test, a physical and a background check. He testified that if Petitioner failed to pass any one of those three, he would not be hired. Mr. Henderson testified that Petitioner did not fill out any tax paperwork, he did not fill out any information for benefits, he received no orientation, no ID card and was never placed on the payroll or put in the personnel files. Mr. Henderson also testified that Petitioner did not fill out an I-9 Immigration Form required by the federal government.

Mr. Henderson testified on cross examination that the drug test was completed along with the background check. He stated that if not but for the failed physical examination Petitioner would have been hired by Respondent.

With respect to issues (B) Employee-Employer relationship and (C) did an accident occur that arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds the following:

Respondent placed an ad indicating that it was looking for painters. Petitioner submitted a resume to Respondent. Mr. Gordon Henderson of the HR Department of Respondent testified that he received, and reviewed Petitioner's resume. He subsequently contacted Petitioner to schedule an interview for April 25, 2011. At or near the time of that interview, Petitioner also filled out a job application. After the interview, Petitioner was given a painting test. After passing the painting test, Petitioner was given a provisional job offer subject to his passing a drug test, a physical and a background check.

Petitioner ultimately passed the drug test. On May 5, 2011, Petitioner underwent a physical at IWIRC. During this physical, Petitioner injured his shoulder. Petitioner never received any pay from Respondent and he never claimed that any pay was due and owing. Mr. Henderson of Respondent testified that while a conditional offer was made to Petitioner, that offer was subject to Petitioner passing a drug test, a physical and a background check. He testified that if Petitioner failed to pass any one of those three, he would not be hired when the provision job offer was made. Petitioner did not fill out any tax paperwork, he did not fill out any information for benefits, he received no orientation, no ID card and was never placed on the payroll or put in the personnel files. Also, Petitioner did not fill out an I-9 Immigration form that the federal government requires of all prospective employees before they can be hired.

After an exhaustive review, the Arbitrator identified the case of *Rita Barry vs St. Francis Motherhouse* 08 IWCC 1426. In that case, Petitioner sought employment with Respondent. Petitioner filled out an application and was called to meet with the Human Resources Director for Respondent. The application for employment was completed sometime in November 2006. Sometime thereafter, the Human Resources Director for Respondent offered Petitioner a position as a CNA. The offer was provisional in that Petitioner was requested to perform a drug test, and a fitness for duty evaluation. During the fitness for duty evaluation Petitioner was lifting a basket of weights when she immediately felt pain in her lower back. Immediately after the fitness for duty evaluation, Petitioner met with Respondent's Human Resources Director and was given a time card, an employment badge, an employee parking tag, as well as numerous documents, including an employee assistance program for the Petitioner to complete.

As is in the present case, Respondent's Human Resources Director testified that employment for Petitioner was conditioned upon passing of the physical examination. The Human Resources Director confirmed that she gave to Petitioner the time card, the badge, the parking pass, and all other documents for her to complete. The Human Resources Director testified that Petitioner would not have been an employee at the time of the fitness for duty evaluation, because the results of the fitness for duty evaluation had not been provided to her and as such no employment status could have been determined until after the results of that test.

Also similar is that Petitioner in *Barry* was under the impression she had been hired as an employee for Respondent. Unlike the present case, Respondent in *Barry* had provided her with an ID badge, time card, parking pass, as well as program documents.

The Arbitrator in *Barry* found the evidence and testimony established an intent on behalf of Respondent to employ Petitioner during a phone call wherein Petitioner was told she had been hired as a CNA for Respondent. The Arbitrator felt there was a meeting of the minds between Petitioner and Respondent of an employee/employer relationship.

On appeal the Commission reversed the Arbitrator citing *Cowger v. Industrial Commission* 313 Ill.App.3d 364 (2000), for the proposition that a contract for hire is made when the last act necessary for the formation of the contract occurs. The majority concluded that the last act necessary for the formation of the contract of employment was the passing of the physical exam.

Based on all the above, the Arbitrator finds that the last act necessary for the formation of an employment relationship would have been the successful completion of the physical examination. Having failed same, the Arbitrator finds Petitioner failed to prove that there was an employee-employer with Respondent on May 5, 2011.

All remaining issues are rendered moot.

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))
	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Helson Martinez,
Petitioner,

vs. NO: 09 WC 44541

Direct SAT USA,
Respondent.

15IWCC0335

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and timely notice given to all parties, the Commission, after considering the issues of accident, medical expenses and temporary disability, and being advised of the facts and law, modifies the April 11, 2014 decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision, which is attached hereto and made a part hereof.

Arbitrator Dollison found Petitioner proved he sustained an accident arising out of and in the course of employment on July 31, 2009 and further found Petitioner proved that his current condition of ill-being, including his low back condition, was causally related to the accident. The Arbitrator awarded Petitioner reasonable and related medical expenses and temporary total disability benefits.

After considering the entire record, and for the reasons as set forth below, the Commission finds that Petitioner's current condition as it relates to his low back is not causally related to his July 31, 2009 work accident. The Commission finds Petitioner did sustain an accident arising out of and in the course of employment which injured his low back and right index finger on July 31, 2009, but finds Petitioner reached maximum medical improvement as of August 25, 2009.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 58 year old satellite dish installer, filed an Application for Adjustment of Claim, claiming injury on July 31, 2009 to his right index finger and person as a whole. Petitioner described the accident as occurring when cable wire he was pulling splintered into his finger while he was on a ladder in a customer's basement. Petitioner then missed a rung of the ladder when descending to care for his finger wound and injured his low back.

2. On the date of injury, Petitioner presented to the emergency room at Illinois Valley Community Hospital. He testified that when he arrived at the hospital, he informed the medical personnel that he was suffering from lower back pain in addition to the injury to his right index finger. Medical records submitted in evidence show his chief complaint was a splinter to his right index finger, but the review of symptoms also noted a positive response for myalgia. Petitioner was treated with removal of the splinter, closure by suture, and antibiotic medication and was instructed to return at a later date for suture removal. Petitioner was not restricted from work at that time.

3. Petitioner advised his employer of the accident close in time to the injury. He testified that over the weekend his back pain progressively worsened. Although in pain, he reported to work on the Monday following the injury and was then terminated from Respondent.

4. On August 12, 2009, Petitioner returned to Illinois Valley Community Hospital for removal of his finger suture. He was discharged and released to full duty work. Petitioner testified that his finger was ok, but he still had back pain at that time.

5. Petitioner testified he had a prior lumbar decompression in 1977 but following his release from care in 1978, had no further treatment for his the low back prior to the July 31, 2009 accident.

6. Petitioner submitted Exhibit 13, a letter he testified he provided to Respondent dated August 13, 2009 indicating he had sustained injury to his right index finger and lower part of his left back on July 31, 2009. Petitioner noted that the pain in his index finger was greater at the time of the accident and he felt the pain in the lower back would go away, but it gradually worsened. Petitioner noted he would seek medical attention in the near future for the back and would forward relevant paperwork to Respondent.

7. On August 18, 2009, Petitioner presented to Dr. Jain at Midwest Orthopedic Institute describing the injury to his finger as well as pain in his low back lateralizing to the to the left, occasionally down the left buttock and the posterior aspect of the left thigh. Petitioner was diagnosed with an acute low back strain secondary to lumbar degeneration, was provided medication, and was instructed to return in one week.

8. Petitioner saw Dr. Jain in follow-up on August 25, 2009. Petitioner reported that he was doing remarkably better and his pain was just about gone. The diagnosis at that time was a resolved acute low back strain. Dr. Jain released Petitioner from care to return as needed.

9. Petitioner did return to Dr. Jain on September 8, 2009. However, at this visit, he reported low back pain radiating into the right buttock and right thigh that began acutely over the last week but without any obvious provocative injury. Dr. Jain noted that Petitioner's symptoms had changed dramatically from the previous diagnosis and he recommended an MRI.

10. Petitioner underwent an MRI of the lumbar spine on March 9, 2010, and Dr. Jain reviewed the results indicating compression of the L5 nerve root on the right side. Dr. Jain diagnosed right L5 radiculopathy and recommended a consultation with pain management.

11. On July 13, 2010, Petitioner was examined at Respondent's request by Dr. Mirkovic, a board-certified orthopedic surgeon. Dr. Mirkovic noted he reviewed medical records which showed Petitioner did not present with any low back or leg complaints until August 18, 2009, and therefore believed the Petitioner did not sustain a low back injury on July 31, 2009, as he failed to experience symptoms for twelve days. Dr. Mirkovic further added that Petitioner's gradual onset of right sided symptoms in the week prior to September 8, 2009 were unrelated to the July 31, 2009 event, noting the complaints on August 18, 2009 were of left low back pain, and on September 8, 2009, Petitioner's complaints to Dr. Jain had changed from the left side to the right and he had new positive straight leg raise on the right.

12. Dr. Mirkovic testified in deposition on April 21, 2011. At that time, Dr. Mirkovic opined that Petitioner's symptoms were related to his degenerative conditions because he detected no findings consistent with neuropathy. He further opined that the right-sided back and leg complaints began in early September 2009 and that they were not related to the July 31, 2009 accident, noting a lack of any mention of right sided symptoms during the first two examinations by Dr. Jain and that the left sided symptoms resolved as of August 25, 2009, per Dr. Jain's records.

13. Petitioner did not seek any additional treatment for the right index finger beyond the suture and its removal administered by Illinois Valley Community Hospital in July and August 2009. He did not testify to any current complaints regarding the right index finger.

14. Petitioner testified that currently he has difficulty getting out of bed and climbing stairs due to his back pain and he occasionally must take pain medication for the low back. He also testified at hearing that he continued to treat at a pain clinic and regularly receives lumbar epidural steroid injections and other conservative treatment to manage his low back pain.

Arbitrator Dollison found that Petitioner was a credible witness and had proven that his current condition of ill-being, including his low back conditions of ill-being, arose out of and in the course of his employment with Respondent on July 31, 2009. The Arbitrator, having found the requisite causal relationship, found Petitioner entitled to medical expenses in the amount of $34,182.75 for medical treatment received through the date of hearing and further awarded prospective medical treatment as recommended by Petitioner's treating physician.

Respondent timely appealed the Arbitrator's award of benefits to the Commission. After considering the entire record, the Commission modifies the Arbitrator's finding of causation for the current condition of ill-being as it relates to the low back. The Commission affirms the Arbitrator's finding of accident with injury to the right index finger and low back on July 31, 2009. Petitioner's testimony is credible regarding the onset of his complaints to the left low back and right index finger. The medical records in evidence from Illinois Valley Community Hospital on the date of accident note myalgia, and Petitioner testified he advised the medical personnel of his low back complaints. Petitioner authored a letter to his employer dated August 13, 2009, specifically noting injury to the lower part of his left back in the July 31, 2009 accident and his desire to seek treatment for his complaints. Petitioner presented to Dr. Jain at Midwest Orthopaedic Institute on August 18, 2009, with low back pain lateralizing to the left occasionally down the left buttock and the posterior aspect of the left thigh. When Petitioner returned to Dr. Jain on August 25, 2009, the note indicated he was doing remarkably better and his pain was about gone with good motion and normal gait. Petitioner was released by Dr. Jain on August 25, 2009. When Petitioner returned to Dr. Jain two weeks later on September 8, 2009, he presented with right sided back pain, as opposed to the left, as he had complained of previously, without any provocative injury. Dr. Jain noted that the low back

15IWCC0335

symptoms Petitioner exhibited on September 8, 2009 were dramatically changed from his previous examinations. The symptoms Petitioner described thereafter continued to be concentrated in the right low back, radiating down the right leg. An MRI obtained May 9, 2010 of the low back read by Dr. Jain showed compression of the right L5 nerve root and Dr. Jain noted in his record of March 11, 2010 that Petitioner was miserable with right L5 radiculopathy and exhibited a positive right straight leg raise. The Commission further notes Petitioner's statement to his employer, dated August 13, 2009, specifically detailed only injury to the lower left back and right index finger.

It was not until Petitioner was examined by Dr. Mirkovic as part of a Section 12 examination in July 2010 that Petitioner was noted to exhibit bilateral low back and lower extremity symptoms. The Commission is not persuaded by Dr. Mirkovic's opinion regarding causation of the left-sided low back complaints, as Dr. Mirkovic stated his opinion would change should there be complaints of low back pain closer in time to the injury, which there were. The Commission finds the opinion of Dr. Mirkovic regarding lack of causal connection between the right sided low back complaints and the work accident credible and compelling. The Commission adopts Dr. Mirkovic's opinion that the left side low back symptoms resolved as of August 25, 2009, per Dr. Jain's records.

The Commission finds Petitioner proved by a preponderance of the evidence he sustained injury to his left lower back, as well as the right index finger in an accident that arose out of and in the course of employment for Respondent on July 31, 2009. The Commission finds a causal relationship exists between the right index finger condition of ill-being and the work accident. The Commission further finds a causal relationship exists between the left low back condition of ill-being and the July 31, 2009 accident. The Commission further finds the Petitioner's left low back condition resolved as of August 25, 2009.

The Arbitrator awarded $34,182.75 for reasonable and related medical expenses pursuant to the Act and also ordered Respondent to authorize medical treatment, as recommended by Petitioner's treating physician. In accordance with the above findings of the Commission modifying the Arbitrator's finding of causation for the low back, the Commission further finds Petitioner is entitled to reasonable and necessary medical expenses contained in Petitioner's Exhibit 12 for treatment through August 25, 2009, when he reached maximum medical improvement with regard to the left low back, as provided in Section 8(a) and 8.2 of the Act. Consistent with the stipulation of the parties at hearing, the Commission finds Respondent entitled to a credit of $2,558.81 for medical expenses paid pursuant to Section 8(j) of the Act. The Commission vacates the Arbitrator's award of prospective medical treatment.

The Arbitrator awarded temporary total disability benefits to Petitioner for the period July 13, 2010 through November 8, 2013. As the Commission finds Petitioner failed to prove his condition of ill-being after August 25, 2009 was related to the work injury, the Arbitrator's award of temporary total disability benefits is vacated.

Given the above findings that Petitioner met his burden of proving accident on July 31, 2009 resulting in a right index finger laceration requiring surgical excision of a foreign object and suture, the Commission finds Petitioner sustained 30% loss of use of the right index finger pursuant to 8(e) of the Act. The Commission finds Petitioner did sustain a left low back strain which resolved as of August 25, 2009 but finds Petitioner did not sustain any permanent partial disability to the person as a whole referable to the low back.

15IWCC0335

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the April 11, 2014 Decision of the Arbitrator is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses is modified. Respondent is to pay Petitioner the reasonable and necessary medical expenses incurred through August 25, 2009 contained in Petitioner's Exhibit 12 pursuant to Section 8(a) and 8.2 of the Act. Respondent is entitled to a credit of $2,558.81 for medical expenses paid pursuant to Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.41 per week for a period of 12.9 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the 30% loss of use of the right index finger.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,900.00. 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: MAY 8 - 2015

Joshua D. Luskin

o-03/18/15
jdl/adc
68

Charles J. DeVriendt

Ruth W. White

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

MARTINEZ, HELSON
Employee/Petitioner

Case# **09WC044541**

DIRECT SAT USA
Employer/Respondent

15IWCC0335

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:

2153 CORTINA & MUELLER
FRANK CORTINA
124 W WASHINGTON ST
MORRIS, IL 60450

1120 BRADY CONNOLLY & MASUDA PC
PAUL W PASCHE
TEN S LASALLE ST SUITE 900
CHICAGO, IL 60603

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)

Helson Martinez
Employee/Petitioner

v.

Direct SAT USA
Employer/Respondent

Case # 09 WC 44541

Consolidated cases: N/A

15IWCC0335

An *Application for Adjustment 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 cities of **Geneva and Chicago, Illinois**, on **November 8, 2013, and January 17, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 31, 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 **$27,769.12**; the average weekly wage was **$534.02**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,323.60** PPD payment, for a total credit of **$3,323.60**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $356.01/week for 173-4/7 weeks, commencing July 13, 2010 through November 8, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay the further sum of $34,182.75 for reasonable and necessary medical expenses as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall further authorize the treatment as prescribed by his treating physician.

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

4/10/14
Date

ICArbDec19(b)

APR 11 2014

FINDINGS OF FACT

Petitioner testified that he had worked for Respondent since 2006 as a satellite dish installer. Petitioner stated that a satellite dish installer carries tools and materials weighing 50-60 pounds and must lift ladders, install satellite dishes on roofs and run cable into the home. He testified that during his time of employment with Respondent, he did not have any lower back problem until the accident and injury on July 31, 2009. Petitioner provided that he had prior lower back surgery in 1977 and had no treatment on his lower back after he was released from treatment in 1978.

Petitioner testified he reported to work on July 31, 2009 and was assigned four installations. While at his first installation, he was in an older home's basement on a six foot ladder attempting to pull cable into the home. As he was pulling cable, the cable got stuck and snapped. Petitioner testified that when the cable snapped, his hand jerked back and he got a deep sliver in his right index finger. He testified the blood was squirting out of his finger and the finger was very painful. Petitioner indicated that in his haste to descend the ladder, he missed a rung and fell from the ladder. Petitioner stated that although the finger pain was the most immediate and painful, he also felt pain in his back. Petitioner also stated that he and the homeowner made an unsuccessful attempt to remove the sliver from his finger. As a result he went to the emergency room at Illinois Valley Community Hospital.

Petitioner testified he when he arrived at the hospital, he informed medical personnel that he was also suffering lower back pain. Records submitted show his chief complaint was splinter to right index finger. During the review of systems, the physician noted a positive response for myalgia. All other systems were negative or non-contributory for chief complaints. Other than his finger, his physical examination was normal. Petitioner was treated with removal of the splinter, closure by a single suture, and antibiotic medication (Keflex.) The discharge instructions have a space available for "Back/Neck Injury," and this space was left blank. He was given a Health Information Management sheet that stated he was released to return to regular work, and was to return in ten days for removal of the suture. (PX 7 and RX 2)

Petitioner testified he advised he employer of the accident and need for medical treatment at the emergency room on the day of the accident. Petitioner testified that over the week-end, his back got progressively worse. Although in pain, he reported to work and further advised his manager of the accident and injury the Monday following the accident. Petitioner testified that he was subsequently terminated from employment reportedly due to a customer complaint.

On August 12, 2009, Petitioner returned to Illinois Valley Community Hospital for removal of the suture. Petitioner was released to regular work and was discharged from care. The diagnosis was: "foreign body finger." (PX and RX 2) Petitioner testified that at that time his finger was "o.k." but his back was still hurting.

Petitioner testified that on August 13, 2009, he notified Respondent that he was seeking additional treatment for his back pain. Petitioner submitted what was marked and admitted as Petitioner's Exhibit #13, being a letter to Respondent dated August 13, 2009. In the letter Petitioner indicated that he sustained an injury to his right index finger on July 31, 2009. Petitioner wrote, "Upon injuring my finger, I was in haste to get down off the ladder. I missed a rung on the way down, lost my balance, and hurt the lower part of my back. Immediately I felt pain when this happened but the pain to my index finger was greater and thought the pain to my lower back would go away. To this date it has not, but has gradually gotten worse. I will be seeking medical

attention in the very near future for this and will forward the paperwork to your office as soon as it becomes available."

On August 18, 2009, Petitioner presented to Midwest Orthopedic Institute where he was seen by Dr. Rajeev Jain. Petitioner reported that "on 7/31/09, [he] was working in a customer's basement, reached up, got a splinter in his hand, stepped down from a ladder hard on his left lower extremity and had instant pain in his low back lateralizing to the left, occasionally down into his left buttock and the posterior aspect of his [left] thigh." Petitioner reported a prior lumbar decompression in 1978, and indicated he had been doing well until the recent occurrence. Petitioner was diagnosed with acute low back strain secondary to lumbar degeneration. Dr. Jain noted that he did not see any signs of neurologic deficit and prescribed Medrol Dosepak and Valium. Petitioner was also instructed to return in one week. (PX 3 and RX 3)

On August 25, 2009, Petitioner returned to Dr. Jain who noted that Petitioner reported he was "doing remarkably better, his pain is just about gone. The diagnosis at that time was resolved acute low back strain. Dr. Jain released Petitioner from care to return as needed. (RX 3)

Petitioner returned to Dr. Jain on September 8, 2009 with low back pain with radiation into the right buttocks and right thigh. Dr. Jain noted he last saw Petitioner in August when Petitioner had more of a back strain that seemed almost resolved, "but then acutely he has now over the last week and into the weekend he has become worse again. He did not really have any provocative injury, he just having more pain to the point that he has a tough time walking…" An examination revealed positive straight leg on the right. Dr. Jain stated that Petitioner's symptoms had changed dramatically from the previous diagnosis of lumbar stain. He felt Petitioner's condition "…seem[ed] more like either an acute disc or some radicular type symptoms. Dr. Jain prescribed Norco and recommended a MRI. (PX 3 and RX 3) Petitioner testified he underwent the MRI months later.

The next time Petitioner sought medical attention was on February 12, 2010, when he went to the Morris Hospital emergency room. Records show Petitioner presented with lower back pain that was progressive over the past several months. It was noted that Petitioner sustained a fall off a ladder approximately five months previous. Also noted was that the "onset of symptoms [was] reported as gradual. Onset was one month ago. Complaint is worse. Complaint is persistent over the last several days..." The pain was located in the back, radiating to the right buttock and right upper leg. In the Nursing Assessment portion of the record, Petitioner reported his pain rating was 8/10 and his initial injury was "last August." He also reported that he was to have a MRI in October which was not done. Petitioner was diagnosed with sciatica and advised to follow-up with Orthopedics. (PX 6)

On March 2, 2010, Petitioner returned to Dr. Jain. The doctor prescribed Norco and referred Petitioner to the Rockford Spine Center for consultation for a diagnosis of right L5 radiculopathy. Dr. Jain again recommended a MRI. (PX 3 and RX 3) The MRI was obtained at Dr. Jain's office on March 9, 2010, and the report showed degenerative changes at L2-3, L3-4, L4-5 and L5-S1, with evidence of the prior surgery. On March 11, 2010, Dr. Jain reviewed the MRI indicating same showed compression of the L5 nerve root on the right side. Dr. Jain continued to diagnose right L5 radiculopathy. He recommended a pain clinic consultation with consideration for injections. (RX 3)

On July 13, 2010, Petitioner was examined at Respondent's request by Dr. Mirkovic, a board-certified orthopedic surgeon. In his report, Dr. Mirkovic noted Petitioner presented with complaints of low back pain radiating across the back equally. Petitioner also reported left leg pain greater than right pain radiating posterolaterally to the calf. Dr. Mirkovic provided that he reviewed Petitioner's medical records provided and performed a physical examination. Dr. Mirkovic opined that based on his review of the records and performing an examination, Petitioner's subjective complaints of low back pain and bilateral leg pain did not appear to be

causally related to the incident of July 31, 2009. The doctor noted that review of the records show Petitioner presented without any complaints of low back or leg injury on two clinic visits, notably on July 31, 2009 and August 12, 2009. The doctor indicated had Petitioner sustained a low back injury on July 31, 2009 it was more likely than not, based on a reasonable degree of medical certainty, he would have experienced symptoms related to his low back injury within a period of twelve days. Dr. Mirkovic also provided that had Petitioner experienced a back injury leading to leg pain, he would have experienced onset of leg symptoms within a week of the injury. The doctor wrote, "The patient states that his leg symptoms began a week after the injury. It is more likely than not that symptomatology related to back injury would have presented within a day or two following the injury." (RX 5, dep #2)

Dr. Mirkovic noted that the complaints given to Dr. Jain on August 18, 2009, included left low back pains but Petitioner denied any leg symptoms. Dr. Mirkovic noted that at that point, Petitioner had a negative straight leg raise and unremarkable physical examination. Dr. Mirkovic provided that on September 8, 2009, Petitioner's symptoms had changed from the left leg to the right leg, and he then had a positive straight leg raise on the right. He also referenced Petitioner reported pain in his right buttock and leg at Morris Hospital on February 12, 2010, and at Dr. Jain's office on March 2, 2010. (RX 5, dep #2)

Dr. Mirkovic reviewed the MRI film from March 9, 2010, and noted evidence of the previous surgery at L5-S1, and a right disk extrusion at L4-5, which he described as a disk herniation. Dr. Mirkovic noted the MRI findings were supported by Petitioner's clinical exam on by Dr. Jain on September 8, 2009 and March 11, 2010. By the date of his examination, Dr. Mirkovic provided that Petitioner had no objective findings consistent with a lumbar radiculopathy suggestive of symptomatic disc herniations. (RX 5, dep #2)

Dr. Mirkovic felt Dr. Jain's diagnosis of acute low back pain was reasonable. The doctor noted Petitioner had a previous history of low back symptoms. He indicated that based on the previous history of low back issues, the previous back surgery and imaging studies consistent with degenerative disc changes at L5-S1, it is more likely than not that Petitioner would have experienced intermittent low back symptoms both related and unrelated to any employment. Dr. Mirkovic went on to state that Petitioner experienced left-sided low back symptoms there were unrelated to the July 31, 2009 occurrence. He indicated the left-sided symptoms more likely than not were related to Petitioner's underlying degenerative condition. He further added that Petitioner's gradual onset of right-sided buttock and right leg symptoms in the week prior to September 8, 2009 were also unrelated to the July 31, 2009 event. (RX 5, dep #2)

Lastly, Dr. Mirkovic provided that Petitioner was capable of functioning at least at a sedentary level with occasional lifting up to 15lbs. He felt Petitioner may benefit from a course of physical therapy. The doctor, relying on the AMA Guidelines 5th Edition, felt Petitioner would not benefit from a course of epidural injections. (RX 5, dep #2)

On August 31, 2010, Petitioner was seen by Dr. Marlene Henze with a history of sustaining a back injury at work one year prior. Petitioner complained of constant low back pain which radiated down his legs. Dr. Henze prescribed Vicodin. (PX 4)

On September 7, 2010, Petitioner reported to Dr. Michael Coulson at Kishwaukee Hospital, with complaints of low back and right greater than left leg pain. Petitioner reported that the onset of his complaints occurred on July 31, 2009 after descending and falling from a ladder. A right L4-5 transforaminal epidural injection was ordered and carried out on September 16, 2010. (PX 8)

Petitioner returned to Dr. Coulson on Septmber 24, 2001. At that time, Petitioner reported that the injection reduced his pain by approximately 5%. Dr. Coulson ordered an EMG/NCV study of the right and left lower extremity. (PX 8)

On October 4, 2010, Petitioner underwent an EMG/NCV study at Midwest Neurology. Dr. Ta who performed the study indicated same was consistent with mild bilateral L5 radiculopathy. (PX 9, RX 4)

On October 22, 2010, Petitioner returned to Dr. Coulson. The doctor noted the results of the EMG/NCV was consistent with bilateral L5 radiculopathies. At that visit, Petitioner provided that he received more than 5% relief from the previous injection. Dr. Coulson recommended a repeat right L4-5 transforaminal epidural injection. The injection was carried out on November 10, 2010. (PX 8)

On November 19, 2010, Petitioner returned to Dr. Coulson. Petitioner reported that he had a couple of days of significant pain reduction following the November 10th injection. Dr. Coulson noted that although Petitioner related that he had episodes of excruciating pain, Petitioner did not demonstrate any pain behavior that day and that Petitioner always reported high pain intensity without accompanying pain behavior when seen. The doctor felt Petitioner likely needed a new MRI, referred him to Dr. Geisler and advised Petitioner to follow up as needed. (PX 8)

Petitioner saw Dr. Geisler on December 1, 2010 with complaints of constant back pain that radiates down the back of his right leg. He also reported pain which was not as bad down the left leg. He further reported tingling and numbness in the feet. Petitioner provided that his symptoms started after the ladder incident on July 31, 2009. After performing an examination and reviewing the March 9, 2010 MRI study, the doctor's primary diagnosis was status post L5-S1 disc surgery in past with severe stenosis L4-5 and L5-S1 and moderate L3-4 stenosis and L2-3 herniated nucleus pulposus. Dr. Geisler recommended a CT scan, a repeat MRI and lumbar fusion surgery. (PX 11)

Petitioner testified that following his visit with Dr. Geisler, he returned to his primary care physician, Dr. Henze. Records show Petitioner presented to Dr. Henze on December 10, 2010 with complaints of chronic back pain. The doctor noted Petitioner fell off a ladder at the jobsite on July 31, 2009. Dr. Henze felt Petitioner had chronic low back pain after an injury while at work. The doctor prescribed medication and noted Petitioner was to follow with neurosurgery at the Back Institute. (PX 4)

Petitioner testified that he continued to see his primary care physician, Dr. Henze, through March 2012. Petitioner stated that on March 10, 2011, Dr. Henze referred him to Dr. Kuo at Meridian Medical Associates

At his deposition on April 21, 2011, Dr. Mirkovic testified that he was a board-certified orthopaedic surgeon specializing in the spine. (RX 5, p. 4) He had performed over 5,000 spinal surgeries over the past 20 years. (RX 5, p. 5) Dr. Mirkovic testified to his findings between Petitioner's medical treatment records and the history he provided at the time Dr. Mirkovic examined him. (RX 5, pp. 8-10) Dr. Mirkovic testified that his impression as of July 13, 2010, was that Petitioner had low back pain and a right sided disk herniation. (RX 5, p. 12) He felt Petitioner's symptoms were related to his degenerative conditions, because he found no findings consistent with neuropathy. He also didn't feel Petitioner's findings were radicular in nature secondary to the disc herniations. (RX 5, pp. 12-13) He opined that Petitioner's right-sided back and leg complaints began in the beginning of September 2009, and that they were not related to the incident of July 31, 2009. His opined that there was an absence of reports of any back symptoms initially after the incident, and then the lack of any mention of the right side symptoms during the first two examinations by Dr. Jain in August 2009. In his opinion, it would be physiologically unlikely that the onset of symptoms would occur weeks after the initial event. (RX 5, pp. 13-14)

Dr. Mirkovic testified that Petitioner's left-sided symptoms began on or about August 18, 2009, and were not related to the incident of July 31, 2009. (RX 5, pp. 14-15) He opined that these left symptoms seemed to resolve as of September, 2009, per Dr. Jain's records. (RX 5, p. 15) Dr. Mirkovic felt that the MRI findings

were not related to the incident of July 31, 2009. (RX 5, p. 16) He opined the right disk herniation at L4-5 was related to the onset in September 2009, and the left disk herniation at L2-3 more likely than not remained asymptomatic. *Id.* He opined that Petitioner had no work restrictions attributed to the work incident of July 31, 2009. (RX 5, p. 17) Dr. Mirkovic opined that Petitioner needed no further treatment as a result of that incident. Although Dr. Mirkovic felt Petitioner's condition was not causally related to the July 2009 incident, he felt Petitioner could have benefitted from a course of physical therapy. (RX 5, pp. 19-20) He stated that epidural steroid injections would only be appropriate if there was clinical and EMG evidence of nerve irritation. Here, he found seen no such evidence. *Id.*

During the deposition, Dr. Mirkovic was posed with a hypothetical that a person with same condition as Petitioner with same history who underwent an epidural steroid injection on September 16, 2010 and reported a 5% improvement eight days later. Further that person underwent an EMG/NCV of bilateral extremities that was consistent with bilateral L5 radiculopathy, and then underwent a second L4/5 epidural steroid injection with reported mild improvement. The doctor was also asked to assume the person was seen by Dr. Geisler on December 1, 2010 who recommended a fusion surgery, CT scan and additional diagnostics. After being presented with the above stated hypothetical Dr. Mirkovic was posed as to whether his causation opinions would change. The doctor replied "no."and that as of the date of his examination, Petitioner was not a candidate for a lumbar fusion. (RX 5, pp. 23-24)

On cross-examination, Dr. Mirkovic replied no when asked "...if you had a patient with these MRI results that was reporting to you intermittent left and right pain in the buttocks, across the back and into the legs, would the MRI findings rule out the honesty of that history?" (RX 5, pp.26-27) The doctor testified that he would not be surprised if a person complained of left side pain with the presence of a left L2/3 paracentral disc herniation with suggestion of disc extrusion to the left of the midline posterior to L2. He further stated that he would not be surprised if a patient complained of right sided pain if a MRI shows at L4, there was evidence of moderate spinal stenosis with evidence of right paracentral dsic herniation with disc extrusions and moderate to severe stenosis. (RX 5, pp. 26-27)

Dr. Mirkovic testified that it was not unusual that a patient can have increased and decreased pain from examination to examination. Dr. Mirkovic opined that if a person sustains a low back injury, the low back symptoms of pain should present within 24 to 48 hours of the incident. He felt Petitioner's first complaint of left sided low back pain and left lower extremity pain did not occur until August 18, 2009 when he saw Dr. Jain. Based on that delay, he felt there was no causal relationship between the left sided complaints and the July 2009 incident. The doctor indicated his opinion would change if there were complaints of back pain immediately on July 31, 2009. When posed as to what is myalgia, the doctor provided same is pain secondary to muscle soreness. (RX 5, pp. 28-31)

Dr. Mirkovic testified that an individual's lower back may present itself with the anatomical conditions found on Petitioner's MRI and the individual could certainly be without any back pain or radicular pain. He stated that an individual with no MRI findings could have a minor trauma that would cause severe issues as a result of that trauma. (RX 5, pp.32-33) Dr. Mirkovic further testified that Petitioner's history of missing a step on a ladder and coming down on the floor hard could develop spinal disorders as complained by Petitioner. The doctor acknowledged that a patient may jam their back by missing a step and coming down on the floor hard and that could certainly cause symptoms based upon a reasonable degree of medical and surgical certainty. (RX 5, p.34)

On November 19, 2012, Petitioner started receiving treatment with Dr. Kuo at Meridian Medical Associates. Dr. Kuo's records show Petitioner was referred by Dr. Henze. Petitioner's complaints and history were consistent. Dr. Kuo diagnosed lumbar radiculopathy, lumbar spinal stenosis, herniated nucleus pulposus, limbar spondylosis, lumbar degenerative disc disease and status post left L5-S1 hemilaminotomy. The doctor

ordered a new MRI which when performed on November 19, 2012 showed left sided laminotomy defects at L4 and L5. At L5-S1 there was left central and left protrusion of the disc. There was also mild left neural foraminal stenosis at this level. At L4/5 there was mild central spinal stenosis do to diffuse protrusions of the disc. There was further a small annular rent at the central area of L2/3. (PX 2)

Petitioner returned to Dr. Kuo on November 26, 2012. Dr. Kuo discussed the results of the MRI findings. The doctor felt that Petitioner had either a congenital defect or he had an actual hemilaminotomy on the left side at L5-S1. Dr. Kuo recommended a "retrial some of the treatment" and started physical therapy. (PX 2)

Pursuant to Dr. Kuo's pain management referral, Petitioner saw Dr. Gary L. Koehn on December 19, 2012. The doctor performed epidural injections on December 27, 2012 and January17, 2013 respectively. Dr. Koehn noted Petitioner's pain had improved. (PX 10)

Petitioner next presented to the Illinois Back Institute where he underwent physical therapy from May 22, 2013 through June 19, 2013. (PX 1)

At Respondent's request, Dr. Mirkovic issued an addendum report following a review of medical records that were sent to him on September 26, 2013. These records included those of Dr. Ta, Dr. Henze/Nurse Loch, Dr. Geisler, Meridian Medical Associates (Dr. Kuo), Dr. Koehn, and included the second MRI report and films. Dr. Mirkovic noted Petitioner's injections in 2010 had no long term effect; he noted the EMG results were interpreted as normal with evidence of mild bilateral L5 radiculopathy; and noted Dr. Geisler's surgical recommendation. He also noted that the most recent records reflected current complaints of low back and bilateral leg pain. Dr. Mirkovic's current diagnoses were 1.) low back pain; 2.) degenerative lumbar spondylosis; 3.) spinal stenosis; 4.) diffuse lumbar disk herniation at L4-5 and suggestion of left disk herniation at L5-S1; and 5.) degenerative disk disease. Dr. Mirkovic provided that the new records did not change his previous opinion that Petitioner's low back and leg symptoms were not related to the events of July 31, 2009. Dr. Mirkovic again opined that any work restrictions or medical treatment to the low back was not related to the events on July 31, 2009. Dr. Mirkovic provided that Petitioner's current symptomatology was related to his degenerative changes of the lumbar spine as well as the underlying spinal stenosis. Although not related, he felt Petitioner might benefit from lumbar surgery noting Petitioner had failed nonoperative care. (RX 6)

With regard to the issues of (C) did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and (F) is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

It is clear from the evidence presented that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on July 31, 2009. What's in dispute is whether his low back complaints and need for surgery is causally related to said accident.

Petitioner worked for Respondent since 2006 as a satellite dish installer. His unrebutted testimony was that during his time of employment with Respondent, he did not have any lower back problem until this accident and injury on July 31, 2009. Petitioner acknowledged his prior lower back surgery in 1977. He testified he did not have any treatment on his lower back after he was released from treatment in 1978. Petitioner's testimony in respect to his prior back injury and being asymptomatic is unrefuted.

Petitioner testified he was able to perform the duties of a satellite dish installer prior to this accident and injury on July 31, 2009. A satellite dish installer carries tools and materials weighing 50-60 pounds and must lift ladders, install satellite dishes on roofs and run cable into the home. Petitioner testified he reported to work

on July 31, 2009 and was assigned four installations. While at his first installation, he was in an older home's basement on a six foot ladder attempting to pull cable into the home. As he was pulling cable, which was difficult, the cable got stuck and snapped. When the cable snapped, his hand jerked back and he got a deep sliver in his right index finger. He testified the blood was squirting out of his finger and the finger was very painful. In his haste to descend the ladder he missed a rung and fell from the ladder. He testified he was hurt and in pain and his back was injured, but the finger pain was the most immediate and severe pain.

Petitioner next presented to the emergency room where the sliver was removed and the finger sutured. Petitioner testified he advised the personnel at the hospital that he was also suffering lower back pain. Hospital records show he was also complaining of myalgia at the time of the visit.

Petitioner testified he advised he employer of the accident and need for medical treatment at the emergency room on the day of the accident. He further advised his manager of the accident and injury the Monday following the accident and was subsequently terminated. Petitioner further gave written notice of the accident and need for treatment on the 13th day of August. Petitioner submitted what was marked and admitted as Petitioner's Exhibit #13, being a letter to Respondent dated August 13, 2009. In the letter Petitioner indicated that he sustained an injury to his right index finger on July 31, 2009. Petitioner wrote, "Upon injuring my finger, I was in haste to get down off the ladder. I missed a rung on the way down, lost my balance, and hurt the lower part of my back. Immediately I felt pain when this happened but the pain to my index finger was greater and thought the pain to my lower back would go away. To this date it has not, but has gradually gotten worse. I will be seeking medical attention in the very near future for this and will forward the paperwork to your office as soon as it becomes available."

Petitioner's injury and the mechanics of same were detailed to his employer, each of his medical providers and is consistent with Petitioner's report of the accident at the time and his testimony.

As noted above, Petitioner had previous lower back surgery in 1977. He returned to full duty work after his release in 1978. Petitioner testified that he had no further medical treatment to his lower back from the time he returned to work in 1978 until the present injury on July 31, 2009. There is no evidence suggesting otherwise. A review of the medical records submitted into evidence by both Petitioner and Respondent contain no mention of any treatment to Petitioner's lower back prior to the accident of July 31, 2009. A review of each of Petitioner's medical providers records detail that Petitioner gave a consistent history of his injury to each provider.

Respondent exercised its Section 12 right and requested Petitioner attend an examination with Dr. Mirkovic, who testified via evidence deposition in this matter. Dr. Mirkovic testified that he reviewed the medical records of Petitioner's treating physicians through June of 2010, being the records of Illinois Valley Emergency Room records for two visits, the records of Dr. Jain of Midwest Orthopaedic Institute, the Morris Hospital Emergency Room records and a MRI of Lumbar Spine dated March 9, 2010. Dr. Mirkovic opined that there was no causal connection between the injury complained of and the accident and trauma experienced. Dr. Mirkovic based his opinion on his belief that there was no complaint of back pain at the emergency room and also Petitioner did not specifically complain of back complaints until he saw Dr. Jain on August 18, 2009 and on the next visit with Dr. Jain in September of 2009. Dr. Mirkovic specifically stated that it is the timing of Petitioner's symptoms that is the key to his opinion in respect to causation. In response to Petitioner's question as to the basis of opinion, Dr. Mirkovic detailed that it was his opinion that Petitioner first complained about his left sided back pain and low extremity pain on August 18, 2009. Dr. Mirkovic further stated that it was this delay of 18 days, without complaint regarding his back, was his basis that no causal connection existed between Petitioner's complaints and the reported incident on July 31, 2009. Dr. Mirkovic further testified that if there were complaints on July 31, 2009, that his opinion would change in respect to the causal connection.

Petitioner testified herein that when he reported to the Occupational Health and the Emergency Room that he did complain about his lower back. His testimony is verified by a review of the Emergency Room records which details under Review of Systems that he did complain in respect to myalgia. Respondent's expert acknowledged that myalgia is a complaint of pain secondary to muscle soreness. Petitioner's unrefuted testimony was that his main concern at the time of the Emergency Room treatment was the sliver in his finger, although his back was injured and hurting at the time. Petitioner further testified that over the weekend his back continued to tighten up and became worse. He reported the need for treatment to his back to the employer, in writing, on August 13, 2009 and orally to his manager, Kelly Dunn, on the Monday following the injury. Petitioner further credibly testified that he had contacted Dr. Jain for an appointment in respect to his back prior to having his stitches removed by the Emergency Room Doctor.

A review of Petitioner's Exhibit 3, being Dr. Jain's records from Midwest Orthopedic Institute, details a consistent history given to Dr. Jain as to accident on July 31, 2009. Dr. Jain prescribed a Medrol dose pack, Valium for his muscle spasm and Norco for pain. Respondent's expert testified that this was reasonable and appropriate treatment although not related to his July 31, 2009 accident.

Petitioner returned to Dr. Jain on September 8, 2009, at which time Petitioner's symptoms had worsened dramatically and Dr. Jain acknowledged that his condition was more than a sprain strain and ordered an MRI. Petitioner testified that his pain gradually worsened and affected both legs, buttock, and lower back. Respondent's expert acknowledged that bilateral leg pain exhibited by Petitioner was consistent with the anatomical condition of his lower back as exhibited by the MRI's.

Petitioner ultimately had the MRI in March of 2010. He was referred to Kishwaukee Health Centers Pain Management by Dr. Jain. Kishwaukee Health Centers records detail Petitioner's consistent history of the accident and injury and the resulting pain. He received a series of three epidural steroid injections and testified that they only gave him temporary relief. He was recommended to see a neurosurgeon and he was referred to Dr. Geisler. Dr. Geisler saw him in November of 2010 and recommended a MRI of the lumbar spine, CT scan of the lumbar spine as well as flexion and extension x-rays of the lumbar spine. Dr. Geisler also referred Petitioner for pain management and medication. Petitioner was also prescribed an EMG which was performed in October of 2010 at the request of Dr. Coulson of the Kishwaukee Pain Management Clinic. Petitioner treated with Dr. Henze who then referred Petitioner to Dr. Kuo of Meridian Medical Association. Dr. Kuo prescribed a new MRI and CT scan with contrast and referred Petitioner to Dr. Gary Koehn at Morris Hospital for pain management. Dr. Henze further prescribed physical therapy which was performed at ATI as well as the Illinois Back Institute. A review of the medical records and the histories taken by each provider details that Petitioner has been consistent and credible with the histories given and the complaints of pain.

Respondent submitted an updated report of Dr. Mirkovic. The doctor maintained his opinion that there is no causal connection between the July 31, 2009 injury and Petitioner's current condition of ill-being, based on a lack of complaints immediately after the accidental injury. Dr. Mirkovic acknowledged Petitioner's need and potential benefit from the medical treatment he has received to date. Specifically in his updated report the doctor opined that Petitioner may benefit from lumbar surgery to decompress and stabilize his spinal canal due to his having failed conservative non-operative care. He further opined that an additional MRI of the lumbar spine and CT scan of the lumbar spine should be done prior to surgery.

Although Dr. Mirkovic testified that he saw no causal relation between the accident and the resulting condition of Petitioner's lower back, the doctor did acknowledge that the MRI findings support a history of both left and right sided pain. The doctor further acknowledged it was not unusual that patients have increased and decreased pain from examination to examination. Respondent's expert agreed that an individual's lower back may present itself with the anatomical conditions found on a MRI and the individual could certainly be without any back pain or radicular pain. Dr. Mirkovic further testified that Petitioner's history of missing a step on a

ladder and coming down on the floor hard could develop spinal disorders such as those complained by Petitioner.

Petitioner has underwent a long process of conservative treatment consisting of physical therapy, oral medication and epidural steroid injections. Petitioner saw a neurosurgeon, Dr. Geisler, who recommended fusion surgery originally in 2010; has seen two pain management specialists who attempted various conservative treatments and is now treating with Dr. Kuo and Dr. Koehn for pain management and surgery. Respondent's independent medical expert did not question the reasonableness or necessity of any of the medical treatment of Petitioner to date and acknowledges that conservative treatment has failed and Petitioner may very well be a surgical candidate, but denies that any of the treatment Petitioner requires can be causally connected to his accident of July 31, 2009.

Based on all the above, the Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on July 31, 2009. The Arbitrator further finds that a casual relationship exists between his right index finger and low back conditions of ill-being and the accident sustained.

With regard to the issue of (J) were the services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services and (K) Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Having found the requisite causal relationship, the Arbitrator finds that Petitioner is entitled to medical expenses in the amount of $34,182.75 for reasonable and necessary medical treatment received to date. Said medical expenses are to be paid consistent with the medical fee schedule under Section 8(a) of the Act. The Arbitrator further finds that Respondent shall authorize the medical treatment as recommended by Petitioner's treating physician.

The Arbitrator notes that although Respondent's independent medical expert denied a causal relationship, he did not question the reasonableness or necessity of any of the medical treatment of Petitioner to date and acknowledged that conservative treatment has failed and Petitioner may very well be a surgical candidate.

Consistent with the parties stipulation, Respondent is entitled to a credit of $2,558.81 for payment of medical bills prior to trial.

With regard to the issue of (L) is Petitioner entitled to any temporary total benefits, the Arbitrator finds as follows:

Petitioner testified that he reported to attempt to work on the Monday following the accident and was discharged. He further testified that the pain in his back grew increasingly worse over the weekend and that he needed to get medical treatment on same. He further reported the need for treatment to his back, in writing, on August 13, 2009. Petitioner went on to testify that he was not capable of performing the heavy physical demands of a satellite dish installer after the date of this accident.

Petitioner's treating physicians, in their records, do not address the issue of Petitioner's inability to work. Petitioner testified he was discharged and therefore did not secure off-work slips from the treating physician.

With exception of the records from Health Information Management, the only reference to Petitioner's work capacity is gleamed from the opinion of Respondent's Section 12 examiner, Dr. Mirkovic. Although the

doctor opined denied causality in his July 13, 2010 report, he opined Petitioner was incapable of performing the duties of a satellite dish installer and could possibly perform a light duty position. Respondent's expert reiterated that opinion in his supplemental report. It is therefore unrefuted that Petitioner was incapable of performing his duty as a satellite dish installer for Respondent on or after July 13, 2010, the date of the Independent Medical Examination.

Based on the above, the Arbitrator finds Petitioner is entitled to temporary total disability benefits from July 13, 2010 through November 8, 2013, or a period of 173-4/7 weeks.

With regard to the issue of (M) should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

The Arbitrator finds that a legitimate dispute existed with respect to whether Petitioner's low back condition of ill-being was causally related to the accident sustained. As such, Petitioner's request for penalties is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANISLAO CALDERON,
Petitioner,
vs.
MARRIOTT OAK BROOK,
Respondent,

NO: 10WC 31110

15IWCC0336

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 temporary total disability, 8 j credit, 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 24, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $49,817.00. 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: MAY 1 1 2015
MJB/bm
o-5/5/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CALDERON, ANISLAO
Employee/Petitioner

Case# **10WC031110**

MARRIOTT
Employer/Respondent

15IWCC0336

On 9/24/2014, 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 0.04% 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:

1855 LAW OFFICE OF TRENT & BUTCHER
DOUGLAS P TRENT
350 S SCHMALE RD SUITE 130
CAROL STREAM, IL 60188

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0336

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

Anislao Calderon
Employee/Petitioner

v.

Marriott
Employer/Respondent

Case # **10WC 31110** _____

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **8/8/14**. 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 **Whether Petitioner exceeded his choice of physicians under the Act.**

15IWCC0336

FINDINGS

On **7/3/2010**, 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 through 9/30/13 is causally related to the accident. Petitioner's condition subsequent to 9/30/13 ***is not*** causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned $**26,678.52**; the average weekly wage was $**551.51**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services through 9/30/13.

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

Respondent shall be given a credit of $**24,875.12** for TTD, $ for TPD, $ for maintenance, and $**4,925.69** for other benefits, for a total credit of $**29,800.81**. ARB EX 1.

Respondent is entitled to a credit of under Section 8(j) of the Act. ARB EX 1.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $330.91/week for 107.50 weeks, because the injuries sustained caused the 25% loss of the left leg, and 25% loss of use of the right leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the causally related injuries through 9/30/13 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner temporary total disability benefits of $367.67 per week for intermittent periods totaling 38 4/7weeks pursuant to Section 8 (b) of the Act. Respondent shall receive credit for amounts paid.

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

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

Signature of Arbitrator

9/23/14
Date

SEP 24 2014

FINDINGS OF FACT

At trial, Petitioner testified via interpreter. The parties stipulated to the issues of accident on 7/3/10 and notice. ARB EX 1. Petitioner testified that he worked 5 years for Respondent as a food service attendant. On 7/3/10, Petitioner sustained a work related accident when he fell on both knees while carrying furniture. Petitioner noticed immediate pain in both knees and reported the injury to a security officer. Petitioner testified that he reported the accident to his boss "James" the following day.

Petitioner initially treated with his family doctor, Dr. Cespedes, on 7/5/10. Petitioner chose to see Dr. Cespedes and was not referred to him for care. X-rays were taken of both knees and pain medication was prescribed. Petitioner was also seen at Advocate Occupational Health Center on 7/8/10. PX 4. Petitioner reported pain in both knees since the accident of 7/3/10 right worse than left. Petitioner was diagnosed with "knee contusion," prescribed medication and a knee sleeve, and given modified duty. PX 4.

Petitioner testified that he continued to treat with Dr. Cespedes from July through November 2010. During that period Petitioner testified that he was referred to Dr. Payne by Dr. Cespedes. Dr. Payne administered injections to Petitioner's bilateral knees. Petitioner also attended physical therapy per Dr. Payne's instruction.

On 12/28/10, an MRI of the right knee indicated a medial meniscal tear involving the midbody and posterior horn along with generalized osteoarthritis especially involving the medial compartment. PX 6. A 12/28/10 MRI of the left knee indicated a large horizontal tear involving the midbody and posterior horn of the medial meniscus.

On 1/6/11, Petitioner saw Dr. Freedberg at Suburban Orthopedics. Petitioner testified that he was referred there by his attorney and not by a physician. Dr. Freedberg was Petitioner's second choice of provider. Petitioner testified that he continued to see Dr. Freedberg once per month between January 2011 and October 2011. Petitioner also attended physical therapy at Suburban Orthopedic during that time. Petitioner testified that while attending PT during the period he could "barely walk" on his right knee. Petitioner described his knee pain as a "disconnected knee" and testified that he would have to "adjust" his right knee in order to walk. He also testified to a "cracking" in his knees. Petitioner testified to the same symptoms with his left knee during this period. Dr. Freedberg diagnosed bilateral medial meniscal tears and discussed an initial course of conservative treatment versus surgery. Petitioner opted for surgery. PX 11.

While waiting for surgical authorization, Petitioner attended a Section 12 exam at Respondent's request with Dr. Verma in March 2011. At that time, Dr. Verma agreed with the recommended bilateral arthroscopic knee surgeries. PX 15, p. 97/104. On October 19, 2011 Dr Freedberg performed right knee surgery in the form of a right knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, chondroplasty of the patella, medial and lateral femoral condyle and debridement of loose bodies. PX 11. Petitioner was taken off work post surgery. PX 11.

Dr. Freedberg performed left knee surgery on 1/11/12 in the form of a left knee arthroscopy, partial medial meniscectomy, chondroplasty to the patella and removal of loose bodies. PX 11. Petitioner followed up after surgery with physical therapy and was off work. He continued to see Dr. Freedberg

post surgeries and continued to complain of some pain and weakness in both knees. At the visit of 2/23/12, Dr. Freedberg recommended continued PT and injections for the right knee. A right knee injection was administered on that visit. PX 11. Petitioner was continued off work. As of 3/22/12, Petitioner reported that the right knee injection helped to relieve his right knee pain so he requested and received an injection to the left knee which was still painful. PX 11. At this point, Petitioner was placed on light duty until a follow up in 4 weeks. PX 11.

Petitioner was continued on light duty as of 4/4/12 when at the visit to Dr. Freedberg he reported continued pain in both knees with continued popping sensation in the left knee. Dr. Freedberg noted that after the left knee injection Petitioner was "1 week improved 70% improved and regressed to 50% improved. R knee was 60% improved but has cracking in knee and pain with walking, pinching pain medially." PX 11. Petitioner was allowed full weight bearing on both knees with continued PT. Dr Freedberg recommended "viscosupplementation for both knees of Orthovisc series." Light duty was continued. PX 11. The same recommendations were made at the visits of 6/13/12, 8/1/12 and 9/26/12 while awaiting approval for the injections. PX 11.

Petitioner attended a Section 12 exam with Dr. Verma on 11/5/12. A supplemental report was prepared on 11/16/12 after Dr. Verma reviewed additional medical records from Dr. Freedberg and a "surveillance report from October 17, 2012, noted the patient was observed driving a vehicle running errands such as stopping in a bank and engaging in maintenance activities around the vehicle surrounding his home. He was not noted to use any brace or cast and did not utilize any support for ambulation." RX 4. In his 11/16/12 report, Dr. Verma noted that his exam indicated "diffuse complaints of pain with no localized tenderness and no effusion with full range of motion. Based on the time frame after max medical improvement as well as the patient's static physical exam findings of multiple exams over longer period of time it is unlikely he developed benefit from further therapy or conservative care. At this point, it is again my opinion that patient requires an FCE and would be placed at max medical improvement." RX 4. Dr. Verma noted indications of symptom magnification on exam.

Petitioner attended an FCE on 11/29/12 at Accelerated Rehab. On November 29, 2012, Petitioner underwent an FCE at Accelerated Rehabilitation Center that found him capable of 35 pound bilateral lifting, 25 pound frequent bilateral lifting, 25 pound bilateral shoulder lifting, and 25 pound horizontal pushing force. RX 5. It also found Petitioner demonstrated inconsistent reliability, produced varied effort, and had 84.3% inconsistent pain complaints. Therefore, it was determined the Medium Category of Work was only a minimal level of function for Petitioner, and he was capable of greater functional abilities. The physical therapist noted Petitioner's pre-injury job as a Food Service Attendant was within the Medium physical demand level.

On 12/12/12, Dr. Freedberg noted continued complaints of pain in both knees with limping, throbbing and popping sensations in both knees. Petitioner was back to work at 4 hours per day. Injections were recommended again. PX 11. As of 1/21/13, Dr. Freedberg reviewed the FCE results with Petitioner who continued to complain of severe bilateral knee pain and symptoms of instability when walking. Dr. Freedberg noted that he disagreed with Dr. Verma based on Petitioner's continued complaints and again recommended injections. He noted that Petitioner was working light duty "per the FCE." As of May 2013, Dr. Freedberg began a series of 3 Orthovisc injections to the right knee despite a lack of approval. In June 2013, Dr. Freedberg completed a series of 3 Orthovisc injections to the left knee. PX 11. As of 6/19/13, Petitioner was to continue light duty work and follow up in 5 weeks.

On 8/5/13, Dr. Freedberg noted that Petitioner's right knee was 60% improved and his left knee 70% improved following the injections. He noted that Petitioner "continues to have some pain in both. He is not able to work for too long. He states his pain wakes him up in the morning. He also feels a burning in his knee and continues to have cracking." PX 11. He noted that Petitioner "did well" with the injections and that "the only problem is with sleep and if he walks a lot." Dr. Freedberg concluded, " Follow up PRN. They have not taken him back to work so I am stating with the lack of progress clinically and not working per restrictions, he is now at MMI. The patient will be on light duty per the FCE until follow up. He doesn't feel he can RTW full duty." PX 11. Dr. Freedberg released Petitioner to light duty with full restrictions against lifting over 20 pounds, and no stooping, kneeling or repeated bending. PX 11. As of 9/30/13, Dr. Freedberg noted these restrictions were permanent and that "patient is able to perform some type of work that fit his restriction and therefore I can't recommend disability." PX 11.

Petitioner attended one final visit with Dr. Freedberg on 1/16/14. At that visit, Petitioner again complained of bilateral knee pain, clicking, popping, mild swelling, knee buckling when walking and that his knees give out when standing from a sitting position. Dr. Freedberg wrote, "The patient presented to the office several times after he was made MMI. I have reinforced to him that MMI is not completely normal. He is not and never will have a normal knee. He is on light duty permanently which is a testament to this. He understands that the issue is just the DJD in the knee and that is the pain generator exacerbated by the accident. He is still at MMI and only treatment will be for the DJD and no further intervention is indicated today." PX 11.

After his release from Dr. Freedberg, Petitioner returned to his primary care doctor, Dr. Cespedes on 2/13/14. The records indicate that Petitioner was seen for complaints of neck and shoulder pain. Dr. Cespedes noted Petitioner longstanding knee pain and treatment with Dr. Freedberg and noted that Dr. Freedberg indicated that nothing more could be done for Petitioner's knees short of a knee replacement. He further noted the permanent restrictions set forth by Dr. Freedberg with regard to Petitioner's knees. Dr. Cespedes wrote a note indicating his opinion that Petitioner should be limited in his walking and standing at work. He concluded, "as far as his upper extremity pain and disability is concerned, patient is still in the midst of a workup for those issues." PX 15. Dr. Cespedes referred Petitioner to Dr. Gonzalez at Illinois Bone and Joint for "left elbow pain, right shoulder pain, B/L knee pain." PX 15.

Dr. Gonzalez saw Petitioner on one occasion on 2/18/14. PX 17. At that time, he noted that he was seeing Petitioner for his elbow and shoulder and noted his long standing knee problems stemming from the July 2010 work accident. Petitioner was sent to 2 weeks of PT for bilateral knee DJD. PX 17.

At trial, Petitioner testified that he currently notices a lot of pain in both knees but more so on the left knee. Petitioner testified that he has a great deal of pain in the morning and that he "massages" and "adjusts" his left knee every morning in addition to home exercises. Petitioner testified to cracking and pain in the right knee but that he does not "adjust" the right knee. He further testified that his "bones rub against each other so it hurts." He is able to do some yard work and he can drive. He testified that he is able to check routine maintenance items on his car and does help care for his grandchildren.

Petitioner testified that he did not have a prior injury or pain in either knee before this accident. However, RX 10 contains records from Elmhurst Clinic providers referencing a fall on his knees in 2005 with

bilateral knee pain and bilateral knee x-rays from August 2005 showing degenerative changes in both knees. Degenerative arthritis was also diagnosed in 2008. RX 10.

Petitioner testified that he did not return to work for Respondent despite his release to permanent light duty per Dr. Freedberg as Respondent would not accommodate the restrictions. He testified that he was never offered any accommodated duty by Respondent after October 2013. RX 7 is a letter in both English and Spanish sent to Petitioner by Respondent's Human Resource manager, Leland Lopez, dated July 22, 2013. The letter clearly offers Petitioner restricted duty per an FCE which included restrictions of lifting 35 lbs bilaterally, frequently lift of 25 lbs bilaterally and shoulder lifting bilaterally of 25 lbs. He was to push 25 lbs of horizontal force. Petitioner was offered his current salary and an immediate placement. Attached to the letter is a signed acknowledgement by Petitioner that he received the letter and that he chose not to return to work for reasons "that were his own." RX 7. At trial, Petitioner denied receiving the Spanish letter and testified that he did not understand the English letter he received or the last page which he signed refusing the job.

RX 9 is a group of video surveillance reports from January and March 2011. In the reports, the investigator noted his observations of Petitioner driving and walking as well as "working" at the La Playa Cantina restaurant including taking orders and carrying dishes. Petitioner testified that the restaurant was owned by his brother and that he went there on an unpaid casual basis to obtain food from his brother. He testified that he would try to help his brother when he could. No video surveillance was submitted at trial.

Respondent called Mr. Sacramento Alcantar to testify in his capacity as Respondent's Human Resource Generalist. T. 71. He testified that the restricted duty job offers are conveyed via letter translated into Spanish. T. 72-73. He testified that if an employee declines a return to work offer it is considered job abandonment. T. 76. He further testified that he is aware Petitioner called another Human Resource employee requesting a return to work under Dr. Freedberg's restrictions. T. 79. He further testified that Petitioner did not return to work for Respondent despite the offer in July 2013. The witness had no personal communication with Petitioner.

Respondent's Exhibit 6 is a job summary of a Food Services Attendant. RX6. It indicates Petitioner was able to stand, sit, or walk for an extended period of time, move/lift/carry/push / pull/place objects weighing less than or equal to 25 pounds without assistance, and reach overhead and below the knees, including bending, twisting, pulling, and stooping. RX6.

CONCLUSIONS OF LAW

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

The Arbitrator makes the following findings on the issue of **(F) is the Petitioner's present condition of ill-being causally related to the injury?**

Based on the record in its entirety, the Arbitrator finds that Petitioner met his burden to prove by a preponderance of the credible evidence that he suffered an exacerbation of underlying degenerative joint disease and meniscal tears as a result of his stipulated work accident on 7/3/10, and that Petitioner reached MMI for the work related injuries as of 9/30/13, when Dr. Freedberg noted these restrictions were

permanent and that "patient is able to perform some type of work that fit his restriction...". Petitioner's condition of ill-being after 9/30/13 is unrelated to his work accident or injury.

Per the medical records from 2005 and 2008, Petitioner had a pre-existing degenerative arthritis in both knees in mild form. RX 10. Petitioner testified he fell on both knees while carrying furniture at work on July 3, 2010. He was initially diagnosed with bilateral knee contusions at Advocate Occupational Health. (PX4). An MRI of the right knee revealed a medial meniscal tear and generalized osteoarthritis. (PX6). An MRI of the left knee revealed a medial meniscal tear. (PX7). After a course of physical therapy, Petitioner underwent a right knee arthroscopic procedure on October 19, 2011 that involved a partial meniscectomy, a chondroplasty of the patella and medial/lateral femoral condyle, and debridement of loose bodies. (PX8). Petitioner underwent a left knee arthroscopic procedure on January 11, 2012 that involved a partial medial meniscectomy and chondroplasty of the patella. (PX9). Both surgeries were recommended by Dr. Freedberg and the Section 12 examining physician Dr. Verma.

Following a course of post-op physical therapy, Petitioner continued to complain of bilateral knee pain and symptoms to Dr. Freedberg and was under Dr. Freedberg's active care which included many injections to both knees in May and June 2013. Dr. Freedberg continued Petitioner either off work or on light duty during this period of time. On August 5, 2013, Dr. Freedberg declared Petitioner had reached MMI, released him from his care, and stated that besides some issues with sleep and with walking long distances, Petitioner had no lingering problems. PX 11. Dr. Freedberg stated that Petitioner was again at MMI as of 9/30/13 and that he could work some type of employment within his restrictions as set forth by the FCE and by Dr. Freedberg. PX 11. On January 16, 2014, Dr. Freedberg wrote, "The patient presented to the office several times after he was made MMI. I have reinforced to him that MMI is not completely normal. He is not and never will have a normal knee. He is on light duty permanently which is a testament to this. He understands that the issue is just the DJD in the knee and that is the pain generator exacerbated by the accident. He is still at MMI and only treatment will be for the DJD and no further intervention is indicated today." PX 11.

Petitioner saw Dr. Gonzalez in February 2014 for his left elbow, right shoulder, and occasional bilateral knee pain. PX 17. (PX17). Dr. Gonzalez found full range of motion of both knees, stability to varus and valgus stresses and ligamentous testing, and only some mild crepitus and antalgic gait with the right knee, but not the left. Dr. Gonzalez diagnosed "very, very subtle subtle degeneration of the bilateral knees", but significant impingement of the right shoulder, right biceps tendinitis, and left lateral epicondylitis at the elbow. RX17. As Petitioner had reported to Dr. Gonzalez that he had never treated before for his knees, and never received any physical therapy, Dr. Gonzalez recommended a course of physical therapy for the shoulder, elbow, and knees. RX17. Petitioner presented to Marianjoy Rehabilitation on April 14, 2014 for physical therapy and reported improved knee pain after surgery, but recent increased knee pain due to underlying arthritis. PX18. After only 3 physical therapy sessions, Petitioner was advised to obtain clearance to continue from his primary care physician as he reported chest pain and shortness of breath. RX 8. Petitioner never sought clearance or a return to physical therapy.

The medical records indicate Petitioner suffered an exacerbation of pre-existing degenerative joint disease and meniscal tears in both knees as a result of his July 3, 2010 work accident. Petitioner underwent surgery to both knees, and after a course of physical therapy and further post op conservative care with Dr. Freedberg, including injections, was released to MMI as of 9/30/13 by his treating physician Dr. Freedberg. Since that time, Petitioner has attempted to return to his treating doctor for more treatment or

work restrictions, and both Dr. Freedberg and Dr. Cespedes have declined. The Arbitrator notes that Dr. Gonzalez' treating records in February 2014 do not clearly or sufficiently state his involvement or treatment plan for Petitioner's bilateral knees so as to extend any finding of causal connection through his dates of treatment.

Accordingly, the Arbitrator finds that Petitioner reached MMI for his causally related work related injuries as of 9/30/13. His condition of ill-being subsequent to 9/30/13 is not causally related to his work accident in July 2010.

The Arbitrator makes the following findings on the issue of **(J) were the medical services provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**

Based on the Arbitrator's finding of causal connection for Petitioner's work related injuries through 9/30/13, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of the causally related injuries only through 9/30/13 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit owed pursuant to Section 8 (j) of the Act. ARB EX 1. Respondent shall not pay for medical expenses incurred subsequent to 9/30/13.

At trial, Respondent raised the issue of whether Dr. Gonzalez exceeded Petitioner's allowable choice of providers under the Act. To the extent the issue was raised at trial, the Arbitrator finds that Petitioner did not exceed his choice of providers in that Dr. Cespedes referred Petitioner to Dr. Gonzalez making the choice within the allowable chain of providers. However, based on the finding of causal connection stated above, Petitioner's medical expenses incurred through his treatment with Dr. Gonzalez are not awarded for reasons other than the allowable choice of provider issue.

The Arbitrator makes the following findings on the issue of **(K) what amount of compensation is due for temporary total disability?**

In awarding TTD, the Arbitrator notes that RX 1 indicates that Petitioner was off work and paid TTD for the periods of 11/17/10 through 11/28/10 and again from 12/15/10 through 1/17/11. Based on Petitioner's continued treatment through that period, the Arbitrator awards TTD for these periods. Petitioner returned to work for Respondent in March 2011 until his first surgery in October 2011. Petitioner was then off work again commencing 10/19/11 through 3/22/12 when Dr. Freedberg released him to light duty work as of March 22, 2012 with no lifting over 10 pounds. (PX11 at 78). Respondent was unable to accommodate the light duty on site. Instead, Petitioner worked at Wings, a non-profit company, in a light duty capacity at Respondent's request. Respondent offered that light duty job commencing 5/29/12. The records indicate Petitioner only worked from May 29, 2012 to June 1, 2012. (RX3). T. 53. Petitioner was seen by Dr. Freedberg on June 13, 2012 and was told to continue light duty work. (PX11 at 6). The medical records continue to reflect light duty work releases provided by Dr. Freedberg up through the permanent light duty restrictions imposed by Dr. Freedberg as of 9/30/13. There is no medical reason presented in the record as to why Petitioner could not continue to work the provided accommodated light duty work after June 1, 2012. As Petitioner was released to light duty on March 22, 2012, and was provided light duty as of May 29, 2012 that accommodated his restrictions, Petitioner is entitled to TTD commencing 10/19/11 through 5/29/12, the date on which he started light duty work for Respondent. Petitioner is not

entitled to any TTD beyond that time based on his failure to continue working the accommodated light duty work offered by Respondent without medical authorization for his absence from the accommodated position.

Finally, in making this TTD award, the Arbitrator placed little weight on the surveillance reports submitted by Respondent. In so doing, the Arbitrator accordingly gave no credence to the assertion that Petitioner worked or was capable of working at his brother's restaurant during the periods observed.

Based on the above, the Arbitrator finds that Petitioner is entitled to TTD for a period of 1-5/7 weeks commencing 11/17/10 through 11/28/10 and again for a period of 4-6/7 weeks commencing 12/15/10 through 1/17/11. Petitioner is entitled to additional TTD for a period of 32 weeks commencing 10/19/11 through 5/29/12 for a total TTD award of 38-4/7 weeks pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid including any overpayment of TTD benefits resulting from this award. ARB EX 1.

The Arbitrator makes the following findings on the issue of **(L) what is the nature and extent of the injury?**

The Arbitrator notes that the date of accident on 7/3/10 is prior to September 1, 2011. No AMA evidence of impairment pursuant to Section 8.1b was provided at trial. The Arbitrator next notes that Petitioner did not request a wage differential and presented no evidence on the issue of wage differential leaving the record devoid of any evidence to be considered by the Arbitrator. Petitioner has been released to work with permanent restrictions. Dr. Freedberg noted in his last note that Petitioner is capable of working at some employment within his restrictions. No vocational evidence was submitted by either party. Therefore, while noting that Petitioner did not request a finding of permanent total disability, the Arbitrator further notes that the record is devoid of any evidence on which to base a finding of permanent total disability.

Based on the evidence presented at trial, the Arbitrator finds that Petitioner sustained bilateral meniscal tears as well as aggravated degenerative arthritis as a result of his work injury on 7/3/10. He underwent extensive surgeries to both knees followed by conservative care and additional injections to both knees. Petitioner credibly testified that following his surgeries, he had continued pain and symptoms of instability in both knees. He credibly testified that he can perform some activities of daily living including lawn, car and child care. Again, there was no evidence of diminished earnings capacity given the above findings on TTD.

Accordingly, the Arbitrator finds that Petitioner sustained a specific loss of 25% loss of use of the right leg and 25% loss of use of the left leg as a result of his work accident on 7/3/10 pursuant to Section 8(e) of the Act.

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

DON L. CAMPBELL SR.,
Petitioner,
vs.

NO: 12WC 19297

RON'S STAFFING SERVICE,
Respondent,

15IWCC0337

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, notice, 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 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 $19,581.00. 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: MAY 11 2015
MJB/bm
o-5/5/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAMPBELL, DON
Employee/Petitioner

Case# **12WC019297**

RON'S STAFFING SERVICE
Employer/Respondent

15IWCC0337

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:

2208 CAPRON & AVGERINOS PC
STEPHEN SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

4944 KOREY RICHARDSON LLC
NICK TATRO
20 S CLARK ST SUITE 500
CHICAGO, IL 60603

15IWCC0337

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

Don Campbell,
Employee/Petitioner

v.

Ron's Staffing Services,
Employer/Respondent

Case # **12** WC **19297**

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 **7/23/14**. 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 _____

15IWCC0337

FINDINGS

On **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 ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**13,936.00**; the average weekly wage was $**268.00**.

On the date of accident, Petitioner was **66** 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 $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 37 weeks, commencing 5/3/12 through 1/16/13, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 3/27/14 through 7/23/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services outlined in PX4, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 per week for 40 weeks, because the injuries sustained caused the 8% 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

9/15/14
Date

SEP 17 2014

STATEMENT OF FACTS:

Following retirement from his full-time occupation, Petitioner began part-time work with the Respondent in approximately March of 2010. He was assigned to Caveo Products and Services in its warehouse. His job involved the packing and loading of skids containing various products weighing from 5 to 65 pounds. Petitioner testified that prior to going to work for Respondent he had no prior medical conditions or issues with his left shoulder.

Petitioner testified that on March 26, 2012, he was in the staging area, pushing and lifting a box with his left arm when he heard a pop in his left shoulder and dropped the box. A co-worker named Aaron helped him put the box up. He did not immediately report it to the Respondent but instead contacted his family physician Dr. Susarla. (PX1). He was examined by Dr. Susarla later that day. Dr. Susarla's office note simply notes complaints of pain in the left shoulder with no reference to any precipitating cause or event. (PX1). Dr. Susarla diagnosed a sprain of the left shoulder and recommended physical therapy and an MRI. (PX1). A subsequent telephone message indicates that Petitioner was informed that the insurance company, Sherman Choice, had denied the MRI and that Petitioner "… was not happy, would like to see an Orthopedic doctor, he refuses to do PT. States that he is in so much pain …" (PX1). A subsequent telephone message dated April 5, 2012 indicated that the HMO would not approve the MRI, and that Petitioner was to complete physical therapy and taken pain medications. (PX1).

Petitioner continued to work. He noted that in the interim a new foreman had been hired, and that Petitioner did light assembly work at that time.

Petitioner's referral to an orthopedic physician by his HMO was approved and he came under the care of Dr. Ankur Chhadia at Suburban Orthopaedic on April 27, 2012. (PX2). In a "Patient Medical History" form on that date Petitioner noted that the date of injury or onset of his symptoms was "approx 8 wk. ago" and that the body part affected was his left shoulder and arm. (PX2). An accompanying typewritten report by Dr. Chhadia on the date of his initial examination, April 27, 2012, reflects onset "approximately on _____ 2/2012" and the cause or mechanism as "overuse work ___ lifts boxes in shipping receiving dock at work noticed pain when he woke up next morning." (PX2). Dr. Chhadia diagnosed left shoulder bicipital tenosynovitis and bursitis/tendonitis with a probable RTC SST tear. (PX2). A subsequent MRI performed on May 12, 2012 revealed a full thickness tear of the supraspinatus tendon at its anterior critical zone. (PX2).

For his part, Petitioner denied that his symptoms first started in February of 2012, maintaining that a single incident on the morning of March 26, 2012 while lifting boxes caused the injury. Petitioner also testified that the chiropractic treatment he had received prior to the accident in question was for his neck down the middle portion, and not the left side, of his neck.

Petitioner testified that on April 30, 2012 he told the foreman at Caveo Products, Tony Disart, that he had hurt himself and that he could not do heavy lifting because he was in too much pain. Petitioner noted that Tony told him to report the matter to Ron's Staffing. Petitioner testified that he called Ron's Staffing that same day and spoke to Cesar Roman, "the head guy at the office." Petitioner noted that he was told to come in and fill out a report, which he did on May 1, 2012. He indicated that Mr. Roman then came in on May 2, 2012 with some forms and said he had been given a three (3) day suspension for not reporting the injury. Petitioner noted that he returned to work on May 8, 2012 at which time Tony informed him that he was off payroll and that he was not to punch in.

Enrique Landeros, safety manager for Ron's Staffing, testified at the request of the Respondent. Mr. Landeros noted that the individual who investigated and filled out the incident report submitted at RX2, Cesar Roman, no longer works for Ron's Staffing. Mr. Landeros indicated that he would have been Mr. Roman's supervisor, and that such a report was created and kept in the normal course of business.

The "Supervisory Incident Investigation Report" in question, signed by Mr. Roman on May 2, 2012, reflects a date and time of injury of "4/9/2012 – 9 am." (RX2). The description noted in this report is as follows: "Employee claims he was carring [sic] boxes onto a skid going to a third level. Upon carring [sic] a box weighing 60-70 lbs he felt a popping sound. He thought nothing by it and continued with the day. His left shoulder got sore and sweled [sic] up for days. He went to see his family doctor at Sherman Health Center with his wife insurance. The Elgin office had no supervisor or employee let us know this incident on the day of occurrence. * incident happened on Monday but did not feel anything until Thursday." (RX2). Petitioner testified that it was not his handwriting on this document, and that the date of injury shown was "very much a mistake."

An accompanying "Employee Statement", signed and dated by Petitioner as well as Mr. Roman on May 1, 2012, noted the following: "I was loading a skid, with finish produce, when I felt a pop in my upper left arm. The boxes weighed between 65 & 75 lbs, that I was putting on the skid. We stack them 3 high and at the time of the injury, I was putting a box on the top, third layer." (RX2). This particular form shows a time of accident of "approx 8:00 am" but does not reflect a date of accident. (RX2).

A separate "Medical Authorization and Release of Medical Records" form, signed by both Petitioner and Mr. Roman, shows a date and time of accident of "4-9-2012 (7-9 am)." (RX2).

Petitioner testified that he did not know why these forms show a date of accident of April 9, 2012, noting instead that he got a new foreman on that date. He also indicated that he did not know why that date was on the original Application for Adjustment of Claim (RX1), which he noted was prepared by his first attorney. Petitioner testified that he even spoke to Tony about the discrepancy and that he was told that they would change the records and that would not be a problem.

Following completion of its investigation, Respondent suspended Petitioner from work for the period May 3, 2012 through May 7, 2012 and subsequently terminated him on May 8, 2012.

On the date of his suspension, May 3, 2012, Petitioner visited Physician's Immediate Care at which time he was examined by Dr. Candace Nowak, D.O. (PX4). On that date, the following history was recorded: "Patient states that while at work on 4/9/12 he was lifting heavy boxes that weighed approximately 65-75 pounds and he felt a 'pop' in his left upper arm. Patient states that for two days he did not have any pain then he started having significant pain in the upper arm on the left. He states that the pain radiates into the shoulder. Patient denies any non-work related incident or event correlating with the development of this condition …" (PX4). Dr. Novak diagnosed left upper arm pain and imposed the following restrictions: "[n]o lifting greater than 5 pounds from floor to waist, waist to shoulder, and overhead and no pulling or pushing greater than 5 pounds until recheck." (PX4).

On May 29, 2012, Dr. Chhadia recommended an arthroscopic rotator cuff repair procedure together with subacromial decompression given the results of the MRI. Petitioner underwent surgery on June 7, 2012. (PX2). Thereafter, he continued under the care of Dr. Chhadia who prescribed physical therapy at the clinic associated with his facility. On October 29, 2012, Petitioner was released to return to work with light duty restrictions which were not accommodated by the Respondent.

Petitioner was last examined by Dr. Chhadia on January 16, 2013. It was noted that he was still experiencing pain on the lateral side of the shoulder but was doing better. Dr. Chhadia deemed him at MMI and released him to return to work without restrictions at that time. Petitioner testified that he effectively retired following his discharge from medical care and received no further treatment to his left shoulder.

Petitioner testified that he currently notices pain all the time, and that he takes over-the-counter medication such as Aleve everyday for his complaints. He indicated that he does not have the strength overhead that he used to, and that his shoulder affects his ability to do odd jobs. He noted that he can raise his arm above his head, but that he has to force it. He also testified that the surgery improved his condition, but not 100%.

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

Petitioner testified that he sustained injuries to his left shoulder while lifting boxes on March 26, 2012. He indicated that he had no physical or medical conditions related to his left arm or shoulder prior to the injury in question, although he did suffer a prior workers' compensation injury in 1990 when he suffered three herniated discs after sliding down 25 steel stairs. He also noted that the chiropractic treatment he received earlier in March of 2012 was for his neck and down the middle portion of his back, and not his left neck or shoulder. The records from this chiropractor dated March 9, 2012, supports Petitioner's claim that the treatment was primarily directed to Petitioner's cervical and lumbar spine with no mention of any shoulder issues. (RX4).

Petitioner initially saw Dr. Susarla on March 26, 2012. Dr. Susarla's office note on that date simply relates complaints of pain in the left shoulder with no reference to any precipitating cause or event. (PX1). Dr. Susarla diagnosed a sprain of the left shoulder and recommended physical therapy and an MRI. (PX1).

Petitioner next saw Dr. Chhadia, his treating surgeon, on April 27, 2012. (PX2). In a "Patient Medical History" form on that date Petitioner noted that the date of injury or onset of his symptoms was "approx 8 wk. ago" and that the body part affected was his left shoulder and arm. (PX2). An accompanying typewritten report by Dr. Chhadia on the date of his initial examination, April 27, 2012, reflects onset "approximately on _____ 2/2012" and the cause or mechanism as "overuse work ___ lifts boxes in shipping receiving dock at work noticed pain when he woke up next morning." (PX2). Dr. Chhadia diagnosed left shoulder bicipital tenosynovitis and bursitis/tendonitis with a probable RTC SST tear. (PX2). A subsequent MRI performed on May 12, 2012 revealed a full thickness tear of the supraspinatus tendon at its anterior critical zone. (PX2).

On May 3, 2012, Petitioner visited Dr. Nowak at Physician's Immediate Care. On that date, Dr. Nowak recorded that "[p]atient states that while at work on 4/9/12 he was lifting heavy boxes that weighed approximately 65-75 pounds and he felt a 'pop' in his left upper arm. Patient states that for two days he did not have any pain then he started having significant pain in the upper arm on the left. He states that the pain radiates into the shoulder. Patient denies any non-work related incident or event correlating with the development of this condition …" (PX4).

Respondent also submitted into evidence the initial Application for Adjustment of Claim showing a claimed date of accident of April 9, 2012. (RX1). The Application was subsequently amended by his current attorney to allege a date of accident of March 26, 2012.

Respondent also submitted several documents relating to the investigation of the alleged incident by Ron's Staffing. A "Supervisory Incident Investigation Report," signed by Mr. Roman on May 2, 2012, reflects a date

and time of injury of "4/9/2012 – 9 am." (RX2). The description noted in this report is as follows: "Employee claims he was carring [sic] boxes onto a skid going to a third level. Upon carring [sic] a box weighing 60-70 lbs he felt a popping sound. He thought nothing by it and continued with the day. His left shoulder got sore and sweled [sic] up for days. He went to see his family doctor at Sherman Health Center with his wife insurance. The Elgin office had no supervisor or employee let us know this incident on the day of occurrence. * incident happened on Monday but did not feel anything until Thursday." (RX2). Petitioner testified that it was not his handwriting on this document, and that the date of injury shown was "very much a mistake."

An accompanying "Employee Statement", signed and dated by Petitioner as well as Mr. Roman on May 1, 2012, noted the following: "I was loading a skid, with finish produce, when I felt a pop in my upper left arm. The boxes weighed between 65 & 75 lbs, that I was putting on the skid. We stack them 3 high and at the time of the injury, I was putting a box on the top, third layer." (RX2). This particular form shows a time of accident of "approx 8:00 am" but does not reflect a date. (RX2).

A separate "Medical Authorization and Release of Medical Records" form, signed by both Petitioner and Mr. Roma, shows a date and time of accident of "4-9-2012 (7-9 am)." (RX2).

Petitioner testified that he did not know why these forms show a date of accident of April 9, 2012, noting instead that he got a new foreman on that date. He also indicated that he did not know why that date was on the original Application for Adjustment of Claim (RX1), which he noted was prepared by his first attorney. Petitioner testified that he even spoke to Tony about the discrepancy and that he was told that they would change the records and that would not be a problem.

It would appear that most of these histories, more or less, reflect an onset of pain or popping in Petitioner's left shoulder as a result of picking up boxes at work weighing in excess of 60 pounds. What isn't consistent is the claimed date of injury. In fact, there is not one history that specifically references a date of accident of March 26, 2012. Instead, the record contains a progress note from family physician Dr. Susarla dated March 26, 2012 that fails to reference any history of accident at all (PX1), followed by a history by treating surgeon Dr. Chhadia on April 27, 2012 that cryptically notes an onset "approximately on _____ 2/2012" and the cause or mechanism as "overuse work ___ lifts boxes in shipping receiving dock at work noticed pain when he woke up next morning." (PX2). The remaining histories, including the one recorded by Dr. Novak on May 3, 2012 (PX4), as well as the investigation records found at RX2, all refer to a date of injury of April 9, 2012. Petitioner, for his part, denies that he was injured on that date.

The Arbitrator notes that the burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of this claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d. 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977). Along these lines, the testimony of the employee, if not impeached or rebutted, is sufficient to support an award. *Pheoll Manufacturing Co. v. Industrial Commission*, 54 Ill.2d 119, 295 N.E.2d 469 (1973); *Sahara Coal Co. v. Industrial Commission*, 66 Ill.2d. 353, 362 N.E.2d 343, 5 Ill.Dec. 872 (1977).

In the present case, Petitioner steadfastly maintains that he was injured as a result of an incident at work on March 26, 2012 – specifically, while picking up a box weighing in excess of 60 pounds. Petitioner also specifically denied being injured on April 9, 2012, or the date noted in the aforementioned investigation report prepared by his supervisor on May 1, 2012, the history recorded by Dr. Novak on May 3, 2012 and the date alleged in the initial Application for Adjustment of Claim. The question is whether this discrepancy as to the actual date of injury effectively impeaches or rebuts Petitioner's testimony as to the accident itself. After careful

consideration of the record, the Arbitrator finds that it does not. More to the point, the evidence shows that Petitioner had no prior injuries to his left shoulder and was working a fairly heavy duty job at the time of the injury, and that following the injury he was diagnosed with a full thickness tear of the supraspinatus tendon and eventually underwent surgery to repair same. Under the circumstances, there would appear to sufficient evidence to support Petitioner's claim that he injured left shoulder in the manner alleged, and that the injury occurred on or about March 26, 2012.

Accordingly, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on or about March 26, 2012.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that he reported his injury to his supervisor at Caveo Products, Tony Durant, on April 30, 2012, and that Mr. Durant in turn instructed him to notify the Respondent, Ron's Staffing. Thereafter, Petitioner contacted Cesar Roman at Ron's Staffing and completed the Employee Statement dated May 1, 2012, or 37 days following the claimed date of accident. (RX2).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner provided Respondent with proper and adequate notice within 45 days in accordance with §6(c) of the Act.

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, the evidence reveals that Petitioner sustained what he initially believed to be a strain to his left shoulder on or about March 26, 2012, that he continued to work thereafter until he was eventually taken off work by Dr. Novak. Following an MRI, Petitioner was diagnosed with a full thickness tear of the supraspinatus tendon and surgery was performed on June 7, 2012. (PX2). Thereafter, Petitioner underwent physical therapy until his ultimate discharge from Dr. Chhadia's care in January of 2013.

Petitioner testified that he did not have any physical or medical conditions relative to his left arm or shoulder prior to March 26, 2012. While Petitioner sought chiropractic treatment earlier in the month, it would appear that this treatment addresses his cervical and lumbar spine and not his left shoulder. Furthermore, there is no evidence to suggest that sustained any other injuries or trauma to his left shoulder subsequent to March 26, 2012.

Therefore, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident (issues "C" and "D", supra), the Arbitrator finds that a causal relationship exists between Petitioner's current condition of ill-being with respect to his left shoulder and the accident on or about March 26, 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:

Respondent stipulated that it paid no medical expenses incurred by Petitioner for treatment of the subject injuries. PX4 consists of an itemization of medical expenses incurred which were submitted for payment through health insurance secured through his wife's employer.

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", "D" and "F", supra), the Arbitrator finds that Petitioner is entitled to the reasonable and necessary medical expenses set forth in PX4 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

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

Petitioner testified that he continued to work following the accident until May 3, 2012 when he was suspended by the Respondent for failure to provide notice of the accident within the time frame mandated by company policy. As of that date a surgical recommendation had been made by his treating orthopedic physician, Dr. Chhadia, and light duty restrictions had been imposed by Dr. Nowak (PX4). Petitioner was subsequently released to full duty work on January 16, 2013 when he was discharged by Dr. Chhadia following surgery.

Petitioner was initially suspended then terminated from his employment while subject to light duty restrictions. Pursuant to the Illinois Supreme Court's decision in *Interstate Scaffolding v. Workers' Compensation Commission*, 385 Ill.App.3d 1040, 896 N.E.2d 1132, 324 Ill.Dec. 913 (2008), Petitioner is entitled to receive temporary total disability benefits following the discharge until such time as his condition stabilized.

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", "D" and "F", supra), the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from May 3, 2012 through January 16, 2013, for a period of 37 weeks as provided in section 8(b) of the Act.

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

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

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

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

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a warehouse worker at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. Petitioner testified that he has essentially retired since his release to return to work, doing odd jobs under the table.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 66 years old at the time of the accident.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there is no evidence that Petitioner has suffered a loss in earning potential as a result of the injury. As previously noted, Petitioner testified that he has essentially retired since his release to full duty work on January 16, 2013.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that as a result of the subject accident, Petitioner sustained a rotator cuff tear necessitating an arthroscopic repair including subacromial decompression and arthroscopic biceps tenotomy. Petitioner underwent a course of therapy and was ultimately released to return to work on January 16, 2013. At that time, it was noted that he still had pain on the lateral side of his left shoulder but it was doing better. As of his last therapy date in November of 2012, he was having difficulty reaching far overhead but that his motion continued to improve. He had problems with lifting and carrying heavy objects at waist height but struggled with heavy objects over shoulder height. Petitioner testified he continues to experience pain and restriction of motion and utilizes over the counter pain medications as necessary. Once again, he testified that he has essentially retired since his release from care.

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

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

Gregory A. Boens,

Petitioner,

15IWCC0338

vs.

NO: 11 WC 46135

Yellow Roadway Corporation,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 2, 2014 is hereby affirmed and adopted.

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

15IWCC0338

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: MAY 1 3 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 4/30/15
45

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

15IWCC0338

BOENS, GREGORY A
Employee/Petitioner

Case# **11WC046135**

YELLOW ROADWAY CORPORATION
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1367 HOPKINS & HUEBNER PC
PAUL SALABERT JR
100 E KIMBERLY RD SUITE 400
DAVENPORT, IA 52806

2904 HENNESSY & ROACH PC
PAUL N BERNARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0338

Case # 11 WC 46135

Gregoray A. Boens
Employee/Petitioner
v.

Yellow Roadway Corporation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **July 28, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0338

FINDINGS

On the date of accident, **June 30, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,872.78**; the average weekly wage was **$1,132.17**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **1** dependent children.

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

Respondent is entitled to a credit of **$599.21** under Section 8(j) of the Act.

ORDER

Respondent shall authorize and pay the reasonable and necessary medical expenses associated with the right shoulder arthroscopy prescribed for the Petitioner by Dr. Stewart, 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

August 21, 2014
Date

11 WC 46135
ICArbDec19(b)

SEP 2 - 2014

15IWCC0338

FACTS:

The Petitioner testified that he started working for the Respondent in October 1978 and that, since that time, he has worked full time as a dock worker and city driver. The Petitioner testified that his job consists of loading and unloading freight and driving a semi-truck to make eight to ten deliveries per day. The Petitioner testified that his job required him to open and close the truck's trailer door repeatedly throughout each day, to load pallets of freight into and out of the trailer using a pallet jack, and to load loose cartons and boxes which vary in weight into and out of the trailer by hand. The Petitioner testified that when making deliveries, he drives around 200 miles per day and that driving in the city requires him to shift the truck's gears almost constantly.

Thomas Rusk, the Respondent's Terminal Manager, testified that he has been employed by the Respondent for thirty years and is familiar with the Petitioner's job duties and activities. Mr. Rusk testified that 95% to 99% of the freight the Petitioner is unloading and loading is done with a pallet jack and forklift and that the Petitioner's actual lifting at the Respondent is now very limited. Mr. Rusk testified that there was a lot more lifting required in past years but, over the last 7 to 8 years the amount of lifting has decreased. Mr. Rusk acknowledged that the Petitioner's job description included physical demand requirements of being able to frequently lift 50 pounds from floor to waist level, and being able to push and pull up to 129 pounds for extensive periods of time. Mr. Rusk also acknowledged that the Petitioner's job requires the ability to perform repetitive tasks including stretching, turning, twisting and reaching. Mr. Rusk testified that the Petitioner has been able to perform all of his job duties for the past three years and he has never been advised of Petitioner reporting any pain or difficulty performing his job duties.

The Petitioner testified that prior to June 30, 2011, he began to experience difficulty and pain in his right arm while he was working, especially when he was working overhead or shifting the gears of his truck. On June 30, 2011 the Petitioner was seen for a DOT physical by Dr. Geeta Mahadavia and was noted to have some limitation in the range of motion in his right shoulder. The Petitioner testified that Dr. Mahadavia recommended that he follow up for his shoulder with his primary care physician. The Petitioner further testified that this was the first time he had been evaluated for his right shoulder condition and that he attributed his condition to his repetitive work activities. The Petitioner testified that he went to work after his evaluation and filled out an injury report for his work injury.

The Petitioner testified that he then saw his family doctor, Maxhn McCaw, D.O., on September 23, 2011 for his right shoulder. Dr. McCaw referred the Petitioner to an orthopedic surgeon, Mark Stewart, M.D., for further evaluation and treatment. .

On October 18, 2011, the Petitioner was seen by Dr. Stewart. The Petitioner complained of right arm and shoulder pain since June 30, 2011. Dr. Stewart noted that lifting bothers him and that he does repetitive work that has bothered him. Dr. Stewart also noted that the Petitioner's job was that of a truck driver and dock worker. Dr. Stewart's diagnosis was right shoulder pain and possible labral or rotator cuff tear and he recommended the

Petitioner undergo MRI testing of the right shoulder to evaluate the labrum and rotator cuff.

On November 22, 2011 the Petitioner underwent the prescribed testing. The arthrogram was reported to demonstrate a large osteophyte arising from the humerus, but no tear in the rotator cuff. The MRI was reported to demonstrate significant posterior labral abnormality, associated with severe chondromalacia on the glenoid and on the head of the humerus, and probable supraspinatus tendinosis, but no tendon tear in the rotator cuff.

On December 6, 2011, the Petitioner returned to Dr. Stewart with complaints of ongoing pain in the right shoulder. Dr. Stewart noted that the MRI was consistent with a posterior labral tear as well as chondromalacia in the shoulder joint. At that time, Dr. Stewart advised the Petitioner to undergo an arthroscopy of the right shoulder with debridement versus repair of the labral tear, and correction of the bony and soft tissues as indicated.

On April 18, 2012, the Petitioner was seen and examined by Dr. Paul Papierski at the request of the Respondent. Dr. Papierski took a history from the Petitioner, reviewed his job description and reviewed all his records and MRI films. Dr. Papierski diagnosed the Petitioner with degenerative joint disease in his right shoulder and tendinosis of the rotator cuff. Dr. Papierski opined that the Petitioner's right shoulder condition is the result of degenerative changes in his shoulder joint and associated structures and is not causally related to the Petitioner's work with the Respondent.

The Petitioner was last seen by Dr. Stewart on May 28, 2013. It was noted by Dr. Stewart that the Petitioner's right shoulder still bothered him and his work activities bother him significantly. Dr. Stewart further noted that the Petitioner was still working and that the Petitioner reported that shifting the truck bothers him and that he occasionally has to use two hands to pull back the gear. Dr. Stewart also noted that the Petitioner's left shoulder was also bothering him now as a result of compensating for the right shoulder.

Dr. Papierski's deposition testimony was admitted into the record as Respondent's Exhibit 1. Dr. Papierski testified that he reviewed the Petitioner's medical records, MRI films, x-ray films, and job description and that he took a history from the Petitioner and personally examined him. Dr. Papierski opined that the Petitioner had degenerative joint disease of the right shoulder and some tendinosis in his rotator cuff. Dr. Papierski opined that the Petitioner's job duties, as reported to him and detailed in his job description, did not cause or aggravate the Petitioner's right shoulder condition. Dr. Papierski opined that patients with Petitioner's condition will become increasingly symptomatic over time as degenerative changes in their shoulder occur. Dr. Papierski testified that the thinning and fraying of the Petitioner's labrum are part of degenerative joint disease's gradual worsening over time. Dr. Papierski opined that these degenerative changes would occur irrespective of a level of activity.

The deposition testimony of Dr. Stewart was admitted into the record as Petitioner's Exhibit 3. Dr. Stewart testified as to his examinations and treatment of the Petitioner and his diagnosis of a posterior labral tear and chondromalacia in the shoulder joint. Dr. Stewart opined that there is a causal relationship between the Petitioner's work activities and his

shoulder pain and injury. Dr. Stewart opined that the Petitioner's repetitive use of the shoulder while picking up and lifting boxes, shifting gears, and performing his work activities are aggravating his shoulder and that the Petitioner's labrum has been torn due to repetitive use over time.

The Petitioner testified that he currently continues to work his regular job without restrictions because the Respondent does not have light duty work. While the Respondent's witness, Thomas Rusk, testified on direct examination that the Respondent did have light duty work available, on cross examination Mr. Rusk admitted that light duty work consisted of part time office work in a make shift job. The Petitioner further testified that his right shoulder pain is constant and that he takes over the counter medication for his pain. The Petitioner testified that he wishes to undergo surgery as prescribed by Dr. Stewart.

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, (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 has been diagnosed with degenerative joint disease and arthritis, as well as a probable posterior labral tear, in his right shoulder by his treating physician, Dr. Stewart, as well as Respondent's examining physician, Dr. Papierski. Both doctors believe the Petitioner likely has a shoulder labral tear. The only difference in the two doctors' opinions is whether or not Petitioner's job duties caused or aggravated his pre-existing shoulder conditions. Dr. Stewart opined that there is a causal relationship between the Petitioner's work activities and his shoulder pain and injury. Dr. Papierski opined that the Petitioner's right shoulder condition is the result of degenerative changes in his shoulder joint and associated structures and is not causally related to the Petitioner's work with the Respondent.

While the Arbitrator notes the findings and opinions of Dr. Papierski, the Arbitrator finds that opinions of Dr. Stewart, the Petitioner's treating physician, to be sufficiently reliable, credible, and persuasive so as to satisfy the Petitioner's burden of proof in the instant matter. The Arbitrator also notes that Dr. Papierski agreed with Dr. Stewart's diagnosis of a right labral tear.

Based upon the foregoing, and having considered the totality if the credible evidence adduced at hearing, the Arbitrator finds that on June 30, 2011 the Petitioner did sustain an accidental injury which arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that the Petitioner's current condition of ill-being is causally related to the June 30, 2011 accident and that the Petitioner has not reached maximum medical improvement. The Arbitrator further finds that the Respondent is responsible for providing the prospective arthroscopic procedure prescribed for the Petitioner by Dr. Stewart.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Huff,

Petitioner,

15IWCC0339

vs.

NO: 12 WC 42048
14 WC 09239
14 WC 09242

Gordon Trucking,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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: MAY 1 3 2015

David L. Gore

DLG/gaf
O: 4/30/15
45

Stephen Mathis

Mario Basurto

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

15IWCC0339

HUFF, GARY
Employee/Petitioner

Case# **12WC042048**

14WC009239
14WC009242

GORDON TRUCKING
Employer/Respondent

On 11/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0438 BROWN & CROUPPEN
KERRY O'SULLIVAN
211 N BROADWAY SUITE 1600
ST LOUIS, MO 63102

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF _____)

☐ 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)

15IWCC0339

GARY HUFF
Employee/Petitioner

v.

GORDON TRUCKING
Employer/Respondent

Case # **12** WC **42048**

Consolidated cases: **14 WC 09239; 14 WC 09242**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **09/29/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/12/12; 01/06/14; 02/12/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,393.08**; the average weekly wage was **$776.79**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

- **The Petitioner's current condition of ill-being is not causally related to his 10/12/12, 01/06/14, or 02/12/14 work injuries.**
- **The Respondent is not liable for any outstanding medical expenses.**
- **All reasonable, necessary and causally related medical bills have previously been paid by the Respondent as evidenced by Respondent's Exhibit No. 10.**
- **The Petitioner has failed to meet his burden of proof as to entitlement to prospective medical care.**

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

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

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

Signature of Arbitrator

11/7/14
Date

ICArbDec19(b)

NOV 17 2014

Gary Huff v Gordon Trucking
12 WC 42048; 14 WC 09239; 14 WC 09242

FINDINGS OF FACT

At the time of trial, the Petitioner was a 57 year old truck driver for the Respondent, Gordon Trucking. Petitioner has worked for Gordon Trucking for 3 years. The Petitioner has been a truck driver for the past 25 to 30 years.

Prior to the Petitioner's 10/12/12 motor vehicle accident, he had undergone extensive low back treatment. In 1984 and 1985 the Petitioner underwent a series of low back surgeries which were the subject of a previous workers' compensation claim made by the Petitioner. The Petitioner testified that from 1985 through the date of his October of 2012 accident he had undergone no treatment, physical therapy, MRIs or injections for his low back since his release in 1985. The Petitioner had missed no time from work as relates to his low back leading up to 10/12/12. The Petitioner also testified that he had no prior neck problems before his 10/12/12 accident.

On the morning of the Petitioner's 10/12/12 accident he presented to Midwest Orthopedic Medicine for a DOT physical which was required through his position as a truck driver. The Petitioner was given a clean bill a health. Later that day the Petitioner was involved in a motor vehicle accident in Godfrey, Illinois when a woman ran a red light and pulled into the intersection, colliding with the truck the Petitioner was driving. The Petitioner denied the need for medical treatment at the scene and did not treat for the next 3 days.

The Petitioner initially sought treatment on 10/15/12 at the Wood River Clinic. The Petitioner testified that he had pain in his low back, neck and left shoulder. The office visit from this date reveals the Petitioner had low back pain and radiating pain into his left leg. (RX 5) Contrary to this Petitioner's testimony, he did not voice any complaints in the area of his neck or left shoulder. (RX 5) The pain diagram from this visit, which the Petitioner admitted he filled out and signed, also does not show any mark of neck or left shoulder pain. (RX 5) X-rays taken of the Petitioner's lumbar spine on this date were normal. No diagnostic studies were taken of the neck or left shoulder.

The Petitioner also informed the Wood River Clinic on 10/15/12 that he suffered from chronic low back pain, stemming from his prior low back surgeries. (RX 5) The Petitioner admitted at trial that despite not seeking treatment since his release from care in 1985, that his low back was symptomatic leading up to the 10/12/12 accident, and he dealt with chronic low back pain.

The Petitioner followed with the Wood River Clinic on 10/18/12. On this visit the Petitioner reported he was doing well and no longer had any radiating pain into his lower extremities. (RX 5) The Petitioner went on to state at this visit that "he feels he is ready to return back to work" and "that he has dealt with chronic low back pain for many years

and that he feels he may be back to his baseline." (RX 5) The Petitioner was in fact given a full duty release at this time.

On 10/18/12, the Petitioner again filled out a pain diagram. The diagram at this visit, which the Petitioner filled out and signed again, revealed strictly low back pain. (RX 5) The diagram is absent any leg, neck, or shoulder pain. The Petitioner also had a negative straight leg raise bilaterally on this date. These findings, and the pain diagram are contrary to the Petitioners testimony that he has immediate and continued leg, neck and shoulder complaints continually from the 10/12/12 accident.

Following the Petitioner's full duty release by the Wood River Clinic on 10/18/12, he did not treat again until 1/3/13. During this 10 week gap the Petitioner continued to work full duty.

On 1/3/13 the Petitioner presented to Dr. Gornet for treatment at the request of the Petitioner's attorney. Contained in Dr. Gornet's initial office visit is the first recorded neck complaint made by the Petitioner. Dr. Gornet allowed the Petitioner to continue working full duty and ordered physical therapy as well as MRI's of the cervical and lumbar spine. Dr. Gornet as of the time of trial has not restricted the Petitioner's activities at any time and the Petitioner has remained at full duty since his 10/12/12 accident. Throughout the Petitioner's treatment Dr. Gornet has recommended epidural steroid injections.

On 6/12/13 the Petitioner met with Dr. Robert Bernardi for an Independent Medical Examination.

The Petitioner is also claiming two additional accidents, dated 1/6/14 and 2/12/14. The 1/6/14 accident stems from an additional motor vehicle accident wherein the Petitioner was rear-ended. The Petitioner did not seek medical treatment contemporaneous with this accident but claims to have reinjured his low back, neck and left shoulder. For the 2/12/14 accident the Petitioner claims to have slipped on ice and yet again injuring his low back, neck and left shoulder. Again, there is no medical treatment contemporaneous with this accident.

The Petitioner testified that he did in fact report all three accidents to his employer and informed his employer of what body parts he injured for each accident. There were three accident reports prepared by the Respondent which were admitted as RX 1. The report for the 10/12/12 accident shows the Petitioner stated he "strained his back." (RX 1) The body part injured list lower back and makes no reference to the Petitioner's neck or left shoulder. The report for the 1/6/14 accident makes no reference to any body part. The report for the 2/12/14 accident lists a date of accident of 2/13/14 and describes a back strain with no reference made to the neck or left shoulder.

As of the time of trial the Petitioner claims to still suffer from low back pain, stiffness, and left shoulder pain. The Petitioner testified this pain is constant. The

Petitioner however, continues to work full duty. The Petitioner testified that he wants the treatment proposed by Dr. Gornet.

Dr. Gornet testified in this matter via evidence deposition. (PX 3) Dr. Gornet initially saw the Petitioner on 1/3/13, and diagnosed him as having structural back pain, neck pain and nerve irritation. Dr. Gornet recommended physical therapy as well as cervical and lumbar spine MRIs. Petitioner was remained on full duty and was scheduled to see Dr. Gornet six weeks later.

Dr. Gornet again saw the Petitioner on 2/25/13. Dr. Gornet testified the Petitioner had essentially no change in his condition and this visit was essentially to review the MRIs and CT scans which had been performed. Dr. Gornet described the cervical MRI scan as having a large disc herniation at C5-6 and C6-7 central with C5-6 more to the right which Dr. Gornet believed correlated with the Petitioner's neck pain to both shoulder, upper back and intermittent tingling in his hands. Dr. Gornet described the Petitioner's lumbar spine films as revealing an obvious acute annular tear at L4-5 into the left foramen at L4-5, consistent with his left sided pain. Dr. Gornet also described a central herniation at L3-4. A CT scan of the Petitioner's lumbar spine showed a solid fusion at L4-5 posteriorly. The L5-S1 disc was clean. Dr. Gornet testified that at this point he was focusing on the Petitioner's low back as that was his greater problem. Dr. Gornet continued the Petitioner on full duty without restrictions. Dr. Gornet recommended the Petitioner undergo epidural steroid injection at L3-4 to the left and transforaminal on the L4-5.

Dr. Gornet last saw the Petitioner on 3/24/14. Dr. Gornet was still recommending injections and testified that he did not believe the Petitioner was at maximum medical improvement. Dr. Gornet testified the Petitioner's future treatment would depend on his result from the recommended injections. If Petitioner fails conservative treatment in the form of injections Dr. Gornet testified that the Petitioner may be a candidate for a fusion or disc replacement at L3-4.

On cross examination Dr. Gornet was not aware as to whether or not the Petitioner denied the need for medical treatment at the time of his accident. Dr. Gornet testified that the findings within the 2/25/13 lumbar spine MRI could predate the accident in question. Dr. Gornet testified that the Petitioner was not asymptomatic prior to his accident and did describe a low level of chronic low back pain.

Dr. Gornet confirmed that as of 10/15/12 the Petitioner had no neck complaints and did not describe any neck problems in his pain diagram at the Wood River Clinic. When the Petitioner followed up on 10/18/12 again the Petitioner had no neck complaints and did not mark any problems in the area of the neck on his pain diagram.

The Petitioner did undergo subsequent diagnostic studies in March 2014. Dr. Gornet testified that the findings in the lumbar spine diagnostic studies in March 2014 showed the Petitioner's condition to be improving including a lesser signal in the area of the Petitioner's alleged annular tear at L4-5. Dr. Gornet also testified the Petitioner gave him

a history of two subsequent accidents occurring on January 16, 2014, and February 12, 2014. Dr. Gornet testified that he was not aware of any medical treatment contemporaneous to these two additional alleged accidents.

Dr. Gornet testified that he believed the Petitioner lumbar and cervical spine condition are causally related to the 10/12/12 accident. Dr. Gornet based his opinions in part on what he called the temporal relationship between the onset of symptoms to the 10/12/12 accident.

Dr. Bernardi aslo testified in this matter. (RX 9) Dr. Bernardi is a board certified spinal neurosurgeon practicing in St. Louis, MO. Dr. Bernardi attended St. Louis University School of Medicine where he obtained an M.D. degree in 1987. Dr. Bernardi underwent a general surgery internship at St. Louis University Hospital from 1987 through 1988 and was a resident in the neurological surgery department from 1988 through 1993 at St. Louis University Hospitals. Thereafter Dr. Bernardi underwent a spine surgery fellowship at the Medical College of Wisconsin in Milwaukee. Dr. Bernardi testified that he performs approximately six surgeries a week and treats all conditions of the spine.

Dr. Bernardi saw the Petitioner for an independent medical examination on 6/12/13. Dr. Bernardi took a history of the accident that occurred on 10/12/12. Petitioner gave a history of no prior neck complaints but did give an extensive history of his prior low back condition. The Petitioner's current complaints at the time of examination were neck pain and low back pain. The Petitioner described 80% of his pain being located in his lumbar spine. This was described to be at waist level left of the mid line.

Dr. Bernardi reviewed the Petitioner's medical records. Dr. Bernardi noted the Petitioner's initial treatment following the 10/12/12 accident was on 10/15/12 at the Wood River Clinic and noted the Petitioner's follow up on 10/18/12. Dr. Bernardi also noted the ten week gap in treatment from 10/18/12 to 1/3/13. Dr. Bernardi noted that 1/3/13 was when the Petitioner initially began to complain of neck pain following the 10/12/12 accident.

Dr. Bernardi reviewed all of the films from the Petitioner's various studies. The CT of the lumbar spine taken on 2/25/13 according to Dr. Bernardi showed a solid fusion at L4-5 from the Petitioner's prior low back surgery many years before the accident in question. Dr. Bernardi noted other various degenerative findings throughout the lumbar spine including calcification as well as bone spurs amongst other findings. The Petitioner's cervical spine MRI from this date showed a broad based disc protrusion at C5-6 and C6-7. Signal within the cervical cord was normal. Dr. Bernardi testified that he found degenerative changes throughout the Petitioner's cervical spine.

In regards to the 2/25/13 MRI of the lumbar spine Dr. Bernardi noted mild degenerative disc disease at L3-4 which is manifested by loss of disc hydration and some relatively minor disc bulging. There was moderate degenerative disc disease at L4-5 with loss of disc height and disc hydration as well as posterior spur formation. Dr. Bernardi did

not agree with Dr. Gornet's interpretation of an acute annular tear at this segment. Dr. Bernardi believed that the other discs were unremarkable. Dr. Bernardi testified that he is of the belief that annular tears are not markers of injury and are a degenerative finding. Dr. Bernardi described annular tears as occurring compared to mud drying in the sun and as it loses its water content it begins to fissure. Dr. Bernardi believes that annular tears are a degenerative phenomenon which develop slowly over time and is not aware of any medical studies which show that annular tears develop acutely in relationship to episodes of back pain or trauma. Furthermore, Dr. Bernardi testified that due to the Petitioner's prior well-healed fusion at L4-5, that it would not make sense for an annular tear to be acute at that level based upon it being a non-mobile segment.

Dr. Bernardi testified that the Petitioner was not taking any prescription medications and the Petitioner was noted to be a half a pack a day smoker.

Dr. Bernardi did perform an extensive physical examination. The Petitioner's neck examination was normal. Petitioner's low back examination revealed some tenderness with palpation towards the upper pull of his mid line scar from his prior surgery. Other than that Dr. Bernardi's examination was normal including a negative straight leg raise. Petitioner's neurological examination was normal, there was no atrophy and the Petitioner's reflexes were also normal.

Dr. Bernardi diagnosed the Petitioner with multi-level cervical disc disease, neck pain of uncertain etiology, status post L4-5 posterior spinal fusion, L3-4 and L4-5 degenerative disc disease, and low back non radicular pain of uncertain etiology. Dr. Bernardi agreed with the Petitioner continuing to work full duty and did not believe restrictions were warranted.

In regards to the Petitioner's cervical spine Dr. Bernardi did not believe that the accident of 10/12/12 in any way caused or aggravated the Petitioner's neck condition. Dr. Bernardi testified his basis for this opinion was the finding on the MRIs as well as the Petitioner's almost three month delay before he began presenting with neck complaints to any physician. Dr. Bernardi did not believe the Petitioner required any treatment for the neck and also testified the Petitioner was not a surgical candidate as far as the cervical spine.

In regards to the lumbar spine Dr. Bernardi did not believe the Petitioner's condition as of the date of Dr. Bernardi's examination was anyway caused or aggravated by the 10/12/12 accident. Dr. Bernardi did believe that it was reasonable to conclude that the Petitioner suffered an aggravation of his preexisting low back pain as a result of the 10/12/12 accident. Dr. Bernardi believed that this was a temporary aggravation as evidenced by the Petitioner's initial medical treatment including 10/18/12 office visit when the Petitioner felt as though he may have been back to his base line and requested to be returned to work full duty without restriction. Dr. Bernardi also believed that this was a temporary aggravation due to the fact that the Petitioner did not treat again for 10 weeks.

Dr. Bernardi testified that individuals who have chronic back pain experience a waxing and waning of their symptoms. Dr. Bernardi testified that the Petitioner may have sustained a temporary aggravation to his low back pain which would have reached its base line condition as of 10/18/12, consistent with the Petitioner's history on this date. Dr. Bernardi testified that when the Petitioner returned to see Dr. Gornet in January 2013 this could have been strictly related to his chronic low back condition and be evidence of a continuing waxing and waning of the Petitioner's chronic low back problem.

Dr. Bernardi did not believe the Petitioner would suffer any permanent impairment as a result of the 10/12/12 accident. Dr. Bernardi testified that the Petitioner would need perhaps a tapered dose of oral steroids followed by regular use of non-steroidal anti-inflammatories and possibly a four to six week course of physical therapy for his low back. Beyond that the Petitioner would be at maximum medical improvement as it relates to his low back. Dr. Bernardi did not believe the Petitioner required any epidural steroid injections. Dr. Bernardi does not believe that epidural steroid injections are warranted for patients with simply back pain. Dr. Bernardi did not believe the Petitioner has a true radiculopathy as it relates to his lower extremities and therefore did not believe epidural steroid injections were warranted. Dr. Bernardi did not believe that the Petitioner was a surgical candidate in regards to his lumbar spine.

ARBITRATOR'S FINDINGS

- The Petitioner's current condition of ill-being is not causally related to his 10/12/12, 01/06/14, or 02/12/14 work injuries.
- The Respondent is not liable for any outstanding medical expenses.
- All reasonable, necessary and causally related medical bills have previously been paid by the Respondent as evidenced by Respondent's Exhibit No. 10.
- The Petitioner has failed to meet his burden of proof as to entitlement to prospective medical care.

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

Keith Abner,

Petitioner,

15IWCC0340

vs.

NO: 13 WC 13921

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 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.

15IWCC0340

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: MAY 1 3 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 4/30/15
45

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

15IWCC0340

ABNER, KEITH
Employee/Petitioner

Case# **13WC013921**

CATERPILLAR INC
Employer/Respondent

On 11/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1727 LEE, MARK N LAW OFFICE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

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) 8(a)

15IWCC0340

KEITH ABNER,
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # 13 WC 13921

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **10/14/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/5/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,730.00**; the average weekly wage was **$802.50**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$34,989.07** for other benefits, for a total credit of **$34,989.07**.

Respondent is entitled to a credit of **$26,505.12** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that is entitled to temporary total disability benefits, as provided in Section 8(a) of the Act. Petitioner has failed to prove by a preponderance of the credible evidence that the forklift driving position he was performing for respondent did not fall within the restrictions imposed by Dr. Chopra and Dr. Hansen, or that he was authorized off work by Dr. Chopra or Hansen.

Respondent shall pay reasonable and necessary medical services for treatment of petitioner's low back from 4/5/13 through 10/14/14, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$26,505.12** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services for the disc replacement surgery recommended by Dr. Pineda, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

5/29/14
Date

ICArbDec19(b)

NOV 5 - 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 40 year old fabrication specialist/welder, alleges that he sustained an accidental injury to his low back that arose out of and in the course of his employment by respondent on 4/5/13. Petitioner was hired by respondent in 2007. In the area petitioner worked there were 4 to 5 stations that he could be assigned on any specific day. These stations include attack, robotic, cleaning area and final prep area. Petitioner testified that he could be welding or grinding based on the stations. Petitioner's primary job was welding heavy weight tandems.

Petitioner was hired by respondent on 7/2/10. Prior to being hired by respondent petitioner sustained a low back strain at the age of 19 when lifting patients at a nursing home. Petitioner noted that he sees his chiropractor about 1-3 times a year for adjustments. He further noted that he had not had any problems since getting adjustments. On the date of petitioner's hire he was examined by respondent's doctor and it was noted that petitioner had full range of motion and no tenderness or neuro deficit. Petitioner was given no restrictions.

In January of 2013 petitioner had complaints of back pain when he presented to Prompt Care. X-rays were done that were negative. Petitioner denied any back pain since 1/22/13. Respondent medical sent him back to his regular work as a welder on 1/22/13.

On 4/5/13 while bent at his waist, over the 140 tack fixture welding tack tandems, petitioner felt a horrible pain in his low back that shot down his legs and into his groin. He testified that his knees were locked supporting himself against the tack fixture. Petitioner testified that the injury occurred while he was bent over and leaning against the tack fixture performing some welding. He testified that he believed he was working on the top right section in a space of 6-8 inches, and this weld would require more twisting. Immediately following the injury petitioner put down his weld lead, shut off the machine, and reported the incident to his supervisor. Petitioner could not recall how far he was bent over when he experienced the pain, but reported that he had to reach out to get to the back plates.

Petitioner testified that he had lifting assistance at the stations to position the plates he was welding on the fixture. He testified that the weight of the plates varied. Petitioner stated that for each tandem he welded a total of 30 times per tandem, and did 10-15 tandems in a shift.

Petitioner testified that the person welding in the pictures did not depict how he was welding at the time of the injury. He noted that the person in the picture was not bent over like he was and was not

wearing any welding gear (PX7). Petitioner did not know if the person in the picture was the same height as him. He also testified that he may be closer to the weld to see because he wears glasses.

Petitioner testified that when the injury occurred he was wearing a leather jacket and leather chaps, respirator pack on back, and welding hood. He testified that the leather jacket weight 5 pounds. His hood weighed 5 pounds. His respirator pack and battery weighed 5 pounds. He also had the weld lead in his hand. He testified that the lead and the rubber coated solid copper core weighed at least 10 pounds.

The accident report petitioner completed on 4/5/13 noted that he was at the "tandem tack area 140 tack fixture welding-bending over". He reported aching pain in his low back, buttocks and groin.

On 4/5/13 an Incident Investigation Interview Questions was completed. Petitioner sought treatment for lower back and groin area pain while setting up a 140 tack fixture. He noted that he was bent over tack fixture welding when he felt the pain.

Following the accident petitioner was first examined in respondent's medical department. He complained of pain in his right buttock and groin area on the right. Petitioner gave a history of first feeling pain when he was bent over welding. Petitioner returned repeatedly to respondent's medical department and was given primarily ice and ibuprofen. On 4/10/13, in addition to his pain, petitioner complained of radiating pain in his right thigh.

On 4/11/13 petitioner performed a shop walk with his supervisor, Doug Cassidy. It was noted that petitioner places spacers, that weigh between 5-8 pounds, on the bottom plate. He noted that "EE states lifts 11 spacers per side, 8 (illegible) and does 8 per shift. Approximately 112 (illegible) a shift. Has to weld 16 (illegible) so have lean over 16 times per plate." The supervisor observed and discussed petitioner's job duties and was of the opinion that there appeared to be no significant bending or twisting required. It was determined that lift and pulling activities were not higher than light levels. On 4/14/13 respondent's determined that momentary bending should not have caused the stated back symptoms. He was of the opinion that the majority of the job involves no bending.

On 4/16/13 Jammie Schimmelpfenning, Adjuster for respondent, drafted a letter to petitioner informing him that his claim regarding his alleged work accident on 4/5/13 was denied.

On 4/19/13 petitioner presented to Dr. Chopra. Petitioner reported that he was standing doing his job, bending over welding, when he had an onset of intense pain in his low back. He reported that the pain was radiating to both legs. Petitioner reported that he had a similar episode in January and did fine after that with medications. Petitioner was assessed with lumbago and sciatica. He was prescribed

Robaxin and Naprosyn. Petitioner was restricted from bending at the waist, no squatting, and no lifting over 20 pounds. Respondent indicated that they could accommodate his restrictions.

On 4/29/13 petitioner returned to Dr. Chopra complaining of back pain radiating down both legs. He denied any tingling or numbness in his legs. Dr. Chopra's assessment remain the same. He ordered an MRI of the lumbar spine. He continued petitioner's medications. Dr. Chopra continued petitioner's restrictions for 1 week.

On 5/4/13 petitioner underwent an MRI of the lumbar spine. The impression was disc desiccation with mild diffuse disc bulge at L5-S2 abutting the S1 nerve roots with borderline narrowing of the right L5-S1 neural foramen.

On 5/6/13 petitioner presented to Dr. Chopra. Petitioner complained of back pain radiating down his right leg. He stated that he was having difficulty walking. Dr. Chopra's assessment remained the same. Dr. Chopra referred petitioner to an orthopedic surgeon and released him to modified duty work with restrictions of no lifting, bending, squatting and stretching for the next 35 days. Petitioner was restricted from lifting in excess of 20 pounds for the next 35 days.

On 5/29/13 petitioner presented to Dr. Narla for possible injections and further evaluation. Petitioner reported that his pain was sometimes 10/10 and he could not sit, and has to stand up frequently. Dr. Narla examined petitioner and his assessment was lower back pain, sciatica. His impression was lumbar back pain with bilateral radiation. Dr. Narla gave petitioner Ultram and prescribed physical therapy exercise program. He also recommended an epidural steroid injection. Petitioner began a course of physical therapy on 6/5/13 at Premiere Physical Therapy.

Petitioner testified that he was taken off work as of 5/29/13 and has remained off since then by Dr. Chopra and Dr. Hansen.

On 6/6/13 petitioner returned to Dr. Chopra. He reported that he had been seen by Dr. Narla and referred to physical therapy. Petitioner continued to complain of back pain going down his leg. Dr. Chopra added Tramadol to petitioner's medications.

On 6/20/13 the petitioner underwent an L5/-S1 right-sided epidural steroid injection. His postoperative diagnosis was L5 – S1 diffuse disc bulge abutting the S1 nerve root, producing right-sided radiculopathy. On 7/18/13 Dr. Narla performed a second epidural steroid injection. His postoperative diagnosis was L5 – S1 disc protrusion asymmetric toward the right producing the lumbar back pain right more than left side.

On 7/24/13 petitioner returned to Dr. Chopra. He reported that he had started physical therapy and was feeling better. He also reported that he had had two epidural shots. Following an examination, Dr. Chopra released petitioner to work on 7/24/13 with a 25 pound weight lifting restriction. He continued petitioner's medications.

On 8/9/13 petitioner was discharged from physical therapy at St. John's Premiere Physical Therapy. Petitioner reported his low back pain and leg pain had improved since starting therapy, but he still had mild pain/soreness in one spot in his low back with increased activity. Petitioner reported that he functions at home on a normal daily basis without significant increase in his symptoms. He reported that he had returned to work during the past week riding a forklift for eight hours. He stated that this activity caused increased low back soreness. Of petitioner's five goals the therapist noted that he had met four and was in progress with regards to the fifth, increasing his lumbar range of motion to within normal limits in eight weeks.

On 8/30/13 petitioner followed up with Dr. Chopra. He reported that after returning to work he started having pain two days ago and has an appointment with Dr. Pineda in four days. He complained that his pain was intense and he was having a hard time walking. Dr. Chopra added Vicodin to petitioner's medications.

On 9/3/13 petitioner presented to Dr. Pineda for severe back pain after an injury at work on 4/5/13. He gave a history of bending over and welding a fixture with a weld lead in hand. He reported that he could not weld anymore, and was driving a forklift that was bouncing all the time. Petitioner complained of low back pain and bilateral leg pain. Dr. Pineda was of the opinion that the MRI showed degenerative disc disease. He noted that petitioner has had a course of physical therapy and oral medications without any success. Dr. Pineda's diagnosis was aggravation of degenerative disc disease. Dr. Pineda allowed petitioner to work or perform activities as tolerated by his symptoms. Dr. Pineda was of the opinion that all petitioner could do is sit down and file, or perform light duty such as driving a forklift if he is cautious. Dr. Pineda ordered a discogram.

On 9/23/13 petitioner followed up with Dr. Pineda. Petitioner reported a lot of back pain. Dr. Pineda noted that the discogram was positive at L5 – S1. He offered petitioner 2 options. One option was controlling his pain with pain management strategies. The seconds was surgery, and that could take the form of either a replacement with an anterior approach or a fusion. Petitioner told Dr. Pineda that he wanted someone else to manage his off work or work status. Dr. Pineda was of the opinion that petitioner may want to see an occupational physician if Dr. Chopra and Dr. Narla are unable to manage

his work issues. Dr. Pineda's restrictions preoperatively were that petitioner work as tolerated by his symptoms.

On 9/27/13 petitioner followed up with Dr. Chopra and continued to complain of pain in his back. He stated that he has not been able to work his light duty. He also reported that he had seen Dr. Pineda and had a discogram done. He stated that Dr. Pineda was recommending surgery.

On 10/4/13 petitioner returned to Dr. Chopra complaining of back pain going down his legs. Petitioner reported that when he was returned to work he drove a forklift and got hurt again. He stated that he was seen by Dr. Pineda and surgery was recommended. Dr. Chopra's assessment was spinal stenosis of lumbar region with the neurogenic claudication. Petitioner reported that he did not wish to go back to the forklift operator job as there are bumps involved and this causes him a lot of pain. Dr. Chopra referred petitioner back to Dr. Narla and an occupational physician. Dr. Chopra told the petitioner to find a different physician to take care of his back problems because he found the petitioner difficult to deal with and no longer wanted to treat him.

On 11/15/13 petitioner followed up with Dr. Narla. He reported that he did not have any significant benefit from the first injection, but stated that the second injection helped for about 3 to 4 weeks. Dr. Narla's impression was L5 – S1 right paracentral disc protrusion with only a minimal amount of benefit from second injection according to petitioner. Dr. Narla stated that there was very little else that he could do. He changed petitioner's naproxen to Mobic, and Robaxin to Flexeril. Petitioner stated that he wanted to continue taking Tramadol and Lidoderm patches. Dr. Narla recommended that petitioner continue with some exercise program to keep himself mobile. He told petitioner to follow-up in six months.

On 1/9/14 petitioner underwent a Section 12 examination performed by Dr. Michael Kornblatt, at the request of the respondent. In addition to examining petitioner Dr. Kornblatt performed a record review. Petitioner gave a history of injuring himself at work on 4/15/13 while welding a tandem fixture. He stated that he was bending over welding the tandem fixture when he experienced severe low back pain with giving way of his legs. He stated that he was placed on light duty work which he performed until the middle of May 2013. This work included assisting his supervisor. Petitioner complained of sharp, aching low back pain, which is worse with activity and without activity. He stated that if he sits more than an hour, stands more than an hour, bends his lumbar spine, twist and walks any distance, he has back pain. He complained of pain in his right buttocks and posterior thigh with a feeling of weakness in his legs and numbness. He denied bowel or bladder incontinence. He stated that he was taking Tramadol

cyclobenzaprine, and meloxicam. Dr. Kornblatt noted that petitioner was treated over the course of a few months and was well until this most recent episode.

Dr. Kornblatt diagnosed lumbar spine condition consistent with mechanical low back pain, secondary to L5 – S1 degenerative disc disease. He opined that this condition is not causally related to specific work duties, since degenerative disc disease is a naturally occurring phenomenon. Dr. Kornblatt was of the opinion that in this case there is no aggravation, as x-rays he performed, failed to reveal significant disk space collapse or abnormal bony pathologic changes consistent with marked degenerative disc disease. Dr. Kornblatt was of the opinion that on 5/5/13 petitioner noted symptoms referable to degenerative disc disease, consisting of mechanical back pain, possibly due to a temporary, self-limiting exacerbation of pre-existing degenerative disc disease. Dr. Kornblatt opined that petitioner has not reached maximum medical improvement regarding his degenerative disc disease, as he continues to note ongoing subjective symptomatology consisting of mechanical low back pain despite no abnormal objective findings on physical examination. Dr. Kornblatt was of the opinion that petitioner does require work restrictions secondary to longevity of inactivity, deconditioned state, and subjective complaints of mechanical low back pain. He advised that the patient resume full employment within the medium physical demand level, which consisted of occasionally lifting up to 50 pounds, and frequently up to 25 pounds. He was of the opinion that these restrictions are unrelated to the work incident of April 2013, but are related to longevity of inactivity, deconditioned state, and pre-existing degenerative disc disease.

On 1/14/14 petitioner began treating with Dr. Hansen's office. Petitioner would most often see Dr. Hansen's nurse practitioners Regina White and Alyssa Gibbs. Petitioner gave a history of a back injury on 4/5/13 at work. He reported that his pain has been ongoing. He stated that a lot of the medications he has been prescribed have been causing him a lot of reflux and stomach pain. Petitioner gave a summary of his treatment to date. Petitioner reported that his urination, bowel habits, and erectile function have been impacted since the injury. Following an examination petitioner was assessed with lower back pain, health maintenance, esophageal reflux, and lumbar radiculopathy. Petitioner was prescribed Omeprazole, and various lab work. Petitioner followed up monthly with Dr. Hansen's office through 9/15/14. During these visits petitioner would report that his pain would ebb and flow from 3-4/10 to 10/10 on a pain scale of 10. Dr. Hansen's office provided petitioner with medication prescriptions and work restrictions of no lifting/pushing/pulling in excess of 5 pounds through 10/16/14.

On 2/13/14 petitioner followed up with White. He reported that he was still having low back pain radiating down both legs. He also complained of numbness, intermittently down both legs. Petitioner was restricted to no bending at the waist.

On 3/5/14 the evidence deposition of Dr. Pineda was taken on behalf of petitioner. Dr. Pineda testified that petitioner told him that bouncing around in the forklift aggravated his pain. Dr. Pineda was of the opinion that fusions typically place restrictions on individuals weight capabilities, and disk replacements potentially give the individual unrestricted activity. He also stated that since replacements are newer than fusions, it may or may not have as predictable of a long-term outcome. Since petitioner was a young individual, and works as a welder, Dr. Pineda suggested that he may probably want to consider a replacement. Dr. Pineda opined that a disc replacement would be reasonable and necessary, and the medical treatment that petitioner received before he saw him was reasonable and necessary. Dr. Pineda opined that there was no connection between petitioner's pain in January 2013 and his pain following the accident on 4/5/13 since his pain following the accident in January lasted only a few days.

Dr. Pineda opined that the mechanism of bending down to weld on a fixture like the one in the picture could have aggravated an underlying condition in petitioner's back, rendering it symptomatic, to the point where surgical intervention became necessary and proper. Dr. Pineda opined that bending or twisting while working or not can aggravate degenerative disc disease. Dr. Pineda opined that petitioner's pain was continuous and non-ending. Dr. Pineda opined that weight, in general, increases the risk of aggravating a pre-existing disc disease. He further opined that forward flexion with weight in front of an individual is going to have a higher risk of aggravating a pre-existing disc disease than other postures. He opined that walking straight up-and-down would be a lower risk than forward flexion. Dr. Pineda opined that the history petitioner provided him was that the onset of pain occurred at or around the time of the event, and based on this history he opined that there is a temporal relationship or a relationship between the back pain and the work-related event.

On cross-examination Dr. Pineda indicated that since petitioner had a pre-existing degenerative disc condition an injury could've occurred while petitioner was doing a number of other things. Dr. Pineda opined that petitioner could have aggravated his pre-existing disc condition with bending or twisting.

On 5/21/14 petitioner returned to Dr. Narla. He rated his pain at a 4.5/10. He stated that he was somewhat better, and was able to function. Dr. Narla examined petitioner and his impression was L5 – S1 right paracentral disc protrusion with mostly right-sided radiculopathy, but occasionally on the left

side. Dr. Narla was of the opinion that there was nothing else he could do for petitioner. He instructed petitioner to follow-up with Dr. Pineda relative to any surgical intervention, and follow up with him in six months.

On 8/18/14 the evidence deposition of Dr. Kornblatt, an orthopedic surgeon, was taken on behalf of respondent. Dr. Kornblatt opined that petitioner's condition of ill being as it relates to his lumbar spine is not related in any way to driving a forklift on restricted duty. Dr. Kornblatt opined that the surgical recommendation was not causally related to the incident on 4/5/13 or driving a forklift.

On cross-examination Dr. Kornblatt did not believe petitioner was malingering or exaggerating pain symptoms. He opined that he would not operate on petitioner with his physical examination and his MRI findings with or without pain complaints.

On 9/3/14 petitioner presented to Dr. Cheruku regarding stomach problems. Petitioner related to stomach problems to the different pain medications that he had been taking. Dr. Cheruku noted an etiology of abdominal pain with nausea, decreased appetite, and weight loss possibly from pain medication and used (meloxicam), gastritis, or introduced dyspepsia. Dr. Toluca ordered a colonoscopy and EGD.

On 9/10/14 petitioner underwent a colonoscopy and EGD with biopsies. This procedure was performed by Dr. Cheruku. His impression was normal esophagus; small to tiny hiatal hernia; gastritis, mild and small gastric polyps, appears benign, fundic gland type of polyps, status post biopsies; normal pyloric channel; normal duodenum, status post random distal duodenal biopsies; and no ulcer.

On 9/15/14 petitioner last followed up with nurse practitioner Gibbs at Dr. Hansen's office. Petitioner complained of low back pain with pain radiating to his bilateral buttocks and sometimes down his right leg. He rated his pain at about 6/10 on a scale of 10. He reported occasional right leg numbness and tingling. Petitioner was released to light duty work with restrictions on no pushing, pulling or lifting in excess of 5 pounds.

Petitioner testified that when he was initially returned to light duty work he was working with his supervisor using a radio. Later on he was assigned the job of forklift driver. He testified that he had excruciating pain in his back while driving a forklift because it had no suspension, hard tires and would go over uneven surfaces causing him to bounce about. Some of these surfaces included uneven concrete floors, cobblestones, wood floors, metal gratings for sewers, outside ramps, and possible gravel. He also reported that he would do a lot of bending and twisting when driving the forklift backwards.

Jeremy Stephens, Section Manager for respondent, was called as a witness on behalf of respondent. Stephens was Manager over the tandem tack welding area where petitioner worked. He agreed that petitioner had to wear safety shoes, chaps, hood, gloves, sleeves, jacket and weld hood connected to air pack. Stephens was of the opinion that the air pack weighed about 3 pounds. He testified that the weld boom supports the weight of the weld gun. Stephens testified that a welder working at a tandem tack station would not twist or bend. He was of the opinion that the fixture will accommodate the over bend. After viewing the photos of a welder working on the tandem tack (PX7), Stephens agreed that a welder may bend that far while working at the station.

Chelsea Sargeant, 2nd Shift Material Handler, was called as a witness on behalf of respondent. She testified that she supervises the forklift drivers and supervised petitioner when he was on light duty driving a forklift. She agreed that the fork lift had hard rubber tires. She was of the opinion that fork lift drivers worked primarily inside on a fairly smooth concrete surface, but admitted that if the there was a "hot dock" the fork lift driver may unload materials outside. Sargeant admitted that the aisle way adjacent to the dock is a wooden brick floor. She saw no reason why a fork lift driver would be bouncing around or jolted while driving a forklift. She also admitted that if the fork lift driver had to distribute to the line they would have to twist to see behind them.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner testified that he sustained an accidental injury to his lumbar spine on 4/15/13 while bent at his waist over the 140 tack fixture welding tack tandems. Petitioner testified that while he was bent over welding in the top right section of the fixture, with his knees locked supporting himself against the tack fixture, he felt a horrible pain in his low back that shot down into his legs and groin.

It is unrebutted that petitioner is a fabrication specialist/welder for respondent who had preexisting problems with his lumbar spine that included a low back strain at the age of 19; chiropractic adjustments approximately1-3 times a year with improvement; and an injury in January of 2013 where petitioner had complaints of back pain that resolved by 1/22/13 when he was released to full duty without restrictions. It is also important to notes that when petitioner was hired on 7/2/10 he was examined by respondent's doctor and demonstrated full range of motion, and no tenderness or neuro deficit.

It is also unrebutted that as a welder for respondent petitioner is required to a wear safety shoes, a jacket, chaps, sleeves, respirator pack connected to a welding hood, and glove while welding. Petitioner

also works with a weld lead in his hand that is connected to a rubber coated solid copper core. There is a dispute however, as to how much these items weighed.

Doug Cassidy noted on the Shop Walk form that petitioner's job duties include placing spacers that weighed between 5-8 pounds, on the bottom plate. Cassidy noted on the form that "EE states lifts 11 spacers per side, 8 (illegible) and does 8 per shift. Approximately 112 (illegible) a shift. Has to weld 16 (illegible) so have lean over 16 times per plate."

Petitioner testified that although the fixture can be rotated so that he can get closer to the area where he is welding tack tandems, he still has to bend and twist to reach some of tack tandems when working on the top right section of the fixture. Each day petitioner performs 30 welds per tandem and works on 10-15 tandems per shift. Petitioner testified that he stands with all his required safety gear on as he performs anywhere from 300-450 welds a day. Petitioner also testified that since he wears glasses he may have to bend closer to the fixture to see what he is welding than other workers do. He stated that at times he may need to twist to get in tighter spaces to weld.

Doug Cassidy noted on the Shop Walk that he was of the opinion that there appeared to be no significant bending or twisting required, and based on this opinion respondent determined that momentary bending should not have caused the stated back symptoms. However, the arbitrator notes Cassidy noted on the Shop Walk form that petitioner has to lean over 16 times per plate.

Additionally, the arbitrator finds it significant that petitioner offered into evidence pictures of a gentleman leaning over a fixture and simulating the welding process (PX7). Before Stephens, Section Manager for respondent, viewed these photos, he testified that a welder working at a tandem tack station would not twist or bend because the fixture will accommodate the over bend. Then after viewing the photos (PX7), he agreed that a welder may bend as far as the individual in the photo was bending while working at the station. Petitioner testified that he bended at least as far as the person in the photo did, if not more. He also testified that he would have all his safety gear on, which the person in the photo did not have on.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained an accidental injury to his low back that arose out of and in the course of his employment by respondent on 4/15/13. The arbitrator bases her opinion on various undisputed facts. These facts include the fact that petitioner, when working on the tack fixture would bend at least as far as the person depicted in the pictures in PX7; that fact that petitioner was required to wear safety shoes, a jacket, chaps, sleeves,

respirator pack connected to a welding hood, and gloves while welding; and the fact that petitioner was bent over welding 30 times per tandem and 10-15 tandems per shift. The arbitrator finds the fact that petitioner would stand in a bent position to weld 300-450 times a shift, while wearing at least 7 different safety items, and holding a welding lead in his hand with his knees locked supporting himself against the tack fixture while welding, supports a finding that petitioner was exposed to a great risk when he was injured on 4/5/13 than those in the general public who may bend over and injure their backs.

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

It is unrebutted that petitioner had a preexisting degenerative lumbar spine condition. However, treatment for this condition was limited to treatment following a back strain when petitioner was 19 years old, and conservative treatment following complaints of back pain in January of 2013. Following these injuries petitioner was released to full duty work without restrictions. Petitioner also testified that he undergoes anywhere from 1-3 chiropractic adjustments a year.

Following the injury in January of 2013 while working for respondent, petitioner was released by Prompt Care to full duty work as a welder on 1/22/13 without restrictions. Petitioner sought no other treatment for his low back, and worked without incident until 4/5/13 when he experienced horrible pain in his low back shooting down his legs and into his groin, while bent at his waist welding tack tandems. Petitioner reported the injury immediately after it occurred and initially sought treatment in respondent's medical department, where he provided a consistent history of the accident.

Following the injury on 4/5/13 petitioner continued to experience low back pain without much relief with conservative treatment. An MRI of the lumbar spine performed 5/4/13 showed disc desiccation with mild diffuse disc bulge at L5-S1 abutting the S1 nerve roots with borderline narrowing of the right L5-S1 neural foramen.

Petitioner continued to treat with Dr. Chopra and Dr. Narla. This treatment included injections and physical therapy without much improvement. Based on his ongoing symptomatology petitioner was unable to perform his full duty job without restrictions after the accident on 4/5/13. Petitioner attempted to return to work in a light duty capacity as a fork lift driver, but stated that this job aggravated his symptoms.

Eventually, petitioner was referred to Dr. Pineda for a surgical consultation. Dr. Pineda gave the petitioner option of dealing with his pain or undergoing a disc replacement or fusion.

Respondent had petitioner examined by Dr. Kornblatt. Dr. Kornblatt diagnosed lumbar spine condition consistent with mechanical low back pain, secondary to L5 – S1 degenerative disc disease. He opined that this condition is not causally related to specific work duties, since degenerative disc disease is a naturally occurring phenomenon. Dr. Kornblatt was of the opinion that in this case there is no aggravation, as x-rays he performed, failed to reveal significant disk space collapse or abnormal bony pathologic changes consistent with marked degenerative disc disease. Dr. Kornblatt did not believe petitioner was a malingerer or exaggerated his pain symptoms.

Dr. Pineda opined that there was no connection between petitioner's pain in January 2013 and his pain following the accident on 4/5/13 since his pain following the accident in January lasted only a few days. Dr. Pineda opined that mechanism of bending down to weld on a fixture like the one in the picture could have aggravated an underlying condition in petitioner's back, rendering it symptomatic, to the point where surgical intervention became necessary and proper. Dr. Pineda opined that bending or twisting while working or not can aggravate degenerative disc disease. Dr. Pineda opined that petitioner's pain was continuous and non-ending. Dr. Pineda opined that weight, in general, increases the risk of aggravating a pre-existing disc disease. He further opined that forward flexion with weight in front of an individual is going to have a higher risk of aggravating a pre-existing disc disease than other postures. Dr. Pineda opined that the history petitioner provided him was that the onset of pain occurred at or around the time of the event. Based on this history, Dr. Pineda opined that there is a temporal relationship or a relationship between the back pain and the work-related event.

Based on the above, as well as the credible evidence the arbitrator adopts the opinions of Dr. Pineda and finds petitioner's current condition of ill-being is causally related to the accident he sustained on 4/5/13. The arbitrator bases this finding on Dr. Pineda's opinion that although bending or twisting while working, or not, could aggravate degenerative disc disease, that carrying additional weight on the body generally increases the risk of the aggravating a pre-existing disc disease. The arbitrator finds this significant given the fact that petitioner was not only carrying additional weight on his body, but this weight was directly related to the safety gear he was required to wear. The arbitrator also relies on Dr. Pineda's opinion that forward flexion with weight in front of an individual is going to have a higher risk of aggravating a preexisting disc disease than other postures. The arbitrator finds it unrebutted that petitioner, while welding, was bent over at least as far as the gentleman depicted in the pictures contained in PX7. The weight petitioner had in front of him would have been related to some of the safety gear, i.e, welding hood, sleeves, gloves, and the welding gun.

The arbitrator also relies on the fact that petitioner's condition was essentially asymptomatic prior to the injury, and had remained symptomatic after the injury to the point where petitioner was either off duty or restricted to light duty. Even Dr. Kornblatt, respondent's examining physician, believed petitioner was a malingerer or exaggerated his pain symptoms.

The arbitrator finds the petitioner sustained an aggravation of his preexisting degenerative lumbar spine condition as a result of the injury on 4/5/13, and further finds petitioner's current condition of ill-being as it relates to petitioner's lumbar spine is causally related to the accident on 4/5/13.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner sustained an accidental injury to his lumbar spine that arose out of and in the course of his employment by respondent on 4/5/13, and his current condition of ill-being as it relates to his lumbar spine is casually connected to the injury on 4/5/13, the arbitrator finds the medical services petitioner received for his lumbar spine from 4/5/13 through 10/14/14 were reasonable to cure or relieve petitioner from the effects of the injury he sustained on 4/5/13.

The respondent shall pay reasonable and necessary medical services for treatment related to petitioner's lumbar spine from 4/5/13 through 10/14/14, 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.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found petitioner sustained an accidental injury to his lumbar spine that arose out of and in the course of his employment by respondent on 4/5/13, and his current condition of ill-being as it relates to his lumbar spine is casually connected to the injury on 4/5/13, the arbitrator finds the disc replacement surgery recommended by Dr. Pineda is reasonable and necessary to cure or relieve petitioner from the effects of the injury he sustained on 4/5/13. The arbitrator adopts the opinions of Dr. Pineda and finds that since petitioner was a young individual, and works as a welder, a disc replacement would be reasonable and necessary.

The respondent shall pay reasonable and necessary medical services for treatment related to the disc replacement surgery recommended by Dr. Pineda, as provided in Sections 8(a) and 8.2 of the Act.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims he was temporarily totally disabled from 5/29/13 through 10/14/14. Respondent claims the petitioner is not entitled to any temporary total disability benefits.

Petitioner testified that he was taken off work as of 5/29/13 and has remained off since then by Dr. Chopra and Dr. Hansen. Petitioner testified that while he was on light duty he assisted his supervisor for a while, and then was assigned the job of a fork lift driver. Beginning 5/29/13 Dr. Chopra restricted petitioner from lifting, bending, squatting and stretching for the next 35 days, and lifting in excess of 20 pounds for the next 20 days. Petitioner testified that the fork lift driving aggravated his back due the bouncing of the fork lift, but Dr. Chopra did not restrict petitioner from driving the forklift. On 7/24/13 he again released petitioner from lifting in excess of 25 pounds. Again, no restriction was placed on fork lift driving and petitioner did not state that he lifted in excess of 25 pounds when performing his forklift driving. Dr. Chopra made no mention of any work status in his report dated 8/30/13 or 9/27/13. In fact, when petitioner presented to Dr. Chopra on 10/4/13 he told petitioner to find a different physician to take care of his back problems because he found the petitioner difficult to deal with and longer wanted to treat him.

On 11/15/13 Dr. Narla examined petitioner, but did not impose any work restrictions.

Petitioner began treating with Dr. Hansen's office on 1/14/14. Petitioner followed-up with Dr. Hansen every month through 9/15/14. From 1/14/14 through 5/13/14 petitioner was restricted from lifting, pulling, and pulling over 5 pounds, no climbing of stairs or ladders, and no bending at the waist through 5/13/14. On 5/14/14 and 6/16/14 Dr. Hansen's office restricted petitioner from lifting, pulling, and pulling over 5 pounds, and no climbing of stairs or ladders. These restrictions were in effect through 7/13/14. On 7/14/14 Dr. Hansen's office restricted petitioner from lifting, pulling, and pulling over 5 pounds, and no reaching above shoulder level through 8/18/14. On 8/15/14 and 9/16/14 Dr. Hansen's office restricted petitioner from lifting, pulling, and pulling over 5 pounds. These restrictions were in effect until 10/16/14. Dr. Hansen never restricted petitioner from driving a fork lift, even over bumpy surfaces.

Since petitioner testified that driving over bumpy surfaces and twisting to look behind him if he had to back up the forklift were the activities that aggravated his symptoms, and petitioner was not restricted from driving over bumpy surfaces or twisting by any doctor, and not authorized off work by any doctor, the arbitrator finds the petitioner's decision not to work from 5/29/13 through 10/14/14 was his alone, and not consistent with any restrictions placed on him by Dr. Chopra or Dr. Hansen, as he testified

to at trial. Although petitioner often told his doctors that he could not perform the light duty he was assigned by respondent, neither Dr. Chopra or Dr. Hansen authorized him off work, or placed him on restrictions that prevented him from performing the fork lift driver job, that appears to be within the restrictions imposed by Dr. Chopra and Dr. Hansen. Had either doctor been of the opinion that petitioner could not perform the fork lift driving job, they could very easily have restricted him from that activity, or taken him off work, which they did not do. The arbitrator reiterates the fact that petitioner's primary complaint was the bumpiness of the ride, which was rebutted in part by Sargeant, and no such restrictions were placed on petitioner during his claimed period of temporary total disability by Dr. Chopra or Dr. Hansen.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he was temporarily totally disabled from 5/29/13 through 10/14/14. The arbitrator finds the petitioner's decision to stop driving a fork lift for respondent was his own, not authorized by Dr. Chopra or Dr. Hansen, and not supported by the restrictions placed on him by Dr. Chopra or Dr. Hansen, even after he reported to them that he was having trouble performing this activity.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Javier Llanos,

Petitioner,

15IWCC0341

vs.

NO: 12 WC 31581

Echo, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, 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 June 24, 2014 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,926.00. 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: MAY 1 3 2015
KWL/vf
O-5/5/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0341

LIANOS, JAVIER
Employee/Petitioner

Case# **12WC031581**

ECHO INC
Employer/Respondent

On 6/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4538 SOFFIETTI JOHNSON TEEGEN ET AL
DAVID J BAWCUM
74 E GRAND AVE PO BOX 86
FOX LAKE, IL 60020

1739 STONE & JOHNSON CHARTERED
PATRICK D DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0341

Javier Llanos
Employee/Petitioner

v.

Echo, Inc.
Employer/Respondent

Case # **12** WC **31581**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **May 27, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0341

FINDINGS

On the date of accident, **July 23, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,200.00**; the average weekly wage was **$350.00**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **4** dependent children.

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

Respondent shall be given a credit of **$7,233.23** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,280.00** for other benefits, for a total credit of **$13,513.23**.

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

ORDER

- *Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $391.95 to Northwest Community Hospital, as provided in Section 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 their credit, as provided in Section 8(j) of the Act.*
- *Respondent shall pay Petitioner temporary total disability benefits of $330.00 per week for 25-6/7 weeks, commencing November 2, 2012 through May 1, 2012, as provided in Section 8(b) of the Act.*
- *Respondent has a credit of $13,513.23.*
- *Petitioner is not entitled to prospective medical treatment.*

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

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

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

#01 George J Andros
Signature of Arbitrator

June 23, 2014
Date

ICArbDec19(b)

JUN 24 2014

Findings of Fact

Petitioner testified through an interpreter. He had worked at the Respondent for about 10 years and last worked at Echo in July 2012. (According to the parties' stipulations, Petitioner worked at Echo until November 1, 2012.) His job duties were to work on the line where they assemble motors. He inserted a long tube into a hole in the motor. He then assembled the motor. The assembled motor weighed about 25 pounds. He assembled about 1,200 motors per day. The job involved constant twisting.

On the date of the accident, he was assembling tubes into motors and before lunch felt pain in the low back. He went to lunch. When he returned, he felt pain and could not work. Before July 23, 2012 he had no back pain and never underwent treatment to the low back.

On July 23, 2012 he went to Northwest Community Clinic and received pain medications. Dr. Joliana Peckus at the Northwest Community Clinic recorded a history of Petitioner working on a machine, a part came loose, and Petitioner jarred his right lower back. Examination was positive for low back pain and tenderness and pain with straight leg raising. Dr. Peckus' diagnosis was acute low back strain with muscle spasm extending into the right leg. Petitioner was limited to sitting work only. (PX 1).

Petitioner testified that in July and August 2012 he followed up on three occasions at Northwest Community Clinic and attended one physical therapy session. Specifically, according to the records, Petitioner returned on July 25, 2012. Petitioner had full range of morion but had pain and tenderness. Dr. Jennifer Sabath changed Petitioner's medications and prohibited Petitioner from pushing and pulling. When Petitioner returned to Dr. Sabath on August 1, 2012, Dr. Sabath noted continuing severe pain and ordered physical therapy. (PX 1).

Petitioner sought physical therapy on August 9, 2012. Twelve sessions had been approved. Petitioner located his symptoms in the low back on the right side extending into the right leg. He assessed his pain as ranging between 5/10 and 8/10. Therapy was provided and a protocol was established. Petitioner followed-up with Dr. Sabath on August 14, 2012. He reported a similar level of pain. Examination revealed slow range of motion and difficulty changing from sitting to standing. There was no subsequent office visits or physical therapy sessions at Northwest Community Clinic. (PX 1).

Petitioner testified that he stopped seeking treatment at Northwest Community Clinic because he was not receiving adequate care. He opted to present to Dr. Juan Alzate at The American Center for Spine and Neurosurgery. At that time he had low back pain radiating into his leg. According to Dr. Alzate's records, Petitioner presented on September 10, 2012 and provided a history of accident consistent with his allegations and testimony. Dr. Alzate's examination was positive for limited range of motion due to muscle spasms; pain and numbness extending into both legs; and possible weakness. Dr. Alzate ordered an MRI. In an apparent error, Dr. Alzate diagnosed "right shoulder pain". He also diagnosed spondylosis. (PX 2).

An MRI of the lumbar spine was performed on September 24, 2012. According to Dr. Alzate, the MRI revealed L3-S1 spondylosis with disc osteophyte complexes at L3-L4-L5. Dr. Alzate recommended injections and then possibly physical therapy. (PX 2).

The next document in The American Center for Spine & Neurosurgery records is a telephone message on October 31, 2012. Dr. Andrew Engel, a pain management physician at Marque Medicos, called Dr. Alzate and requested a referral. (PX 2). This contradicts Petitioner's testimony wherein he testified that Dr. Alzate opted to refer Petitioner to Dr. Engel in Chicago.

On October 29, 2012 Dr. Engel examined Petitioner. He complained of bilateral low back pain with numbness extending into the left leg to the ankle. Dr. Engel diagnosed a lumbar herniated disc. He ordered an EMG. Petitioner underwent the EMG/NCV on November 16, 2012. It revealed denervation of the left side at S1 and involvement of the L5 nerve on the right. On December 19, 2012 Dr. Engel administered a transforaminal epidural steroid injection at L5-S1. (PX 4).

Dr. Engel referred Petitioner to physical therapy. Petitioner sought physical therapy on October 30, 2012. The physical therapist noted Petitioner complained of low back pain and numbness into the left leg. Petitioner assessed his pain at 8/10. Petitioner sought treatment on 14 occasions between October 30, 2012 and November 27, 2012. He sought chiropractic treatment concurrent with physical therapy. (PX 4). Marque Medicos transported Petitioner to and from his home to their facility at 3735 West Fullerton in Chicago. According to Google Maps, this trip is 41 miles from his home at 690 West Liberty in Wauconda. Petitioner testified that he changed health care providers because he was not satisfied with the treatment at Northwest Community Clinic. He only attended one physical therapy session at Northwest Community Clinic.

On January 4, 2013 Dr. Engel referred Petitioner to Dr. Robert Erickson, a neurosurgeon at The American Center for Spine and Neurosurgery. Petitioner presented to Dr. Erickson on January 15, 2013 and complained of low back pain with bilateral radicular symptoms. Dr. Erickson recommended a follow-up examination. In the interim Dr. Erickson would review the MRI films and EMG study. On January 29, 2013 Dr. Erickson noted Petitioner's complaints of numbness correlated with the S1 dermatome. He recommended Petitioner return to physical therapy. On March 4, 2013 Dr. Erickson performed an SSEP. Dr. Erickson concluded the SSEP results were consistent with an L5-S1 disc herniation. (PX 2).

Dr. Erickson performed surgery on March 8, 2013; specifically, he performed an L5-S1 foraminotomy. (PX 2). Post-operatively, Petitioner followed up with Dr. Erickson. On March 18, 2013 Petitioner told Dr. Erickson that he had progressed well with increased ability to walk and decreased pain in the back and leg. He ordered physical therapy. Petitioner presented to Dr. Engel on March 26, 2013 and reported significant improvement in his pain following the surgery. He described a persistent aching pain that he assessed at 5/10. Examination was normal except for diminished reflexes. He recommended physical therapy and continued medication consistent with Dr. Erickson's recommendations. (PX 4).

Petitioner returned to physical therapy on March 27, 2013. He attended 41 sessions of physical therapy between March 27 and July 23, 2013. On April 22, 2013 he assessed his symptoms as the same. He made similar comments on May 6, 2013. (PX 4). He sought chiropractic treatment concurrent with the physical therapy treatment between May 2 and July 23, 2013. (PX 4).

Petitioner returned to Dr. Engel on April 30, 2013. He continued to assess his pain as improved but noted the radiating numbness had returned. It returned during physical therapy. (PX 3). His comment regarding the return of numbness contradicts the April 22, 2013 physical therapy record wherein he stated there was no change in symptoms, and the only complaint regarding the left lower extremity was weakness in the left ankle. In the May 6, 2013 physical therapy record Petitioner complained of left ankle pain and weakness, but not numbness. Nowhere in the therapist's records does it refer to an event where Petitioner's radiating symptoms returned. (PX 3).

Pursuant to Respondent's request, Petitioner presented to Dr. Andrew Zelby, a neurosurgeon, for an IME on May 1, 2013. There was a translator present. Petitioner did not arrange for the translator. Petitioner testified that the exam lasted about five minutes. According to Dr. Zelby's report, examination was positive for tenderness of the lower lumbar and upper gluteal regions, even with non-physiologic touch; pain in the back during straightleg raising; an intermittent antalgic gait; and diminished pin and vibratory sensation throughout the left lower extremity. After examining Petitioner and reviewing the medical records, Dr. Zelby concluded that he needed to review the MRI films before commenting on the reasonableness and necessity of the surgery. Examination was positive for four out of five Waddell signs. Petitioner's symptom magnification suggested Petitioner's symptoms were not related to a medical condition. He recommended a four week work hardening program. After four weeks, Petitioner should be released to full duty. Petitioner was able to return to work with a 20 pound occasional lifting limit. (PX 1).

For some reason, despite increased symptoms, Petitioner did not return to his surgeon until June 5, 2013. In the interim he underwent an MRI pursuant to the order of Dr. Engel. The radiologist reading the MRI report noted herniations at L3-S1 most prominent at L5-S1, and annular disc bulging from L3-S1 most prominent at L5-S1. The MRI report did not reference the prior surgery. When Petitioner presented to Dr. Erickson on June 5, 2013, Dr. Erickson reviewed the MRI films and concluded there was enhanced scar tissue at L5-S1, not a herniated disc. Examination revealed weakness at the left gastrocnemus with instability of the left ankle ascending stairs. Dr. Erickson performed an SSEP that showed mild elevations at S1 bilaterally. He recommended continued physical therapy and noted injections may be appropriate. Dr. Erickson noted that he reviewed the May 1, 2013 IME report of Dr. Zelby (RX 1), and disagreed with Dr. Zelby's comment that an SSEP was not necessary for a surgical evaluation. He did not otherwise comment on Dr. Zelby's opinions. (PX 4).

Dr. Engel administered injections injections on the left at L5 and at S1 on July 1, 2013. Petitioner did not improve. Dr. Engel recommended a lysis of adhesions. (PX 3). On August 7, 2013 Petitioner returned to Dr. Erickson who reported no change in Petitioner's symptoms. On September 11, 2013 Petitioner underwent a lysis of adhesions. He returned to Dr. Engel on September 17, 2013 and reported dramatic improvement following the lysis of adhesions. Dr. Engel deemed Petitioner to be approaching maximum medical improvement and recommended an FCE. (PX 4).

He underwent an FCE on October 4, 2013. The FCE concluded Petitioner was able to work at the light to medium physical demand level. (PX 8). Petitioner returned to Dr. Erickson on October 16, 2013. He permitted Petitioner to return to light/medium work and ordered work hardening. Regardless, there is an October 16, 2013 no work script in the Marque Medicos records. (PX 3).

On November 11, 2013 Dr. Zelby provided an addendum report after reviewing the MRI films and additional records. He concluded the surgery was not necessary, and Petitioner was able to work full duty and no additional treatment was necessary. (RX 2).

On December 18, 2013 and January 22, 2014 Petitioner presented to Dr. Leonard Krantzler, Dr. Erickson's colleague. Dr. Kantler reviewed Petitioner's treatment and testing. In neither record does he refer to Petitioner having undergone surgery. Petitioner reported working out at a gym and developing low back pain with left leg pain. Dr. Kantzler did not think surgery was appropriate. They discussed a return to work within the restrictions of the FCE. Again there was a January 22, 2014 no work script in the Marque Medicos records. Petitioner was considering another injection. (PX 3).

Petitioner testified that the surgery helped a little but the pain persists. He is able to walk but not too much and can sit but not for too long. Petitioner presented work restrictions to Echo, but Echo could not accommodate. He spoke with the group leader, Dan Fernandez, and Fernandez told him that the employer could not accommodate the restrictions. Petitioner lives in Wauconda and cannot drive a long distance. He had to accept the transportation from the medical providers. He sought treatment with Dr. Alzate in Wauconda but was referred to physicians in Chicago.

Petitioner acknowledged working light duty for a period following the accident. He was vague as to whether he complained of radiating symptoms at the Northwest Community Clinic. He acknowledged that an October 30, 2012 pain drawing in Marque Medicos' records showed no radiating symptoms. He agreed that the pain drawing was in his handwriting. He drove to the Commission (21 miles) for trial, but he testified that he was not able to drive long distances; ie. 8 – 41 miles to Marque Medicos.

Petitioner could not explain what happened between March 26, 2013 when he told Dr. Engel that he had no radiating symptoms and April 30, 2013 when he complained of numbness radiating into his lower extremities.

He has applied for a total of about seven jobs. He has applied at golf courses, pizzerias, and printing companies. He felt that he could try doing these jobs.

Conclusions of Law

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

Petitioner testified to persistent low back pain and symptoms radiating into his lower extremity. Petitioner sustained a lifting/twisting injury on July 23, 2012. Following the injury, he underwent a course of physical therapy and chiropractic injection and an epidural steroid injection. He reported no relief, and on March 8, 2013 Dr. Erickson performed a minimally invasive foraminotomy at L5-S1.

Following surgery, Petitioner initially made a good recovery. On April 22, 2013 Petitioner told his therapist that he was doing well. He reiterated these comments on May 6, 2013. However, in between—on April 30, 2013, he told Dr. Engel that radicular symptoms had returned.

Dr. Zelby examined Petitioner on May 1, 2013. With the exception of positive Waddell signs, his examination of Petitioner was normal. Dr. Zelby recommended a four week course of physical therapy. In four weeks, Petitioner would be able to return to full duty. In the interim Petitioner could return to work, lifting between 20 to 30 pounds occasionally. Dr. Zelby asked to review the MRI films. After reviewing the MRI films and other records, Dr. Zelby concluded Petitioner was able to return to full duty and needed no additional treatment. After the fact, Dr. Zelby concluded the surgery was not necessary. The Respondent authorized and paid for that surgery.

Dr. Zelby's opinion notwithstanding, Petitioner continued with a course of physical therapy and chiropractic care. On July 1, 2013 Dr. Engel administered an injection at L5-S1. Petitioner reported no change in his symptoms. On September 11, 2013 Dr. Engel performed a lysis of adhesions. Petitioner reported improvement. Dr. Erickson referred Petitioner for a functional capacity evaluation. Petitioner participated in the FCE on October 4, 2013. The therapist conducting the FCE concluded Petitioner was able to return to light to medium work. Regardless, there are scripts prohibiting Petitioner from working.

Petitioner testified that following the FCE, he sought jobs at several locations and thinks he was able to attempt to work those jobs.

The Arbitrator finds Petitioner reached maximum medical improvement on May 1, 2013. His current condition of ill-being is not related to the accident.

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

(K)—Is Petitioner entitled to prospective medical care?

As stated above regarding causation, the Arbitrator concludes Petitioner achieved maximum medical improvement on or before May 1, 2013. Except for the treatment identified below, the medical treatment prior to that date is reasonable and necessary, and the Respondent is responsible for payment of those services. The Arbitrator concludes the Petitioner's chiropractic treatment is not reasonable and necessary because it was contemporaneous with physical therapy. Petitioner offered no basis for the need for both modes of treatment at the same time. The Arbitrator also finds Petitioner's transportation to/from Chicago for medical treatment was not reasonable and necessary. There were no orders preventing Petitioner from driving. Petitioner testified that he drove to the Commission, 21 miles from his home. There is no basis to conclude that he was able to drive 21 miles but not able to drive 41 miles. Finally, many of Petitioner's trips were for physical therapy/chiropractic treatment. There is no basis for Petitioner selecting these treatment providers more than 40 miles from his home.

After reviewing Petitioner's bills, the Arbitrator concludes Respondent is responsible for the bill in the amount of $391.95 to Northwest Community Hospital. The Respondent is not responsible for any other bills.

Because of the Arbitrator's findings regarding causation, the Arbitrator concludes Petitioner is not entitled to prospective medical treatment.

(L)—Is Respondent responsible for TTD benefits?

As stated above, the Arbitrator concludes Petitioner achieved maximum medical improvement on or before May 1, 2013. The Arbitrator also concludes Petitioner was able to return to full duty. Consequently, Respondent shall pay to Petitioner and his attorney and is entitled to TTD from November 2, 2012 through May 1, 2013.

Moreover, Petitioner underwent an FCE on October 4, 2013 and was deemed able to return to light to medium work. In the more than seven months between the FCE and the hearing date, Petitioner testified that he had applied for about seven jobs. Petitioner's motivation too seek gainful employment and or return to work is questionable. Petitioner has the burden to establish not only that he did not work but could not work. No matter what maximum medical improvement date exists,he would not be entitled to any award of TTD following the date of the FCE—October 4, 2013. Page Four

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nancy Smith,

Petitioner,

15IWCC0342

vs.

NO: 13 WC 28559

Lakeside Transportation,

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 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 28, 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 $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: MAY 1 3 2015
KWL/vf
O-5/5/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0342

SMITH, NANCY
Employee/Petitioner

Case# **13WC028559**

LAKESIDE TRANSPORTATION
Employer/Respondent

On 7/28/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5278 MARKS & ASSOC LTD
JASON S MARKS
495 N RIVERSIDE DR SUITE 210
GURNEE, IL 60031

0530 TUCKER ROBIN & MERKER LLC
BONNIE BIJAK
30 N LASALLE ST SUITE 2736
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0342

NANCY SMITH,
Employee/Petitioner

v.

LAKESIDE TRANSPORTATION,
Employer/Respondent

Case # 13 WC 28559

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 **Waukegan**, on **June 26, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0342

FINDINGS

On the date of accident, **March 12, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,442.98**; the average weekly wage was **$489.29**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **one** dependent child.

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

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

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

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

ORDER

Respondent shall pay to Petitioner the cost of reasonable and necessary medical services, pursuant to the Medical Fee schedule, in the amount of **$586.00**, as provided in Section 8(a) and 8.2 of the Act.

Respondent is ordered to provide and pay for the prescribed cortisone injection and physical therapy as prescribed by Dr. Pavlatos.

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

July 17, 2014
Date

ICArbDec19(b)

JUL 28 2014

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

Petitioner works for Respondent as a bus driver. On March 12, 2013, she arrived at work at approximately 6:30 a.m. She was walking through Respondent's parking lot to get to her bus in order to start her morning route, when she slipped and fell on snow and ice. Petitioner testified she fell onto her left knee and then continued falling forward with her right hand and arm extended in front of her. Petitioner testified the fall was witnessed Ms. Blanca Ramirez, a co-employee.

Following the fall, Ms. Ramirez assisted Petitioner to her feet. Petitioner reported her fall to dispatch and then completed driving her morning bus route. When she returned after concluding her route, Petitioner was referred by Respondent to see Lake Forest Occupational Health.

Petitioner received treatment at Lake Forest Occupational Health later that day. Complaints were recorded of pain in her left knee and bilateral hands. X-rays were prescribed to her left knee, lower back and both hands. Petitioner was provided an ace wrap for her left knee and advised to return to work with no medical restrictions. Petitioner was diagnosed with multiple contusions and abrasions on that date.

Petitioner then returned to Lake Forest Occupational Health on March 15 and 28, 2013. She continued to complain of left knee pain and swelling. She was then referred to see an orthopedic surgeon.

On March 26, 2013, Petitioner saw Dr. Christ Pavlatos, an orthopedic surgeon. Dr. Pavlatos recorded a history of injury consistent with Petitioner's testimony, and following examination prescribed an MRI. Petitioner underwent the MRI to the left knee on April 4, 2013. This revealed edema over the medial collateral ligament consistent with a contusion.

Petitioner then returned to see Dr. Pavlatos on April 8, 2013. Dr. Pavlatos following review of the MRI diagnosed a medial collateral ligament sprain and chondromalacia. Dr. Pavlatos prescribed physical therapy that was performed for approximately one month and provided little relief of her symptoms.

Petitioner then returned to see Dr. Pavlatos on August 26, 2013 with continuing symptoms to her left knee. Dr. Pavlatos performed a steroid injection to the left knee and prescribed additional therapy. The therapy was not performed due to lack of approval by the insurance carrier.

Petitioner last saw Dr. Pavlatos on October 28, 2013. She continued to complain of pain to her left knee and Dr. Pavlatos prescribed a second steroid injection along with physical therapy. Respondent refused to authorize this treatment. Dr. Pavlatos also indicated on that date that Petitioner may be a candidate for left knee arthroscopic surgery, as she may have a chondral injury where a meniscus tear was not picked up by the MRI.

Petitioner was examined by Dr. David Zoellick, an orthopedic surgeon, on October 11, 2013. This examination was at the request of Respondent. Following recording a history consistent with her testimony and his examination, Dr. Zoellick felt the MRI revealed anterolateral edema and a small joint effusion that he felt was consistent with her fall. Dr. Zoellick also noted chondromalacia which he felt was chronic and not caused by the fall. Dr. Zoellick diagnosed a left knee contusion and felt she had sufficient time to recover from this condition. He felt her current condition was related to the underlying chondromalacia and its natural progression. He further felt she did not require any further treatment to the left knee as it relates to this injury according to his opinion, and that the symptoms she is experiencing is due to underlying chondromalcia and not from the work injury.

Dr. Pavlatos was of the opinion that while the chondromalacia was pre-existing, the work accident aggravated this condition. In light of her continued symptoms, Dr. Pavlatos believed Petitioner requires an additional steroid injection, physical therapy and potentially, arthroscopic surgery. Dr. Pavlatos felt the need for such treatment was caused by the accidental injury.

Petitioner testified that the condition of her left knee has not changed since she last saw Dr. Pavlatos. She continues to experience pain and swelling to her left knee. Petitioner testified that prior to this accidental injury, she did not injure her left knee or experience symptoms to that knee.

Based upon the above, the Arbitrator adopts the opinions of Dr. Pavlatos, the treating orthopedic surgeon, and finds his opinion to be more credible than that of Dr. Zoellick in this case. The Arbitrator notes that Petitioner experienced no symptoms to her left knee prior to the work accident of March 12, 2013, and that Dr. Zoellick's opinion failed to consider that the pre-existing, asymptomatic condition was aggravated as a result of the fall.

Based further upon the above, the Arbitrator finds that the injury of March 12, 2013 aggravated the pre-existing conditions to the left knee, and that such aggravation and resulting conditions are causally related to the work accident.

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

Petitioner introduced into evidence the medical charges of Dr. Pavlatos in the amount of $586.00.

Based upon the findings of this Arbitrator in "F" above, the Arbitrator further finds these charges to represent reasonable and necessary medical care and treatment caused by this accidental injury, and that said treatment was designed to reasonably cure or relieve the conditions of ill-being caused or aggravated by this accident.

Respondent is found to be liable to Petitioner for these charges which total $586.00.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "F" above. Having found causation in this matter, the Arbitrator further finds that Petitioner is entitled to the second cortisone injection to the left knee and physical therapy, as prescribed by Dr. Pavlatos. Respondent is ordered to authorize and pay for such treatment under these circumstances.

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

Eric Kiszenia,

Petitioner,

15IWCC0343

vs.

NO: 08 WC 15363
10 WC 45249
10 WC 45250
10 WC 45301

Garda Cash Logistics,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 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.

15IWCC0343

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,200.00. 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: MAY 1 3 2015
KWL/vf
O-5/5/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0343

KISZENIA, ERIC
Employee/Petitioner

Case# **08WC015363**

10WC045249
10WC045250
10WC045301

GARADA CASH LOGISTICS
Employer/Respondent

On 3/13/2013, 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 0.11% 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:

4070 LAW OFFICES OF CHARLES A FANUCCHI
2069 CHESHIRE DR
HOFFMAN ESTATES, IL 60192-4136

2965 KEEFE CAMPBELL BEIIRY & ASSOC LLC
SEAN BROGAN
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

15IWCC0343

Eric Kiszenia
Employee/Petitioner

v.

Garda Cash Logistics
Employer/Respondent

Case # 08 WC 15363

Consolidated cases: 10 WC 45249, 10 WC 45250 , 10 WC 45301

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **January 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. ☒ Did an accident occur that arose out of and in the course of 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 _____

15IWCC0343

FINDINGS

On January 22, 2008, July 7, 2010, August 31, 2010 and September 7, 2010, 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 January 22 2008, Petitioner *did* sustain an accident that arose out of and in the course of employment. On July 7, 2010, August 31, 2010 and September 7, 2010, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment

Timely notice of the January 22, 2008 accident *was* given to Respondent. Notice of the July 7, 2010, August 31, 2010 and September 7, 2010 incidents is moot. SEE DECISION

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

In the year preceding the injury, Petitioner earned $**36,000**; the average weekly wage was $**692.00**. ARB EX 1

On the date of accident, Petitioner was **28** years of age, married with **0** dependent children. ARB EX 1

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services. ARB EX 1.

Respondent shall be given a credit of $**36,468.32** for TTD, $**6,776.91** for TPD, $**0** for maintenance, and $**13,432.32** for other benefits, for a total credit of $**56,677.55**.

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 $461.33 per week for the undisputed period of 45-6/7 weeks commencing 1/22/08 through 12/18/08 pursuant to Section 8(b) of the Act. ARB EX 1. Respondent shall receive credit for amounts paid during this period.

Respondent shall pay Petitioner temporary partial disability benefits of $136.71 per week for the undisputed period of 21-5/7 weeks commencing 6/7/10 through 11/5/10. ARB EX 1. Respondent shall receive credit for amounts paid during this period.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred through 12/19/08 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid. ARB EX 1.

Respondent shall pay Petitioner permanent partial disability benefits of $415.20/week for 175 weeks, because the injuries sustained as a result of the January 22, 2008 accident caused the **25%** loss of the person as a whole for Petitioner's **right shoulder injury** and **10%** loss of use of the person as a whole for Petitioner's **cervical injury** for a total loss of **35%** of the person as a whole as provided under Section 8(d)2 of the Act. Respondent shall receive credit for advances paid. ARB EX 1.

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

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

3/13/13
Date

MAR 13 2013

15IWCC0343

FINDINGS OF FACT

Petitioner, a 28 year old driver, worked for Respondent making deliveries in Respondent's armored truck. As a driver for Respondent, Petitioner was required to lift between 50 to 75 pounds to and from the truck. Petitioner mainly lifted bags of coins. On 1/22/08 Petitioner was at work making deliveries with the truck and working a route that differed from his normal route. On that day in the early afternoon, Petitioner was delivering a load of coin to an auto parts store carrying a bag of coin over his right shoulder as he exited the truck. Petitioner testified that he made it through the customer's doors and then slipped on a patch of water from accumulated melted snow. Petitioner fell backward with his arm extended and landed on the tile floor. The coin load landed on the top of his shoulder and neck area. T. 15. Petitioner testified that he briefly lost consciousness. When he woke he could not move his right arm and as someone was helping him to stand up, Petitioner heard two loud pops in his right arm. After hearing the pops Petitioner stated he could again move his right arm. T. 16.

Petitioner went to the Holy Family urgent care center at Holy Family where he was x-rayed and then recommended to a hospital ER. Petitioner testified that his employer picked him up and took him to the company sports medicine doctors at Advanced Occupational Medicine. T. 19. Petitioner was treated by Dr. Khanna. More x-rays were taken and the doctors attempted to reset Petitioner's right arm. Pain injections and muscle relaxants were administered to reset the arm. T. 20. Petitioner was released with medications and instructions to ice his arm. T. 20. The diagnosis was a right shoulder contusion/strain/pain. PX 9. Petitioner was placed on light duty.

On 1/24/08, Dr. Khanna noted that Petitioner's right shoulder was "improving" and the pain level was 3/10. Petitioner also complained of neck and headaches. Dr. Khanna prescribed physical therapy at Advanced for all conditions and continued light duty. Petitioner testified that he also made complaints of thoracic pain during this period but that those complaints were ignored. Dr. Khanna ordered an MRI of the right shoulder which revealed a labral tear of the right shoulder and Petitioner was sent to Dr. Tu, a shoulder surgeon. PX 35. T. 30. A cervical MRI dated 3/19/08 indicated shallow central disc protrusions at C5-6 and T1-2 without neural foraminal narrowing or central stenosis. There was no evidence of a disc herniation or extrusion. PX 35. Dr. Khanna stated that the neck and headache symptoms should clear after the shoulder was repaired.

Dr. Tu performed right shoulder surgery and Petitioner attended physical therapy thereafter. Petitioner testified that he followed up with Dr. Tu after surgery and reported continued issues with range of motion, mobility and strength in his shoulder. He also expressed continued pain in his back and neck to Dr. Tu. T. 32. Petitioner testified that the pain was across his shoulder blades toward the center of his back and the cervical pain was in his neck up to the back of his head. T. 33.

After continued PT and medications, Dr. Khanna sent Petitioner to a pain specialist, Dr. Abdul-Latif in July 2008. T. 35. Petitioner underwent cervical injections to which he had a reaction that sent him to the ER at a community hospital in Munster Indiana where Petitioner resides. T. 38. Petitioner was advised to conclude his treatment PT at Advanced Occupational Medicine and his treatment with Dr. Khanna and to attend PT at a facility closer to his home in Indiana. T.

38. Petitioner initially treated at Community Hospital in Munster and then eventually began treating with local doctors, Drs. Tyndall and Einhorn in Munster Indiana in October 2008. T. 39. More PT for the shoulder and neck was prescribed and Petitioner transferred his PT to the offices of Dr. Tyndall and Einhorn. T. 41. Petitioner testified that he made the same complaints to Drs. Tyndall and Einhorn as he did to Drs. Khanna and Tu which included severe headache, pain in the back of the head, stabbing between the shoulder blades and pain in the right arm. T. 42. Drs. Tyndall and Einhorn diagnosed right shoulder impingement and cervicalgia with cervical disc herniations. T. 46.

Drs. Tyndall and Einhorn sent Petitioner for an FCE which he had at ATI in November 2008. The FCE was stopped due to Petitioner's rapid heart rate. Petitioner went back to Dr. Lewis at Community Hospital for cardiac testing who then released Petitioner to finish the FCE after prescribing blood pressure medication. T. 52. Petitioner took the medication through his second FCE in December 2008 after which he was released to the medium level work duty. Petitioner testified that he was again light headed from stabbing pain in the right shoulder, neck and mid back during the second FCE. Drs. Tyndall and Einhorn agreed with the FCE results and returned Petitioner to work.

Petitioner testified that he did not return to work as the FCE medium level work release was based on the description of a guard and his job as a delivery driver was in the heavy physical demand level. T. 56. In January 2009, pursuant to an addendum to the December 2008 FCE, Petitioner was eventually released back to work at the medium level which excluded his prior position as a driver. T. 57. PX 11. Petitioner testified that he called Respondent for several months and was told that no position was available. T. 57. Petitioner testified that several positions in management became available during that period but he was not allowed to interview despite having the qualifications. T. 58. Petitioner was paid TTD during this period. T. 59. HE conducted his own job search applying for 15 to 20 jobs per week in the administrative, public relations, and marketing fields based on his education level. T. 63. Out of 1200 contacts, Petitioner received 3 interviews between January 2009 and June 2009. Between June 2009 and December 2009 Petitioner contacted 500 employers expanding the search to administrative and banking jobs as well as in the automotive industry. Petitioner worked 7 years as a service advisor for a car repair company. Petitioner did not receive any job offers or interviews. T. 65-66. Between January and June 2010 Petitioner testified that he contacted 300 to 400 more employers without success. T. 67.

In June 2010, Petitioner returned to a light duty position with Respondent as a security guard. T 69. Petitioner testified that the job started as light duty checking people into the premises and walking the property doing surveillance through September 2010. However, Petitioner testified that the job "expanded about a month into it to include fueling trucks and as well as monitoring parked vehicles and in charge of towing vehicles." T. 70. Petitioner testified that after checking people in and collecting id badges, he bent down to put the badge in a bin and that he checked in approximately 150 badges per day coming into the facility bending at least 120 times per day. T. 74.

Petitioner further testified that he was required to fuel trucks at the onsite fuel pumps requiring him to remove metal plating from the side of the truck which required two hands and the use of a

key. T. 75. Petitioner testified that he was required to fuel the trucks and did so every day for 3 weeks in July 2010 fueling about 120 trucks per day. Petitioner testified that his right hand started to swell and that the pain began to spread "to the neck and everything." He complained of the pain to a supervisor but was kept on the fueling job. T. 78. Petitioner was eventually sent to see Dr. Khanna on July 7, 2010 and reported problems with his neck, back, arm and down his right leg. Petitioner advised Dr. Khanna that his leg problems began one month earlier when he returned to the guard light duty job. T. 80. Petitioner continued to see Dr. Khanna and included complaints of pain between the shoulder blades at the end of July 2010.

Petitioner testified that he did not have a specific injury on 7/7/10 but rather a gradual pain development while working fueling the trucks at work. He developed pain in the right shoulder, back of the head, neck and between his shoulder blades. Petitioner testified that the gas pumps he used were heavier than normal pumps and that he had to reach up and untangle the hose to fill the tanks. Again, Petitioner testified that he fueled approximately 120 tanks per day. Jeff Brenka was Petitioner's supervisor in July 2010. Petitioner testified that he told Mr. Brenka about his pain developed while fueling tanks at that time but that his complaints were ignored. Petitioner alleges a third incident on August 31, 2010 involving repetitive motion during the fueling of trucks and a final repetitive motion injury on 9/7/10 resulting from the collection of agent badges while working security for Respondent.

Jeff Brenka currently works for Respondent as armored transport supervisor. He has work 15 years for Respondent. In 2010, Mr. Brenka was the facility manager in Broadview Illinois where Petitioner worked light duty. Mr. Brenka testified that he was Petitioner's direct supervisor in 2010 and he was aware of Petitioner's restrictions. He made every attempt to accommodate Mr. Brenka and denied that Petitioner talked to him about hurting his right shoulder or injuring his back fueling trucks in 2010. T. 166. Petitioner did not report more injuries in 2010.

Mr. Brenka testified to 120 armored trucks on site which are fueled on site with diesel fuel. He described the fueling process as the same as the process involved in filling up a regular car. T. 159. The handle and the fuel hose weigh 5 pounds. Mr. Brenka testified that drivers fill their own tanks and that premise guards do not fuel tanks. It is not a part of the premise guard duties. He further testified that fueling trucks was never a regular part of Petitioner's job. T. 165-166.

Finally, Mr. Brenka testified that the job requirements of a premises guard fall within Petitioner's permanent work restrictions in 2010. The premises guard buzzes in visitors , monitors visitors to the premises, checks id's, escorts people around the facility and checks bags when people leave the facility. T. 156. On occasion, premises guards would spread oil dry over spills in the fuel area, Petitioner in fact testified that he was required to clean up fuel spills at work on 9/28/10 by opening a 30 pound bag of kitty litter and spilling the litter on the gas spill.

Respondent introduced a video which was viewed at trial. RX 16. The video was taken by Jeff Brenka and depicts the door guard station including a desk and a chair. Again, Petitioner wands employees, checks bags, admits visitors by buzzing the door and checks for parking violators in the lots. The video also depicts the gas pumps which are regular pumps with normal handles and operation. RX 16. The video does not depict the fueling of a truck and does not depict a guard at the door or the actual performance of guard duties.

In rebuttal, Petitioner testified that Jeff Brenka was present when Petitioner complained to another employee, Mr. Gertz, of difficulties with the work and that Mr. Brenka picked Petitioner up from the Hospital and took him back to Garda on July 7, 2010 and also drove and picked Petitioner up from a doctor's office on one of the other aggravation dates. Mr. Brenka denied these occurrences on cross exam. T. 177-180.

Petitioner chose next to see Dr. Fisher on August 4, 2010. Petitioner provided a history of working for an armored car service when he slipped and fell on a wet floor 2 years before this visit. Petitioner advised of his prior shoulder surgery and that he was diagnosed with cervical disc protrusions at C5-6. Dr Fisher testified that he noted Petitioner's prior trigger point and facet injections administered by Dr. Abdellatif followed by Petitioner's bad reaction. He also reviewed the FCE from December 2008 and that Petitioner was released to return to work at a medium physical demand level. PX 7, 7-9. Dr. Fisher further noted that Petitioner returned to work light duty fueling trucks which he reported was repetitive motion which increased his neck pain, right shoulder pain, right forearm pain and produced numbness in his fourth and fifth digits. Petitioner also reported low back pain and numbness in both legs while driving. PX 7, p. 10. Petitioner's main complaint on that date was right shoulder pain, pain between his shoulder blades, right sided neck pain and right upper extremity numbness. PX 7, p. 10. Following an exam of the right shoulder and right upper extremity as well as a thoracic exam, Dr. Fisher diagnosed right shoulder internal derangement, cervicalgia, low back pain, right cubital tunnel and bilateral lower extremity sciatica. PX 7, p. 12. He sent Petitioner for a cervical MRI and a right shoulder MRI and sent Petitioner to Dr. Newman for his shoulder complaints. As of the next visit on September 15, 2010, Dr. Fisher reviewed the MRI of the neck and shoulder. HE diagnosed shoulder derangement, cervicalgia and thoracic back pain. PX 7, p. 13. Again, Petitioner was to follow up with Dr. Newman for his shoulder and Dr. Fisher restricted him to no lifting over 20 pounds and no repetitive twisting and lifting. PX 7, p. 14.

Petitioner saw Dr. Newman and he read the shoulder MRI to include findings of chronic tendonitis explaining his impingement pain and chronic inflammation. Dr. Newman opined that the findings were consistent with a shoulder impingement and that this had been an issue since his original injury "since he had not been pain free." In his opinion, Petitioner never recovered or responded to the treatment of the original injury in 2008. PX 32, p. 10, 28. He further opined that the repetitive fueling of trucks in July 2010 "could have exacerbated the underlying chronic tendonitis and bursitis." PX 32, p. 11. Dr. Newman opined that without further treatment Petitioner had reached MMI and had permanent disabilities identified by the FCE. He recommended surgery as a possibility to improve his condition. PX 32, p. 12.

On 11/5/10, Dr. Newman performed an arthroscopy, acromioplasty and a biceps tenodesis to address the chronic tendinopathy of the biceps tendon. Again, he opined that the surgery was necessitated by the injuries received in the original 2008 accident. PX 32, p. 14. Petitioner attended PT in follow up and then by February 17, 2011, Dr. Newman determined that Petitioner was doing well and making good progress with his shoulder but was complaining about severe back pain at that point. PX 32, p. 16. Dr. Fisher continued to see Petitioner for thoracic pain and Dr. Newman planned to start Petitioner on work conditioning and an expected return to work one

month later. PX 32, p. 17. In the interim, Petitioner was diagnosed with a herniated thoracic disc by Dr. Fisher and Petitioner could not return to work.

While Petitioner followed up with Dr. Newman after his shoulder surgery, Petitioner returned to Dr. Fisher on January 19, 2011. At that visit, Petitioner reported improved neck pain, headaches and arm numbness after the shoulder surgery but continued mid thoracic back pain. PX 7, p. 14. Exam revealed tenderness over the paraspinous muscles at T6-7. Dr. Fisher assessed thoracic back pain and advised continued physical therapy for his back pain originally prescribed in September 2010 while Petitioner followed up with Dr. Newman to determine his work restrictions post shoulder surgery. On March 24, 2011, Petitioner returned to Dr. Fisher and noted that he had a trigger point injection by Dr. Newman in his thoracic areas with temporary relief. A thoracic MRI was ordered and revealed a T5-6 right paracentral herniated disc extending 7.5 millimeters, slightly displacing the spinal cord to the left but without significant stenosis. Dr. Fisher clarified that the MRI mistakenly referred to T5-6 when it actually should have read T6-7. Dr. Fisher performed a T6-7 right sided microdiskectomy on July 26, 2011. PX 7, p. 24. With regard to the cause of the T6-7 herniation Dr. Fisher testified, "Given his history of new onset pain at the time of the work accident and pain persisting since then, most likely it occurred at the time of the work accident." PX 7, p. 24. Petitioner was to add thoracic physical therapy to his shoulder physical therapy.

After the thoracic disc surgery, Petitioner returned to Dr. Newman in September 2011 complaining of mild shoulder pain and exhibiting impingement signs. As of October 2011 the shoulder was doing well with minimal impingement sings and full range of motion. PX 32, p. 23. Dr. Newman placed Petitioner at MMI for his shoulder as of 11/29/11 and he was released to return to work as far as the shoulder was concerned. PX 32, p. 24. Petitioner had restrictions of no lifting over 10 pounds and no work above the shoulder level. Dr. Newman has not seen Petitioner since the November 2011 visit.

Petitioner continued with thoracic physical therapy pursuant to Dr. Fisher's orders as of January 2012. Petitioner reported continued thoracolumbar pain worse with activity and right lower extremity radiculopathy as of January 11, 2012. T. 7, p. 30. Dr. Fisher ordered another thoracic MRI and a lumbar MRI. The thoracic MRI revealed a previous C6-7 diskectomy with a small recurrent disk herniation without any stenosis or indentation of the spinal cord. No surgery was required. PX 7, p. 33. Dr. Fisher thought that irritation to the spinal cord at the area of the surgery may be a cause of the lower extremity radiculopathy so he ordered an evaluation for a spinal cord stimulator. A temporary stimulator was placed by Dr. Alzoobi in April 2012 and Petitioner reported significant improvement in symptoms. He no longer felt his legs would buckle but still used a cane "just in case." Petitioner was sent back to Dr. Alzoobi to see if he was a candidate for a permanent stimulator. PX 7, p. 35.

Petitioner's treating pain management doctor, Dr. Alzoobi, testified that he implanted a trial stimulator on April 5, 2012 to try and control the thoracic and lumbar pain. Only the lumbar pain and radiculopathy was controlled. PX 33, p. 37. A permanent stimulator was installed on May 3, 2012. PX 33, p. 12. Dr. Alzoobi's treatment plan for Petitioner was chronic pain management including pain medication. PX 33, p. 15. He restricted Petitioner to no lifting over 10 to 15 pounds and no sitting for prolonged periods. PX 33, p. 16. Petitioner was also advised

not to drive more than 20 to 30 minutes and he was restricted from bending beyond 30 or 40 degrees. PX 33, p. 17. Dr. Alzoobi testified that the stimulator was to address Petitioner's lower back and radicular problems. It was not possible for the stimulator to address all of Petitioner's back and neck complaints. PX 33, p. 30. He also recommended Petitioner attend a psychiatric evaluation to help him deal with his current physical restrictions. Finally, he testified that Petitioner could work at a light job as long he is not required to carry large items or bend frequently. PX 33, p. 35. Finally, Dr. Alzoobi testified that Petitioner would need pain management for a long period of time and counseling for the current time to "come out of this status." PX 33, p. 36.

Petitioner's last visit to Dr. Fisher was in September 2012. Petitioner testified that Dr. Fisher told him there was nothing else to do other than another surgery for which Dr. Fisher felt Petitioner was too young. Petitioner was at MMI with permanent restrictions of no lifting over 10 pounds, alternate sitting and standing and laying every 15 minutes and no repetitive bending or twisting. T. 99. Petitioner testified that he is unable to walk or drive. He is unable to turn his head sideways and can only sit 15 minutes while driving.

Dr. Babek Lami evaluated Petitioner on September 28, 2012. RX 2. Dr. Lami testified via deposition on December 6, 2012. He confirmed all opinions documented in his report. The doctor testified claimant was at maximum medical improvement in December 2008 following his work related fall in January 2008. Dr. Lami opined, "As far as his spine was concerned, the reports of the MRI of the cervical spine show a bulge at C5-6, and evaluation by spine surgeon did not find significant findings. So I did not find a cervical spine injury to Mr. Kiszenia." RX , p. 14. Thus, it was the Doctor's opinion claimant sustained a cervical strain at most as a result of the January 2008 fall for which he was MMI one year later. RX 1.

With regard to Petitioner's thoracic condition, Dr. Lami testified that the April 6, 2011 MRI showed a soft disk herniation at T5-6 disc herniation. Dr. Lami testified that he was not able to support a thoracic herniation was related to his injury in 2008, the fall. If he had injury, he would have had symptoms in the T5 or T6 nerve distribution. It would have been noticed by doctors especially spine surgeon and none of them exist. So, therefore, I did not support a thoracic disk herniation to be related to the injury. ... The disk herniation he had is not something could have existed there from 2008." RX 1, p. 15,17

With regard to causal connection between the thoracic disk injury and the alleged accidents of 2010, Dr. Lami testified that the events of scanning ID cards were not sufficient to cause the acute thoracic disk herniation seen on the MRI. RX 1, p. 18. Dr. Lami further testified Petitioner did not give a history of a specific incident of trauma while fueling trucks in July 2010. Dr. Lami explained that soft disc herniations generally result from an acute incident of trauma. The claimed mechanisms of injury—repetitively fueling tanks and twisting/turning while scanning ID badges—were not acute in nature. Thus, he testified none of the alleged work aggravations/injuries in 2010 could have led to the soft thoracic disc herniation and need for thoracic spine surgery. RX 1, RX 2. Dr. Lami further testified that he does not know what caused the thoracic herniation but knows that it occurred acutely in 2011. RX 1, p 46.

Dr. Lami testified claimant's diagnosis referable to the spine was subjective pain with no objective findings at the time of his examination. He further testified placement of the permanent spinal cord stimulator was unreasonable and unnecessary irrespective of cause. RX 1, p. 20-22. Dr. Lami did not render any opinion with regard to Petitioner's shoulder condition. RX 1, p. 14.

Dr. Aribindi performed a Section 12 examination on October 15, 2012. Dr. Aribindi testified that he reviewed the surgical report from the first shoulder surgery in April 2008 wherein Dr. Tu found a fraying of the labram and impingement. No biceps pathology was noted during the surgery. RX 3, p. 11. Dr. Aribindi further notes that Petitioner was released at MMI following the December 2008 FCE and his last visit with Dr. Tyndall. RX 3, p. 15. He noted that Petitioner had returned to restricted duty in 2010 for Respondent and that Petitioner reported pain in the right shoulder, right arm, and back while fueling trucks at work on July 7, 2010. RX 3, p. 16. No specific injury was reported. Dr. Aribindi testified that the work activities of 2010 of refueling trucks would not cause a biceps tendinopthay for which Petitioner received surgery in November 2010. RX 3, p. 19.

Dr. Aribindi testified both the February 2008 right shoulder MRI and Dr. Tu's operative report confirmed Petitioner's biceps tendon was intact. RX 3 at p. 11. As such, the biceps tenodesis performed by Dr. Newman on November 5, 2010 could not possibly be related to the January 22. 2008 fall as his biceps was intact at the time of Dr. Tu's surgery. Furthermore, Petitioner's work duties in 2010 including fueling trucks could not cause biceps tendinopathy without specific incident of trauma. RX 3 at p. 19. Dr. Aribindi testified there were no objective findings at the time of his examination of Petitioner to support his ongoing subjective complaints. RX 3 at pp. 23-24.

CorVel reviewed the medical necessity and reasonableness of physical therapy sessions for the cervical and thoracic spine along with the right shoulder for dates of service beginning September 29, 2010 and ending February 17, 2012. RX 6. Of 18 physical therapy sessions ordered on October 20, 2010 for the cervical and thoracic spine, 6 sessions were certified while the remaining 12 sessions were non-certified. Regarding 68 physical therapy sessions for the right shoulder and thoracic spine from November 16, 2010 to April 26, 2011, 30 sessions were certified and the remaining 38 sessions were non-certified. RX 6. An additional 55 physical therapy sessions for the right shoulder between May 23, 2011 and December 1, 2011 were reviewed by Dr. Anderson. Of those sessions, 6 were certified and 49 were non-certified pursuant to the evidence based guidelines outlined in Official Disability Guidelines – Treatment in Workers' Comp ("ODG-TWC"). RX 6.

Last, Dr. Anderson reviewed the medical necessity and reasonableness of 65 physical therapy sessions from September 19, 2011 through February 17, 2012 of which 19 sessions were certified and the remaining 46 sessions were non-certified. Again, the reviewing physician's opinions are supported by the evidence based guidelines of ODG-TWC. RX

Petitioner testified he has a high school degree and his highest degree of education is a Bachelor's Degree in Communications with a specialty in Public Relations from Purdue University which he obtained prior to his employment with Respondent. T. 116-117. According to Petitioner's "New Hire Report" admitted as Respondent's Exhibit 10, Petitioner has

specialized skills in public relations, human resources, staffing and journalism. RX 10. T. 123-124. Petitioner denied having undertaken any post-Bachelor studies or work towards a Master's Degree although he reported partaking in an independent study program for his graduate degree when he underwent an EMG/NCS in June 2008. T. p, 16, 118. PX 9.

Petitioner completed five years of training with the Air Force Auxiliary where he was trained in first aid, search and rescue, firearms, etc. T. 118-119. RX 10. As for employment prior to that with Respondent, Petitioner worked as a coordinator for the marketing, communications and public relations department at Rehabilitation Institute of Chicago. T. 119-120, RX 10. He also has extensive experience in the automobile service industry including employment with Pep Boys as a parts manager and senior service advisor. T. p. 120; RX 10.

Petitioner testified he is semi-fluent in German and plays several stringed instruments. T. p. 120-121. Petitioner testified he operates a "club" called Phobic Photography Creations where he "...takes pictures to kind of bring out fears and phobias..." T. p. 121. Phobic Photography Creations has its own Facebook Page. Petitioner testified his computer skills are advanced and he is social media savvy. T. 122-123. He testified he has his own Facebook page, Twitter account and LinkedIn profile. T. p. 122.

Ms. Alla Massat, a vocational case manager employed with Encore testified on behalf of Respondent. T. 195-196. She is a certified rehabilitation counselor with over 18 years of experience and a Masters' Degree in Rehabilitation Counseling. RX 14. Ms. Massat testified that her job consists of helping people with disabilities obtain alternate employment. T. 196. She testified she prepared a labor market survey for Petitioner on January 7, 2013. T. 197. She reviewed various medical records in conjunction with performing the survey including the Section 12 reports of Dr. Aribindi and Dr. Lami along with the January 15, 2009 FCE report and Dr. Fisher's September 13, 2012 report in which permanent restrictions were recommended. T. 199-201. She further testified she was able to review Petitioner's past work experience and educational background. T. 201.

Ms. Massat performed a transferable skills analysis after reviewing Petitioner's medical, professional and educational information. T. 203. She testified she contacted employers directly by phone and Internet to determine whether there were job openings that meet the various medical restrictions outlined in the records. T. 203-204. She limited her search to a fifty mile radius of Petitioner's home address in Highland, Indiana. T. 204.

Based on her survey, Ms. Massat opined that Petitioner could obtain alternate employment within the restrictions outlined by the January 2009 FCE and Dr. Fisher in September 2012. T. 205. She further testified Petitioner was both educationally and professionally qualified for many job opportunities. T. 208. Ms. Massat documented six available positions in her report that fell within the restrictions outlined in the January 2009 FCE. T. 207. Those positions included service advisor, assistant automotive manager, quick lube advisor and assistant store manager with a wage range of $11.50 to $19.23 per hour. RX 15; T. 207.

She testified she documented six additional available positions that fell within the restrictions outlined by Dr. Fisher on September 13, 2012. T. 207. Those positions included desk clerk,

customer service representative, human resources specialist, administrative assistant and dispatcher with a wage range of $11.83 to $20.33 per hour. RX 15; T. 207-208.

Ms. Massat was asked about her opinion regarding whether Petitioner would have been able to find work within the restrictions outlined in the January 2009 FCE during 2009 and 2010. However, the Arbitrator sustained an objection to her response in that the witness was not retained to opine as to the availability of jobs in 2009 and 2010 but rather was retained to perform a labor market survey for Petitioner's viability in the current market. T. 209-212.

Again, Petitioner testified that since September 2012, he has been looking for a job and has contacted 50 to 70 places in the last few months. T. 104. He has registered on line at job websites without result. Petitioner testified that he looks for work every day. On cross exam, Petitioner testified that during the 17 month period from his MMI date of 12/18/08 through 6/6/10 he looked at thousands of jobs but has no documentation of those searches. He also confirmed that he has never supplied any documentation corroborating his efforts to find a job following Dr. Fisher's September 2012 release. T. 141.

CONCLUSIONS OF LAW

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

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

Based on the record as a whole, the Arbitrator finds that Petitioner sustained a fall at work arising out of and in the course of his employment for Respondent on 1/22/08. This accident finding is buttressed by Petitioner's testimony and the initial treating medical records replete with reference to a fall at work.

With regard to notice, the Arbitrator notes that Petitioner sought immediate care following the accident of 1/22/08 and that the contemporaneous medical records reflect complaints of pain and treatment following an acute accident at work in 2008. Petitioner was at work when the fall occurred and was sent by Respondent for urgent care and to the company physician Dr. Khanna for follow up treatment. The Arbitrator further finds that proper and timely notice of the 2008 accident was provided to Respondent.

With regard to the alleged accident dates of July 7, 2010, August 31, 2010 and September 7, 2010, the Arbitrator finds that Petitioner failed to prove he sustained new injuries arising out of or in the course of his employment or exacerbations of the injury causally connected to the accident of 1/22/08 on any of those dates. The Arbitrator notes that Petitioner did not allege specific or acute trauma on any of the dates but rather that he was engaged in repetitive work that resulted in new complaints. After consideration of the ample testimony provided by both parties on the mechanics of tank fueling, the Arbitrator finds that the act of filling a tank is akin to fueling a personal vehicle at any commercial gas station which is a process that is not physically demanding. The Arbitrator viewed the video depicting the fuel tanks at issue and notes the

resemblance to regular gas station fuel tanks, despite the fact that the act of fueling was not depicted on the video. In addition to the Arbitrator's finding that Petitioner did not sustain a compensable accident on July 7, 2010 while fueling trucks, the Arbitrator further finds Petitioner did not exacerbate his alleged pre-existing injuries as result of fueling trucks.

Petitioner also claims he was injured on August 31, 2010 while at work but again denied any specific incident of trauma. There is no mention of an August 31, 2010 injury in the medical evidence. Further, Petitioner's testimony in support of an accident or exacerbation on this date is unclear, speculative and fails to support a finding of compensable injury on that date.

Finally, Petitioner testified he was injured a final time on September 7, 2010 while at work due to repetitively twisting to collect agent cards. He denied any defect with the floor or any specific incident of lifting leading to his pain. Again, the Arbitrator finds Petitioner's testimony speculative and unsupportive of an accident finding. Twisting, Petitioner's reported mechanism of injury is a normal, every-day activity that is not unique work duties and does not arise out of employment. Thus, the Arbitrator finds Petitioner failed to establish he sustained a compensable accident arising out of and in the course of his employment with Respondent on September 7, 2010. See Decision on causal connection below.

Based on the finding of no accident on the 2010 accident dates, the Arbitrator makes no finding on the issue of notice in those matters.

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

The Arbitrator has found that Petitioner did not sustain compensable accidents or exacerbations on July 7, August 31 or September 7, 2010. Thus, the sole issue is whether Petitioner's current condition of ill-being is casually related to the compensable accident of January 22, 2008.

Petitioner underwent right shoulder surgery and treated conservatively for cervical complaints as a result of the January 22, 2008 incident. He was deemed MMI on December 19, 2008 and released to the medium level work after an FCE in December 2008. RX 8.

In addition to the findings of no accident on the dates stated above, the Arbitrator further finds no causal connection for Petitioner's thoracic injury or for continued cervical, shoulder or low back care subsequent to December 19, 2008. In so finding, the Arbitrator further notes that 20 months after his MMI release and one month after his return to light duty work for Respondent in June 2010, Petitioner began treating with Illinois Bone and Joint Institute, and Dr. Alzoobi thereafter, for complaints unrelated to his work accident of January 22, 2008. Those doctors performed right shoulder surgery in November 2010, thoracic sine surgery in July 2011 and placement of a permanent spinal cord stimulator in May 2012.

The Arbitrator assigns weight to the opinions of Petitioner's treating doctors, Dr. Einhorn and Dr. Tyndall who found Petitioner had achieved MMI on December 19, 2008 and that no further treatment was indicated other than home exercise for Petitioner's original shoulder injury. Again, the Arbitrator finds it significant that Petitioner sought no treatment for his right shoulder or for any complaints alleged to be related to the 2008 accident between December 2008 and July

2010. In finding no causal connection for conditions after 2008, the Arbitrator assigns greater weight to the opinions of Drs. Einhorn, Tyndall, Lami and Aribindi than to the opinions of Drs. Fisher, Newman and Alzoobi on the issue of causal connection for the injuries alleged after 2008.

With regard to the right shoulder, Dr. Aribindi testified regarding the pathological differences between Dr. Tu's and Dr. Newman's arthroscopies. Accordingly, the biceps tenodesis performed by Dr. Newman on November 5, 2010 was not related to the January 22. 2008 fall as his biceps was found intact at the time of Petitioner's initial shoulder surgery performed by Dr. Tu in 2008. Further, Dr. Aribindi testified that Petitioner's work duties in 2010, including fueling trucks, could not cause biceps tendinopathy without specific incident of trauma. RX 3 at p. 19. Petitioner did not allege any specific trauma to his shoulder in 2010. Again, as Petitioner denied an acute mechanism of injury in 2010 his biceps tendinopathy which was treated surgically in 2010 is unrelated to any repetitive duties performed on July 7, August 31 and September 7, 2010.

With regard to the thoracic spine disk herniation, the Arbitrator places greater weight on the testimony of Dr. Lami. Dr. Lami credibly testified that the January 2008 fall did not cause the soft thoracic disc herniation at T6-T7 visualized on the April 6, 2011 MRI. If it had, the Arbitrator notes that contemporaneous medical records in 2008, 2009 and 2010 would have documented findings of myelopathy or complaints other than general complaints of neck pain, head pain and pain between the shoulder blades as reflected in the 2008 FCE report. Furthermore, the Arbitrator places greater weight on the lack of follow up medical care for any complaints of mid back pain between December 2008 and July 2010 than on Petitioner's testimony regarding his continued complaints of pain in the mid back area following the January 2008 accident. Finally, Dr. Lami credibly opined that soft thoracic disc injuries such as Petitioner's are acute in nature and do not arise from short term repetitive activities such as those performed by Petitioner in 2010. Again, Petitioner did not allege acute injury in 2010.

Last, Petitioner's low back and right lower extremity complaints are not casually related to the January 22, 2008 incident. Upon examination by Dr. Khanna on July 13, 2010, Petitioner gave a history of back pain and right leg radiculopathy starting in May 2010. It is undisputed Petitioner was not working for Respondent in May 2010. Petitioner's current condition of ill-being emanates from his unrelated right shoulder surgery of November 5, 2010, thoracic spine surgery of July 26, 2011 and placement of a permanent spinal cord stimulator to treat his subjective low back pain and right lower extremity radicular complaints that he reported began in May 2010 when it is undisputed he was not working for Respondent.

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

Based on the above findings of accident and causal connection, the Arbitrator finds that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred to treat Petitioner's causally related right shoulder and cervical complaints through December 2008 pursuant to Sections 8 and 8.2 of the Act.

Respondent's UR evidence does not pertain to the treatment received in 2008.

K. What temporary benefits are in dispute? TTD/ TPD

Petitioner requests maintenance benefits for the period of December 19, 2008 through June 6 2010, the period of time after MMI and release to medium level work and prior to starting a light duty job with Respondent. The Arbitrator notes that per the addendum FCE released in January 2009, Petitioner was not able to return to his heavy duty position and could work only at the medium duty level. PX 11. Petitioner testified that Respondent had no medium level work available so he looked for work on his own during this period of time and is thus entitled to maintenance benefits during this search. However, the Arbitrator does not find Petitioner's job search testimony credible in this regard and finds that he is not entitled to maintenance benefits during this requested period. The Arbitrator notes that Petitioner produced insufficient evidence to carry his burden of proof that he was actively seeking employment within his restrictions following his release. Specifically, Petitioner claims he contacted as many as 2100 employers or applied for as many jobs during the 17 month period from December 19, 2008 through June 6, 2010. However, Petitioner produced no documentation corroborating his efforts at trial and admitted numerous times to never submitting documentation of his self-directed job search to Respondent or any of its agents.

As Petitioner has failed to carry his burden of proof that he was actively seeking employment within his restrictions from December 19, 2008 through June 6, 2010, he is not entitled to maintenance benefits. Accordingly, Respondent is to receive credit for amounts paid.

With regard to the period of time commencing June 7, 2010 and November 5, 2010 the Arbitrator finds that Petitioner is entitled to a period to TPD benefits. Petitioner returned to a light duty job for Respondent after receiving a medium level work return in January 2009 per the addendum to the FCE. PX 11. The light duty work stemmed from the original 2008 accident and injury. Petitioner testified that he was earning less in his position as a premises guard at Respondent than he was as an armored truck driver, his position at the time of his injury. Petitioner testified that Respondent's insurer paid differential benefits of $136.71 per week during this period. T. 127-128. The Arbitrator finds that Petitioner was entitled to the paid differential benefits during this period. Respondent shall receive a credit for these amounts paid.

As explained above, Petitioner failed to establish he sustained compensable accidents arising out of and in the course of his employment with Respondent on July 7, August 31 and September 7, 2010 or that his condition of ill-being is causally related to the compensable January 22, 2008 work accident. Thus, the issue of whether Petitioner is entitled to temporary total disability or maintenance benefits from November 5, 2010 to the present is rendered moot.

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

The Arbitrator notes initially that Petitioner did not request vocational rehabilitation at trial. Petitioner placed nature and extent at issue and is specifically requesting a finding of permanent total disability.

The Arbitrator finds that Petitioner failed to prove permanent total disability. The Arbitrator again notes the above findings with regard to accident and causal connection. As a result of the January 2008 fall at work, Petitioner sustained an injury to his right shoulder requiring surgery and extensive physical therapy as well as symptomatic cervical disk bulges/herniations which were treated conservatively. Based upon the FCE exam in December 2008 and the addendum issued in January 2009, Petitioner is unable to return to work driving armored trucks but can work in a medium level capacity.

In denying Petitioner's request for PTD, the Arbitrator notes the findings of Ms. Massat with regard to Petitioner's employability as well as Petitioner's young age (28) and his considerable skills. Petitioner speaks German, plays several instruments, is computer and social media savvy, and possesses a 4 year college degree and ample prior work experience. The Arbitrator finds that Petitioner failed to prove he is not employable in an existing branch of the labor market within his restrictions.

Based on Petitioner's right shoulder and cervical injuries in 2008 and on his resulting loss of the ability to work in a heavy capacity, the Arbitrator finds Petitioner sustained 10% loss of the person as a whole for his cervical injury and 25% of the person as a whole for his shoulder injury for a total loss of 35% of a person as a whole under section 8(d)(2) of the Act.

M. Should penalties or fees be imposed upon Respondent?

Based on the findings above, the Arbitrator further finds that Respondent's conduct was not so unreasonable or vexatious so as to support an award of penalties under Sections 19(k) and 19(l) or fees under Section 16 of the Act.

N. Is Respondent due any credit?

Respondent is due the credits noted in the foregoing sections of this Decision and those reflected in the Order section of the Decision and in ARB EX 1.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Dolnak,

Petitioner,

vs.

NO: 11 WC 39647

Argonne National Laboratory,

15IWCC0344

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 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 views the Petitioner's disability differently than that of the Arbitrator.

Petitioner's statement to Dr. Patel that he never had right sided numbness prior to the injury was not credible. (Petitioner Exhibit 4) The records of Dr. Drancik indicate that Petitioner saw him with pain radiating into his right leg. (Respondent Exhibit 3) Petitioner also saw Dr. Dorning in 2010 and 2011 with problems in his lower back and pain radiating into his right leg and thigh. This was prior to his accident date of August 12, 2011. Dr. Dorning prescribed lumbar injections prior to August 11, 2012. (Respondent Exhibit 4)

Outside of Petitioner's subjective complaints there is no medical evidence that Petitioner's condition was aggravated or made worse due to this injury.

The Commission finds that Petitioner is entitled to 10 weeks of compensation at a rate of $600.00 because the injuries sustained caused a loss of use to the person as a whole to the extent of 2%.

15IWCC0344

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.00 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 the loss of use to the person as a whole to the extent of 2%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,379.00 for medical expenses under §8(a) of the Act 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,100.00. 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: MAY 15 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HF
O: 3/17/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

DOLNAK, GREGORY
Employee/Petitioner

Case# 11WC039647

ARGONNE NATIONAL LABORATORY
Employer/Respondent

15IWCC0344

On 9/19/2013, 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 0.03% 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:

4595 WHITESIDE & GOLDBERG LTD
BRENT R EARNES
155 N MICHIGAN AVE SUITE 540
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC
SEAN C BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

15IWCC0344

☐ 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

Gregory Dolnak
Employee/Petitioner

v.

Argonne National Laboratory
Employer/Respondent

Case # **11** WC **39647**

Consolidated cases: _____

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

FINDINGS

On **August 12, 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 **$52,000.00**; the average weekly wage was **$1,000.00**.

On the date of accident, Petitioner was **53** years of age, *married* with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $600.00/week for **25** weeks as provided under Section 8(d)2 of the Act, as Petitioner sustained **5%** loss of use of man as a whole.

Respondent shall pay reasonable and necessary medical services of **$14,379.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

9/18/13
Date

SEP 19 2013

Petitioner testified he is employed by Argonne National Laboratory (hereinafter "Respondent") and has been so employed for 22 years. He works as a waste mechanic and his job duties include handling and disposing of hazardous waste along with dismantling experiments and using various equipment. Petitioner also owns and operates a part-time business, G & M Cleaning Service, which provides general office cleaning services including disposing of garbage, wiping down countertops and vacuuming. He has owned this business for nine years.

Petitioner testified that on August 11, 2011, he was working in the course of his employment for Respondent, moving a large Shield Cask. Later that day, he noticed some lower back pain which he did not feel was very significant. Petitioner continued to work for the remainder of the day and reported to work the following morning. Petitioner testified that on the morning of August 12, 2011, he was once again moving a large Cask with another employee which weighed approximately 5000 to 6000 pounds. Petitioner indicated that this Cask was too heavy to move with just two workers, so they called for additional help. Petitioner stated that after additional help arrived and they finished moving the Cask. Petitioner provided that he noticed new and intense and increasing pain in his lower back.

Petitioner filled out an Incident Description. The report, dated August 12, 2011 at 8:50 a.m., notes "[y]esterday 8-11-11 … in the afternoon I was standing and was feeling some ache around waist and back side." (RX 1) Petitioner testified that he indicated that to be his date of accident due to the fact he experienced minor pain in his lower back after moving the Cask on August 11, 2011 and he thought he needed to report that as his accident in order to comply with company rules.

Petitioner also reported to Respondent's medical department for evaluation on August 12, 2011. At that time an Injury Report was completed noting Petitioner "stated that yesterday morning he and one other employee were moving a 6000 lb cast manually" and "[h]e said that afternoon he was standing and started to feel an ache in the right side of his lower back that radiated around his right waist." Petitioner was diagnosed with a lower back sprain. He was sent home for the day and instructed to follow up on August 15, 2011. (RX 2)

Petitioner returned to Respondent's medical department on August 15, 2011. Records submitted show Petitioner provided that resting over the weekend helped to relieve his lower back pain. Petitioner also advised the medical department that he made a mistake in his incident description and that he was actually injured on August 12, 2011 as opposed to August 11, 2011. Petitioner was assessed with resolving low back muscle strain and returned to work full duty. (RX 2)

On August 16, 2011, Petitioner met with his supervisors to conduct a formal Fact-Finding Meeting regarding the accident. A report titled, "Fact-Finding Report," show that Petitioner discussed the accident with his supervisors and provided a history of accident, indicating that he hurt his back on the morning of August 12, 2011 while moving a heavy Cask. It appears the accident date was officially found to have occurred on August 12, 2011. (PX 6)

Petitioner returned to Respondent's medical department on August 17, 2011. At that time he complained of worsening pain. It was noted that his pain had gotten worse after returning to work full duty. On physical exam, Petitioner exhibited good flexion of the lumbosacral spine area with some tightness present with toe touch. Petitioner was diagnosed with a low back strain. Petitioner was to avoid strenuous physical duties and

prolonged walking or sitting. Petitioner was also instructed to ice as needed and follow up with his personal doctor with whom he had treated for a prior back issue. (RX 2)

Petitioner testified that prior to the subject incident, he had a history of lower back pain. He described this prior pain as an aching pain. Petitioner testified that following the accident, his lower back pain changed. Specifically, this pain became more severe and he had trouble walking following the accident.

Prior to this incident, Petitioner was treating with Dr. Udit Patel of the Pain and Spine Institute. Dr. Patel's medical records contain a "Description of Pain" form completed by Petitioner on May 23, 2011. (RX 3, pp. 5-10) Petitioner described his pain as "sore", "aching" and "constant". He further indicated his pain radiated to his butt area. (RX 3, p. 5)

On May 25, 2011, Petitioner presented to Dr. Patel with lumbar radiculopathy and low back pain. He complained of pain radiating to his left lower extremity. On physical examination, pain was elicited over the bilateral lumbar paraspinal muscles. The doctor assessed lumbar radiculopathy and low back pain. Physical therapy was recommended along with possible injections if therapy was ineffective. (RX 3, pp.43-44)

On June 17, 2011, Petitioner returned to Dr. Patel. His symptoms were unchanged from the previous visit. Bilateral lumbar paraspinal/gluteus maximus trigger point injections were administered. Dr. Patel administered the same bilateral injections a second and third time on June 24 and July 22, 2011, respectively. Dr. Patel's again assessed lumbar radiculopathy and low back pain. (RX 3, pp. 45-50)

Petitioner reported to Dr. Udit Patel on August 19, 2011. Dr. Patel noted Petitioner presented complaining of right hip/groin and back pain. Petitioner reported his current episode of pain started after pushing a steel cast on August 12, 2011 at work. Dr. Patel noted "this is an acute episode with no prior history of back pain." Dr. Patel assessed lumbar radiculopathy, low back pain, hip pain and sacroiliac syndrome. The doctor prescribed Flexeril, Tramadol and ordered him to follow up to report his progress. (PX 2 pp. 8-10)

Petitioner returned to Respondent's medical department on August 22, 2011. The physician suspected Petitioner had suffered strained muscles or an exacerbation of preexisting back issues. Petitioner's was placed on work restrictions including no lifting greater than 25 pounds and no pushing or pulling greater than 35 pounds. (RX 2 p. 5) Petitioner returned to Respondent's medical department on August 25, 2011 complaining of worsening symptoms in his lower back. Petitioner complained of pain after walking. The physician in the medical department felt physical therapy would help but did not order same as he was waiting a decision regarding "work relatedness." He instructed Petitioner to continue icing and taking the medications as prescribed by Dr. Patel. (RX 2 p. 6)

Petitioner followed up at Respondent's medical department on September 1, 2011 complaining of continued pain. Petitioner was provided with a script for physical therapy and instructed to arrange his own physical therapy. (RX 2 p. 7) Petitioner also returned to see Dr. Patel on September 1, 2011. Dr. Patel noted that Petitioner was feeling worse since the last visit and that he was suffering from pain over the right glut medius and max muscles, as well as radiculopathy. Dr. Patel agreed with the physical therapy recommendation. Additionally, Dr. Patel ordered an MRI of the lmbar spine. (P2 pp. 11-12)

Petitioner underwent his initial physical therapy evaluation at Elite Rehabilitation Institute on September 7, 2011. Petitioner gave a consistent history of the subject injury as the source of his pain and problems, indicating that he was injured as a result of pushing a heavy cask with other workers on August 12, 2011.

Petitioner was prescribed a regimen of therapy which consisted of analgesic modalities, manual therapy, ROM, passive manual stretching, lumbar dynamic stabilization, and progressive-resistive strengthening. (PX 3 p. 7)

Petitioner underwent a lumbar MRI at Future Diagnostics Group on September 15, 2011. The radiologist's impressions was diffuse lumbar spondylosis, mild central spinal canal narrowing at L3-L4, L4-L5 and L5-S1, shallow right disc protrusion at L4-L5, shallow far left lateral disc protrusion at L1-L2 and bulging disc and facet arthropathy most prominent at the L5-S1 level bilaterally. (PX 2 pp. 14-15)

Petitioner returned to Respondent's medical department on September 16, 2011. He complained that his condition was deteriorating and he experiences weakness and numbness in his right thigh which felt like it was going to give out. Petitioner indicated that although physical therapy felt good while he was doing it, it was not helping his overall condition. The physician increased Petitioner's work restrictions and advised him to follow up to report his progress. (RX 2 p. 8)

Petitioner followed up with Dr. Patel on September 20, 2011. The doctor reviewed the MRI results noting Petitioner had multiple issues with the lumbar spine which included foraminal stenosis which could be causing right lower extremity pain. Dr. Patel noted Petitioner "did have a hx of existing LBP" but "he didn't have RLE pain" while under the doctor's care. Dr. Patel opined that Petitioner aggravated the pre-existing disc/facet issues with the subject accident and that he may be a candidate for transforaminal epidural steroid injections. (PX 2 p. 16)

On September 29, 2011, Petitioner reported to Respondent's medical department that his right leg gave out. Petitioner provided that "...he was just standing [and] talking to someone when he felt that something was not right with [the] right leg and he rushed to sit down just before it gave out." The examining physician, Dr. Stalker provided that he reviewed the recent MRI which showed no evidence exacerbation or new injury. He felt the MRI showed no change when compared to the prior MRI in 2010. The doctor advised Petitioner that his issues stem from prior personal back symptoms and that he had reached maximum medical improvement from the strain which he suffered from the subject incident. The physician also advised him that he was not fit for duty because his leg gave out and sent him home, instructing him to return when his symptoms improved. Respondent's physician also instructed him to follow up with his physical therapy. (RX 2 p. 10)

On October 3, 2011, Petitioner reported to Dr. Cary Templin of Hinsdale Orthopaedics. Petitioner gave a consistent history of the subject injury as the source of his pain and problems, indicating that he was injured as a result of pushing a heavy cask with other workers on August 12, 2011. Petitioner reported suffering from lower back pain prior to his accident, but a worsening of symptoms following the accident with new pain, numbness and tingling in his right groin and right lower extremity. Dr. Templin reviewed Petitioner's lumbar MRIs from December of 2010, as well as September of 2011. Dr. Templin noted that on the September 2011 MRI film, there is forward advanced protrusion of the disc at the L3-4 level into the extraforaminal region and further impingement of the nerve root. After exam, Dr. Templin opined that Petitioner suffered an exacerbation of a right L3 radiculopathy secondary to the subject work accident. Dr. Templin agreed with Dr. Patel's treatment plan of performing epidural steroid injections. Dr. Templin also restricted Petitioner's work duties to include no lifting greater than 50 pounds and no overhead lifting. (P4 pp. 12-13)

Petitioner returned to see Dr. Patel on October 5, 2011 and underwent a L3 transforaminal epidural steroid injection. (PX 2 p. 18)

Petitioner returned to Respondent's medical department on October 11, 2011 and reported feeling much better but not 100%. Dr. Stalker felt it was safe to return Petitioner to work with restrictions of 20lb. lifting, 30lb pushing and pulling. (RX 2 p. 11)

Petitioner returned to see Dr. Patel on October 21, 2011 and underwent an L3, L4 transforaminal epidural steroid injection. (PX 2 p. 20) Petitioner testified that this injection helped to improve his pain and overall condition.

Petitioner followed up with Dr. Templin or November 8, 2011. Dr. Templin once again noted Petitioner suffered a work-related aggravation of his back condition. Petitioner expressed that the injections helped relieve his pain and symptoms, although he was still suffering pain which he rated as a 4/10. Dr. Templin instructed Petitioner to maintain his 50-pound lifting restriction and follow up to report his progress. (PX 4 p. 17)

Petitioner followed up with Dr. Patel on December 9, 2011 and underwent an L3, L4 transforaminal epidural steroid injection. (PX 2 p. 23) He followed up with Dr. Patel on January 9, 2012 reporting an 80% relief of pain. (PX 2 p. 25) Petitioner returned to Dr. Templin on January 17, 2012 reporting improvement with some lingering pain which affects him at work. Dr. Templin did not feel surgical intervention was warranted. The doctor instructed Petitioner to maintain his 50-pound lifting restriction and continue under the care of Dr. Patel. He was instructed to follow up on an as-needed basis. (PX 4 p. 21)

Petitioner continued to treat with Dr. Patel until March 1, 2012. (P2 p. 29) On that date, Petitioner indicated that although his pain had improved, he continued to experience minor burning in his right lower extremity which would come and go. Petitioner expressed an desire to return to work full duty, which Dr. Patel allowed. Dr. Patel instructed Petitioner to follow up to monitor his progress. (P2 pp. 29-30)

Petitioner testified that he attended an appointment with an independent medical examiner per Respondent's request.

Regarding Petitioner's prior lower back pain, he initially testified that he had never been diagnosed with radiculopathy prior to the subject incident. However, Petitioner subsequently testified that he was confused regarding the medical definition of radiculopathy and that if his medical records did indicate he had a prior diagnosis of radiculopathy, then he would not dispute the medical records. Petitioner's prior medical records from Meridian Medical Associates indicate that on December 17, 2010, he presented to Dr. Joel See complaining of back pain along with numbness and tingling radiating to his bilateral legs present for the past 3-6 months. (RX 4 p. 360) Dr. See diagnosed Petitioner with bulging lumbar discs and lumbar radiculopathy and noted that Petitioner's spinal stenosis may be responsible for the numbness in his bilateral legs. (RX 4 p. 363)

Surveillance footage taken on October 1, 3, 5 and 6. 2011 was introduced into evidence as Respondent Exhibits 5(a) and (b). The October 3, 2011 footage shows Petitioner driving a van with G & M Cleaning written on its side. He is visualized exiting/entering the van and walking briskly. He is further visualized dusting, vacuuming, wiping down surfaces, bending at the waist and reaching in all directions as he cleaned a facility. (RX 5(a)) The October 5, 2011 footage shows Petitioner walking, stretching his back, washing windows, dusting, wiping down countertops and desks and carrying trash to a dumpster. The October 6, 2011 footage shows Petitioner exiting/entering his vehicle and various buildings. He is also visualized cleaning a facility during which he bends at the waist, squats and gets down on one knee, washes windows, mops and vacuums. Petitioner carried a step stool and mop buckets to his vehicle. (RX 5(b))

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Petitioner's testimony regarding his mechanism of accident is unrebutted. Petitioner's testimony demonstrates that he suffered a work accident on August 12, 2011 while moving a large Cask with another employee which weighed approximately 5000 to 6000 pounds. This testimony is further corroborated by the Fact-Finding Report on August 16, 2011 which was prepared by Respondent after meeting with Petitioner and investigating this incident.

Respondent offered into evidence the Incident Description prepared by Petitioner on August 12, 2011 in which he indicated that his date of injury was August 11, 2011. However, Petitioner convincingly testified that he erroneously indicated that to be his date of accident due to the fact he experienced minor pain in his lower back after moving the Cask on August 11, 2011 and he thought he needed to report that as his accident in order to comply with company rules. However, after talking about the incident with company representatives, Petitioner realized that he had made a mistake and he should have indicated that his date of accident was August 12, 2011. Petitioner's testimony was corroborated by the medical records of Respondent's medical department, as Petitioner noted to the physician on August 15, 2011 that his date of accident would need to be amended to reflect August 12, 2011 as opposed to August 11, 2011.

Although Petitioner testified that he did experience back discomfort on August 11, 2011, he did not feel the pain was serious until after moving the cask on August 12, 2011. Petitioner did not attempt to obtain medical treatment until following the incident on August 12, 2011. Based upon the greater weight of the evidence, the Arbitrator finds that Petitioner sustained an accident on August 12, 2011 that arose out of and in the course of Petitioner's employment by Respondent.

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

Petitioner offered the opinions of his two (2) treating physicians, Dr. Patel and Dr. Templin. Both of these physicians opined that Petitioner suffered a work-related aggravation of his back condition from the subject incident. Dr. Templin based part of his opinion upon his personal review of the MRI films and noted forward advanced protrusion of the disc at the L3-4 level into the extraforaminal region and further impingement of the nerve root. Further, Dr. Patel treated Petitioner for lower back pain both prior to and subsequent to the subject incident. Thus, Dr. Patel's is accorded greater weight regarding his causal connection opinion. Dr. Patel not only opined that Petitioner aggravated the pre-existing disc/facet issues with the subject accident, but his working diagnoses changed following the subject incident to include lumbar radiculopathy, low back pain, hip pain and sacroiliac syndrome.

The only medical opinion contrary to the above noted treaters is an opinion offer by Dr. Stalker, Respondent's medical department physician. Dr. Stalker felt Petitioner suffered only a strain and any complaints he had were merely unrelated and preexisting. The doctor provided that he reviewed the recent MRI which showed no evidence of exacerbation or new injury. He felt the MRI showed no change when compared to the prior MRI in 2010. This opinion however is in direct conflict with opinions of both Drs. Patel and Templin. Dr. Patel reviewed the MRI results noting Petitioner had multiple issues with the lumbar spine which included foraminal stenosis which could be causing right lower extremity pain. Dr. Patel noted Petitioner "did have a hx of existing LBP" but "he didn't have RLE pain" while under his care. Dr. Patel opined that Petitioner aggravated the pre-existing disc/facet issues. As noted above. Dr. Templin reviewed Petitioner's lumbar MRIs

from December of 2010, as well as September of 2011. Dr. Templin noted that on the September 2011 MRI film, there is forward advanced protrusion of the disc at the L3-4 level into the extraforaminal region and further impingement of the nerve root. Dr. Templin opined that Petitioner suffered an exacerbation of a right L3 radiculopathy secondary to the work accident.

The record is clear that Petitioner suffered from long-standing back pain prior to the accident in August 2011, however his pain and discomfort changed following the subject incident. It is axiomatic under the Workers' Compensation Act that an 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. Sisbro, Inc. v. Indus. Comm'n. 207 Ill.2d 193, 205 (2003). 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. Caterpillar Tractor Co. v. Indus. Comm'n. 92 Ill. 2d 30, 36 (1982).

The Arbitrator has viewed the video surveillance. Although same demonstrates that Petitioner is certainly capable of performing work activities, it does not show any evidence of Petitioner performing tasks outside of the 50 pound lifting restriction placed upon him by Dr. Templin.

Based upon the greater weight of the evidence, the Arbitrator finds that a causal relationship exists between Petitioner's low back and associated conditions of ill-being and the accident sustained on July 18, 2011. The Arbitrator further finds that Petitioner is permanently disabled to the extent of 5% as provided in Section 8(d)(2) of the Act.

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

Petitioner submitted medical expenses in the amount of $14,379.00. (PX 1) Based upon the Arbitrator's finding that Petitioner's current condition of ill-being is causally related to the August 12, 2011 accident, Petitioner has established that he is entitled to satisfaction of his past medical expenses. The Arbitrator hereby awards Petitioner past medical expenses in the amount of $14.379.00 as outlined in Petitioner's Exhibit 1. Consistent with the parties stipulation, Respondent is entitled to a credit under 8(j) of the Act to the extent that any of the associated medical expenses were paid by his employer's group health insurance plan and shall further hold Petitioner harmless for group payments as provided by Statute.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ahmet Trashani,

Petitioner,

15IWCC0345

vs.

No: 12 WC 39454

Caterpillar,

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 expenses, temporary disability benefits and prospective medical treatment and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection with respect to Petitioner's low back condition and modifies the award set forth in 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 compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 47-year-old tractor assembly worker, filed an Application for Adjustment of Claim on November 14, 2012, alleging injuries to the body as a whole resulting from a work-related injury on October 8, 2012. Petitioner testified that he was swinging a twenty-five pound sledgehammer to hit a metal pin when he felt a pop and pain in his neck and left shoulder. Petitioner testified that the occurrence was witnessed by a coworker and he immediately sought treatment at Respondent's on-site medical clinic. Petitioner claimed that he developed low back and left leg pain within a few days of the accident.

The parties agreed that Petitioner was temporarily totally disabled from October 9, 2012 through June 30, 2013. Respondent denied that Petitioner sustained a lumbar spine injury on

October 8, 2012 and refused to authorize treatment for the lumbar spine. Respondent accepted that Petitioner sustained a cervical strain and a left shoulder strain in the accident but disputed causal connection for anything more extensive than strains. Respondent claims no liability for temporary total disability benefits after June 30, 2013.

In a July 17, 2014 Decision, the Arbitrator found that Petitioner proved accident and causal connection with respect to the neck, low back and left shoulder. The Arbitrator awarded temporary total disability benefits for the disputed period from June 30, 2013 through the date of hearing, medical expenses for treatment related to the cervical spine, low back and left shoulder, and the requested medical treatment including lumbar epidural steroid injections recommended by Dr. Lorenz. The Arbitrator found that Petitioner failed to prove that his carpal tunnel syndrome is causally connected to the October 8, 2012 accident. After considering all of the evidence, we reverse the Decision of the Arbitrator on the issue of causal connection with respect to the low back.

The "Caterpillar Employee Incident Report" dated October 8, 2012 indicates that Petitioner reported feeling a pop in between his neck and left shoulder with tingling and numbness in both hands. The "Initial Medical Report" from Respondent's medical clinic notes that Petitioner felt a pop in his shoulder between his neck and deltoid then felt a "*funny bone sensation*" down to his fingertips. The report noted that Petitioner is right hand dominant but swings a hammer left-handed. The "Witness Statement" of a coworker indicates that Petitioner said that his neck was in pain after swinging a sledgehammer. (RX 3)

Petitioner returned to Respondent's clinic on October 10, 2012 and was seen by Dr. Neu. Petitioner complained that he was unable to sleep due to pain in his neck and left trapezius and pain and numbness in both arms. Petitioner reported that medication did not help. Dr. Neu noted that Petitioner's pain was of "indeterminate etiology;" he prescribed Norco and referred Petitioner to Dr. McGivney at Castle Orthopaedics. Dr. Neu excused Petitioner from work and recommended a cervical collar. On October 10, 2012 Dr. Neu noted that Petitioner's symptoms were unchanged. (RX3)

On October 11, 2012 Petitioner was examined by Dr. Thomas McGivney at Castle Orthopaedics. Petitioner testified that by this time he "*was having pain in my back area and it was actually numb so it was hard to distinguish exactly where it was coming from at the time plus I was on medication right away.*" (T. 16) The pain drawing indicates bilateral forearm and hand numbness, aching pain, and pins and needles; left neck pins and needles with aching and stabbing pain; and left buttock and posterior thigh burning and stabbing pain. On physical examination, Dr. McGivney noted good range of motion of the neck but that Petitioner could not lift his left shoulder above ninety degrees and had subacromial tenderness. Dr. McGivney also noted Petitioner's complaints of pain in the left buttock that radiated "*like a charley horse*" down his posterior thigh with pain into his foot and the last two toes. X-rays of Petitioner's neck and shoulder showed no obvious abnormalities. Dr. McGivney offered differential diagnoses of cervical radiculitis, acute vibratory syndrome, left shoulder disorder and joint pain, possible rotator cuff tear, and lumbar radiculitis. Dr. McGivney recommended MRI scans, prescribed a Medrol Dosepak and discussed a possible referral to a shoulder specialist. (PX4)

The following day, Dr. Neu's notes include the statement "*Ahmet first noted L leg symptoms on 10/10/12 – L buttock & L thigh & L lateral foot ache.*" Dr. Neu continued to authorize Petitioner off of work and recommended a cervical MRI; he also agreed to send Petitioner for a shoulder examination. (RX3) On October 16, 2012 Petitioner underwent a cervical MRI with findings of a mild annular bulge of the C6-7 intervertebral disc; a small left paracentral through far left lateral disc osteophyte complex; mild central canal stenosis with mild posterior displacement of the left C8 nerve root and moderately severe left C6-7 neural foraminal narrowing; a minor annular bulge at C2-3 and C3-4 and mild annular bulges of the C4-5 and C5-6 intervertebral discs; mild developmental central canal stenosis from C3-4 through C5-6; and mild developmental central canal stenosis from C4 through C6. Also on October 16, 2012, Petitioner underwent a lumbar MRI. The report listed findings of a loss in height of the L5-S1 intervertebral disc with an annular disc bulge with a four millimeter left paracentral through far left lateral disc protrusion with L5 and S1 marginal osteophytic changes; secondary mild posterior displacement of the proximal left S1 nerve root; mild annular bulge of the L4-5 intervertebral disc with a small protrusion on the left; secondary mild to moderate bilateral L4-5 neural foraminal narrowing; and a minor annular bulge of the L3-4 intervertebral disc. (PX4)

On October 19, 2012, Dr. McGivney interpreted the MRI as showing a left central disk herniation at C6-7 and a degenerative disk at L5-1 that had herniated. He noted that Petitioner continued to complain of pain in the left shoulder and some cramping in his forearms. Dr. McGivney recommended physical therapy for the neck and back; a pain management consultation with Dr. Bathina; and a referral to Dr. Saleem for the left shoulder. Dr. McGivney noted that he did not think Petitioner could work. (PX4) On the same day, Dr. Neu examined Petitioner but had not obtained the MRI reports. Dr. Neu noted that lumbar spine treatment was not authorized by workers' compensation. Petitioner began physical therapy on October 24, 2012 and Dr. Neu continued to authorize Petitioner off of work. (RX3)

On November 1, 2012, Petitioner was examined by Dr. Bathina at the Aurora Pain Clinic. Petitioner reported having been off of work since the October 8, 2012 accident. Petitioner described using a sledge hammer to hit a pin and Dr. Bathina recorded, "*Because of the impact, the sledgehammer mushroomed out. He has been doing the same work for the last four months*" and had "*severe and acute onset of pain with numbness spreading from the hands proximally towards the forearms, upper arms, shoulders, and into the neck.*" Petitioner complained of feeling electrical shocks in both upper extremities lasting a few seconds and then disappearing spontaneously. Dr. Bathina diagnosed possible whiplash syndrome with neck and bilateral shoulder pain and disc degeneration at L5-S1 and L4-L5 with annular disc bulges. Dr. Bathina noted that there was no clinical evidence of radiculopathy even though Petitioner reported radicular symptoms down the left lower extremity. Dr. Bathina recommended bilateral cervical medial branch blocks. (PX3)

On November 2, 2012, Petitioner was examined by Dr. Saleem at Castle Orthopaedics for left shoulder pain. Petitioner gave a work accident history of using a twenty-five pound hammer to hit a steel pin into a tractor on October 8, 2012. He reported feeling multiple vibrations going into his arms. He reported that by the fourth hit, he experienced a sharp pain and a pop in his neck and felt numbness and tingling all the way down the left arm. Petitioner denied any relevant past medical history. On physical examination, Petitioner had pain with range of motion of the

left shoulder but demonstrated no anterior or posterior instability; rotator cuff strength was intact. Petitioner had moderate pain with Hawkin's test and mild biceps pain and tenderness but no tenderness over the acromioclavicular joint. Dr. Saleem diagnosed left shoulder internal derangement and a possible labral tear and he recommend a left shoulder MRI with arthrogram. (PX4)

On November 5, 2012, Dr. Neu noted that Petitioner complained of neck and shoulder pain with tingling in the neck and numbness extending down both arms to the fingers. Petitioner also complained of pain and aching in his left buttock, posterior thigh and calf. Petitioner reported changing positions frequently and leaning to the right when he sits; he described walking with a limp in order to offload the left leg. Dr. Neu continued to authorize Petitioner off of work. (RX3)

Petitioner filed his Application for Adjustment of Claim on November 14, 2012. (PX13) On November 20, 2012, Dr. McGivney noted that Petitioner had "*some unusual symptoms that involve bilateral upper extremities and he really does not have anything to explain that on his neck.*" For Petitioner's symptoms that Dr. McGivney believed were most likely associated with the left-sided disk protrusion at C6-7, Dr. McGivney recommended a cervical epidural steroid injection rather than the cervical medial branch blocks recommended by Dr. Bathina. Dr. McGivney added, "*to explain his right upper extremity complaints which he complains of numbness at night, I think it could be carpal tunnel.*" Dr. McGivney recommend a bilateral upper extremity EMG/NCV and potentially an evaluation by a hand specialist. He discussed Petitioner's narcotic use and noted that he was concerned about narcotic tolerance. Dr. McGivney wrote, "*I discussed with him that I do not know what is going on with him.*" On November 27, 2012, Dr. Bathina performed cervical medial branch blocks. (PX3)

One month later on December 26, 2012, Petitioner was examined by Thomas Pittman PA-C and Dr. Lorenz at Hinsdale Orthopaedics. Petitioner was diagnosed with C5-6, C6-7 spondylosis with axial neck pain, bilateral arm numbness and tingling, and an L5-S1 disk herniation with left leg radiculopathy and possible carpal tunnel syndrome. Petitioner was advised to remain off work, continue pain medications and return for further evaluation after an EMG/NCV of the upper extremities and left leg. (PX7) On January 10, 2013 Petitioner underwent electrodiagnostic testing at Hinsdale Orthopaedics and the results indicated a focal conduction abnormality of the median nerve at the wrists consistent with mild carpal tunnel syndrome and possible left C6-7 radiculitis but no ulnar or plexopathy abnormalities. The lower left extremity results suggested L5-S1 polyradiculitis or radiculopathy. (PX5)

On January 30, 2013, Petitioner was seen by Leah Brown, PA-C at Pain Care Specialists. Petitioner reported daily use of a steel sledgehammer to pound steel pins and developing numbness in his hands over time. Petitioner reported that he continued to work for three months until one day he felt neck pain followed by numbness down both arms and was not able to continue working; one to two days later he developed left buttock and thigh pain. PA-C Brown recommend cervical epidural injections, left sided L4-5, L5-S1 and SI transforaminal epidural injections, physical therapy, and a behavioral evaluation and risk assessment for opioids. PA-C Brown also indicated that Petitioner's conditions are due to the work injury. (PX5)

On February 2, 2013, Petitioner began physical therapy at ATI for the cervical strain and radiculopathy with left-sided neck pain going into the left shoulder and bilateral upper extremity numbness at night. Petitioner also reported left sided back and buttock pain going down to the left foot. He reported an accident history of using a twenty-five pound sledgehammer on a steel pin and feeling pain and numbness in both hands and neck and left shoulder pain. (PX2) Also on February 2, 2013, Petitioner was seen by Dr. Neeraj Jain at Pain Care Specialists; an interlaminar cervical epidural steroid injection was administered. (PX5) In follow-up on February 20, 2013, PA-C Brown noted that Petitioner reported the cervical injection provided 50% improvement for one and a half weeks but the left neck and trapezius pain returned. Petitioner also continued to complain of low back and left leg pain, but PA-C Brown noted that the recommended left lumbar transforaminal epidural injection was not authorized under workers' compensation. (PX5)

On March 11, 2013, Dr. Lorenz reviewed the EMG/NCV and diagnosed C5-6 and C6-7 spondylosis with a left C6-7 disk herniation and left arm radiculopathy; bilateral carpal tunnel syndrome; an L4-5 annular tear and an L5-S1 disk herniation with left S1 radiculopathy. Dr. Lorenz recommended a referral for carpal tunnel syndrome and advised Petitioner to continue physical therapy for his neck and back. He also recommended a second epidural steroid injection in the neck and a left L5-S1 epidural steroid injection. Dr. Lorenz continued to authorize Petitioner off of work. (PX7) On March 13, 2013, Petitioner was reevaluated at ATI. After twelve visits, Petitioner was noted to have improved his cervical function. (PX2) On March 20, 2013, Petitioner underwent an interlaminar cervical epidural injection by Dr. Jain. In follow up on March 26, 2014, Petitioner reported 70% improvement in pain. (PX5) On April 16, 2013, Petitioner ended physical therapy sessions at ATI; after twenty-three visits Petitioner reached a plateau. The physical therapist believed that Petitioner was capable of lifting up to ten pounds. (PX2)

On June 24, 2013, Petitioner was examined by Dr. Steven Mather of M&M Orthopaedics at the request of Respondent for an independent medical evaluation. Petitioner recounted that on October 8, 2012 he was using a twenty-five pound sledgehammer to hit a pin when he felt immediate neck pain with numbness and tingling down both arms. Dr. Mather noted that Petitioner demonstrated the occurrence of his injury in a very animated manner, showing no signs of pain or distress. Dr. Mather reviewed the witness statement and a job video; however, we note that the video was not offered into evidence at hearing. In his report, Dr. Mather stated that he reviewed the records of ATI, Dr. McGivney, Dr. Saleem, Dr. Bathina, and the EMG/NCV. Petitioner's complaints to Dr. Mather consisted of neck, left shoulder, left buttock, posterior calf and left leg pain. On exam, Petitioner's straight leg raise test was negative. His sensation and strength were normal and he had full lumbar range of motion without tenderness. Petitioner complained of bilateral hand symptoms, mostly at night, and reported having a diagnosis of carpal tunnel syndrome. Dr. Mather believed that the October 16, 2012 cervical MRI showed a very small, non-compressive herniated disc on the left at C6-C7 that appeared to be associated with an osteophyte. He believed that the lumbar MRI from the same date showed an osteophyte and disc degeneration on the left at L5-S1 that was also non-compressive. Dr. Mather also noted a small right L4-L5 foraminal disc protrusion against the right L4 nerve root, but no foraminal or canal stenosis. A December 12, 2012 left shoulder MRI showed a no tear but a degenerative condition of the labrum and supraspinatus tendinosis. Dr. Mather diagnosed strains of the neck, left shoulder and low back, with psychogenic pain or functional overlay. He

opined that Petitioner was at maximum medical improvement. He noted the lack of significant objective findings or explanation for Petitioner's symptoms. Dr. Mather opined that cervical injections were not reasonable or necessary. He opined that the condition of Petitioner's lumbar spine was not related to the accident. He concluded that Petitioner could work full duty and he offered no opinion on carpal tunnel syndrome. (RX1) Pursuant to Dr. Mather's opinions, Respondent ceased payment of temporary total disability benefits on June 30, 2013.

On July 3, 2013, Dr. Jain performed an interlaminar cervical epidural steroid injection. (PX5) On July 8, 2013, PA-C Strand at Hinsdale Orthopaedics noted that Petitioner's neck pain subsided post injection, but that Petitioner complained that he had a constant ache in his lower back radiating to the left leg with numbness in the left foot. PA-C Strand recommended an L4-5 and L5-S1 epidural steroid injection. (PX8) On July 10, 2013, PA-C Brown at Pain Care Specialists noted 60% reported improvement following the three cervical epidural injections; Petitioner rated his neck pain at a level three out of ten. Petitioner still complained of left-sided low back pain with a burning sensation down the left leg and intermittent tingling in the fifth toe, and he claimed to be unable to tolerate sitting on his left buttock. (PX5) On August 5, 2013, PA-C Strand noted that Petitioner brought Dr. Mather's IME report from June 27, 2013. PA-C Strand stated disagreement with Dr. Mather's opinion that cervical injections were not necessary and the lumbar spine complaints were not related to the accident; PA-C Strand continued to recommend a lumbar epidural steroid injection. (PX8)

On August 21, 2013, Dr. Jain at Pain Care Specialists performed cervical facet injections bilaterally at C3-4, C4-5, C5-6; he subsequently issued a letter supporting the medical necessity of the injections. (PX5) On October 10, 2013, PA-C Brown at Pain Care Specialists noted that Petitioner reported 50% relief. To determine Petitioner's candidacy for cervical rhizotomies, diagnostic medial branch blocks were recommended. (PX5) On November 20, 2013, Dr. Jain performed bilateral C3, C4, C5, C6 medial branch nerve block for the facet joints at C3-4, C4-5, C5-6. On December 4, 2013, Dr. Jain repeated the nerve blocks. (PX5) On December 24, 2013, PA-C Brown at Pain Care Specialists noted Petitioner's reported 50% improvement and recommended proceeding with the bilateral cervical rhizotomies. (PX5)

On January 10, 2014, Dr. Mather testified via deposition. On direct examination, Dr. Mather testified consistently with his report. He concluded that many of Petitioner's symptoms were likely "*nonorganic in origin. We really couldn't find a physical examination finding that would be consistent with his diffuse symptoms*." He did not believe that the objective findings correlated with Petitioner's symptoms. (RX2, p. 14) He did not believe that the accident caused more than a cervical strain and he believed that Petitioner was at maximum medical improvement at his examination on June 24, 2014. (*Id.* at 15) Dr. Mather opined that reasonable and necessary treatment for the injury would have been a cervical and left shoulder MRI and eight to ten sessions of physical therapy. (*Id.* at 18)

On cross-examination, Dr. Mather testified that EMG/NCV studies are 93% accurate; he agreed that there is a 7% chance of undetected radiculopathy on testing, but he explained that he also relied on clinical tests, distribution of symptoms and replication of symptoms, and clinical correlation with the MRI findings to arrive at his opinion that there was no true cervical radiculopathy. (*Id.* at 21) Dr. Mather testified that he did not believe that the low back symptoms

were caused by the accident. On redirect examination, he agreed that the Respondent's medical clinic records from October 8, 2012 and October 9, 2012 were absent any any low back pain complaints. (*Id.* at 23)

On March 10, 2014 Dr. Lorenz noted that Petitioner's lower back pain radiated down his left buttock and leg. Dr. Lorenz recommend lumbar injections and stated that because Petitioner wished do to some type of work, he could safely work lifting fifteen pounds occasionally, but with no exposure to vibrations. Petitioner reported 50% improvement in cervical pain subsequent to the epidural steroid injections. (PX8) On March 13, 2014, Dr. Jain noted that Petitioner continued to complain of severe neck and upper extremity symptoms. Dr. Jain recommended bilateral C3 through C6 cervical medial branch radiofrequency ablation. (PX5)

On March 17, 2014, Dr. Mark Lorenz testified via deposition. (PX9) On direct examination, Dr. Lorenz testified that the diagnostic results and Petitioner's neck and back symptoms were consistent with the mechanism of injury and appeared to be related to the accident: "*Well, it was my opinion that the patient swinging the hammer as described is a competent cause or aggravating a neck and back condition.*" (*Id.* at 7) He had no opinion with respect to Petitioner's carpal tunnel syndrome: "*The carpal tunnel really is usually not an acute thing. It could be related to chronic movement but he gave me no history and I didn't inquire about it. So the carpal tunnel was separate and distinct from the particular event that caused his neck and back pain.*" (*Id.* at 8) Dr. Lorenz testified that he read but did not agree with the opinions of Dr. Mather. Dr. Lorenz saw Petitioner most recently on March 10, 2014 and Petitioner's cervical condition was subjectively "*pretty good*," but Petitioner continued to complain of radiating pain down the left lower extremity in the S1 distribution. Dr. Lorenz testified that he kept Petitioner off of work pending lumbar injections. (*Id.* at 11-12)

On cross-examination, Dr. Lorenz testified that he did not review records from Respondent's on-site medical clinic, from Castle Orthopaedics or from Aurora Pain Clinic. (*Id.* at 13) Dr. Lorenz had no opinion regarding the left shoulder injury and the treatment he provided was limited to the neck and lower back areas and associated radiculopathy. (*Id.* at 15) Dr. Lorenz agreed that both the cervical and lumbar MRI scans showed evidence of degeneration pre-existing the October 8, 2012 accident. (*Id.* at 19)

On April 30, 2014, Dr. Jain performed the left C3, C4, C5, C6 medial branch radiofrequency ablation. (PX11) At arbitration, Petitioner testified that the procedure was extremely beneficial and his cervical pain was reduced to 1/10. (T. 20) Petitioner testified that he no longer has any left shoulder pain. (T. 21) With respect to the low back, Petitioner testified that he has not had the lumbar injections recommended by Dr. Lorenz. (T. 18) Petitioner testified that he has shooting pain going down to his left foot that has been constant ever since one or two days following the accident. (T. 21)

After considering all of the evidence, we reverse the Decision of the Arbitrator on the issue of causal connection with respect to Petitioner's low back condition. We affirm the Arbitrator's findings and conclusions on the issue of causal connection with respect to Petitioner's neck and left shoulder conditions. We agree with the Arbitrator that the preponderance of the evidence presented supports causal connection between Petitioner's neck

and left shoulder conditions and the October 8, 2012 accident and we affirm the Arbitrator's award of medical benefits for reasonable and necessary treatment related to the neck and left shoulder. The nature and extent of the injuries was not at issue at arbitration.

However, we find insufficient evidence of lumbar injury and conclude that Respondent's denial of authorization for low back treatment was reasonable and supported by the record. Dr. Mather examined Petitioner at the Request of Respondent on June 24, 2013 and reviewed all of Petitioner's treatment records and the accident documentation. Dr. Mather testified that if Petitioner injured his back on October 8, 2012 swinging the sledgehammer, he would expect Petitioner to make a report of symptoms within twenty-four to forty-eight hours. The record shows that Petitioner did not report a low back injury or low back symptoms during that time period. The initial documentation and medical reports, the witness statement, and the follow-up appointment records from the next two days after the accident do not specify low back complaints related to the mechanism of injury. We note that Dr. Lorenz was not given the opportunity to review the accident documentation, the medical records from the on-site clinic or the records of Dr. McGivney, and he relied on the history given by Petitioner. Furthermore, Dr. Mather noted an essentially normal lumbar examination on June 24, 2013: Petitioner's straight leg raise test was negative and his reflexes were normal. The MRI showed degenerative changes and an osteophyte on the left at L5-S1. We are not persuaded that Petitioner's eventual lumbar complaints arose out of the October 8, 2012 injury and were not merely an incidental and unrelated finding. Dr. Mather testified that Petitioner did not require any additional medical treatment for the lumbar spine and could work regular duty. During his deposition, Dr. Lorenz testified that Petitioner was kept off of work pending the low back injections. We modify the Arbitrator's award to strike temporary total disability benefits after June 30, 2013, per the opinion of Dr. Mather.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $423.65 per week for a period of 37 and 6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical bills related to the neck and left shoulder and subject to the limitations of the medical fee schedule, as provided in §8(a) and §8.2. Any medical bills related to carpal tunnel syndrome or the low back are denied.

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.

15IWCC0345

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: MAY 15 2015
RWW/plv
o-3/17/15
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0345

TRASHANI, AHMET
Employee/Petitioner

Case# **12WC039454**

CATERPILLAR
Employer/Respondent

On 7/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0190 LAW OFFICES OF PETER F FERRACUTI
JENNIFER L KIESEWETTER
110 E MAIN ST
OTTAWA, IL 61350

2851 CATERPILLAR INC
ELIZABETH C LeBARON
PO BOX 348
AURORA, IL 60507

15IWCC0345

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Ahmet Trashani
Employee/Petitioner

v.

Caterpillar
Employer/Respondent

Case # **12** WC **39454**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **May 21, 2014 and June 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. [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, **October 8, 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 as explained *infra*.

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

In the year preceding the injury, Petitioner earned **$33,044.96**; the average weekly wage was **$635.48**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **no** dependent children.

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

Respondent shall be given a credit of **$14,577.65** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,577.65**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $423.65/week for 84 & 2/7th weeks, commencing October 9, 2012 through May 21, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from October 9, 2012 through May 21, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay reasonable and necessary medical bills related to the neck, left shoulder, and low back subject to the limitations of the medical fee schedule totaling $80,513.69 as provided in Sections 8(a) and 8.2 of the Act. Any medical bills related to carpal tunnel syndrome are denied.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective injections recommended by Dr. Lorenz pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

July 11, 2014
Date

ICArbDec19(b)

JUL 17 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Ahmet Trashani
Employee/Petitioner

v.

Caterpillar
Employer/Respondent

Case # **12** WC **39454**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection, Respondent's liability for payment of certain medical bills, as well as Petitioner's entitlement to a period of temporary total disability benefits and further recommended medical treatment consisting of lumbar injections. Arbitrator's Exhibit[1] ("AX") 1. The parties stipulated that the Petitioner suffered an accident on October 8, 2012, but Respondent disputes causal connection between Petitioner's claimed current conditions of ill being beyond a cervical strain and left shoulder strain. AX1. The parties have stipulated to all other issues. AX1.

Background

On October 8, 2012, Petitioner worked for Respondent in tractor assembly. His duties were to assemble different sized tractors and, specifically, to put the boom on the tractors. At the time of his accident, Petitioner testified that he was swinging a 20-25 pound sledgehammer from left to right hitting a 200-300 pound metal pin into a hole. He explained that this pin holds the boom in place to prevent it from falling and it should slide in easily after being greased. However, on the date of accident he was working with a hole that was not bored through properly in the engineering department requiring him to use the sledgehammer to pound in the pin. Petitioner testified that doing this was not strictly protocol, but it was done occasionally.

In relation to his body, Petitioner testified that he was standing on the right side of the tractor swinging from the left. After pushing the pin in, which should be shoulder height for safety, Petitioner swung from the left approximately 5-7 times at shoulder height. He testified that he noticed a popping sensation in the back of his neck and after that he could not hold the sledgehammer. Petitioner testified that the sledgehammer dropped and he felt numbness down both arms. He further testified that he had no symptoms or medical treatment in his left shoulder, neck or low back prior to this date.

Petitioner acknowledged that he completed an incident report on October 8, 2012. RX3 at 1, 16. In that report, he listed the affected body parts as neck, left shoulder and both hands. *Id.* He also reported that he was injured while "Swinging sledge to hit pin for boom. Felt a pop between neck and left shoulder. Tingling and numbness in both hands." *Id.*

[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 or agreed exhibits are denominated "JX" with a corresponding number or letter as indentified by the parties.

Petitioner also testified that on cross examination that he spoke with a nurse at Caterpillar on October 8th and provided the same description of injury and list of affected body parts. Respondent's incident/injury report as completed by Cindy Day, R.N. ("Nurse Day") reflects Petitioner's report that he was swinging a 25 pound sledgehammer hitting a pin into a boom because the pin was tight and, after 4-5 swings, he felt a pop in his shoulder between the neck and deltoid regions and a numbness sensation in both hands. RX3 at 3-4. Petitioner testified that he did report that he had low back pain at this time.

Petitioner testified that his partner was inside the tractor and that they had to lower the platform that he was on after which they carried him to a safe location. Pete Abalos ("Mr. Abalos") also completed a statement for Caterpillar in which he indicated that Petitioner was on the left side of the boom, took a swing and said that the pin didn't move at all, dropped the hammer and said that his neck was in pain. RX3 at 17.

Petitioner testified that he was taken by ambulance to Respondent's doctor, Dr. Neu, located on the premises. Petitioner testified that he was taken off work by Dr. Neu and, within the next day or so, he returned to Respondent's medical center at which time they referred him to Castle Orthopedics. Petitioner testified that he had pain and numbness in his back and that he was on medication at this time as prescribed by Dr. Neu. He explained that the pain was from the top of his neck on the left side toward the left shoulder and going down his back to about his belt line.

Medical Treatment

The medical records reflect that Petitioner first saw Thomas McGivney, M.D. ("Dr. McGivney") on October 11, 2012 at Castle Orthopaedics & Sports Medicine. PX4 at 21-22, 35-42; RX3 at 6, 14, 18-20, 34. Petitioner provided a history that on the date of accident he was using a steel hammer to hammer a pin in four or five times which happened periodically on the line when all of a sudden he had to drop the hammer and he had a severe pop in his neck and pain going down both arms and numbness and tingling. PX4 at 21-22. He complained of neck, arm, shoulder, and hand pain with continuing numbness, tingling, and burning. *Id.* On examination, Petitioner also reported complaints of pain in his left buttock that radiated down to his thigh as well as pain in his foot. *Id.* Petitioner had a negative Spurlings sign and inability to lift his shoulder above 90 degrees, which caused significant pain on passive motion. *Id.* Dr. McGivney diagnosed Petitioner with: (1) possible cervical radiculitis; (2) possible acute vibratory syndrome; (3) left shoulder derangement with possible rotator cuff tear; and (4) lumbar radiculitis. *Id.* He ordered cervical and lumbar MRIs, a Medrol Dosepak, and discussed referring Petitioner to a shoulder specialist. *Id.* Dr. McGivney took Petitioner off work. PX4 at 41. Petitioner acknowledged that he did not report low back pain or any low back injury to Dr. McGivney, but testified that he indicated to Dr. McGivney in the intake forms and verbally where he was experiencing symptoms at the time.

On October 12, 2012, Dr. Neu's medical records from Caterpillar reflect that Petitioner first noted left buttock, left thigh, and left lateral foot symptoms on October 10, 2012. RX3 at 7. Petitioner continued to follow up with Dr. Neu at Caterpillar while treating at Castle Orthopaedics. RX3.

Petitioner underwent the recommended cervical MRI on October 16, 2012. PX4 at 19-20; RX3 at 22-25. The MRI revealed a mild annular bulge of the C6-7 intervertebral disc with a small left paracentral through far left lateral disc osteophyte complex, minor annular bulge of the C2-3 and C3-4 mild annular bulge of the C4-3 and C5-6 intervertebral discs. *Id.* The lumbar MRI revealed an annular disc bulge in L5-S1 with a left paracentral through far left lateral disc protrusion, as well as mild annular bulge at L3-L4 and L4-L5. *Id.* It also showed a small protrusion on the left far laterally with annular fissuring at L4-5. *Id.*

On October 19, 2012, Dr. McGivney reviewed the MRI results and found them to reveal a left central disc herniation at C6-7, a degenerative disc at L5-S1 with a herniated disc at that level, a small disc herniation on the right at L4-5 without pain, and a left parecentral disk at L5-S1 with intermittent symptoms to the left leg. PX4 at 16-17; *see also* RX3 at 35-39. Dr. McGivney diagnosed Petitioner with a cervical herniated disc, a lumbar herniated disc, lumbosacral spondylosis, and disorders of bursae and tendons in the shoulder region. *Id.* He recommended physical therapy for the neck, left shoulder and low back, and referred Petitioner to Dr. Bathina for pain management and to follow up with his partner, Dr. Saleem, for the shoulder. *Id.* He kept Petitioner off work. *Id.*

On November 1, 2012, Petitioner met with Ramesh Bathina, M.D. ("Dr. Bathina") at the Aurora Pain Clinic, in Aurora, Illinois. PX3 at 6, 6a, & 7; RX3 at 26-30. Petitioner reported a consistent mechanism of injury and complained of pain in his neck, in both suprascapular and interscapular areas, and being slightly more severe to the left than the right. *Id.* Petitioner described the pain at a level of 5-8/10 generally and at a level of 5/10 at the time of his examination. *Id.* Dr. Bathina diagnosed Petitioner with possible whiplash phenomena or syndrome due to the high energy impact resulting in neck and bilateral shoulder pain as well as with disc degeneration at L5-S1 and L4-L5 with annular disc bulges without clinical evidence of radiculopathy even though he has radicular symptoms down the left lower extremity. *Id.* Dr. Bathina recommended bilateral cervical medial branch blocks on the left side, then to repeat those if given good results before considering radiofrequency neurotomy. *Id.* Dr. Bathina noted that he did not have approval to see Petitioner for right sided issues and would seek approval for this. *Id.*

On November 2, 2012, Petitioner saw Arif Saleem, M.D. ("Dr. Saleem") at Castle Orthopaedics & Sports Medicine. PX4 at 13-14, 27-29; RX3 at 31-33. He reported left shoulder pain, describing that he has had constant pain in his neck and arms with numbness and tingling. *Id.* His shoulder pain included anterior and posterior shoulder pain. *Id.* On examination, Petitioner had significant pain with O'Brien testing, moderate pain with Hawkins sign as well as mild pain and tenderness in his biceps. *Id.* Dr. Saleem diagnosed Petitioner with left shoulder internal derangement, with possible labral tear. *Id.* He ordered a left shoulder MRI with arthrogram and kept Petitioner off work for his neck and shoulder. *Id.* Petitioner acknowledged that Dr. Saleem refused to refill his narcotic pain medications.

On November 20, 2012, Petitioner returned to Dr. McGivney reporting a burning pain in his arm and some unusual symptoms in both upper extremities without any explainable source from the neck. PX4 at 11-12, 26. In his letter to Dr. Nguyen, Dr. McGivney expressed thoughts that Petitioner should receive an epidural steroid injection to address the left-sided disc protrusion at C6-7 and that the right upper extremity complaints could be carpal tunnel. *Id.* He disagreed with Dr. Bathina about medial branch blocks. *Id.* Dr. McGivney ordered a bilateral upper extremity EMG/NCV and referred him to an upper extremity surgeon. *Id.* He diagnosed Petitioner with a herniated cervical disc and disorders of bursae and tendons in the shoulder region, and kept Petitioner off work. *Id.* Petitioner testified that he continued to treat with Dr. McGivney through November 20, 2012 and that he was counseled to decrease his use of narcotic pain medication.

On November 27, 2012, Petitioner underwent cervical medial branch blocks at C3, C4, C5, and C6 with Dr. Bathina. PX3 at 8-9; PX4 at 24-25. Petitioner was instructed to follow up the next day and, if at that time he reported more than 80% pain relief, Dr. Bathina planned on repeating the block. *Id.*

On December 26, 2012, the Petitioner met with Mark Lorenz, M.D. ("Dr. Lorenz") at Hinsdale Orthopaedics. PX7 at 17-19; PX9 at 4-7, 18. Petitioner reported that his injuries occurred when he felt a pop in his neck while hitting a 5 foot pin into a bore with a 25 pound sledgehammer, and he developed neck pain and bilateral arm

tingling. *Id.* He also reported about that he started developing back pain and left leg pain about two days later. *Id.* Petitioner rated his neck pain at a level of 6/10 and complained of numbness and tingling down the backs of both arms going into the fingers of both hands, weakness in his hands, and left buttock pain going into his calf/thigh and into his small toe. *Id.*

Dr. Lorenz reviewed the Petitioner's MRIs, x-rays, and conducted a physical exam. *Id.* He diagnosed Petitioner with: (1) C5-6, C6-7 spondylosis with axial neck pain, bilateral arm numbness and tingling; (2) L5-S1 disk herniation with left leg radiculopathy; and (3) possible carpal tunnel syndrome. *Id.* Dr. Lorenz kept Petitioner off work, prescribed Norco, ordered a bilateral upper extremity and left leg EMG and referred him for pain management. *Id.* He also opinioned that Petitioner's "objective and subjective findings were consistent with neck pain, bilateral arm tingling, and left leg radiculopathy emanating out of injury where he was manning a sledgehammer hitting a 5 foot pin while working for Caterpillar October 8, 2012, giving rise to his ill-being." *Id.*

On January 10, 2013, the Petitioner met with Dr. Lorenz's partner, Marie Kirincic, M.D. ("Dr. Kirincic") at Hinsdale Orthopaedics for an EMG/NCV for bilateral upper extremities and left lower extremity evaluation per Dr. Lorenz's recommendation. PX7 at 12-16. On examination, she noted no pain on forward flexion and extension of the low back, but a positive straight leg raise on the left. *Id.* Petitioner underwent the recommended EMGs. PX7 at 26-29. The upper extremities EMG showed a focal conduction abnormality of the median nerve at the wrist, consistent with mild to moderate R>L mild carpal tunnel syndrome, as well as possible left C6-7 radiculitis. *Id.* The left lower extremity EMG showed electrical findings suspicious for left L5-S1 polyradiculitis/radiculopathy. *Id.* Dr. Kirincic kept Petitioner off work and recommended that he follow up with Dr. Lorenz. PX7 at 12-16.

On January 30, 2013, Petitioner had an initial evaluation at Pain Care Specialists with Leah Brown, PA-C ("Ms. Brown") per Dr. Lorenz's referral. PX5 at 37-39. By way of history, Petitioner indicated that he injured himself pounding a 200 pound pin and developed left buttock and thigh pain one to two days later. *Id.* Petitioner reported shoulder pain, constant left-sided neck pain radiating into the shoulder with radiating numbness into the fingers, as well as constant left buttock pain radiating down his leg and pain over the lateral aspect of his left foot. *Id.* Ms. Brown diagnosed Petitioner with the following: (1) carpal tunnel syndrome; (2) cervical discogenic pain; (3) cervical facet syndrome; (4) cervical radiculopathy; (5) cervical spinal stenosis; (6) lumbar facet syndrome; (7) lumbar discogenic pain; and (8) lumbar radiculopathy. *Id.* She referred Petitioner for cervical epidural injections as well as left-sided transforaminal epidural injections, and recommended physical therapy. *Id.* Petitioner was given a two week refill of naproxen, Norco, and omeprazole, and kept off work per Dr. Lorenz's orders. *Id.*

On February 13, 2013, Petitioner underwent an interlaminar cervical epidural steroid injection performed by Neeraj Jain, M.D. ("Dr. Jain") at the Aiden Center for Day Surgery in Addison, Illinois. PX5 at 32-33. Dr. Jain diagnosed Petitioner with cervical facet syndrome, cervical radiculopathy, and cervical discogenic pain. *Id.* He was instructed to follow up at Pain Care Specialists in 7-10 days. *Id.*

Petitioner was then evaluated and completed physical therapy sessions at ATI in Geneva, Illinois from February 13, 2013 through April 15, 2013. PX2.

On January 30, 2013, Petitioner had a drug screen and was evaluated at by Dr. Peter R. Brown, a pain psychologist, at Brownstone, LLC per Dr. Jain's referral. PX10. On February 20, 2013, Dr. Brown issued a

report in which he concluded that Petitioner was compliant with his pain medication regimen and not over-medicated. *Id.* Dr. Brown recommended a home treatment program. *Id.*

Also on February 20, 2013, Petitioner saw Ms. Brown at Pain Care Specialists complaining of low back and left leg pain as well as left neck and trapezius pain. PX5 at 27-28. He also reported pain in left buttock and down into left leg as well as numbness in his forearms. PX5 at 30. The lumbar transformational epidural injection as recommended had not yet been performed due to denial by the workers' compensation carrier. PX5 at 27-28. A second cervical epidural injection was recommended, as well as left-sided lumbar transforaminal epidural injections. *Id.* Ms. Brown prescribed continued Norco at the same dose and continued physical therapy. *Id.* Petitioner was to follow up with Dr. Lorenz and remain off work at his direction. *Id.*

On March 11, 2013, Petitioner saw Dr. Lorenz and his physician's assistant, Thomas Pittman, PA-C ("Mr. Pittman"), at Hinsdale Orthopaedics for reevaluation and to discuss his EMG results. PX7 at 8, 10-11; PX9 at 7-9. Petitioner reported neck pain which radiated down the left arm, numbness in his hands, and back pain that radiated down his left leg. *Id.* He recommended continued therapy for his neck and back, injections for his neck, and referred him to Dr. Schiffman for his wrist. *Id.* Dr. Lorenz also kept Petitioner off work. *Id.*

On March 20, 2013, Petitioner underwent a second interlaminar cervical epidural steroid injection performed by Dr. Jain for cervical facet syndrome, cervical radiculopathy, and cervical discogenic pain. PX5 at 21-23. He was instructed to follow up with Pain Care Specialists. *Id.*

On March 26, 2013, Petitioner returned to Pain Care Specialists. PX5 at 16-17. He reported 70% improvement, but was still off work per Dr. Lorenz's recommendations and complaining of low back and left leg pain. *Id.* A third cervical epidural injection was recommended to optimize improvement. *Id.*

Section 12 Examination – Dr. Mather

On June 24, 2013, Petitioner saw Steven Mather, M.D. ("Dr. Mather") at M&M Orthopaedics for an independent medical evaluation at Respondent's request. RX1. Dr. Mather took a history from Petitioner, examined him, reviewed various treating medical records, and short videos before rendering his opinions. *Id.*

Petitioner reported that his job was to assemble tractors and part of his duties included swinging a sledgehammer overhead to hit a pin when it was stuck. *Id.* On October 8, 2012, Petitioner reported that he was using a 25 pound sledgehammer to hit a pin when he felt immediate neck pain with numbness and tingling down both arms. *Id.*

On examination, Dr. Mather noted Petitioner was quite animated in explaining how the injury occurred and that there were no signs of pain during the explanation. *Id.* On focused examination, Petitioner complained of pain centrally at the cervicothoracic junction with some local tenderness in this region. *Id.* Dr. Mather noted that extension of the cervical spine did not bring on any paresthesias of the arms. *Id.* He also noted a negative Spurling test bilaterally, full cervical range of motion, complaints of cervicothoracic pain at extremes of range of motion, and normal strength. *Id.* Seated straight leg raise testing was negative for any pain complaints as was supine straight leg raising even to 90°. *Id.* Dr. Mather also noted no lower back tenderness, mild left lower back discomfort with extension to 30°, a pulling sensation down the back of the left leg went touching his toes with a straight knee, full overall range of motion in the lumbar spine, and no spasms. *Id.*

Dr. Mather reviewed Petitioner's lumbar MRI which showed a non-compressive osteophyte with disc degeneration on the left at L5-S1, a small right L4-L5 foraminal disc protrusion against the right L4 nerve root, approximately 50% loss of disc height at L5-S1 with no foraminal stenosis at this level, and no significant stenosis in the lumbar spine. *Id.* He also reviewed Petitioner's cervical MRI and noted a very small non-compressive herniated disc on the left at C6-C7 that appeared to be associated with an osteophyte that Dr. Mather noted may be old and no central stenosis in the cervical spine. *Id.*

In addition, Dr. Mather noted his review of three short job videos several minutes in length noting that the employee in the video used a 24 inch rubber mallet to "tap" in the pin from the right side and uses a hammer a couple of times on the pin per pin insertion. *Id.*

Dr. Mather diagnosed Petitioner with a cervical strain, left shoulder strain, low back strain, and psychogenic pain/functional overlay. *Id.* In so concluding, Dr. Mather noted that there were no objective findings on physical examination. *Id.* With regard to Petitioner's cervical spine, he noted that the usual clinical finding to support a diagnosis of cervical radiculopathy is the Spurling maneuver, which was negative as noted by all of Petitioner's treating physicians, that his cervical EMG did not support a cervical radiculopathy diagnosis as all of his cervical muscles enervated were normal and minimal and nothing in the EMG suggested a nerve injury with innervations, and that his initial treating physicians (Dr. McGivney and Dr. Bathina) could not explain on an organic basis the source of Petitioner's symptoms including Dr. Bathina's note that Petitioner did not have cervical radiculopathy. *Id.* With regard to Petitioner's lumbar spine, Dr. Mather noted no disc herniation on the MRI, but rather an osteophyte on the left that was not displacing the nerve root. *Id.* he also noted that his treating physicians failed to show any objective physical examination evidence that his lumbar spine was injured on the date of accident. *Id.*

Ultimately, Dr. Mather concluded that Petitioner's cervical spine and lumbar spine conditions were not causally related to his injury at work. *Id.* He also opined that the cervical injections administered were not reasonable or necessary because there were no objective findings on physical examination by his treating physicians to correlate Petitioner's diffuse upper extremity complaints to a cervical radiculopathy diagnosis, and that the lumbar spine treatment was not reasonable or necessary to any condition stemming from his injury at work. *Id.* Dr. Mather did find that the cervical and left shoulder MRIs were appropriate as well as eight to ten visits of physical therapy for a cervical strain. *Id.* Dr. Mather placed Petitioner at maximum medical improvement and indicated that he required no work restrictions. *Id.*

Continued Medical Treatment

On July 3, 2013, Petitioner underwent the third recommended interlaminar cervical epidural injection with Dr. Jain at the Oak Brook Surgical Centre. PX5 at 10-12. He was instructed to follow up with Pain Care Specialists in 7-10 days. *Id.*

On July 8, 2013, Petitioner returned to Dr. Lorenz reporting that his neck pain had subsided to a level of 2/10, but he continued to have pain radiating into the interscapular region as well as into the lateral aspect of the left tricep. PX8; PX9 at 9-10. With regard to his back, Petitioner reported consistent aching low back pain that radiated into the left buttock, posterior thigh, calf, and into the lateral foot. *Id.* With regard to his wrists, he reported seeing Dr. Schiffman and receiving wrist splints for his carpal tunnel. *Id.* On examination, Dr. Lorenz noted good motion of the cervical spine, neck pain with Spurling's testing, negative straight leg raising, and slightly decreased strength with dorsiflexion. *Id.* Petitioner also indicated that his lower back and leg were causing him more pain than his neck. *Id.* Dr. Lorenz diagnosed Petitioner with an L4-5, L5-S1 disk herniation

with left sided radiculopathy. *Id.* He recommended an L4-5 and L5-S1 epidural steroid injection and kept Petitioner off work. *Id.*

On July 10, 2013, Petitioner followed up at Pain Care Specialists. PX5 at 6-7. He reported overall benefit and 60% pain resolution following his three injections, but also reported intermittent numbness and tingling in the forearms as well as sharp pain in the upper extremities. *Id.* He also reported constant neck pain and radiating pain from the neck into the scapula as well as left-sided low back pain with a burning sensation radiating down the left leg. *Id.* Ms. Brown prescribed gabapentin and a topical analgesic and recommended bilateral cervical facet injections. *Id.*

On August 5, 2013, Petitioner returned to Dr. Lorenz reporting neck pain, be it more tolerable, and more bothersome lower back and left leg pain. PX8; PX9 at 10-11. Petitioner provided his recent independent medical evaluation report from Dr. Mather to Dr. Lorenz, who maintained that Petitioner required the recommended lumbar epidural injections and that the cervical injections were medically necessary. *Id.* Petitioner remained off work. *Id.*

On August 21, 2013, Dr. Jain performed the recommended cervical facet injection with anesthesia. PX6. Specifically, Petitioner underwent a bilateral C3-C4, C4-C5, C5-C6 facet joint injection at the Aiden Center for Day Surgery in Addison, Illinois. *Id.*

In a narrative letter dated September 25, 2013, Dr. Jain stated that after Petitioner's prior cervical steroid injections he continued to complain of persistent axial neck pain radiating into his left scapula. PX6. Thus, he opined that the interventional procedures performed were medically necessary and agreeable to the standard of care. *Id.*

On October 10, 2013, Petitioner returned to Pain Care Specialists reporting 50% relief following the injection. PX6. He reported that he did not receive the prescribed gabapentin as the workers' compensation carrier ould not cover it. *Id.* Ms. Brown recommended two-step diagnostic cervical medial branch blocks to determine whether Petitioner was a candidate for cervical rhizotomies, and that the recommended gabapentin be dispensed. *Id.* Petitioner remained off work per Dr. Lorenz and a cold compression therapy order was made for post-procedural swelling and pain. *Id.*

On October 10, 2013, the Petitioner was prescribed a Vascutherm unit from Advanced Rehab for the cervical back for the purpose of managing pain and reducing swelling as hot/cold durable medical equipment compression. PX12.

Petitioner then underwent a series of two medial branch nerve blocks as recommended. PX6. On November 20, 2013, Petitioner underwent a bilateral C3, C4, C5, C6 medial branch nerve block for the facet joint of C3-C4, C4-C5, and C5-C6 performed by Dr. Jain at the Oak Brook Surgical Centre. *Id.* On December 4, 2013, he underwent a second bilateral C3, C4, C5, C6 medial branch nerve block for the facet joint of C3-C4, C4-C5, and C5-C6. *Id.* He was instructed to follow up with Pain Care Specialists in 7 to 10 days. *Id.*

On December 24, 2013, Petitioner returned to Pain Care Specialists. PX6. At this visit, he reported a return of his usual type of neck pain following the numbness wearing off after his first block, and a reduced pain score of 1/10 for two weeks following the second block. *Id.* Petitioner reported pain at the time of this examination to be 4/10. *Id.* Ms. Brown recommended bilateral cervical rhizotomies, kept him off work per Dr. Lorenz, and recommended continuation of his home exercises. *Id.*

Deposition Testimony – Dr. Mather

Respondent called Dr. Mather as a witness and he gave testimony via evidence deposition on January 10, 2014. RX2. Dr. Mather opined consistent with the opinions contained in his independent medical evaluation report. *Id.*

He noted that Petitioner's cervical MRI showed a partially calcified, non-compressive disc herniation on the left at C6-7 which he would expect to cause symptoms if any along the C7 nerve root which would affect the triceps reflex or strength or numbness and tingling of the index and long fingers, but not the thumb. RX2 at 11. With regard to the lumbar MRI, he noted that it showed a non-compressive osteophyte on the left at L5-S1 and a right sided disc herniation at L4-5 on the right which was up against his L4 nerve root and a fair amount of disc degeneration at L5-S1. *Id.* Dr. Mather also testified that the job video showed a person using a rubber mallet that was "more tapping in a pin than swinging it[,]" which did not appear to be heavy work and he testified was something his wife could do. RX2 at 12.

Dr. Mather maintained his opinion that Petitioner sustained a cervical strain and left shoulder strain as a result of his injury at work based on the lack of objective findings (i.e., absence of triceps reflexes, negative Spurling's maneuver testing by all treating physicians, no arm symptoms with head rotation on the same side of his symptoms, non-compression of the protrusions on his nerve roots, Dr. McGivney and Dr. Bathina's lack of organic findings to support cervical radiculopathy, negative straight leg raise testing, and lack of disc herniation evident in the lumbar spine MRI), and that he did not strain his low back. RX2 at 13-14, 16-18. He explained that a lot of Petitioner's symptoms were non-organic in origin and that he really could not find a physical examination consistent with Petitioner's diffuse symptoms. RX2 at 14-15. Dr. Mather again noted that no one had any objective findings on physical examination and that a valid medical diagnosis requires a physical examination to correlate with the patient's subjective symptoms which in turn correlates with diagnostic tests, all of which were lacking in Petitioner's case. *Id.*

On cross examination, Dr. Mather acknowledged that he viewed a general video of the pin being put in and that it was not of the actual incident involving Petitioner. RX2 at 19-20. The video reviewed by Dr. Mather was not offered into evidence at the hearing.

Continued Medical Treatment

On March 10, 2014, Petitioner saw Dr. Lorenz and reported pain radiating down the left glute and leg with numbness in the foot[2] PX8; PX9 at 11-12. Dr. Lorenz noted that Petitioner continued to have pain radiating down the left lower extremity in the S1 distribution and a positive straight leg raise at 35 degrees. *Id.* He continued to recommend a lumbar epidural injection given Petitioner's improvements following the cervical injections. *Id.* He released the Petitioner to work light duty work with restrictions of lifting 15 pounds occasionally and no exposure to vibrations. *Id.*

[2] The progress note from this date refers to the right foot, which appears to be a scrivener's error in reviewing the physical examination notes addressing pain radiating down the left lower extremity in the S1 distribution. Id.

On March 13, 2014, Petitioner returned to Pain Care Specialists and saw Dr. Jain reporting severe neck and upper extremity symptoms. PX6. Dr. Jain recommended cervical medial branch radiofrequency ablation from C3 through C6 at the right and left side. *Id.* He prescribed continued Norco, Naprosyn, and Xanax and kept Petitioner off work. *Id.* He also noted that Petitioner's date of maximum medical improvement was indeterminable at that time. *Id.*

Deposition Testimony – Dr. Lorenz

Petitioner called Dr. Lorenz as a witness and he gave testimony via evidence deposition on March 17, 2014. PX9. Dr. Lorenz opined consistent with the opinions contained in his medical records that Petitioner's cervical and lumbar spine conditions were either caused or aggravated by his accident at work. *Id.* Specifically, he opined that the mechanism of injury described to him by Petitioner (i.e., swinging a hammer) was a component cause or aggravating factor of Petitioner's neck and back condition. PX9 at 7, 13-14. He also reiterated his recommendation that Petitioner undergo an injection at the L5/S1 level. PX9 at 10. He further maintained his disagreement with Dr. Mather's opinion as reflected in his report and recommended the lumbar spine injection. PX9 at 10-11.

On cross examination, Dr. Lorenz acknowledged that he did not have the opportunity to review the medical records from Caterpillar's medical department, Aurora Pain Clinic, or Castle Orthopedics other than a notation on Petitioner's MRI. PX9 at 12-13.

Continued Medical Treatment

On April 30, 2014, Petitioner underwent a left C3, C4, C5, C6 medial branch radiofrequency ablation performed by Dr. Jain at the Oak Brook Surgical Centre. PX11. He was instructed to follow up with Pain Care Specialists in 7-10 days to be reevaluated. *Id.*

Additional Information

Petitioner testified that he received temporary total disability checks through June 30, 2013, but has not received any payments after that date. He also testified that the November 14, 2013 invoice from Walgreens references insurance, but he had no group insurance through any new employer or his wife at that time. He also testified that he began receiving unemployment benefits on November 17, 2013. Petitioner has not return to work since date of accident and testified that he was kept off work by his doctors.

Regarding his neck, Petitioner testified that most of the neck injections were some fluid that were not really helping him, but the last two procedures about three weeks ago "burned" the nerves and relieved his neck pain through the date of hearing. He testified that his pain diminished from a level of 10/10 to a level of 1/10. Regarding his shoulder, Petitioner testified that he has no pain. Regarding his low back, Petitioner testified that he has a shooting pain going down his buttocks to his left foot, which has been constant since approximately 1-2 days after the injury.

Petitioner testified that he wants to continue to treat with Dr. Jain and that he wishes to get the lumbar injections recommended by Dr. Lorenz.

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:

After reviewing all of the evidence, the Arbitrator finds that Petitioner's testimony was overall consistent with the medical records that he sustained injuries to the neck, left shoulder, and low back as a result of his accident at work on October 8, 2012. In so concluding, the Arbitrator takes note of the inconsistencies noted by Dr. Mather during his independent medical evaluation, but finds it significant that the job video given to him for review was not submitted into evidence and that Petitioner's testimony about the twisting mechanism of injury using a 25 pound sledgehammer to pound in a pin weighing hundreds of pounds is corroborated by his incident report of the same day, Caterpillar's medical records, and the medical records of Dr. McGivney, the orthopaedic physician to whom Dr. Neu referred Petitioner. Moreover, Petitioner reported symptoms radiating into the lower left extremity within days of his accident, which is documented by Nurse Day or Dr. Neu and Dr. McGivney's office. Finally, Dr. Mather examined Petitioner on one occasion as compared to Dr. Lorenz who saw him repeatedly and opined that based on these several examinations, Petitioner's conditions of ill being are causally related to the reported mechanism of injury. Based on all of the foregoing, the Arbitrator finds that Petitioner has established by a preponderance of the evidence that his claimed cervical, lumbar, and left shoulder conditions are causally related to his accident at work on October 8, 2012.

With regard to the carpal tunnel syndrome diagnosis, the Arbitrator notes that no physician opined that this condition was causally related to Petitioner's injury at work and Petitioner's treating physicians specifically denied causal connection between this condition and the work injury. Thus, the Arbitrator finds that Petitioner's carpal tunnel syndrome condition is not causally related to his accident at work on October 8, 2012.

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 above, Petitioner has established causal connection between his neck, left shoulder, and low back conditions of ill being and his accident at work. Moreover, the Arbitrator finds that the outstanding bills related to Petitioner's neck, left shoulder and low back were reasonable and necessary to alleviate him of the effects of his injury at work and that the bills for carpal tunnel syndrome were not reasonable or necessary given that no physician causally connects this condition to the accident at work.

The parties submitted a joint exhibit reflecting the bills and payments. JX1. After application of the fee schedule and/or negotiated rates, the medical bills total $80,793.63 less $279.94 in bills, which appear to be solely related to the carpal tunnel syndrome diagnosis. *Id.* Thus, the Arbitrator awards $80,513.69 for bills related to the neck, left shoulder, and low back subject to the limitations of the medical fee schedule and Sections 8(a) and 8.2 of the Act. Respondent shall be entitled to a credit for any payments made.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current condition of ill being is causally related to his accident as claimed. Thus, the Arbitrator awards the recommended prospective medical care in the form of injections as prescribed by Dr. Lorenz pursuant to Section 8(a) of the Act as it is reasonable and necessary to alleviate Petitioner from the effects of his injury at work.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

As explained above, the issue of causal connection has been resolved in Petitioner's favor. Moreover, the record does not reflect that Petitioner's condition has yet stabilized or reached maximum medical improvement. Thus, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits commencing October 9, 2012 through May 21, 2014 as claimed. Respondent shall receive a credit for any such benefits already paid.

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 Causal Connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Seth Whitmer,

15IWCC0346

Petitioner,

vs. NO: 13 WC 17355

Dawn Food Products, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary disability benefits and prospective medical treatment and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection as stated below and vacates the Arbitrator's award of medical expenses and treatment after September 26, 2013 and temporary total disability benefits after October 11, 2013. The Commission further remands this case to the Arbitrator for further proceedings for a determination of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 29-year-old employee at an industrial baking facility, alleged accidental injuries to the person as a whole and the lower left extremity on occurring in the course of and arising out of his employment by Respondent on April 19, 2013. Petitioner testified that he was performing his job duties of lifting fifty-pound bags of baking ingredients when he felt a sharp pain in his back. Petitioner testified that he began working for Respondent in 2012, cleaning machinery used to make baked goods. In March of 2013, he voluntarily changed job designations and became a batter mixer. He worked from 5:00 a.m. to 5:30 p.m. four to six days per week. His primary duties were to "*manually lift fifty pound bags of cake base and usually fifty pound*

buckets of soy oil on to an automatic vat that would mix them themselves." Petitioner denied having any problems performing his job prior to April 19, 2013. (T. 11-15) On the date of accident, he was lifting a bucket of soy oil when he "*felt a sharp pain in my back.*" He set the bucket down and stretched his back; the pain was on both sides and extended down from the middle of the back, shooting down his left foot. "*I just figured I would work through it about an hour or two later it became so unbearable I had to report it to my supervisor.*" Petitioner testified that they completed an incident report and he was taken in his supervisor's vehicle for medical attention. (T. 15-18) Dr. J.M. Panuska at Provena St. Mary's Occupational Health noted that Petitioner complained of low back pain going down his left leg and into his left foot after lifting fifty-pound bags. Petitioner was diagnosed with a lumbar strain and sciatica and prescribed Medrol Dosepak and Vicodin. He was authorized off of work for the remainder of the day and released to light duty work thereafter. (PX4) Petitioner testified that he attempted work light duty - emptying cupcake or muffin wrappers and straightening lines of product on the conveyor belt. He testified that he was unable to perform even the light duty work due to "*bad back muscle spasms and a hard time sitting or standing.*" (T. 18-20) On April 22, 2013, Dr. Panuska noted no changes in Petitioner's presentation since the prior visit. He prescribed Naprosyn and Vicodin and recommended light duty work with a five pound lifting restriction. Dr. Panuska scheduled Petitioner to return for follow-up on April 29, 2013. (PX4)

Petitioner did not return to St. Mary's and sought treatment with his primary care doctor, Dr. Dharam Anand. On cross-examination, Petitioner agreed that during the month prior to the date of accident he had an x-ray for hip complaints, but he did not recall reporting any back pain prior to the date of accident or that he has ever being diagnosed with the condition of sciatica. (T. 31) The records of Dr. Anand show that Petitioner treated for left hip pain, back pain and anxiety in March of 2013. On April 25, 2013, Petitioner reported to Dr. Anand that he injured his back at work on April 19, 2013: "*Lifted something and felt a burning and painful sensation in left side. Later radiated down left leg to toes.*" Dr. Anand noted that Petitioner tried to go back to work but had spasms and his medications did not help. Dr. Anand noted back tenderness on straight leg raise testing. (PX2) On direct examination, Petitioner testified that he was taken off of work by Dr. Anand beginning on April 26, 2013 and he never returned to work for Respondent. (T. 21-22)

A May 30, 2013 lumbar MRI showed multilevel degenerative spondylosis, disk bulges at L1-L2 through L4-L5 with a superimposed small posterior central disk herniation at L3-L4 and a small posterior central disk protrusion at L4-L5. There was no evidence of central canal stenosis. (PX2) Dr. Anand diagnosed sciatica with degeneration of lumbar or lumbosacral intervertebral discs and prescribed medications, physical therapy, and a referral to a pain specialist. Petitioner testified that he was unable to attend physical therapy due to a lack of authorization, and he claimed that over the summer his symptoms continued to worsen. (T. 20-23) The records of Dr. Anand show that Petitioner complained of severe and increasing pain with any activity through the summer of 2013; Petitioner also reported that pain disrupted his sleep and pain medications caused intractable nausea. (PX2)

On August 29, 2013 Petitioner was examined by Dr. Jesse Butler at the request of Respondent. Dr. Butler's report indicates that he reviewed the complete set of medical records from Dr. Anand. Petitioner reported to Dr. Butler that on April 19, 2013 he was lifting a barrel of soy oil that weighed about fifty pounds and developed back pain and left leg pain. He denied any prior relevant injuries. Petitioner reported that he was not working and was taking Norco and Soma for pain management. Dr. Butler noted that Petitioner smokes one pack of cigarettes per day and uses chewing tobacco. No neurological deficits were found on exam. Dr. Butler assessed a lumbar strain that "*appears to be causally related to the work injury*" and morbid obesity with deconditioning. Dr. Butler wished to view the actual MRI films before rendering a final opinion on whether any further treatment was medically necessary, and he recommended that Petitioner remain off of work in the meantime or work light duty with a twenty-five pound lifting restriction. (RX1)

On September 26, 2013, Dr. Butler issued an addendum report after he was provided with the MRI films for review. Dr. Butler interpreted the MRI as showing a degenerative central protrusion of the L4-5 disc with facet hypertrophy at multiple levels and some mild stenosis at the L4-5 and L5-S1 levels. He noted that the L2-3 and L3-4 disc levels were normal. Dr. Butler confirmed his diagnosis of a lumbar strain, caused by the work accident, however he opined that: "*The MRI films do not suggest the presence of any acute structural pathology affecting the lumbar spine. The patient's morbid obesity contributes significantly to his current status. I don't agree with the performance of epidural injections. There is no documentation of a significant radicular component to justify.*" Dr. Butler opined that Petitioner could work full duty because there was no structural contraindication for regular work. Dr. Butler opined that Petitioner was at maximum medical improvement for the work-related lumbar strain. (RX2)

Dr. Anand noted that Petitioner had been denied authorization under workers' compensation insurance for epidural injections; Petitioner requested a referral to a spine specialist. On November 14, 2013, Petitioner was examined by Dr. Anthony Rinella. Petitioner described the mechanism of injury on April 19, 2013 to Dr. Rinella consistent with prior histories. Petitioner claimed that his pain gradually increased in severity. He reported that he returned to light duty work for approximately one week but had pain and was unable to continue. Dr. Rinella reviewed the lumbar MRI and diagnosed lumbago with left lower extremity radiculopathy, bilateral stenosis at L4-L5, and central to left-sided disc herniation at L5-S1. Dr. Rinella recommended physical therapy and continued medications, x-rays and a new MRI for prospective left-sided epidural steroid injection at L5-S1. (PX3) Petitioner testified that the recommended treatment was not approved, and he continues to take medications prescribed by Dr. Anand that do not fully control his pain. (T. 25-27) On March 21, 2014, Dr. Rinella issued a narrative report after he reviewed Dr. Butler's August 29, 2013 report and addendum. Dr. Rinella disagreed with Dr. Butler's opinion that epidural steroid injections were not medically necessary and that there was no evidence of significant radiculopathy. Dr. Rinella noted that Dr. Butler had agreed that the MRI showed L4-5 spinal stenosis and L5-S1 spinal stenosis. Dr. Rinella believed that Petitioner's obesity could be contributory but not a basis to limit care when injections may improve Petitioner's radicular symptoms in the left posterior thigh and calf. (PX1)

On May 22, 2014 Dr. Butler reviewed the updated medical records and offered his opinions. Dr. Butler explained that he examined the records for any support for an acute radicular condition and he did not believe any such support existed. He noted that Petitioner apparently gained forty-four pounds over the course of his care and while he has remained entirely off of work his complaints of pain and disability have steadily increased. Dr. Butler also noted narcotic tolerance: Petitioner continued to use narcotic medications despite reporting no improvement in pain level. Dr. Butler further noted that Petitioner saw Dr. Anand two-and-a-half weeks prior to the accident with complaints of lower back pain, further indicating a pre-existing condition. Dr. Butler noted that the MRI did not show any acute disc pathology that clearly related to the accident and he opined that Petitioner's condition was the result of his morbid obesity, poor conditioning and smoking, and longstanding degeneration. (RX3)

The Arbitrator found that Petitioner's account of the accident and report to his employer was not rebutted. Furthermore, the history and mechanism of injury was consistently reported in the medical records. The Arbitrator found that Petitioner's testimony was credible and supported by the medical evidence and the opinions of Petitioner's treating physicians to be more persuasive than the opinion of Dr. Butler. We do not agree. The records of Dr. Anand show that in the weeks preceding the injury, Petitioner reported back pain and left hip pain. The back pain appears to be a new finding on March 29, 2013; it was not present at the prior visit on March 18, 2013. There is no indication that Petitioner's onset of back pain and left hip pain resolved prior to the injury and Petitioner's credibility is affected by his denial of prior back pain clearly indicated in the records in evidence. Prior to the accident, Petitioner was already being prescribed medications for back and left hip pain.

Petitioner was paid temporary total disability benefits beginning on from April 20, 2013 through October 11, 2013. By the time Petitioner saw Dr. Butler in August of 2013, the back strain had resolved and Petitioner's condition returned to its pre-accident state of low back pain and left lower extremity pain. After Dr. Butler's independent medical examination, Petitioner reported to Dr. Anand that he had been told he could work light duty, but Petitioner told Dr. Anand that he did not believe he was capable of any work. We note that Petitioner ceased treatment at St. Mary's Occupational Health Clinic and stopped working on his own accord, rather than continuing to perform light duty. During his first post-accident visit, Dr. Anand recorded Petitioner's complaint that the occupational medicine doctor would not take him off of work. Petitioner testified that he did not feel capable of performing the light duty work, but there is no indication that the work was beyond the five pound lifting restrictions. On April 25, 2013, Dr. Anand noted that Petitioner was not working, but he did not issue a work excuse until Petitioner specifically requested one on May 20, 2013.

After reviewing all of the evidence, we reverse the Decision of the Arbitrator on the issue of causal connection as stated below and vacate the Arbitrator's award of medical expenses and medical treatment after September 26, 2013 and temporary total disability benefits after October 11, 2013. Dr. Butler opined that the Petitioner's weight, deconditioning and degenerative

15IWCC0346

condition is the current cause of his pain. We find Dr. Butler's opinion more persuasive because it addresses Petitioner's pre-existing back pain and left hip pain where Dr. Rinella's opinion does not do so.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $492.23 per week for a period of 24 and 3/7 weeks, from April 20, 2013 through April 21, 2013 and from April 26, 2013 through October 11, 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 compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical bills related to the low back through September 16, 2013 and subject to the limitations of the medical fee schedule, as provided in §8(a) and §8.2.

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: MAY 15 2015
RWW/plv
o-3/17/15
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0346

WHITMAR, SETH
Employee/Petitioner

Case# **13WC017355**

DAWN FOOD PRODUCTS INC
Employer/Respondent

On 7/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0307 ELFENBAUM EVERS & AMARILIO PC
IAN ELFENBAUM
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0766 HENNESSY & ROACH PC
DANIEL WELLNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

15IWCC0346

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
19(b)

Seth Whitmer
Employee/Petitioner

v.

Dawn Food Products, Inc.
Employer/Respondent

Case # 13 WC 17355

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **5/29/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

15IWCC0346

FINDINGS

On the date of accident. **4/19/2013**. Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury. Petitioner earned **$38,394.20**: the average weekly wage was **$738.35**.

On the date of accident. Petitioner was **29** years of age. *single* with **0** dependent children.

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

Respondent shall be given a credit of **$12,692.50** for TTD, $ for TPD, $ for maintenance, and $ for other benefits. for a total credit of **$12,692.50**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $492.23/week for 57 2/7 weeks. commencing 4/19/13 through 4/21/13 and 4/26/13 to present. as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD already paid to date.

Respondent shall pay reasonable and necessary medical services of $7,830.41.subject to the fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $1,942.07 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 medical care recommended by Petitioner's treating physicians. including physical therapy and injections as indicated by Dr. Rinella.

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

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

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

Signature of Arbitrator

7/21/14
Date

JUL 23 2014

FINDINGS OF FACT

Petitioner was employed at Respondent as a mixer. He was hired in 2012, and originally worked in the environmental control department. In March 2013 he became a mixer. He alleges that on April 19, 2013, he was lifting 50 lb. cake mix and soy oil bags to pour into a vat. He felt a sharp pain in his back which shot down into his left foot. He reported the injury to his supervisor. He also completed an incident report. Petitioner denied prior treatment to the back and denied any prior pain in the back.

The records of Dr. Anand show that Petitioner had been a patient prior to the injury. (Px. #2). He went there for a wellness examination on March 25, 2013, and had no complaints of joint or back pain.

On March 29, 2013 Petitioner returned to Dr. Anand. (Px. #2). He went there for anxiety and back pain. He was diagnosed with anxiety, back pain and left hip pain. Dr. Anand provided preventative counseling on diet, exercise and tobacco cessation.

Petitioner was seen at Provena St. Mary's Hospital under the care of Dr. Panuska on April 19, 2013. (Px. #4). He provided a consistent history of his injury. He had positive findings during his physical examination. Dr. Panuska diagnosed Petitioner with a lumbar strain and sciatica on the left. He provided him with medication and returned him to modified work including a restriction of no more than 5 lbs. lifting, pushing and pulling. He also limited him to bending, stooping and twisting with alternate standing and sitting as needed.

Petitioner returned to Dr. Panuska on April 22, 2013. He indicated there was no change in his condition. He provided him with medications and continued work restrictions.

Petitioner testified that he attempted to return to work light duty and worked a few days. He testified as to his inability to perform the job. He then sought treatment with his personal care physician, Dr. Anand.

Following the work injury Petitioner was first seen by Dr. Anand on April 25, 2013. (Px. #2). He provided a history of lifting something and feeling a burning sensation in his left side, which later radiated down to his left leg and toes. Dr. Anand's physical examination noted back tenderness. He diagnosed Petitioner with back pain and sciatica and provided him with medication. (Px. #2).

Petitioner followed up with Dr. Anand on May 3, 2013. He complained of continued pain and wanted additional medication. Dr. Anand ordered a MRI scan of the lumbar spine and physical therapy. A similar examination occurred on May 13, 2013. On May 20, 2013 the Respondent authorized a MRI scan. (Px. #2). However, during the May 20, 2013 appointment Dr. Anand said the MRI scan was not yet authorized. Dr. Anand noted Petitioner was off of work due to his back pain. There had been no improvement. The physical examination only included a back tenderness finding.

Petitioner had the lumbar MRI scan on May 20, 2013. (Px. #2). According to the report the scan was interpreted as showing multi-level degenerative spondylosis with disc bulges identified at L1-L2 through L4-L5 and a small posterior disc herniation at L3-L4. There was no evidence for central canal stenosis throughout the lumbar spine. The scan was found to have multilevel foraminal compromise.

On June 7, 2013 Petitioner returned to Dr. Anand. He indicated that his pains were getting worse. He had back tenderness. The diagnosis was sciatica and degenerative lumbar lumbosacral disc disease. He had the same findings at a June 21, 2013 appointment. His medications were continued. He returned to Dr. Anand on July 12, 2013. It appears that he was being referred for a surgical evaluation. On July 12, 2013 he indicated that his pain had increased and he wanted additional medication. He also needed an off-work note. (Px. #2).

On August 9, 2013, Petitioner complained of a lack of employment and continued pain. Dr. Anand referred him for pain management and physical therapy. He continued his medications.

On August 29, 2013 Petitioner was seen by Dr. Jesse Butler for an independent medical evaluation. (Rx #1). Dr. Butler took a history and physical examination. He noted that Petitioner was 368 lbs. During the physical examination Petitioner had some tenderness on palpation of the lumbosacral spine. His straight leg raising tests were negative. He diagnosed Petitioner with a lumbar strain and noted that there were no objective neurological defects on the examination. He found Petitioner had morbid obesity with deconditioning and that the lumbar strain was causally related to the work injury. He placed Petitioner on a light-duty restriction of 25 lbs. lifting with limited bending and stooping pending his review of the films.

Petitioner returned to Dr. Anand on September 12, 2013. Petitioner said he was unable to work. Dr. Anand continued his pain medications and referred him for physical therapy and pain management.

On September 26, 2013 Dr. Butler issued an addendum opinion following his review of the MRI scan. (Rx #2). Dr. Butler found a degenerative central protrusion of the L4-L5 disc with facet hypertrophy at multiple levels with some mild stenosis at the L4-L5 and L5-S1 levels. He concluded that the MRI films did not show the presence of any acute structural pathology affecting the lumbar spine. He found that Petitioner's morbid obesity contributed to his status, and he did not agree with the performance of epidural injections. Dr. Butler did not believe there was a significant radicular component to justify it. He found Petitioner had a lumbar strain, could return to work full duty, and that Petitioner had reached maximum medical improvement.

Petitioner returned to Dr. Anand on October 11, 2013. (Px. #2). He complained of continued pain in the back and numbness in the leg. He still had back tenderness. The diagnosis remained sciatica and degenerative lumbar disc disease. He continued to refer Petitioner for pain management or therapy. He indicated he was waiting for the attorney to advise on approval of a re-evaluation by another back specialist.

Petitioner returned to Dr. Anand on October 28, 2013. He noted that Petitioner's lawyer wanted Petitioner to see a neurosurgeon. He noted the findings of Dr. Butler that Petitioner had pain and disc problems due to his weight. Petitioner complained of continuing pain and was given additional medications.

On November 14, 2013 Petitioner was seen by Douglas Stevens, a physician's assistant to Dr. Anthony Rinella. Petitioner provided a history of his injury, symptoms and his continued off-work status. Mr. Stevens took a physical examination. During this examination Petitioner had pain with extension and

15IWCC0346

flexion and some decreased sensation over the L5 nerve root distribution. He reviewed the MRI scan and noted findings at L4-L5 with a herniation at L5-S1. Mr. Stevens diagnosed Petitioner with lumbago with left lower extremity radiculopathy, bilateral stenosis at L4-L5 and a central left sided disc herniation at L5-S1. He recommended physical therapy and medication. He also recommended epidural steroid injections. He also wanted a new MRI scan. (Px. #3).

Petitioner returned to Dr. Anand on December 5, 2013. He had continued complaints of pain and wanted injections and physical therapy. He reported that he was not able to work. (Px. #2).

Dr. Rinella examined Petitioner on December 20, 2013. (Px. #4). He noted Petitioner had some lumbosacral tenderness and some diminished sensation on the left side at L4-L5 and L5-S1. Otherwise, he was neurologically intact. Dr. Rinella found Petitioner had bilateral stenosis at L4-L5 and a central to left sided disc herniation at L5-S1. He had lumbar spondylotic radiculopathy. Dr. Rinella recommended Petitioner remain off of work and have an epidural steroid injection. He told Petitioner to maintain a course of physical therapy.

Petitioner returned to Dr. Anand on January 9, 2014. (Px. #2). He had continued complaints and was there for a refill on medications and a note to remain off of work. The diagnosis remained the same. There were similar findings at a February 14, 2014 appointment.

Dr. Rinella issued a narrative report at the request of Petitioner's attorney on March 21, 2014. (Px. #1). He reviewed Dr. Butler's independent medical evaluation and noted his disagreement. He found Petitioner had lumbar back pain extending into his left posterior thigh and calf which corresponded with his review of the MRI scan. He acknowledged Petitioner's obesity contributed to his lumbar back pain, but did not believe it was a basis to limit his care. He recommended epidural steroid injections.

Dr. Butler issued a narrative addendum report on May 22, 2014. (Rx. #3). He again reviewed the records and noted that Petitioner had lower back pain beginning on March 29, 2013, two and a half weeks prior to the injury. He found that the only changes to the diagnosis originally rendered were additional diagnoses of morbid obesity and narcotic tolerance. He noted that the causal connection for his pain and work injury was "soft" as the pain was present two and half weeks prior on March 29, 2013. He did not find documentation or resolution of the back pain and sciatica prior to the work injury. Dr. Butler found the MRI scan did not show acute disc pathology that would clearly relate to the work incident. He disagreed that there was a disc herniation on the left side causing the current pain. Petitioner had long-standing degeneration, which he believed was related to his morbid obesity and poor conditioning. He also noted Petitioner smoked a pack of cigarettes and chewed tobacco, which did not help the health of his spine. He found Petitioner could return to work and was at maximum medical improvement, as an epidural would not reverse his condition.

Petitioner testified that his continued pain in his back and left leg interrupted his activities and sleep. He denied having back pain prior to the injury. He testified that he wanted treatment including the epidural steroid injections. He acknowledged that his benefits were paid by Respondent through October 11, 2013.

CONCLUSIONS OF LAW

1. The Arbitrator finds that Petitioner had an accident arising out of and in the course of his employment with Respondent on April 19. 2013. Petitioner testified that his job duties on the date of injury involved lifting heavy bags. He then testified to having pain after performing this activity. There were no facts offered into evidence refuting this history of injury. and the Arbitrator notes that this history was consistently reported in the medical records. Therefore. the Arbitrator finds that Petitioner had an accident arising out of and in the course of his employment.

2. With regard to the issue of causation. the Arbitrator finds that the Petitioner has met his burden of proof. Thisfinding is based on the Petitioner's credible testimony the supporting medical evidence. Each of the Petitioner's treating doctors found causation and that his subsequent disability began with the lifting incident. Respondent offered the opinion of Dr. Butler. who. agreeing the injury occurred. thought the Petitioner's weight is presently the cause of his pain. In support. Dr. Butler draws from Dr. Anand's visit prior to the injury and the MRI. The Arbitrator finds more persuasive the opinions of Petitioner's treating physicians on this issue.

3. Based on the Arbitrator's findings with regard to the issue of caustion. the Arbitrator concludes that the care requested by the Petitioner is reasonable and necessary to cure and relieve the Petitioner's current condition of ill being. Dr. Rinella's proposed treatment. including physical therapy and injections. shall be authorized by Respondent.

4. Based on the Arbitrator's findings above. the Petitioner is awarded TTD from April 20. 2013 through May 29. 2014. This conclusion is supported by both the Petitioner's credible testimony and the medical evidence showing Petitioner has been authorized off work due to this work-related condition and has not reached maximum medical improvement (MMI). Respondent shall receive a credit for any and all TTD it has paid to 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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

George Oakey,

Petitioner,

15IWCC0347

vs.

NO: 10 WC 10162
10 WC 10163
10 WC 10164

Panduit Corporation,

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, notice, causal connection, temporary disability benefits, permanent disability and vocational rehabilitation and being advised of the facts and law, reverses the Decision of the Arbitrator in 10 WC 10163 and 10 WC 10164 to deny benefits because we find that Petitioner failed to prove repetitive injuries manifesting on August 12, 2009 and February 24, 2010. Furthermore, we modify the Decision of the Arbitrator in 10 WC 10162 on the issue of permanent partial disability benefits because we find that Petitioner failed to prove permanent impairment resulting from a temporary aggravation of a pre-existing condition.

Petitioner worked full time for Respondent in manufacturing and packaging. The majority of his employment by Respondent, he performed work on an assembly line. He started working for Respondent in 2006 and he was 46-years-old on December 1, 2008, the first date of accident wherein he alleged that he "stepped wrong" and strained the right side of his groin. Petitioner furthermore claims repetitive injury to his right groin, low back and right hip manifesting on August 12, 2009 and February 24, 2010. Petitioner's three cases were concurrently filed with the Commission and were consolidated for hearing at the time of arbitration. In all three cases, the Arbitrator found for Petitioner and the Decision of the Arbitrator is attached hereto and made a part hereof. For the reasons set forth below, we view the evidence differently and find that Petitioner failed to prove that he is entitled to any benefits under the Act.

In case number 10 WC 10162, Petitioner alleged that he sustained accidental injury to his groin when he "stepped wrong" onto his right foot on December 1, 2008 and felt a sharp pain in

his right groin, hip and low back. He was diagnosed with a right groin strain and was off of work through December 8, 2008. The records in evidence show that he had been examined by his primary care physician, Dr. Chaudhry, five months prior to the accident and complaints of ongoing groin pain were documented in the records. After December 8, 2008 Petitioner returned to regular duty work and did not obtain any further treatment related to his right hip, groin, or low back until August of 2009. Temporary total disability benefits and medical expenses with respect to case number 10 WC 10162 have been paid by Respondent. The Arbitrator awarded 2% of the person as a whole pursuant to §8(d)2 of the Act. We find that this award is not supported by the preponderance of the evidence because Petitioner sustained a temporary aggravation of a pre-existing condition that did not result in permanent disability.

In case number 10 WC 10163, no specific injury was alleged but Petitioner returned for medical treatment for his right hip in August of 2009. The basis of Petitioner's claim is repetitive injury to the right groin, right hip and low back manifesting on August 12, 2009, when he stopped working because he felt that he could not physically continue due to increasing pain. Petitioner began treating with an orthopedic surgeon in September of 2009 and went off of work until February 22, 2010. Petitioner's supervisor, Mr. Hossbach, testified that there were no injuries reported to him in August of 2009 and he denied that he knew that Petitioner's job duties were causing his inability to work. The Arbitrator awarded temporary total disability benefits from August 14, 2009 through February 21, 2010, incurred medical expenses, and 10% of the person as a whole pursuant to §8(d)2 of the Act. We find that Petitioner failed to prove a compensable claim for repetitive injury and the Arbitrator's award is not supported by the preponderance of the evidence.

In case number 10 WC 10164, the basis of Petitioner's claim is also repetitive injury. The manifestation date, February 24, 2010, is the last date that Petitioner attempted to return to work for Respondent. At arbitration, Petitioner testified to some facts indicating a sudden occurrence of injury, but Petitioner's attorney clarified that the basis of the claim was in fact repetitive injury. Petitioner testified that he was at work for only a brief period of time performing the work of assembling doors when while carrying a twenty to twenty-five pound box he bumped his right foot into a pallet and felt sharp and severe pain in his right hip. He testified that he did not fall, but he felt that his right leg almost gave way due to the pain. Petitioner testified that he talked to his supervisor, Mr. Hossbach, and showed him his right foot and explained what had occurred. Mr. Hossbach testified that he did not recall Petitioner being at work on February 24, 2010 and denied any notice of injury. Mr. Hossbach did recall that two days earlier, on February 22, 2010, Petitioner returned to work for the first time since his medical leave. After only twenty minutes Petitioner spoke to Mr. Hossbach and claimed that he was in too much pain to continue his job duties and left work. Petitioner testified that his pain was already at a level of eight out of ten when he arrived at work on February 22, 2010. A letter documenting Petitioner's complaints on February 22, 2010 was submitted into evidence. Petitioner did not return to work for Respondent after February 24, 2010; he testified that he already knew that he would be having hip surgery. In June of 2010, Petitioner underwent a right total hip replacement. The Arbitrator awarded temporary total disability benefits from February 24, 2010 through July 11, 2013, medical expenses and prospective medical treatment and vocational rehabilitation. We find that the Decision of the Arbitrator is not supported by a preponderance of the evidence because we do not find that Petitioner proved he sustained accidental injuries as a result of repetitive work and

manifesting on February 24, 2010.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified that he worked full time for Respondent in manufacturing and packaging. (T. 15) Petitioner worked for Respondent for 2-3 years prior to the first date of accident on December 1, 2008. (27) His job required him to lift components weighing from eight to eighty pounds (with help if needed) from the floor or from knee-level to a hip-level table. An assembly quota dictated the number of items he needed to complete per day on the assembly line, depending on the item. (T. 22) On the "powder coat line" he performed "take downs," meaning he lifted assembled items down from the overhead conveyor belt, inspected them and place them on a pallet. The items could weigh up to eighty pounds and require two people to lift down from the conveyor belt, but on average the items weighted ten to fourteen pounds. (T. 25)

On December 1, 2008 Petitioner testified that he and two other workers were assigned to the packaging line for metal shelving units known as "PRV's." He described his subjective physical condition when he arrived to work on December 1, 2008: *"just the same old nagging aches, you know, from doing the job I was doing. You know, just run down and – achy and pain and, you know, the beginning of the day, you would have to stretch and try to crack your back or something. It was like that all the time."* Petitioner testified that the daily aches and pains he lived with prior to the December 1, 2008 accident were primarily located in the right hip, the groin, and lower back. (T. 31-32) Petitioner testified that on December 1, 2008 as he pushed a forty-pound PRV into a box with his left hand, holding the box with his right hand, he stepped up onto a platform (approximately two-and-a-half feet in height) with his right foot and that this caused sudden pain in his right groin, hip and low back: *"I don't know, my foot just, it gave way. I don't know if I hit the step. I don't know. I felt a bad pain in my leg, a burning sensation. I kind of like fell."* (T. 33) He continued: "*Just my leg gave way. I felt excruciating pain in my right hip and right side*" specifically the "*right side, hip, groin, mainly because there was a lot of burning in my back.*" Petitioner clarified his statement that he *"kind of like fell"* and explained that he caught himself and did not actually fall. (T. 35) On cross-examination, Petitioner attempted further description of the stepping motion: *"Like my whole side went – it just – I don't know if I twisted my foot, but when I stepped up, I just remember going like to the side."* (T. 95) Petitioner denied that the platform was slippery or in any way out of the ordinary on that day. (T. 97)

Petitioner testified that he described the occurrence to the floor manager, Don Hossbach, and that Mr. Hossbach asked whether Petitioner needed medical attention. Petitioner believed this occurred in Mr. Hossbach's office and that they completed an accident report and then Petitioner went to Willowbrook Clinic. (T. 37) Respondent offered the testimony of Don Hossbach at arbitration. Mr. Hossbach testified that he worked for Respondent for thirty-two years and was familiar with all job duties in the assembly and packaging areas. He agreed that during packaging a worker stands on a platform, but he denied that he ever saw workers step up with one foot in order to push the assembled item into a box in the manner that Petitioner described performing on December 1, 2008; in his opinion it did not make logistical sense to do so. (T. 170) On cross-examination, Mr. Hossbach agreed that he did not witness the alleged occurrence. (T. 209)

At Willowbrook clinic, Dr. Bilotta diagnosed a right groin strain resulting from an injury at work where Petitioner's right foot slipped and his leg twisted. Petitioner complained of severe pain in his right groin, especially when flexing his hip. Dr. Bilotta prescribed medications and took Petitioner off of work for several days. (PX 9) Petitioner returned to Dr. Bilotta on December 4, 2008 and was excused from work until December 8, 2008. Dr. Bilotta noted that Petitioner's right groin strain was resolving and he could resume full duty work and return for follow up only as needed. (PX9, T. 39) Petitioner testified that he subsequently returned to work and notice that *"things just started getting harder. The pain was – it was just – I don't know how to describe it. My pain levels were going up."* Petitioner described constant pain in his right hip, lower back and groin that increased with work activities: *"All the bending and lifting, putting pieces up, you know, everything was pain, bending and lifting and stooping."* Petitioner testified that he took over-the-counter medications and tried to stretch and reposition himself. (T. 40)

Petitioner testified that after eight months back at work, on August 12, 2009: *"it was getting a lot harder to get myself, you know, able to work. I would get a lot more pain. It was just everything was hurting, you know, and I was getting it progressively more as I worked."* (T. 42) Petitioner testified that he spoke with Don Hossbach and "James Agey," his other supervisor, and told them some jobs activities were causing discomfort and pain. Petitioner testified *"I would sit and talk to him [Don] about when I found out the job I did, I told him how much it was bothering me. There was sometimes everybody would go on break for ten minutes, toward the later part, I would say July, my breaks consisted of lying on the table and stretching."* (T. 43) On August 12, 2009, Petitioner was working on the "powder coat line," continually taking items down from the overhead conveyor belt, inspecting them, and placing them in buckets. Petitioner testified that he worked with two coworkers on the line. He explained: *"It was just I couldn't take it anymore. The pain was excruciating, the bending. Even standing was a hard time for me, and I just couldn't."* (T. 49) Petitioner testified that he finished working that day but talked Don and told him: *"I'm going to see if my wife could get me in and/or I might have to go to the emergency room, but I am trying to go see my doctor tomorrow."* Petitioner believed that they did not complete an accident report. (T. 50) At arbitration, Mr. Hossbach denied that Petitioner reported any accident in August of 2009. (T. 174) Mr. Hossbach agreed that as part of his job, he documents all work-related injuries. (T. 175) He identified RX2 as the spreadsheet of all injuries occurring in 2009 and agreed that no injuries were indicated for August of 2009. (T. 178)

Petitioner saw Dr. Chaudhry on the following day with complaints of right leg, hip and groin pain; no mechanism of injury was indicated. Petitioner was prescribed medications and excused from work. (PX 7) On cross-examination, Petitioner denied any medical treatment between his return to work in December of 2008 and August 13, 2009. (T. 108) Petitioner underwent an MRI of both hips on August 18, 2009 that showed osteoarthritic changes. (PX4, T. 52) Petitioner treated with Dr. Brannigan, a chiropractor, from August 31, 2009 through October 5, 2009. Dr. Brannigan's records indicate that Petitioner had a history of back problems and that his pain and problems occurred with daily activities. (PX8, T. 113) Petitioner agreed that he was not working during the time he treated with Dr. Brannigan, yet his pain increased. (T. 115) Dr. Chaudhry referred Petitioner to an orthopedic specialist, Dr. Booker. Dr. Booker first examined Petitioner on September 23, 2009 and noted that Petitioner reported pulling a groin muscle in December of 2008 and that it became progressively worse and was interfering with daily activities. Dr. Booker diagnosed right hip arthritis, and noted "no specific injury." (PX4) Dr.

Booker administered a right hip cortisone injection on October 7, 2009. (T. 54) During cross-examination, Petitioner was questioned about an unrelated fall onto the right hip reported to Dr. Booker on October 9, 2009. Petitioner initially denied any recollection of the occurrence, but then recalled "*as I was getting in my car, it was like my foot gave away, and I fell. And that's when I felt it, and I told that to the doctor*" and "*I don't know if I would call it a fall though.*" He agreed that Dr. Booker was concerned about a potential hip fracture and ordered a new MRI on that date. (T. 117-118; PX4) The right hip MRI on October 24, 2009 revealed an effusion and arthritis but no fracture resulting from the fall. Dr. Chaudhary noted that a right hip replacement had been recommended for Petitioner. Petitioner subsequently underwent a series of Supartz injections by Dr. Booker during January of 2010. (PX4) On February 15, 2010, Dr. Chaudhary filled out disability paperwork indicating that Petitioner was capable of limited duty work with no stooping and bending and Petitioner was allowed to return to work. (PX7) By this time, Petitioner had been on medical leave for six months. Petitioner testified that his light duty restrictions were not accommodated by Respondent and he worked his regular duties beginning on February 22, 2010. (T. 56)

Petitioner testified that on February 22, 2010, he did not feel well and he was sore and in pain. (T. 57) On that day, he was working building doors which involved bending down and lifting items weighing eight to ten pounds. (T. 58) After assembling "a few" doors he felt that he could not physically continue and he went speak with Don. Petitioner testified that Don told him that if he could work he would need to go home. (T. 60) Petitioner returned to work on February 24, 2010 and started work at 2:48 p.m., testified that he was still in pain and was assigned to build even heavier doors. (T. 61) He had only assembled a twenty to twenty-five pound doors when he picked one up "*and as I walked around and put it in another box, I don't know if my leg just gave way. I hit a pallet, but I heard a clunk, and I went down. And I just – it was just stinging pain in the hip and in the back, but that clunk is what scared me.*" (T. 62) He clarified that he heard the "clunk" inside his body, in his hip, but that he did not actually fall onto the ground. (T. 63) He further explained that he stepped with his right foot and his foot struck a pallet and it was at that moment that he felt the pain and heard the clunk and felt his leg "*give way.*" (T. 64-65) He described the pain as burning and excruciating. (T. 65) He testified that looked for Don but could not find him but he talked to "Garret," another floor manager. He told Garret that he had been injured and wanted to see Don. Petitioner testified that when he was able to talk to Don, he "*showed him what happened. I showed him my foot. I told him what kind of pain I was in, and I told him, "I would like to go – I need to go to the doctor or clinic."*" Petitioner testified that Don filled out paperwork but Petitioner could not be sure that it was an accident report. (T. 68) Dr. Chaudhry examined Petitioner on February 25, 2010 and noted right thigh and calf cramping and pain beginning at work on February 24, 2010. (PX7)

Petitioner testified that he has not returned to work for Respondent since February 24, 2010. (T. 75) On cross-examination, Petitioner testified that his low back, hip and groin became progressively worse the entire time he was off of work, but that he returned on February 22, 2010 only because he had exhausted his medical leave time and believed he would be terminated if he did not return. (T. 121-122) Mr. Hossbach agreed that Petitioner returned to work in February of 2010. He testified that he was aware of Petitioner's restrictions and that he provided accommodating work. He recalled that Petitioner was sent home on February 22, 2010 because he was struggling to perform any work. Mr. Hossbach did not recall that Petitioner ever returned

to work after that. (T. 180) On cross-examination, Mr. Hossbach was shown PX 1, the letter dated February 22, 2010 stating that after twenty minutes of work Petitioner showed signs of discomfort. (T. 186) On redirect examination, Mr. Hossbach testified that he was aware that Petitioner was having pain while working, but Petitioner did not report an injury. (T. 216) Petitioner agreed that after February 24, 2010, he never asked Respondent about trying again to return to work. He testified, *"that's when I determined that I was going to have hip surgery shortly after that."* (T. 128) He agreed that prior to February 22, 2010, Dr. Booker discussed hip surgery *"as a course down the road."* (T. 129) Petitioner testified that he always knew there was a chance he would have to have his hip replaced, and that his pain was probably already at a level eight out of ten when he returned to work on February 22, 2010. (T. 131) As Dr. Chaudhry's records show, right hip replacement was recommended by October of 2009. (PX4)

On April 7, 2010, Dr. Booker scheduled Petitioner for surgery and noted his opinion: *"The repetitive bending and stooping at work on 2/24/10 essentially led to an exacerbation of his hip arthritis based on my best estimate with any degree of medical certainty."* (PX4) On June 11, 2010, Petitioner underwent a total right hip replacement by Dr. Booker. Petitioner testified that currently his hip is still painful. Surgery somewhat improved his condition, but in addition to residual hip pain, his lower back and right groin are still significantly painful. (T. 133) We note that Petitioner denied having any treatment for groin pain prior to December 1, 2008. (T. 77) However, during cross-examination Petitioner was shown a record from a visit to Dr. Chaudhry in July of 2008 that contradicted that testimony. Petitioner denied any recollection of the visit. The record shows that Petitioner complained of right groin pain for six months on July 14, 2008 with noted swelling in the groin. The record shows that Petitioner reported having difficulty climbing stairs and tying his shoes and that Dr. Chaudhry advised Petitioner to continue taking Vicodin and added a prescription for Flexeril. Petitioner then testified that he remembered going to see Dr. Chaudhry about his groin, but he denied any recollection that this occurred prior to the first accident. (RX1, T. 85)

With respect to case number 10 WC 101062, the claim for a right groin strain occurring on December 1, 2008, we agree with the Arbitrator that Petitioner proved that the accident occurred, but we find that Petitioner failed to prove any permanent disability. Petitioner's testimony and the records show that Petitioner returned to full duty work less than a week later and did not return for any further medical treatment or report any complaints with respect to that injury. Furthermore as stated above, the records of Dr. Chaudhry show that Petitioner had a pre-existing chronic right groin strain for which he was seen five months prior to accident. We conclude that while Petitioner likely sustained a temporary aggravation of his pre-existing right groin condition on December 1, 2008, but that there is no causal connection to his current condition of ill being or any evidence of permanency resulting from the December 1, 2008 accident. Accordingly, we vacate the Arbitrator's award of 2% of the person as a whole pursuant to §8(d)2 of the Act.

With respect to case number 10 WC 10163 and case number 10 WC 10164, the alleged repetitive injury claims manifesting on August 12, 2009 and February 24, 2010, we find that Petitioner failed to prove accident and that the Arbitrator's award is not supported by the preponderance of the evidence. Accordingly, we deny both cases and vacate the Arbitrator's award of temporary total disability benefits from August 14, 2009 through February 21, 2010,

15IWCC0347

medical expenses, and 10% of the person as a whole in case number 10 WC 10163 and the Arbitrator's award of temporary total disability benefits from February 24, 2010 through July 11, 2013, medical expenses, and prospective medical treatment and vocational rehabilitation in case number 10 WC 10164.

In case number 10 WC 10163 and case number 10 WC 10164, the basis of Petitioner's claims is repetitive injury even though some elements of specific occurrence were alleged and caused some confusion during Petitioner's testimony. (T. 106-107) We find that Petitioner failed to prove accident and timely notice to Respondent of his claim for repetitive injury manifesting on August 12, 2009. Petitioner subsequently remained off of work with increasing complaints of pain and disability. When Petitioner attempted to return to work on February 22, 2010 he almost immediately stopped working and claimed to be in too much pain. We find it significant that Petitioner testified he was already experiencing pain at a level of eight out of ten prior to performing any work on February 22, 2010. Furthermore, Petitioner had been recommended for a right total hip replacement since October of 2009 and testified that he knew in February of 2010 that he would be going off of work for a right hip replacement. (T. 131) Petitioner testified that he briefly returned to work on February 24, 2010, but almost immediately stopped working again due to pain. The preponderance of the evidence shows that Petitioner had longstanding degenerative arthritis in his right hip and his condition progressed irrespective of his employment by Respondent. We find that in case number 10 WC 10163 and case number 10 WC 10164 Petitioner failed to prove his condition is work-related and not merely the result of age-related changes. Dr. Booker testified that objectively Petitioner's hip was "bad enough" at his first examination on September 23, 2009 that it could have been replaced; it was more a matter of how symptomatic Petitioner was and how much his quality of life was affected. Dr. Booker testified that after the report of the October 2009 fall, Petitioner's symptoms were more severe and bothersome. (PX1, p. 54) Respondent's Section 12 examiner, Dr. Gleason, opined that Petitioner's MRI findings were consistent with a longstanding condition. (RX7, p. 21) We find that Petitioner failed to prove compensable injuries in case number 10 WC 10163 and case number 10 WC 10164 and we hereby deny both claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that all awards in the Arbitrator's Decision dated January 3, 2014 are vacated. Petitioner failed to prove entitlement to any benefits under the Workers' Compensation Act.

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

DATED: MAY 15 2015
RWW/plv
o-3/18/15
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

☒ Affirm with changes	☐ 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

LaRone Crittenden,
Petitioner,

vs. NO: 11 WC 37121

State of Illinois,
Singer Mental Health Center,
Respondent.

15IWCC0348

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and timely notice given to all parties, the Commission, after considering the issue of accident, and being advised of the facts and law, modifies the April 3, 2014 decision of Arbitrator Falcioni with alternative reasoning as stated below, and otherwise affirms and adopts the decision of the Arbitrator, which is attached hereto and made a part hereof.

After considering the entire record, the Commission affirms and adopts the Arbitrator's findings of fact but vacates the conclusions of law.

The Arbitrator's decision laid out the evidence as contained in the record in great detail. Petitioner had worked as a mental health technician at Singer Mental Health Center for 16 years at the time of the alleged accident. Petitioner testified that on May 20, 2011, she had just returned from a break when she realized she was the only staff member on the unit. After doing rounds, she noticed two male patients fighting. Petitioner testified one patient was beating another in the face. Petitioner called a "code red." Staff from another unit came to assist and Petitioner testified the aggressive patient turned toward Petitioner and raised his fist, but he was restrained. Petitioner was not physically injured as a result of the fight between the patients. She continued to work the remainder of her shift, as well as her scheduled shifts the following two days. On Petitioner's scheduled day off, she presented to her primary care physician, Dr. Darland. In the medical records, Dr. Darland noted that Petitioner's job was stressful and a co-worker was threatening Petitioner. He also noted Petitioner advised "another inmate, ex-marine, beat up two people." The office note went on to mention Petitioner had 24 years with the State, she would be 60 in February 2014, and she needed one month off and then would request disability and workers' compensation. Dr. Darland authored an off work note May 26, 2011 stating Petitioner had been under his care for several years and was unable to work through July 6, 2011 due to anxiety and depression over work conditions. It wasn't until July 8, 2011, over a month after witnessing the patient fight, that Petitioner began focusing on that fight as the inciting event that manifested her alleged injury.

The Arbitrator, in finding Petitioner failed to prove by a preponderance of the evidence that she sustained a compensable accident under the Act on May 20, 2011, cited the Commission case, Malec v. W.R.Grace, 12 IWCC 941. The Arbitrator found, as in Malec, the record in the instant case failed to establish Petitioner had an immediate reaction to the incident, and the Section 12 examiner opined Petitioner did not suffer from PTSD. The Arbitrator, as a factor in his decision finding Petitioner failed to prove she sustained an accident, notes Petitioner had no immediate reaction to viewing the fight and did not seek medical treatment until a few days after the altercation.

Petitioner argues on appeal, and the Commission agrees, the case law cited by the Arbitrator as a factor in his denial of Petitioner's claim for benefits under the Act has been superseded by later controlling Appellate Court cases, such as Chicago Transit Authority v. Ill. Workers' Comp. Comm'n, 2013 IL App (1st) 120253WC. As such, the Commission modifies the Arbitrator's Conclusions of Law contained in the Arbitration Decision pages 13 through 16. In its place, the Commission makes the following Conclusions of Law:

a. Did an accident occur that arose out of and in the course of Petitioner's employment with the Respondent-Employer?

In Illinois, psychological injuries are compensable under one of two theories, either "physical-mental," when the psychological injuries are related to and caused by a physical trauma or injury, or "mental-mental," when the Petitioner's psychological injuries are related to and caused by non-physical work related factors. Matlock v. Industrial Comm'n, 321 Ill. App. 3d 167, 171, 746 N.E. 2d 751 (2001).

In Pathfinder Co. v. Industrial Comm'n, the Supreme Court stated an employee who suffers a sudden, severe emotional shock traceable to a definite time, place and cause which causes physiological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained. 62 Ill. 2d 556, 343 N.E. 2d 913, 917 (1976). In Chicago Transit Authority, the Appellate Court explained that, "Under Pathfinder, the emotional shock needs to be 'sudden,' not the ensuing psychological injury." 2013 IL App (2d) 120253WC, ¶20. Thus, a "claim may be compensable even if the resulting psychological injury did not manifest itself until sometime after the shock." Id. Therefore, the fact that Petitioner may have delayed seeking treatment for a psychological injury is not fatal to the claim. However, the Appellate Court went on to state that "although not dispositive as a matter of law, evidence that a claimant delayed seeking treatment for alleged psychological injuries for an extended period of time...may still be relevant in a given case. Depending on the facts of the case, such evidence might undermine the inference that the claimant suffered a severe emotional shock that caused a psychological injury." Id. at ¶21.

In the case at bar, Petitioner testified she claims psychological injuries stemming from a single traumatic work-related incident on May 20, 2011, when she witnessed a fight between patients. Therefore, analysis of Petitioner's claim falls within the sphere of Pathfinder regarding compensability under the Act. Petitioner must prove, by a preponderance of the evidence that the event she witnessed on May 20, 2011, caused a sudden severe emotional shock resulting in psychological injury. The Commission finds Petitioner failed to prove this element of her claim.

The Commission acknowledges that the fight between patients Petitioner witnessed on May 20, 2011 presented a potentially dangerous and precarious situation for Petitioner, but it did not result in a sudden severe emotional shock. The record as a whole consistently establishes that Petitioner did witness a fight between patients on May 20, 2011, and she points to this specific incident as the traumatic event which she claims prevents her from returning to work. However, the evidence in the record shows Petitioner had recently reported injuries, including an incident in July 2010, when a patient grabbed her neck and threatened to kill her and an incident in March 2011 in which a patient punched her in the eye. The Record further outlined pre-disciplinary meetings with Petitioner's supervisors for conduct unbecoming a state employee and extensive concerns and frustrations revolving around conflict with a co-worker. When Petitioner presented to her primary care physician in May 2011, she complained of many factors in her life which she believed contributed to her symptoms. Dr. Darland authored a letter "to whom it may concern" on May 26, 2011, stating he was taking Petitioner off of work for one month due to anxiety and depression over work conditions. Dr. Darland noted in his May 26, 2011 record that Petitioner would like one month off of work and then would "go for disability" and that she "wants to get w/c." It wasn't until July 8, 2011 when Petitioner presented to Mr. Person at Geiger Psychiatric, about a month and a half after witnessing the fight between patients, that Petitioner began focusing on the fight as the inciting event that caused her alleged mental injury. The treatment records of Geiger Psychiatric Clinic mostly center on Petitioner's anxiety and stress over financial issues. While not dispositive, this evidence certainly undermines any inference that Petitioner suffered a severe and sudden shock after witnessing the May 20, 2011 fight.

The Commission further observes numerous inconsistencies in the record which undermine Petitioner's credibility regarding the cause of her alleged psychological injury. Petitioner's story changed numerous times in record as it relates to the events of May 20, 2011, whether she witnessed an attack on a co-worker, her own medical history, the causes of her work stress, her disciplinary record at work and whether she had any disputes with co-workers. Furthermore, objective testing of Petitioner clearly reveals symptom exaggeration and invalid test results with a finding of malingering and Petitioner testified that she was aware that the facility where she worked was slated to close. The Petitioner's credibility is highly suspect, rendering her testimony and complaints to physicians regarding her psychological symptoms and the cause of any symptoms dubious at best.

Finally, Dr. Hartman's testimony and his objective test findings are credible. The tests clearly show Petitioner is malingering and attempting to sway her answers to a finding of post-traumatic stress disorder or a psychological condition stemming from her work. While Petitioner's blood pressure was high during Dr. Hartman's examination, the record notes that her pulse rate was normal, lending credibility to Dr. Hartman's opinion that the blood pressure was not at all related to anxiety or stress.

The record and the reasonable inferences drawn from the record support a finding that Petitioner failed to prove she suffered a sudden severe emotional shock which resulted in psychological injury or harm. The Commission finds Petitioner has failed to meet her burden of proof that she sustained a compensable injury that arose out of and in the course of employment. The Commission further finds that the Petitioner has failed to credibly establish any causal relationship between her psychological state of ill-being and her employment. All other issues are rendered moot given the above analysis.

15IWCC0348

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2014, is hereby modified. Benefits are denied.

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: MAY 18 2015

Joshua D. Luskin

o-03/17/15
jdl/adc
68

Charles J. DeVriendt

Ruth W. White

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

CRITTENDEN, LaRONE
Employee/Petitioner

Case# **11WC037121**

15IWCC0348

SINGER MENTAL HEALTH CENTER
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:

2489 THE LAW OFFICES OF JIM BLACK & ASSOCIATES
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4987 ASSISTANT ATTORNEY GENERAL
LAURA HARTIN
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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

APR 3 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LaRone Crittenden
Employee/Petitioner

v.

Singer Mental Health Center
Employer/Respondent

Case # 11 WC 37121

Consolidated cases: _____

15IWCC0348

An *Application for Adjustment 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 **Woodstock,**, on **March 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 _____

15IWCC0348

FINDINGS

On the date of accident, **May 20, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$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 awards no benefits as Petitioner did not sustain an accident that arose out of and in the course of her employment. All other issues are therefore moot and no findings are made with regard thereto. Al benefits are denied based on this finding.

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

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

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

Signature of Arbitrator

March 20, 2014
Date

ICArbDec19(b)

APR 3 - 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

LaRone Crittenden, Petitioner v. Singer Mental Health Center, Department of Human Services, Respondent.	)	Case No. 11 WC 37121 15IWCC0348

Findings of Facts and Conclusions of Law

An Application for Adjustment of Claim was filed in this matter. The case was heard by the Honorable Robert Falcioni, Arbitrator of the Workers' Compensation Commission, in the city of Woodstock, on March 6, 2014. The Respondent was represented by the Illinois Attorney General's Office. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. FINDINGS OF FACT

Petitioner LaRone Crittenden was employed as a mental health tech II at Singer Mental Health on May 20, 2011. Petitioner worked for Singer for 16 years and worked for the State for 30 years. She has worked with developmentally disabled patients as well as those with mental illnesses. Petitioner counseled wards of the court and monitored medications and activities.

Prior to May 20, 2011, Petitioner had suffered multiple attacks by patients. She has been bitten, punched, scratched, kicked, and choked by patients. In 2010, she was attacked as well as choked by a patient; she suffered head, neck, and shoulder injury. (Rx E). She promptly reported the accident and injury, but did not suffer any mental injury. (Rx E). Petitioner was very aware of the injury and accident reporting process at Singer.

Petitioner testified that she did not have any health problems prior to May of 2011. Petitioner specifically testified that she did not have blood pressure problems except for when she was upset, specifically when she thought about the May 20, 2011. However, Petitioner's medical records indicate that she in fact has had high blood pressure prior to the May 20, 2011 incident. On April 30, 2010, her blood pressure was 144/92. On September 16, 2010, her blood pressure was 150/94. On October 5, 2010, her blood pressure was 156/92. On November 11, 2010, her blood pressure was 147/92. Furthermore, Dr. Darland noted on 10/30/09, Petitioner has hypertension. (Rx C). It is not clear from Dr. Darland's records whether Petitioner was on blood pressure medication prior to May 20, 2011.

Petitioner testified that on May 20, 2011, she returned from break to do rounds and discovered she was the only staff on unit. There was one other staff member there, but the staff was assigned to a one-on-one with a suicidal patient. Petitioner went to report the situation. Petitioner witnessed one patient, Jack, attacking another patient, Stewart. Petitioner attempted to intervene by yelling "No, Jack stop" and "Code Red", requesting additional help. Petitioner testified that Jack was a large ex-marine and at that moment it was like he was "in another world." Jack attacked Stewart with both his hands and his knee. Petitioner testified that there was blood everywhere. Male security guard staff ran in as Jack raised his fists to Petitioner; at that

moment a security guard grabbed Jack and put him in a restraining hold. Petitioner testified that she believed that Jack was going to attack her. The guard walked Jack to another unit and Petitioner helped perform medical care on Stewart. She claims this attempted attack was reported to her doctors, however this is not indicated by the medical records. Petitioner testified that staff wanted to take her blood pressure, but she refused. Petitioner escorted Stewart to Swedish American Hospital. She was informed that Stewart had broken bones in his face and suffered a retinal detachment. Petitioner returned to work, but her shift was over. She testified that she reported the work incident that day, but upon further questioning she admitted that all staff has to file incident reports whenever a patient is violent. Petitioner did not file her own notice of injury report or call Caresys until October 27, 2011. (Rx A).

The next day Petitioner returned to work and attended a Personal Support Program with social worker Cindy Riplenger through her union, AFSCME. (Rx C). Petitioner initially insisted that she never saw Cindy Riplinger after the May 20, 2011 incident and she only treated with Dr. Geiger. She also suggested that the dates listed on the treatment records could have been changed. (It is not clear if Petitioner did not recall the treatment or wished to deny when it occurred). The day after the incident, Petitioner discussed a conflict with a co-worker. She reported that she had been threatened and pushed by a co-worker (Sheila) in March. (Rx C). She reported receiving a variety of text messages and felt she was being harassed. (Rx C). In testimony, Petitioner testified that it was a patient sending her harassing text messages; she did not explain how a patient would have gained access to her personal cell phone number. She also reported that she felt unsupported by management and that her ward was always in chaos. (Rx C). She reported that a co-worker was assaulted the night before and that this increased her distress about work. (Rx C). Cindy Riplenger noted that Petitioner met the criteria for an

adjustment disorder. (Rx C). There is no mention of Petitioner witnessing a fight between patients or a patient attempting to attack her. (Rx C).

Petitioner worked on Saturday and Sunday. She discussed what happened with doctors on the unit. Stewart also returned to the facility on Sunday. Petitioner testified that she stayed at the nurses' station during her shift and that the other patients were talking about the fight. Petitioner was off of work on Tuesday (she did not address what happened on Monday). On May 26, 2011, first thing in the morning she went to Dr. Darland, her primary care physician. (Rx C). She testified that she had a breakdown and had been playing the events of the fight over in her head and that she could not cope. Dr. Darlan's records are difficult to read and portions are illegible. On May 26, 2011, it is noted that Petitioner's blood pressure was 212/110 and 205/105. Ambien is listed as current medication (November 4, 2010 record appears to list insomnia as a current psych issue). Petitioner's current complaints were depression and noted that her job is stressful and she gets attacked a lot. Petitioner reported that a co-worker was threatening suicide, and she then threatened Petitioner. (Petitioner testified that the individual that threatened her was not the same co-worker that was suicidal). There are also unclear and somewhat illegible notes referring to a law suit (which Petitioner denied in her testimony), and being bullied/harassed. She reported that an ex-marine beat up two people. Petitioner complained about having trouble sleeping. She also discussed that she was 27 years into the job (with a retirement rule of 85) and would be 60 in July of 2014. Petitioner was diagnosed with anxiety, insomnia and hypertension. She was put on a work medical leave for one month.

The Arbitrator notes that these records do not indicate that Petitioner witnessed a fight or that she was almost attacked. The reports to Dr. Darland appear to address general fears about

the safety at work from both co-workers and patients. Petitioner testified that Dr. Darland gave her Ambien and anti-depressants to help her relax. Petitioner testified that Dr. Darland provided Mary Seely in Human Resources a letter telling her what had happened. Dr. Darland provided a SRS (State Retirement Systems) occupational disability medical report dated June 2, 2011. Petitioner was diagnosed with anxiety and depression with an onset date of May 24, 2011 to July 6, 2011. Dr. Darland listed the accident date of March 13, 2011 (near the time of the reported conflict with Petitioner and co-worker Sheila).

On June 2, 2011, Petitioner returned to Cindy Riplenger at the personal support program. She reported that she was on medical leave as well as blood pressure medication, Pristique and Clonazepam. There, she reported that she continues to ruminate on nothing having been done about the threatening co-worker, but witnessing the beating of male co-worker the day before her first appointment has made it difficult to get past the incident that happened to her. Petitioner reported problems sleeping and decreased appetite. Cindy Riplenger's assessment was Adjustment Disorder for anxiety and depressed mood.

Petitioner returned to Dr. Darland on June 7, 2011 and reported feeling a little better. She was diagnosed with "PTSS" (this appears to refer to Post-Traumatic Stress Disorder, as there is no disorder referred to as PTSS). On June 9, 2011, Petitioner attended her last personal support program meeting with Cindy Riplenger. She reported that she keeps replaying 2 violent thoughts in her head (is it not clear which events Petitioner was referring to). She reports having nightmares of struggling with someone. She also reported not going to the library after seeing the co-workers [Sheila's] car there. Petitioner reports being hyper-vigilant at work since she was threatened and shoved by Sheila. She reports that she no longer finds her job rewarding and does

not think she can function on the unit anymore. Cindy Riplenger noted that Petitioner appeared to meet the criteria for PTSD and had OCD like traits, which have increased.

Petitioner was referred to the Psychiatric Clinic of Dr. Marianne Geiger. Petitioner testified that she once met Dr. Geiger, but she never treated with her. Petitioner exclusively treated with Bruce Pearson, a licensed clinical social worker and nurse Schullanberger. On July 8, 2011, Petitioner first met with Bruce Person and for the first time reported that witnessing a patient being attacked by another patient was what traumatized her. Prior to this visit, Petitioner reported various stressors, specifically her conflict with Sheila, chaos on her ward, and her co-worker being attacked. Petitioner reported that she attempted to stop the fight and accompanied the victim to the hospital. During this time, her co-worker was attacked as well. At no point did Petitioner report that Jack or a patient attempted to attack her. There is not much detail recorded about the attack in Mr. Person's notes.

Petitioner returned to the clinic on July 15, 2011 and reported that she is on medical occupational disability leave from work. She reported depression, anxiety, and sleep and appetite impairment. She reports that she would have to be hyper-vigilant at work and fears for her safety. She reported meeting with Mary Seely and completed paperwork for her retirement. Petitioner returned again on August 4, 2011 and again reported fearful about returning to work, fearing a similar trauma would happen again. Petitioner asked for a recommendation for an attorney and was referred to Jim Black's law office by the Psychiatric Clinic.

Petitioner continued to treat with Bruce Person and nurse Schullenger about once a month. On October 27, 2011, Petitioner finally called Caresys and filled out the First Notice of Injury Report. (Rx A). There she reported a mental injury from witnessing a fight between patients.

Petitioner noted that she had orally reported her injury to her supervisor, but the Supervisor's Report disputes any prior notice of injury.

On February 20 2012, Petitioner was sent to an Independent Medical Exam with Dr. David Hartman, a clinical and forensic neurophsychologist. (Rx B). Dr. Hartman discussed Petitioner medical and social history as well as the May 20, 2011 fight with Petitioner during his clinical interview. Dr. Hartman, unlike all of Petitioner's treaters, performed objective exams on Petitioner. Dr. Hartman uses objective tests because, as he testified, "just listening to the person talk to you about their problems is about the least accurate way to determining whether somebody is accurate describing those problems." Dr. Hartman testified that specifically symptom validity is a great concern because recent literature indicates 30% to 70% of individuals presenting with mental health related symptoms are performing in a highly exaggerated way and 30% to 40% of individuals perform with non-credible effort on tests. This is especially a problem with post-traumatic stress disorder, 40 to 50% of individuals report non-credible symptoms.

Dr. Hartman gave Petitioner several different objective tests: Shipley-2 Intelligence Test, Word Memory Test (WMT), Morel Emotional Numbing Test (MENT), Minnesota Multiphasic Personality Inventory- 2RF (MMPI-2RF), Structured Inventory of Malingering Symptomology (SIMS), Personality Assessment Inventory (PAI) as well as a Medical History Questionnaire. The MMPI-2RF test is a validity scale that is a gatekeeping scale for the rest of the tests. Petitioner produced an invalid profile with inconsistent admission of rare and unusual psychological and somatic symptoms suggestiveive of symptom magnification or other secondary gain. Dr. Hartman indicated that Petitioner's level of distortion rendered the test

invalid with respect to interpretation of psychological difficulties. Petitioner reported non-credible memory problems (but did not appear to have impairment during the Word Memory Test). Dr. Hartman testified that Petitioner's test results looked like Petitioner was claiming the most extreme responses she can. By contrast, individuals with PTSD tend to have elevated clinical scores, but much closer to normal than Petitioner's results.

Petitioner next took the MENT, which she was told that the test was sensitive to symptoms of PTSD; in fact, PTSD and other conditions do not greatly impact the results of the test. Dr. Hartman explained that individuals with PTSD get an average of 2 errors, schizophrenics or very elderly people get an average of five errors on the test. The cut off for malingering on the test is 7 errors. Petitioner's score was 14, double the cut off for malingering. Dr. Hartman's believed that this was another instance of Petitioner admitting to symptoms that she believed would enhance the possibility of being diagnosed with PTSD.

Petitioner next took the SIMS, a multi-axial self-administered measure designed to screen for feigned or exaggerated psychiatric disturbance and cognitive dysfunction. Petitioner also produced results above the cutoff for exaggerated and non-credible symptoms in 4 out of 5 sections of the SIMS, including neurological symptoms, depression/anxiety, psychotic symptoms and symptoms suggesting very low intelligence. The only symptoms she did not endorse in an elevated way were memory-related symptoms. Dr. Hartman opined that Petitioner's results again were highly atypical of credible patients and suggests high likelihood of feigned symptom admission.

Petitioner also produced a distortion on the validity scales of the PAI. Her results indicated minimization in some areas and exaggeration in others. Dr. Hartman's opinion was that

Petitioner was not revealing the full scope of what she experiences. Dr. Hartman testified that if she has actual problems, she does not want to talk about them, and other problems she is trying to make them twice as large as they actually are. Based on these tests, Dr. Hartman believes that they could not be interpreted to show actual patterns of psychological disability.

Dr. Harman also tested Petitioner's intelligence in the Shipley-2, which tests crystalized knowledge and fluid reasoning. It involves a vocabulary test involving picking the most similar word to the target provided word. In this area, Petitioner produced a low-average score. Petitioner's fluid reasoning was measured in a block pattern scale and abstraction scale. Her ability to manipulate block patterns and shapes is average. Her verbal reasoning was very poor, within the level that could be mildly impaired. Assuming Petitioner is exerting maximum effort, her IQ in her 20's would have been low-average to average. Dr. Hartman was unsure if Petitioner suffered from chronic hypertension and vascular dementia and if this was affecting her intelligence scores. He did not think her score results in the other tests might have been affected by possible extreme hypertension and loss of executive function. If that had been the case, her scores would have looked random, rather than extreme and non-credible.

Dr. Hartman testified that Post-Traumatic Stress Disorder is a severe anxiety disorder caused by extreme trauma. He described extreme trauma as threatened death, actual or threatened sexual or physical abuse. Other examples provided were prisoners of war, soldiers who have been shot or shot at, someone grievously injured or watching your own child die violently. Dr. Hartman testified that PTSD requires gatekeeping criteria, which has to be extremely severe, near or threatened death phenomenon and having shock and horror at the time of the incident. He noted that other symptoms include being numb to the world, withdrawing,

having dissociative episodes reliving the trauma, nightmares, irritability, personality changes, losing interest in activities. He specifically denied verbal threats or threatening body language causing PTSD, unless it was accompanied a knife or a gun.

Dr. Hartman extensively discussed with Petitioner the events of May 20, 2011, her symptoms and treatment. Petitioner reported to Dr. Hartman that while she was the only staff on unit, she witnessed Jack beat up another patient, Stuart. Petitioner yelled at Jack to intervene and "Code Red." She reported:

> That was something that I had never seen. If looks could kill. He looked at me, and I said 'Jack!', and he finally put his guard down and he went right past me and I got my patient that he was beating up.

Petitioner's description of the event did not include Jack raising his fist or attempting to attack her. Petitioner also reported that same night Jack attacked another nurse and broke bones in her face. Petitioner reported that after she found out she went home and cried and prayed because it could have been her. Petitioner reported than on the 26th (Tuesday, May 26, 2011) she walked to the hospital at Rockford Memorial Clinic to see her doctor. She reported that she was going to have a nervous breakdown. Petitioner also report very specifically that her vital signs were 259/179. She reports she was taken off work then.

Petitioner initially reported to Dr. Hartman that she had never been a witness or victim to a workplace assault, but later admitted that in 2010, she sustained a head injury, pinched nerve and dislocated disc from an attack by a patient. (Petitioner testified at trial that she has been attacked on several occasions and everyone she works with has also been attacked by patients.) Dr. Hartman asked the Petitioner why this particular incident was so upsetting when she was not

hurt. Petitioner replied, it was because the look in Jack's eyes said 'if I can kill you, I'll kill you.'

Petitioner reported to Dr. Hartman that her symptoms are nighttime anxiety, flashbacks, and trouble sleeping. She reported that she no longer watches "Criminal Minds" and no longer sees friends from work because it stresses her out. She reported that there are no circumstances that would allow her to resume work. She couldn't work a desk job because she would have to bring papers into the ward and could not tolerate any position where she would see psychiatric patients. Petitioner reported that she regularly sees her daughters, talks to her brother once a month. She walks every day, reads the newspaper and is trying to eat healthier.

Petitioner did not report autonomic arousal such as sweating, heart racing, which would normally be seen as reactive to a traumatic event. Dr. Hartman noted that Petitioner during the evaluation, Petitioner was cooperative and had a normal range of emotion; she did not have any sort of breakdown of emotional control. She described herself as getting stressed more easily, having sleep problems. Petitioner reported "flashbacks", but Dr. Hartman indicated it was more re-thinking the event, not the dissociative experiences of true PTSD flashbacks. Dr. Hartman testified that individuals with PTSD, when discussing the inciting events are "really a raw nerve" and they destabilize. They suffer from personality changes and their whole lives change. That is not the case with the Petitioner. Based on both the objective test results producing invalid results, the non-traumatic inciting event, and Petitioner's self-reported symptoms, Dr. Hartman did not believe she suffered from PSTSD. Instead he diagnosed her with malingering, hypertension with a rule out of vascular dementia. Dr. Hartman testified that individuals with PTSD could have

blood pressure spikes, accompanied by racing pulse under as stressful situation; PTSD would not cause chronic hypertension.

Dr. Hartman, upon learning of Petitioner's history of hypertension, he took her blood pressure with an electronic cuff. Her results were severely hypertensive at 214/128, while her pulse was 72. She did not have any observable emotional or sympathetic arousal. Dr. Hartman noted that she was calm and friendly throughout the evaluation. Dr. Hartman directed the Petitioner to call her doctor's office regarding the results and was directed to a nearby emergency room and her evaluation was terminated. Petitioner was taken to Rush Presbyterian St. Luke's hospital and was admitted for three days. (Px 3).

There, Petitioner reported a medical history of PTSD, hyperlipidemia, hypertension, and smoking. She reported left temple pain due to a head injury in 2010 at work, and since then has suffered from PTSD, headaches, blood pressure spikes with flashbacks. She also reported hyper-vigilance at work, but continued working until May 20, 2011 when she had a similar episode. She reported that she witnessed a coworker being attacked by a patient, resulting in multiple skull fractures. Petitioner reported trying to intervene but was paralyzed by fear and has been having nightmares and flashbacks ever since. She reported that she is fearful of going outside at night and in her flashbacks hears voices including her own. Petitioner's current symptoms were blurred vision, headache, and sweats. Petitioner reported that her hypertension coincides with her PTSD, but she also reported being on anti-hypertensives since 2009. The doctors noted that the hypertension could be due to pheochromocytoma or rental artery stenosis. A echocardiogram was suggestive of renal artery stenosis.

Petitioner continued treating with Bruce Person and nurse Schullenberger. She reported that she was in cardiac rehab and that on June 5, 2012 had a heart attack and emergency cardiac surgery. The medical records involving the heart attack and claimed diagnosis of stress contributing to a stroke were not submitted into evidence. There is also no medical opinion linking Petitioner's history of hypertension with her work incident.

II. CONCLUSIONS OF LAW

a. Did an accident occur that arose out of and in the course of Petitioner's employment with the Respondent-Employer?

The Arbitrator initially notes that 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, 509 N.E.2d 1330 (1987). Liability cannot rest upon imagination, speculation or conjecture. Psychological injuries are compensable when the injuries are related to or caused by physical trauma ("physical-mental") or when the injuries are caused by a sudden severe emotional shock traceable to a definite time and place and cause even though no physical trauma or injury was sustained ("mental-mental"). City of Springfield v. Industrial Comm'n., 291 Ill.App.3d 734, 738, 685 N.E.2d 12, 14 (4th Dist. 1997). Recovery for non-traumatically induced mental disease is limited to those employees who can establish that: (1) the mental disorder arose in a situation of a greater dimension than the day-today emotional strain and tensions which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the

major contributing cause of the mental disorder. Runion v. Industrial Comm'n,. 245 Ill.App.3d 470, 473, 615 N.E.2d 8, 10 (5th Dist. 1993).

In this matter, the records and the testimony consistently establish that Petitioner did witness a fight between patients. At trial, Petitioner points this as the traumatic event that prevents her from returning to work. However, Petitioner had no immediate reaction to viewing the fight. She testified that she continued at her job and escorted the injured patient to the hospital and worked for at least two more days. Additionally, Petitioner's medical records make clear that Petitioner's initial concerns were not the fight she witnessed. The next day, she reported extensive concerns and frustrations revolving around a conflict with a coworker. She discussed the chaos in the ward. She focused much of her distress on a a co-worker being assaulted (an incident she did not witness). There was no mention of the fight she witnessed. Her first visit with Dr. Darland, Petitioner again voiced concerns about her conflicts with co-workers as well as being frequently attacked at work.

It wasn't until July 8, 2011, about a month and half after witnessing the fight, that Petitioner began focusing on the fight as the inciting incident that caused her mental injury. Much of Petitioner's immediate concerns, recorded in her medical treatment records, revolve around co-worker conflicts.

The Arbitrator notes that the present case is similar to Malec v. W.R. Grace, 07 IL.W.C. 33638, 12 I.W.C.C. 0941, 2012 WL 5332397 (Ill.Indus.Com'n). There, a co-worker of the claimant suffered finger amputation. Claimant did not witness the accident, but volunteered to go to the hospital to see the injured co-worker. Claimant also received a glove with the severed fingers inside of it. Petitioner maintained possession of the glove for an extended period of time and took the glove to a hand specialist for reattachment. Claimant testified as a result of the

incident, he was nervous, had headaches, trouble sleeping, panic symptoms, hyper-vigilance, irritability, trouble concentrating, and nightmares about his family. Claimant reported distress that the injury could have been him. He also reported problems with his marriage, not receiving respect at work, concerns over work safety, and disputes with the employer over the union contract. Claimant was diagnosed by a psychologist with PTSD. Claimant also underwent a Section 12 exam, where numerous inconsistencies between the treating records and patient report was discovered. The IME doctor diagnosed anxiety disorder and felt it was not related to work. The Section 12 exam also noted that Claimant lacked many of the hallmark symptoms of PTSD. The Arbitrator found a compensable injury under the theory of mental-mental. However, the Commission found that the Claimant failed to meet his burden of proof under Pathfinder Company v. Industrial Commission, 62 Ill.2d 556 (1976) based on the Claimant's lack of credibility, the nature of the injury itself and the credible testimony of the Section 12 examining doctor. The Commission noted that in Pathfinder, the claimant had an immediate reaction of fainting when she pulled a co-worker's hand out of punch press and that evidence of such an immediate reaction was missing from the record.

In the instant case, the Arbitrator notes the Petitioner also has numerous inconsistencies in the record. Petitioner's story changed numerous times as it relates to the events of May 20, 2011, whether she witnessed the attack on her co-worker, her own medical history, the causes of her work stress, and whether she had any disputes with co-workers. In both Malec and the instant case, the record fails to establish an immediate reaction to the accident. Similar to the Malec case, here a Section 12 exam disputes a finding of PTSD. The instant case also includes objective testing of the Petitioner that clearly reveals symptoms exaggeration, and invalid test results with a finding of malingering. Petitioner, similar to the claimant in Malec, also seems to be focused

on the idea that a co-worker's serious injury (that both Petitioner and claimant did not witness) could happen to them. For these reasons, the Arbitrator finds that Petitioner has failed to meet her burden of proof that she sustained a compensable injury that arose in the course of her employment. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jackie L. Page,
Petitioner,

vs.

No. 13 WC 03582

Aramsco, Inc.,
Respondent.

15IWCC0349

DECISION AND OPINION ON REVIEW

A Petition for Review having been timely filed by Respondent and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and the nature and extent of the permanent disability and being advised of the facts and law, reverses the finding of Arbitrator Dollison that Petitioner proved his left hip/leg condition was causally related to his work accident on August 24, 2011 and vacates the Arbitrator's award of medical expenses, temporary total disability and permanent partial disability associated with Petitioner's left leg condition. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 50 year old truck driver, alleged that he suffered injuries to his lumbar spine and left hip when he slipped off the back of his truck on August 24, 2011. Petitioner timely reported his accident and continued working full duty until August 29, 2011, when he sought treatment at the company clinic at Sherman Health. He complained of low back pain radiating to his left groin and was diagnosed with a lumbosacral strain. He was prescribed Flexeril and Motrin for his complaints. The clinic restricted his lifting to ten pounds with limited bending, stooping, twisting, squatting, and kneeling.

Petitioner returned to Sherman Health on September 1, 2011. At that time, X-rays of his left hip revealed spurring and joint space narrowing, and the doctor prescribed physical therapy and continued work restrictions. On September 20, 2011, Petitioner returned, complaining of low back and hip pain and was diagnosed with a lumbosacral strain/sprain and left hip strain. Petitioner was referred to Dr. Berkson at Associates of Orthopedic Surgery for evaluation of his continuing left hip complaints.

On October 10, 2011, Dr. Berkson examined Petitioner and reviewed his left hip x-rays. Dr. Berkson diagnosed Petitioner with post-traumatic left hip pain and an exacerbation of left hip pain secondary to osteoarthritis, and recommended hip replacement surgery. Dr. Berkson opined that Petitioner's accident exacerbated his pre-existing arthritic condition and caused worsening symptoms. Petitioner returned to work at that time. On October 24, 2011, he reported to Dr. Berkson his left hip pain had improved to a level of 2/10, and declined the recommended hip replacement at that time.

Petitioner worked regular duty for Respondent through March 16, 2012, when he returned to Dr. Berkson complaining of worsening hip pain and limited range of motion. Dr. Berkson scheduled Petitioner for hip replacement surgery, which was performed on April 3, 2012. Petitioner completed 12 sessions of post-operative physical therapy and returned to work full duty on July 16, 2012. He last saw Dr. Berkson on August 23, 2012.

Dr. Kevin Walsh performed a Section 12 examination for Respondent on June 11, 2013. By way of deposition, Dr. Walsh testified that Petitioner's hip condition was unrelated to his work accident. This opinion was based on the mechanism of injury and on the absence of immediate hip complaints. Although the accident might have aggravated Petitioner's hip symptoms, Dr. Walsh opined that it did not affect the hip anatomically, because the initial pain would have been much higher than reported if there had been structural damage. Dr. Walsh concluded that Petitioner's surgery was necessitated by his pre-existing osteoarthritis, which was caused by non-traumatic aging and degenerative processes.

Arbitrator Dollison was not persuaded by Dr. Walsh's opinion, noting a lack of evidence of pre-accident left hip pain and noting complaints of hip pain on September 1, 2011, when hip x-rays were taken, and September 20, 2011, when Petitioner was diagnosed with left hip strain. The Arbitrator adopted Dr. Berkson's causation opinion, relating Petitioner's need for hip replacement surgery to his work accident and awarding medical, temporary total and permanent partial disability benefits related to Petitioner's hip condition.

The Commission weighs the evidence differently. The petitioner did not seek medical treatment for several days after his accident and at that time the complaints were lumbosacral in nature, at a pain level of 3 on a scale of 1 to 10. Dr. Walsh credibly noted that a permanent aggravation of pre-existing hip arthritis would have provoked immediate pain to a more significant extent. Dr. Walsh also questioned whether hip replacement surgery was necessary, given the following considerations: (1) Petitioner estimated that his pain level was at only 3 on a scale of 1 to 10 when he initially sought treatment and improved after physical therapy; (2) he was not provided with crutches; (3) he was not admitted to the hospital; (4) he did not receive a cortisone injection. One would have expected these steps to have been taken before a doctor would recommend surgery. Dr. Walsh concluded that Petitioner's surgery was aimed at treating and was necessitated by his osteoarthritis, a pre-existing degenerative condition that was not worsened or structurally altered by his accident. Dr. Walsh noted that Petitioner's arthritic symptoms might have been temporarily aggravated by the accident, but no permanent damage would have occurred given the mechanism of injury and absence of immediate severe hip pain. He opined Petitioner reached maximum medical improvement a few weeks after the accident.

15IWCC0349

In light of the above, the Commission finds Dr. Walsh's opinions more persuasive than those of Dr. Berkson, and accordingly finds Petitioner's hip condition to be unrelated to his work accident. The Commission therefore reverses the Arbitrator's finding that Petitioner's hip condition is causally related to his accident and also vacates the award of related medical expenses and 45% loss of use of the left leg as permanent partial disability for Petitioner's hip injury. The Arbitrator's award of medical benefits related to Petitioner's hip condition, the award for 21-6/7 weeks of temporary total disability, and the award of 45% loss of use of the left leg are vacated.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the February 5, 2014 Decision of the Arbitrator is modified as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the reasonable and necessary medical expenses related to his lower back strain, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $433.25/week for 15 weeks, because the injuries sustained caused a 3% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,600.00. 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 the Circuit Court.

DATED: MAY 19 2015

Joshua D. Luskin

o-03/17/15
jdl/dak
68

Ruth W. White

15IWCC0349

DISSENT

I must respectfully dissent from the majority's decision to reverse the Arbitrator's finding that the Petitioner's hip replacement was causally related to the accident on August 24, 2011.

The majority adopts the findings of Dr. Kevin Walsh who opined there was no causal connection between Petitioners left hip replacement and the accident. (Respondent Exhibit 1 Pg. 15) He based his testimony on Petitioner's failure to allege any hip pain at the time of the initial trauma. (Respondent Exhibit 1 Pg. 16)

However, Petitioner complained of left groin pain at the initial visit at Sherman Health. (Petitioner Exhibit 1) Petitioner had X-rays taken of his left hip on September 1, 2011. This was within a week of his accident.

Dr. Berkson also testified that he believed the injury sustained exacerbated the pre-existing condition the Petitioner had in his left hip and clearly caused a worsening of his symptoms. (Petitioner Exhibit 3)

Petitioner testified that he had no prior medical treatment to the left hip and was asymptomatic prior to August 24, 2011.

I find Dr. Berkson testimony to be much more credible than Dr. Walsh.

The Petitioner sustained an injury to his hip and lower back on August 24, 2011 and complained of pain radiating into the left groin at his initial visit and left hip pain one week later. Eventually he came under the care of Dr. Berkson on October 10, 2011 and gave a history of injuring his hip on August 24, 2011. The left groin pain and X-rays of the hip taken within a week of the accident verify that he was in fact having hip pain.

The Arbitrator therefore should be affirmed and adopted.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PAGE, JACKIE L
Employee/Petitioner

Case# **13WC003582**

ARAMSCO INC AND LIBERTY MUTUAL INSURANCE CO
Employer/Respondent

15IWCC0349

On 2/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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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

JACKIE L. PAGE
Employee/Petitioner

v.

ARAMSCO, INC., and LIBERTY MUTUAL INSURANCE CO.
Employer/Respondent

Case # **13** WC **003582**

Consolidated cases:

15IWCC0349

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

FINDINGS

On 8/24/11, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $37,548.68 the average weekly wage was $ 722.09.

On the date of accident, Petitioner was 50 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 $ 2,338.18 for TTD, $ -0- for TPD, $ -0- for maintenance, and $ -0- for other benefits, for a total credit of $ 2,338.18.

Respondent is entitled to a credit of $4,176.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $433.25/week for 111.75 weeks, because the injuries sustained caused a 45% loss of use of the left leg (96.75 weeks) and 3% loss of a person as a whole (15 weeks), as provided in Section 8(e) and (d)(2) of the Act.

Respondent shall pay Petitioner the reasonable and necessary medical services admitted into evidence, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $ 481.39/week, for 21-6/7 weeks for the periods September 6, 2011 through October 9, 2011 and March 19, 2012 through July 15, 2012.

Respondent shall pay Petitioner compensation that has accrued from August 24, 2011 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

2/4/14
Date

FEB 5 - 2014

Attachment to Arbitrator Decision
(13 WC 3582)

FINDINGS OF FACT:

Petitioner, a 50-year old truck driver was employed with Respondent, Aramsco, Inc. On August 24, 2011, Petitioner slipped off the back of his truck twisting his left leg. His left foot slipped off the platform on the back of the truck, and he twisted his back. Petitioner reported the accident and continued working until August 29, 2011 when he sought medical treatment from the company clinic at Sherman Health.

Petitioner initially complained of low back pain when he slipped stepping into the truck that radiates to left groin. Petitioner was diagnosed with lumbosacral strain, prescribed Flexeril and Motrin for pain and issued 10-pound lifting restrictions with limited bending, stooping, twisting, squatting/kneeling. (Px. 1)

Petitioner returned to Sherman Health on September 1, 2011 complaining of low back and left buttock pain. X-rays of the left hip revealed spurring and joint space narrowing. Petitioner was prescribed a course of physical therapy for his low back and left hip pain. (Px. 1 and 2) He remained restricted to a 10-pound lifting restriction with limited bending, stooping, twisting, squatting/kneeling. (Px. 1) He completed seven (7) physical therapy sessions between September 12, 2011 and September 27, 2011. (Px. 2)

Petitioner returned to Sherman Health on September 20, 2011 with low back and hip pain. The clinical impression was lumbosacral strain/sprain and left hip strain. He returned to Sherman Health on September 29, 2011 complaining of low back and left hip pain with only minimal improvement with physical therapy. Petitioner's clinical impression remained the same and his light duty work restrictions were continued. Petitioner was also referred to Associates in Orthopedic Surgery for further evaluation. (Px. 1)

On October 10, 2011, Dr. Berkson examined Petitioner who reported ongoing left hip pain. (Px. 3) X-rays of the left hip from Sherman Health were reviewed which revealed advanced arthritic changes. Dr. Berkson's diagnosis was left hip pain post-trauma and exacerbation of left hip pain secondary to osteoarthritis. Dr. Berkson stated felt the injury sustained exacerbated the pre-existing condition and caused worsening symptoms. Dr. Berkson recommended hip replacement at that time. (Px. 3)

Petitioner returned to work on October 10, 2011 and experienced difficulty walking, standing, moving and lifting freight at work. He followed up with Dr. Berkson on October 24, 2011 complaining of left hip pain. Petitioner reported that his left hip pain had decreased and it felt better. The pain level was a 2/10. Dr. Berkson noted that if Petitioner's symptoms worsen significantly, a hip replacement arthroplasty would be indicated. (Px. 3)

Petitioner testified that he decided to hold off on surgery. He continued working full-duty for Respondent until March 16, 2012. During that period he continued to experience difficulty walking, standing, moving and lifting at work. On March 16, 2012, Petitioner returned to Dr. Berkson complaining of progressively increasing left hip pain and discomfort. An examination revealed limited range of motion in the left hip. Dr. Berkson scheduled Petitioner for left hip replacement surgery. (Px. 3)

On April 3, 2012, Dr. Berkson performed a left total hip replacement arthroplasty. Osteotomy of the femoral neck was completed followed by removal of the femoral head. A Trilogy acetabular shell was fixed

into place with two (2) fixation screws. A polyethylene liner was then impacted into place. A Zimmer femoral stem prosthesis was then fitted into position. (Px. 6)

Petitioner followed up with Dr. Berkson post-operatively. Petitioner remained restricted from work activity and was prescribed a course of physical therapy. He completed 12 physical therapy sessions at 1st Choice Physical Therapy between May 5 and June 19, 2012. (Px. 5) Petitioner saw Dr. Berkson on May 25, 2012 and continued to be restricted from work activity. On June 28, 2012, Dr. Berkson noted Petitioner continues to walk with a Trendelenberg gait and recommended continued use of the cane. Dr. Berkson released Petitioner to return to full duty work on July 16, 2012. (Px. 3)

Petitioner testified that he returned to work for Respondent and resumed truck driving activities. Petitioner was last seen by Dr. Berkson on August 23, 2012. At that time Dr. Berkson noted minimal left hip pain and a satisfactory result post left hip replacement arthroplasty. Dr. Berkson recommended that Petitioner stay of ladders. (Px. 3)

Petitioner testified that he has difficulties around the house, including shoveling, cutting grass and anything with a lot of walking or pushing. The left hip replacement has limited his ability to do recreational activities like golf, bike riding and basketball. He continues to have pain. He testified that the more active he is, the more pain he has. Petitioner testified he had difficulty climbing in and out of his truck at work. When Petitioner is not driving a truck, he works in the warehouse where he has difficulty moving skids of freight and pulling orders. Petitioner is not able to put all of his weight on his left hip and experiences pain when lifting over 50 pounds. Petitioner takes Advil for the left hip pain and has not seen Dr. Berkson since August 2012. Petitioner testified that because his position was eliminated, he was terminated from work by Respondent in May, 2013. He is currently temporarily disabled from another unrelated job injury to his shoulder.

Lisa Siegmann, the Co-Director of Aramsco, Inc, testified on behalf of Respondent. Ms. Siegmann testified she is responsible for plant management at the Elgin Facility. She is knowledgeable about Petitioner's workers' compensation claim and had contact with him on a regular basis. She testified that Petitioner did not make any complaints or incident reports resulting from the alleged ongoing left hip difficulty after his return to full-duty work. She confirmed that there are no light-duty positions at Aramsco, Inc.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Kevin Walsh on June 11, 2013. The doctor testified via deposition on October 24, 2013. Dr. Walsh opined to a reasonable degree of medical certainty that Petitioner's left hip condition was not causally related to the work in jury on August 24, 2011. He felt that the work injury did not accelerate or exacerbate the left hip condition. The doctor based his opinion on the mechanism of Petitioner's injury, Petitioner's lack of left hip complaints immediately after the work injury, and subsequent x-rays. Dr. Walsh indicated that the mechanism of injury, getting into a truck, slipping, twisting the hip, does not cause an aggravation and acceleration of osteoarthritis. He acknowledged that pain may have resulted from the maneuver, but the osteoarthritis was not anatomically altered by the injury. Dr. Walsh also indicated that Petitioner did not complain of left hip pain until one week after the accident. Dr. Walsh opined that if the injury actually did cause a worsening of Petitioner's pre-existing osteoarthritis, his left hip pain level would have been much more significant than the reported 3 out of 10. Dr. Walsh found that Petitioner suffered from pre-existing osteoarthritis which was not caused by the work accident, and it was unlikely that it was accelerated or exacerbated by the injury described. He attributed the osteoarthritis to the degenerative process or aging, probably exacerbated by Petitioner's obesity. (Rx. 1)

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO ISSUE F - IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner injured his back and left hip at work on August 24, 2011 when he slipped off the back of his truck twisting his left leg. Petitioner initially complained of low back pain that "radiates to left groin." He received medical treatment at the company clinic (Sherman Health) for low back and left hip pain. X-rays of the left hip revealed advanced arthritic changes with loss of joint space, irregularity of the femoral head with large spur formation about the acetabulum and femoral neck. The company clinic referred Petitioner to Associates in Orthopedic Surgery for treatment of the left hip.

The history recorded by Dr. Berkson at Associates in Orthopedic Surgery states as follows, "he slipped while stepping up into the rear of a truck on a wet surface 6-7 weeks ago and injured his left hip" (Px. 3). Dr. Berkson diagnosed Petitioner with 1). left hip pain post trauma; and 2). exacerbation of left hip pain secondary to osteoarthritis, left hip. Dr. Berkson also stated, "I believe the only thing that will solve this patient's hip condition is hip replacement arthroplasty. I believe the injury sustained exacerbated the pre-existing condition, but clearly caused worsening symptoms."

Respondent retained Dr. Kevin Walsh to conduct a §12 examination of Petitioner. The doctor opined that the hip replacement surgery was not caused or necessitated by the August 24, 2011 injury at work. A major component of his opinion is based on his belief that Petitioner did not have pain in his hip at the time of the initial trauma. The Arbitrator notes, however, that Petitioner complained of "radiating left groin pain" at the initial visit at Sherman Health. Petitioner complained of "left hip pain" three (3) days later on September 1, 2011, whereupon x-rays of the left hip were taken. On September 20, 2011, the clinical impression was lumbosacral strain/sprain and left hip strain. Furthermore, the Arbitrator notes that Petitioner had no prior medical treatment to the left hip and was asymptomatic prior to the August 24, 2011 injury at work.

Dr. Walsh testified that Petitioner's pre-existing left hip condition was not aggravated or accelerated by the work accident because, "Dr. Berkson didn't insist the patient have a hip replacement when he initially saw him." However, at the initial examination of Petitioner on October 10, 2011, Dr. Berkson clearly stated, "I believe the only thing that will solve this patient's hip condition is hip replacement arthroplasty. … I don't see any way to get this patient better short of hip replacement." The Arbitrator is not persuaded by the opinions of Dr. Walsh.

Based on the foregoing, the Arbitrator finds a causal relationship exists between Petitioner's accident of August 24, 2011 and his left hip injury.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO ISSUE J - WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings of causal connection between the August 24, 2011 injury at work and Petitioner's left hip injury, the Arbitrator awards the medical expenses admitted into evidence (Px. 7 – Px. 12) payable pursuant to Section 8.2 of the Act. With respect to the charges of Dr. Joshi in Petitioner's Exhibit #9, Respondent is only liable for the charges related to Petitioner's pre-op visit with the doctor. Also, Respondent is entitled to a credit for all medical expenses previously paid.

IN SUPPORT OF THE ARBITRATORS DECISION RELATING TO ISSUE K - WHAT TEMPORARY BENEFITS (TTD) ARE IN DISPUTE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was initially restricted to light duty work by the company clinic and did not work during the period September 6, 2011 through October 9, 2011. Petitioner returned to work with Respondent on October 10, 2011 and continued working through March, 2012 when he returned to Dr. Berkson for additional medical treatment. Thereafter, Dr. Berkson restricted Petitioner from all work activity from March 19, 2012 through July 15, 2012.

Therefore, the Arbitrator finds that Petitioner is entitled to receive temporary total disability benefits for the periods September 6, 2011 through October 9, 2011 and March 19, 2012 through July 15, 2012.

IN SUPPORT OF THE ARBITRATORS DECISION RELATING TO ISSUE L - WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner, a 50-year old truck driver injured his back and left hip at work on August 24, 2011. Petitioner underwent left total hip replacement arthroplasty on April 3, 2012. Thereafter, Petitioner completed a course of physical therapy and was released to return to full work duties on July 16, 2012 with Dr. Berkson recommendation that Petitioner stay off ladders.

Petitioner returned to work with Respondent but experienced pain in the left hip, a loss of strength and restricted movement. Petitioner testified he had difficulty climbing in and out of his truck at work and walking more than a half mile. When Petitioner is not driving a truck, he works in the warehouse where he has difficulty moving skids of freight and pulling orders. Petitioner is not able to put all of his weight on his left hip and experiences pain when lifting over 50 pounds.

Petitioner testified he has difficulty cutting the grass, shoveling snow, moving furniture and is unable to run or jog. Petitioner takes Advil for the left hip pain and has not seen Dr. Berkson since August 2012.

With respect to his low back condition of ill-being, the Arbitrator finds that he suffered a low back strain. Upon completing physical therapy, his condition resolved completely and did not require treatment after September 27, 2011

Based on the evidence presented at trial, the Arbitrator finds that Petitioner sustained a 45% loss of use of the left leg pursuant to Section 8(e) of the Act along with a 3% loss of use of a 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

David Reim,

Petitioner,

vs.

NO. 08WC 16350

Cunningham Lindsey,

15IWCC0350

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, benefit rates, medical expenses, evidentiary and procedural issues, penalties, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 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. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 19 2015
SJM/sj
o-5/7/2015
44

Stephen J. Mathis

Maria Basurto

David L. Gore

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

REIM, DAVID E
Employee/Petitioner

Case# **08WC016350**

CUNNINGHAM LINDSEY
Employer/Respondent

15IWCC0350

On 10/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1454 THOMAS & ASSOCIATES
MICHAEL C PILLER
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

15IWCC0350

DAVID REIM
Employee/Petitioner

Case #08 WC 16350

v.

CUNNIIGHAM LINDSEY
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 September 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. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☐ Prospective medical care?

FINDINGS

- On March 28, 2008, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- At the time of injury, the petitioner was 40 years of age, single with no children under 18.
- The petitioner agreed to waive an award for paid medical bills.
- The parties agreed that the respondent paid $210,622.62 in benefits to the petitioner.

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

October 17, 2014

Date

OCT 17 2014

FINDINGS OF FACTS:

The petitioner sought medical care for neck and lower back pain on March 30, 2008, at Elmhurst Memorial Lombard Health Center and reported being rear-ended by a car. Cervical x-rays revealed no acute fractures, slight reversal of the normal cervical lordosis and mild-to-moderate degenerative cervical spondylosis. A CT of his brain and head on April 1st was normal. Dr. Jay Mohindra saw the petitioner on April 3rd and followed up with him through the 17th. His treatment records are handwritten and are subject to misinterpretation. An MRI of his brain on April 8th was normal. The petitioner reported persistent daily pounding headaches – occipital, bifrontal and occasionally on the top of his head – associated with nausea and more noticeable in the afternoon, evenings and at night.

Dr. Esther Young performed a neurologic reevaluation of the petitioner on April 29, 2008, and noted evidence of left occipital nerve irritation and gave him a left occipital nerve block. On May 28, 2008, Dr. Young noted the petitioner had decreased pressure in his head, opined that his condition was due to occipital neuritis and muscle tension and repeated the occipital nerve blocks. Dr. Young administered bilateral occipital nerve blocks again on July 1, 2008, and noted that occipital nerve blocks provided good improvement and provided the petitioner a significant decrease in head pressure and pain and a decrease in the spasms above his eyes and the pulsation in his head. Dr. Esther Young opined that the petitioner's symptoms were slowly improving, his head pressure was significant and his condition was due to occipital neuritis and muscle tension headaches.

Psychologist Jackson Turner performed seven neuropsychological examinations of the petitioner from May 21 through June 30, 2008, and noted difficulty with determining the precise proportion of neurological versus psychological etiology. The petitioner started care with Dr. Parag Patel at Spine Pain Family Physicians on June 5, 2008, for pain in both shoulders and difficulty lifting his hands over his head. His examination revealed no pain and a full range of motion. On June 18, 2008, the petitioner reported jaw pain since the accident to Dr. Patel. He saw Dr. Gbabi Kaspo at Michigan Clinic for Facial Pain for jaw pain on June 25, 2008. Dr. Kaspo's primary diagnosis was temporomandibular joint disorder and bilateral capsulitis/synovitis of the temporomandibular joint. The petitioner complained to Dr. Anil Gulati on August 16, 2008, of feeling unsteady on his feet, difficulty walking and concentrating, a sense of dizziness or fullness in his head, forgetfulness and excessive fatigue. Dr. Gulati noted after a spinal tap that the petitioner reported that his head felt better. The doctor's diagnosis was cerebral concussion. The petitioner reported breathing difficulties, ear pain and runny nose for eight months to Dr. Patel on October 9, 2008. The petitioner started care with Dr. DiStefano for jaw and ear pain, dizziness, headaches, neck pain and loss of balance on November 24, 2008. An MRI of his temporomandibular joints on November 26, 2008, was unremarkable.

The petitioner started care with Dr. Young of Rehab Associates of Chicago on October 31, 2008. Dr. Young noted cognitive and personality changes including short-term memory and concentration, dizziness and balance disorder, temporomandibular joint dysfunction, myofascial pain and closed cranial trauma. Dr. Young recommended a temporomandibular joint specialist and prescribed medicine and activity restrictions. He

treated with Dr. Barbara Briner from November 24, 2008, through May 19, 2009. Dr. Debby Feinberg evaluated the petitioner on December 19, 2008, and opined that there was an ocular cause for the petitioner's symptoms. Dr. Feinberg performed an annual neurovisual evaluation on September 13, 2013, and opined that there was an ocular cause for the petitioner's symptoms.

FINDING REGARDING THE AMOUNT OF WAGES:

The petitioner started a different type of an employment relationship with the respondent on January 8, 2008. Therefore, as the petitioner argues, his average weekly wage should be based on the earnings pursuant to the contractual agreement. (The acceptance date on the agreement by the HR director of January 8, 2007, is believed to be a typo, since it was signed by the petitioner on December 30, 2007.)

The petitioner failed to prove wages greater than $48,000.00 per year. The petitioner's reliance on two different 2008 W2s from the respondent to establish his wages is not sufficient without a reasonable explanation as to the accounting utilized for the $11,063.51 indicated for Utah and the smaller amount, $7,538.26, indicated for Illinois. There was no evidence or accounting to explain the two W2s. Even assuming that the two W2s were intended to indicate the petitioner's 2008 income separately as a Utah resident/employee and as an Illinois resident/employee, the uncertainty and puzzlement is increased since he worked pursuant to the contractual agreement in the State of Illinois for 11-4/7 weeks, leaving only an eight-day period for Utah. Also, there is no evidence regarding the wage period for Utah or whether the amounts are separate income or overlapping income. The $1,400.00 the petitioner received from the respondent is not sufficient since the $750 claimed for wages was after the full pay period

on March 14, 2008, and there was no evidence to establish that it was earned by the petitioner and was not a compromised settlement by the respondent.

More importantly, there is no actual evidence of the petitioner's paychecks, bank deposits from the respondent or total billings from January 8, 2008, through March 14, 2008, which would readily reveal his compensation. Total billing by the petitioner over $155,000.00 would exceed $48,000.00 in compensation for him. However, there is no tangible evidence of the number of billings performed or even the nominal or average billing per inspection. The petitioner failed to prove that his production share of his total billing through March 14, 2008, exceeded his base salary of $48,000.00. The petitioner's average weekly wage was $923.08.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on March 28, 2008, arising out of and in the course of his employment with the respondent. The petitioner was a traveling employee and would be in the course of employment while traveling from and to his abode to perform the duties of inspecting the property damage at claim sites. The medical histories by the petitioner to Elmhurst Memorial Lombard Health Center and the other medical providers are the only support for his claim that his vehicle was rear-ended while stopped at an intersection on March 28, 2008. However, there is no actual evidence of a rear-end collision or of any type of vehicle collision on March 28, 2008. There is no documentary evidence of a vehicle accident, its location, time and place, the types of vehicles involved, the identity of the other party or the extent and location of the damage to the vehicles to support the petitioner's testimony. The lack of concrete evidence is especially puzzling

since the petitioner testified that there were police at the scene and it is expected that his inclination as a property damage adjustor would be to document the collision scene and the damaged vehicles with the photo equipment he allegedly used earlier. An additional concern is the absence of any evidence to support the petitioner's testimony that he regularly worked after business hours after or even prior to January 8, 2008.

More importantly, there is no evidence supporting a property damage inspection of the Glendale Heights property at any time on March 28, 2008, even though he stated he had taken time-and-date-stamped photos of the Glendale Heights site during his inspection and had data, notes and information used to complete and input the electronic claims process. Also baffling is how the petitioner could adequately inspect a damage claim at night with only a flashlight. The petitioner's uncorroborated and questionable testimony is not sufficient to establish by a preponderance of evidence that he sustained an accident arising out of and in the course of his employment. The petitioner's request for benefits is denied and the claim is dismissed. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Reim,

Petitioner,

vs.

NO. 08WC 16350

Cunningham Lindsey,

Respondent.

15IWCC0351

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 the Order Suspending Benefits and all other issues pertaining thereto, including all hearing and evidentiary issues and being advised of the facts and law, affirms and adopts the Order of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator filed April 17, 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.

15IWCC0351

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

DATED: MAY 19 2015
SJM/sj
o-5/7/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

STATE OF ILLINOIS)
)
COUNTY OF COOK)

15IWCC0351

ILLINOIS WORKERS' COMPENSATION COMMISSION
ORDER

DAVID REIM
Employee/Petitioner

v.

CUNNINGHAM LINDSEY
Employer/Respondent

Case #08 WC 16350

This matter was set for hearing in the city of Chicago on April 15, 2014, on the respondent's petition to suspend benefits. A record of the parties' arguments was made and the evidence was considered.

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

It is hereby ordered that the petition to suspend benefits is granted for temporary total disability benefits only, effective March 18, 2014, until the petitioner complies with the respondent's request for a Section 12 evaluation in the State of Illinois.

Robert Williams

April 15, 2014
Date

APR 17 2014

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

Kathleen Limbach,

Petitioner,

15IWCC0352

vs.

NO: 10 WC 21210

Our Lady of Angels Retirement Home,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, 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 February 24, 2014 is hereby affirmed and adopted.

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

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

15IWCC0352

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,200.00. 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: MAY 19 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/7/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0352

LIMBACH, KATHLEEN
Employee/Petitioner

Case# 10WC021210

OUR LADY OF ANGELS RETIREMENT HOME
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:

2121 McNAMARA PHELAN McSTEEN LLC
BRIAN C CICHON
3601 McDONOUGH ST
JOLIET, IL 60431

1295 SMITH AMUNDSEN LLC
GAIL A GALANTE
3815 E MAIN ST SUITE A-1
ST CHARLES, IL 60174

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

15IWCC0352

Kathleen Limbach
Employee/Petitioner

v.

Our Lady of Angels Retirement Home
Employer/Respondent

Case # 10 WC 21210

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 village of **New Lenox, Illinois**, on **December 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/20/2010**, 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 **$11,097.26**; the average weekly wage was **$241.25**.

On the date of accident, Petitioner was **18** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of 213.33/week for 53.75 weeks because the injuries sustained caused 25 loss of the left leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $213.33/week for 22-2/7 weeks, commencing 6/1/2010 through 11/3/2010, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services as ordered hereafter as enumerated in Petitioner's Exhibits 6 through 12, pursuant to the medical fee schedule.

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

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

Signature of Arbitrator

2/21/14
Date

ICArbDec p. 2

FEB 24 2014

Findings of Fact:

Petitioner testified that she is 22 years old, resides in Joliet and is currently a student at St. Francis University studying nursing. On her alleged accident date of April 20, 2010, she was 18 years old and employed at Our Lady of Angels Retirement Home. At that time, she was working about 20 hours per week performing CNA duties for Respondent and was also attending nursing school.

Petitioner testified that on April 20, 2010, while performing these duties, she was responsible for helping an elderly patient bathe. In order to do this she had to push the patient in her wheelchair to the shower room. While performing this task there were no other persons present. Once the patient was transported to the shower room Petitioner had to assist her from her wheelchair to the shower chair in the shower stall. Petitioner provided that after the shower she was helping the patient dry off and went to reach for a towel. When she reached for a towel, her left leg slipped on some water that had collected on the tiled floor. She caught herself by placing her left leg back down. Petitioner testified that she twisted her knee and felt a sharp, stabbing pain in her left knee.

Petitioner testified that she had previous left knee problems. Records submitted show that on September 27, 2006, she was treated by her primary care physician, Dr. Bierma, for a left knee injury that occurred on September 16, 2006, at a parade; she was referred to an orthopedist. Dr. Bierma's record states that she saw Dr. Komanduri. (RX 3) Petitioner also sustained a previous injury on January 20, 2010 where she had struck and twisted her left knee. She ultimately treated with Dr. Dworsky at Hinsdale Orthopedics for this injury, having first seen him on January 27, 2010. She had been diagnosed with patellar instability of her left knee and described her pain from this injury as being a dull ache. She remained off work from this injury from January 22, 2010 to March 22, 2010. While off work, Petitioner remained in school and was able to attend all of her classes. Her treatment for this injury consisted of conservative modalities including immobilization and physical therapy. The last visit that she had with Dr. Dworsky prior to the work injury was on March 17, 2010. The records from that visit indicate that she had excellent improvement and minimal discomfort. In his note from that date, Dr. Dworsky indicated Petitioner was performing full activities. She was told to finish her physical therapy and was given permission to return to work the next week with restrictions of no squatting, crawling or climbing. (PX 2)

Petitioner testified that she followed these treatment recommendations, finished her physical therapy and returned to work under the restrictions given to her by Dr. Dworsky. Petitioner provided that upon her return to work, she was no longer in any type of formal physical therapy. Petitioner testified that she felt good at the time of this release and was able to perform all of her job duties without pain or difficulty. Petitioner provided that although she had been given restrictions by Dr. Dworsky, she felt that she was working without restriction and had been able to perform her job tasks for almost one month without incident before her work injury. While working during this time she did not complain of pain or weakness and was able to perform her job functions without the need of any sort of brace or pain medication.

Petitioner testified that her work injury consisted of a slip and not that her knee gave out. She did not fall but after her slip caught herself by bracing with her left leg which caused the twisting of her left knee and subsequent feeling of giving out. She described the pain from her work injury as being different from her previous pain in that this pain was a sharp, stabbing pain and her previous pain was a dull, aching pain. She

reported this injury to the nurse on duty, completed an incident report and did not work the rest of her shift. She was seen at the emergency room at St. Joseph's Hospital that day.

Records from St. Joe's indicate that Petitioner complained of a twisting injury occurring as a result of a slip and fall (Petitioner testified that there was no fall). X-rays taken of the left knee were negative. She was diagnosed with knee pain. She was given a knee immobilizer, crutches, taken off work and told to follow up with Dr. Dworsky. (PX 1)

On April 21, 2010, Petitioner was seen by Dr. Metrou at Physicians Immediate Care. Petitioner provided history that on April 20, 2010, she was grabbing a towel, her right foot slipped on the wet floor; she caught herself with her left leg and felt like something shifted. She complained of left knee pain. She said she was under Dr. Dworsky's care and work restrictions for a non-work related left knee injury of January 2010; Dr. Dworsky was about to discharge her and she had an appointment on April 26, 2010. Petitioner was diagnosed with left knee sprain/strain. She was released to primarily sit down work and advised to continue the use the crutches and stabilization brace she had at home. (RX 10))

Petitioner returned to work for Respondent in a stationary position shredding papers. She continued to work through May 31, 2010 and continued to attend nursing school.

Petitioner next saw Dr. Dworsky on April 26, 2010. This appointment had already been scheduled on her previous March 17, 2010 visit. (PX 2) Petitioner provided that because her work injury occurred just before her regularly scheduled appointment, she called ahead to Dr. Dworsky's office to let them know of the new injury. Petitioner informed Dr. Dworsky that while bathing a patient she slipped, twisted and felt like her knee gave out again. She denied any specific impact or blow to the knee but rather just a slip and twist. Petitioner indicated that the knee felt painful to the point she could not ambulate. (PX 2) At hearing, Petitioner was asked about this record and she stated that she did feel her knee giving out but that this happened only after she slipped and caught herself with her left leg. Her knee was not giving out and felt strong prior to this slip. Her slip was not because her knee gave out but resulted from slipping on water on a tiled floor. After examination, Dr. Dworsky diagnosed patella dislocation, left knee, and recommended surgery. Dr. Dworsky stated that "[g]iven her recurrent discomfort, the patient's gross sense of instability despite a long period of physical therapy and apparent success with this, I do feel her patella is demonstrating that it is very unstable and will continue to cause instability with further conservative management..." Petitioner was released to modified duty and scheduled for surgery on her left knee. (PX 2)

On April 27, 2010 and May 17, 2010, Petitioner saw Dr. Metrou under a diagnosis of unchanged left knee sprain/strain. She denied any incidents of left knee locking or giving out. She complained of left knee tenderness if she was not wearing the brace to walk. She complained of pain at 3/10. Petitioner also provided that the April 20, 2010 exacerbated the previous injury to the knee. Petitioner was released to sit down work. Dr. Metrou also noted she would have surgery in June. (RX 10)

Petitioner underwent surgery with Dr. Dworsky on June 1, 2010. She underwent an open reconstruction of the medial patellofemoral ligament of the left knee with allograft, arthroscopic lateral release left knee and chondroplasty of the medial patellar facet, left knee. Her preoperative and postoperative diagnosis was dislocation and subluxation of the left knee. After surgery she was provided with a home exercise program and kept off work. (PX 2)

Post surgery, Petitioner eventually progressed to weight-bearing and a therapy program. Early on in her therapy program, Petitioner complained of feeling heat on her incision and shortly thereafter complained of left

lower extremity swelling. There was some thought of a possible infection and Petitioner underwent some modalities to reduce the swelling and it eventually subsided. Ultimately the swelling in Petitioner's left leg went away and she was able to increase her activity level. (PX 2)

On July 15, 2010, Dr. Dworsky noted Petitioner was doing well. The doctor recommended Petitioner switch to a range of motion brace and continued with physical therapy. On August 12, 2010, she was fully ambulatory and was allowed to return to work in a light duty capacity of no pushing, lifting or pulling of patients. (PX 2) Petitioner stated that Respondent could not accommodate these restrictions and she remained off work.

On September 10, 2010, Petitioner finished her physical therapy program consisting of 36 sessions. On September 13, 2010 Petitioner began a work hardening program. She continued with work hardening and follow ups with Dr. Dworsky making progress with strength and range of motion.

On October 29, 2010 Petitioner completed her work hardening program consisting of 35 sessions. Having completed work hardening Petitioner was progressed to a home exercise program and was given a release to full duty on November 4, 2010. (PX 2)

Petitioner testified that returned to work on November 6, 2010 and was able to perform all of her job functions without complaint. Her last visit with Dr. Dworsky occurred on January 10, 2011. At that time she advised Dr. Dworsky that she had returned to work and was having no difficulties performing her job duties. She was released from Dr. Dworsky's care at that appointment. (PX 2)

At the hearing, Petitioner testified that she notices that she has difficulty going up and down stairs and notices creaks and cracks when she goes up and down. She also notices that she feels an aching in her knee during cold weather. When she has this type of pain she takes an over the counter Tylenol. Petitioner testified that there were a number of medical bills that remain outstanding as a result of her injury and submitted these bills as part of her exhibits. Petitioner also provided that she did not receive any temporary total disability compensation for the time that she remained off work.

Petitioner also presented the testimony of her treating physician, Dr. Dworsky. The doctor testified that he initially treated Petitioner for a patellar subluxation resulting from an injury in January of 2010. (PX 5 at 6) After examination and an MRI, Dr. Dworsky determined that Petitioner could be treated conservatively with bracing and physical therapy. (PX 5 at 7) Petitioner underwent this treatment and Dr. Dworsky felt that she was making excellent progress and was benefitting greatly from this treatment. (PX 5 at 8-9) Dr. Dworsky provided that as of February 24, 2010, Petitioner had made excellent progress in a short period of time. He thought she would be able to return to work after two more weeks of therapy. (PX 5 at 8)

Dr. Dworsky testified that when Petitioner returned on March 17, 2010, he again thought she was making excellent progress and that she should be able to return to work with some restriction. (PX 5 at 8-9) He indicated the reason for the restriction was to ease her back into the workplace in a protective measure (PX 5 at 9) and that many of the restrictions given were merely precautionary. He also provided that it was possible that Petitioner could have done more activity without pain complaints. (PX 5 at 43) Dr. Dworsky clarified that the restriction on bending referred to no bending of the left knee or leg. (PX 5 at 34-35) Dr. Dworsky testified that he believed Petitioner had progressed so well that on the next examination date she would be discharged to full duty and would need no further medical care. (PX 5 at 10) Dr. Dworsky testified that as of March 17, 2010 Petitioner had recovered from her subluxation where it was safe for her to return to work and had no expectation for any further medical or surgical intervention. (PX 5 at 15)

Dr. Dworsky testified that when he saw Petitioner on April 26, 2010, he had learned that she had been seen in the emergency room after slipping and twisting her knee. (PX 5 at 10) Up to this point, he believed that Petitioner had progressed well but this second episode created a situation requiring surgical intervention. (PX 5 at 11-12) The doctor provided that this recommendation was different than the treatment regimen he had recommended for Petitioner on March 17, 2010. (PX 5 at 12) Dr. Dworsky testified that after being provided with Petitioner's history, his clinical assessment and the need for emergency medical care, he concluded that Petitioner's April 20, 2010 accident caused a second subluxation of her patella. (PX 5 at 16) He further opined that the treatment rendered to Petitioner after her April 20, 2010 incident was due to the April incident resulting from her slip at work. (PX 5 at 16) He based this conclusion on the fact that Petitioner had a successful recovery from her previous treatment demonstrating good control of her knee and not having any episodes until she slipped and twisted her knee. (PX 5 at 16-17) He added that any chondromalacia present in Petitioner's knee was present prior to the injury and a traumatic event could cause that chondromalacia to become symptomatic. (PX 5 at 40) Dr. Dworsky believed that this is what occurred in this case. (PX 5 at 40-41) The doctor also provided that Petitioner's medical treatment was reasonable and necessary. (PX 5 at 17)

Respondent presented the testimony of Dr. Mercier who saw Petitioner on October 28, 2010 for Independent Medical Examination. (RX 1 at 6) After examination and having reviewed her medical records, Dr. Mercier diagnosed her with patellofemoral degenerative arthritis with lateral patellar instability on the left knee, post-surgery, not work related. (RX 1 at 9) Dr. Mercier provided Petitioner had this left knee condition since September 2006, when she saw Dr. Bierma for the left knee injury at the parade, and in January 2010, when she saw Dr. Bierma for the left knee injury when she fell and jammed her knee into her car fender. (RX 1 at 10-12) Dr. Mercier testified that as of March 17, 2010, Petitioner was doing well, had minimal discomfort and that with appropriate therapy she was getting better. (RX 1 at 18) He also noted that on March 17, 2010, her diagnosis was left knee patellar instability; she would continue to have this condition unless she had surgery; she was still under Dr. Dworsky's care; she had significant work restrictions that would not be a release to work as a Certified Nurse Assistant; she had left knee pain; she was using a stabilization brace; she was scheduled to return to Dr. Dworsky in 3 weeks or April 26, 2010. (RX 1 at 19-20)

Dr. Mercier testified that Petitioner was still under Dr. Dworsky's care and had work restrictions on April 20, 2010. The doctor stated that her treatment by Dr. Dworsky since April 26, 2010, was due to her pre-existing left knee condition; the treatment was unrelated to the work incident; the April 26, 2010, office visit was set up prior to the April 20, 2010, incident. (RX 1 at 14, 19-22, 24) Dr. Mercier testified that on April 20, 2010, Petitioner twisted her left knee at work and had increased pain but conservative care could have returned her to her pre-injury status. (RX 1 at 29) He stated Petitioner twisted her knee and may have caused some irritation of the patellofemoral joint. He provided that there was no evidence of patellar subluxation. The doctor stated there was no new structural injury to the left knee. (RX 1 at 30-31)

As noted above, Dr. Mercier testified that the June 1, 2010, left knee surgery was not related to the April 20, 2010, work incident. He indicated the surgery was performed to treat her pre-existing patellar instability and arthritis. There was no change in her pre-existing left knee patellar instability as a result of the April 2010, work incident. He felt
Petitioner's left knee condition was such that any normal walking or moving could have caused her knee to subluxate indicating, "She was an accident waiting to happen." (RX 1 at 25-28, 46-50) The doctor acknowledged that Petitioner's condition had improved from January 2010 to March 2010and that April 20, 2010, her condition worsened. (RX 1 at 45-46)

Respondent called Martha Klima to testify. She is the Human Resources Director at Our Lady of Angels and was working in that capacity on Petitioner's accident date. In her position she is responsible for reviewing work status to determine if light duty can be accommodated. When given a light duty release she meets with the Director of Nursing and the Scheduler to determine if light duty can be accommodated. At hearing, she was shown Dr. Dworsky's office note from March 17, 2010 indicating Petitioner should not bend. Ms. Klima testified that had this restriction been given to her that it could not have been accommodated. She testified that Petitioner was able and did return to work in March of 2010 under the off work slip that was actually given to her. Ms. Klima further testified that she never heard that Petitioner was not able to perform the work under the restrictions given to her. She also testified that Petitioner told her that she slipped in the shower room and caught herself on her left leg.

In support of the Arbitrator's decision relating to disputed issue (C) accident and (F) causal connection, the Arbitrator makes the following conclusions of law:

After having considered the testimony at hearing, the medical depositions presented by the parties and the exhibits, the Arbitrator finds that Petitioner sustained a work injury that arose out of and in the course of her employment with Respondent. The Arbitrator further finds that Petitioner'left knee condition of ill-being is causally related to the accident.

The issue to be resolved focuses on whether Petitioner sustained a new injury in April of 2010 or whether her treatment was a simply a continuation of her prior injury from January of 2010. The Arbitrator concludes that the April 20, 2010 incident was a separate, different injury from her prior injury.

In coming to this conclusion it is important to first look at Petitioner's initial January 20, 2010 injury. At that time, Petitioner was diagnosed with a patellar subluxation of her left knee and was taken off work for this injury. Dr. Dworsky testified and the medical records support the fact that Petitioner was successful with conservative treatment and was on the road to a full recovery. Respondent's IME phycian, Dr. Mercier, agrees with these facts. The evidence shows that Petitioner was returned to work on March 17, 2010 and that on her next appointment on April 26, 2010, it was anticipated that she would be released from doctor's care. The evidence also shows that she was no longer in any type of formal physical therapy after March 18, 2010.

Petitioner testified that when she returned to work in March of 2010 she was able to work without limitation. Petitioner was returned back to work with some restrictions that were accommodated by Respondent. However, there is nothing in the evidence presented that shows Petitioner was hindered in her job activities or that she was having any type of problems performing her work. Petitioner unrebutted testimony show she did not feel any type of pain, was not bracing or taping her knee, and was able to perform all the job tasks that were asked of her.

Respondent presented evidence that Dr. Dworsky intended to give Petitioner a limitation of no bending but that this restriction was not written on the release that Petitioner gave to Respondent. Respondent further presented the testimony of Martha Klima who testified that if this restriction was presented to her, it could not have been accommodated. The testimony is a moot point in that Petitioner was actually returned to work without issue. Furthermore, the testimony of Dr. Dworsky show that the restrictions were precautionary and that Petitioner had shown in therapy the ability to work and perform all of her job functions. Dr. Dworsky testified that the purpose of these restrictions were to help Petitioner ease back to the workforce if necessary.

Petitioner's testimony as to what transpired on April 20, 2010 was un-rebutted and confirmed by numerous medical records. Her testimony was that she was in the course of her employment providing a bath to a patient at the nursing home. While in the tiled shower room, Petitioner went to grab a towel and her left leg slipped. To prevent herself from falling, she then braced herself with her left leg which caused her knee to twist and become painful. Petitioner further testified that the character and nature of this pain was different than the character and nature of the pain from her previous injury. This is a separate, distinct injury that occurred on April 20, 2010 and not simply that her leg had suddenly reverted back to the condition it had been in from her January 20, 2010 accident. The mechanism of injury as described would be a compensable work injury. The evidence shows that Petitioner had made a recovery from her previous condition and was working asymptomatically and without issue at the time of her April 20, 2010 injury. This conclusion is corroborated by both treating physicians who both indicated in their testimony that this was a separate traumatic event.

The next question for determination is whether or not this event and the medical treatment that followed were as a result of the April injury and not the January injury. A review of Petitioner's testimony demonstrate that she was feeling good after being released to work in March of 2010. She was able to work without complaint and expected to be released to work in a full-duty capacity. Further, the medical records submitted substantiate the fact that Petitioner was making excellent progress from conservative treatment and that she had been discharged from all formal therapy. The records also indicate that it was anticipated that as of her next appointment that she would have been released to work in a full-duty capacity. As noted earlier, Dr. Dworsky, indicated Petitioner had made an excellent recovery and that she was expected to be released to work in a full-duty capacity. He also testified that after her April 20, 2010 injury, her condition had worsened. These facts were also corroborated by Dr. Mercier who agreed that Petitioner was improving with conservative treatment and that her condition had worsened after her April 20, 2010 injury.

Dr. Dworsky testified that it was his opinion that Petitioner's April 20, 2010 injury caused the need for surgical intervention and subsequent medical care. Without this slip in April Petitioner would not have required the treatment and was essentially returned to her pre-January injury status. He based this opinion on the fact that Petitioner had recovered from her January injury. It was only after her second accident that her condition changed to a surgical one and that her knee pain was so symptomatic to the point that surgery was warranted. In contrast to Dr. Dworsky's opinion is the conclusion of Dr. Mercier who indicated that he did not believe Petitioner's second injury to be the cause of the surgical intervention because there was no evidence of acute trauma. He based this on the fact that there was no new pathology noted that could be directly related to the incident in question as observed in either an MRI or the operative findings. The Arbitrator has considered these two differing opinions and finds that Dr. Dworsky's conclusion is supported by the facts and record of this case. Of note is that Dr. Mercier did not address the fact that Petitioner had recovered from her January injury and that this slip and fall caused her to have a drastic change in her symptoms and pain complaints.

In support of the Arbitrator's decision relating to disputed issue (J) medical services and (K) temporary benefits, the Arbitrator makes the following conclusions of law:

Having determined that Petitioner sustained a compensable work injury, it therefore follows that Petitioner is entitled to TTD benefits for the time period that she remained off work for her injury. There is no dispute that Petitioner was off work from June 1, 2010 to November 3, 2010 and that the reason that she was off work was due to the surgery performed by Dr. Dworsky. Petitioner shall be awarded TTD benefits for this duration.

Petitioner testified that the medical bills presented at Arbitration in her Exhibits 6-12 all remain unpaid as described in her Exhibit list and corresponding medical invoices. Dr. Dworsky testified that the medical

treatment incurred by Petitioner was all reasonable and necessary. As all of this treatment is related to and follows from her treatment resulting from the accident on April 20, 2010, it shall be awarded and Respondent shall pay those amounts pursuant to the medical fee schedule.

In support of the Arbitrator's decision relating to disputed issue (L) nature and extent, the Arbitrator makes the following conclusions of law:

Having reached the aforementioned conclusions, the Arbitrator finds that Petitioner sustained a work injury that required surgical intervention and a course of physical therapy and work hardening. During her recovery Petitioner had some concerns with hotness and swelling near the surgical area and underwent additional modalities to contain these complaints. Further, Petitioner did return to work in a full duty capacity and testified that she felt that she made a good recovery from this surgery. Petitioner testified that she does feel some discomfort going up and down stairs and during cold weather. When she feels the discomfort she treats these complaints with over the counter pain medication.

Having considered all of the evidence, the Arbitrator finds that Petitioner sustained a 25 % loss of use of her left leg under Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Smith,

Petitioner,

15IWCC0353

vs.

NO: 11 WC 12784

Winnebago County Special Education,

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, permanent partial disability, temporary total disability, medical expenses, prospective medical expenses, vocational rehabilitation, maintenance benefits, 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 November 14, 2013 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: MAY 19 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/7/15
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0353

SMITH, LINDA
Employee/Petitioner

Case# **11WC012784**

WINNEBAGO COUNTY SPECIAL EDUCATION
Employer/Respondent

On 11/14/2013, 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 0.09% 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:

2489 LAW OFFICE OF JIM BLACK
TRACY JONES
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0445 RODDY LEAHY GUILL & ZIMA LTD
GEORGE E POWELL
303 W MADISON ST SUITE 1500
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0353

Linda Smith
Employee/Petitioner

v.

Winnebago County Special Education
Employer/Respondent

Case # 11 WC 12784

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 **October 22, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **January 7, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$11,804.00**; the average weekly wage was **$227.00**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** paid 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 **$118,510.19** under Section 8(j) of the Act.

ORDER

The Arbitrator orders the Respondent to pay $0.00 to Petitioner for temporary total disability benefits.

The Arbitrator orders the Respondent to pay to the Petitioner unpaid medical bills in the amount of $0.00.

The Arbitrator orders that Petitioner is not entitled to vocational rehabilitation benefits, and is therefore not entitled to maintenance benefits associated with vocational rehabilitation.

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

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

Curt Lee
Signature of Arbitrator

11/13/13
Date

NOV 14 2013

Proposed Arbitration Decision Addendum 15IWCC0353

Statement of Facts

On January 8, 2010, Linda Smith (hereinafter "Petitioner") presented to Rochelle Community Hospital Emergency Room following a motor vehicle accident. PX. 2. Petitioner stated that on that day she was driving when she lost control of her motor vehicle on the ice. *Id.* She fishtailed and hit two guard rails. *Id.* Following the accident, Petitioner began to experience neck pain, right knee pain, and right hip pain. *Id.*

Petitioner subsequently sought treatment with her primary care physician, Dr. Williams, on January 12, 2010. PX. 3. Petitioner provided a history of the motor vehicle accident. *Id.* The record from this date of treatment indicates that Petitioner works for a school, though doesn't do much lifting. *Id.* Following examination, Dr. Williams diagnosed Petitioner with an acute cervical strain, right shoulder strain, and right upper/mid/lower back strain. *Id.* Dr. Williams prescribed pain medication and physical therapy. *Id.* Dr. Williams referred Petitioner to a spine specialist for further evaluation. *Id.*

On March 10, 2010 Petitioner presented for treatment with Dr. Sliva with complaints of back and right sided groin pain. PX. 1. Petitioner advised Dr. Sliva that her symptoms began after she was involved in a motor vehicle accident on January 8, 2010. *Id.* Petitioner testified that she had not experienced any back pain prior to January 8, 2010. Dr. Sliva reviewed an MRI of the lumbar spine taken March 3, 2010. PX. 1. The MRI revealed a large disk herniation at L1-2. *Id.* Following examination and review of the MRI, Dr. Sliva diagnosed Petitioner with a large disc herniation at L1-2 with radiculopathy, multilevel spinal stenosis, and isthmic spondylolisthesis at L5-S1. *Id.* Dr. Sliva prescribed a Medrol dose pack, possible nerve block injection, and recommended a possible lumbar microdiscectomy at L1-2. *Id.*

Petitioner next presented for treatment with Dr. Sturm at the Center for Pain Management on April 6, 2010. PX. 2. Petitioner advised Dr. Sturm that she developed pain following a motor vehicle accident. *Id.* Her pain had not improved. *Id.* After examining Petitioner, Dr. Sturm diagnosed Petitioner with L1-L2 disc herniation. *Id.* Dr. Sturm proceeded with a right-sided L2 nerve block injection. *Id.* Petitioner returned to treat with Dr. Sturm on April 13, 2010. *Id.* Petitioner advised Dr. Sturm that she was not experiencing pain radiating down her right leg. *Id.* Dr. Sturm released Petitioner from care. *Id.*

Petitioner testified that she was not working during the summer of 2010. Petitioner testified that she returned to work sometime in August of 2010. Petitioner testified that she is a teacher's assistant for Winnebago County Special Education (hereinafter "Respondent"). She testified that as part of her job duties, she often has to physically handle small children. She testified specifically that she "subdues" children who are acting up, lifts children on and off the toilet, and lifts children on and off of swing sets. Petitioner testified that she receives assistance when performing these duties. Petitioner testified that she began experiencing back pain after her return to work in August or September of 2010.

Petitioner testified that she worked with a teacher, Laura Lough, during the fall of 2010. Petitioner testified that she told Ms. Lough that her back was hurting. Petitioner further testified that she called a "supervisor" to advise that she was experiencing back pain. Petitioner testified that she could not remember the entire conversation with this supervisor, and that she could not remember the entire conversation with Ms. Lough. Petitioner testified that she believed she advised Ms. Lough that her work activities were causing her pain.

Petitioner testified that she did not work over the "holiday break" in December of 2010. Petitioner testified that she hoped the pain would "go away" over the break period. Petitioner

testified that she returned to work in early January following the break period. Petitioner testified that she could not remember which dates in January she worked. Petitioner testified that the pain persisted following the break period.

On January 7, 2011, Petitioner returned to treat with Dr. Williams. PX. 3. According to the record from this date, Petitioner advised Dr. Williams that she had missed work since January 3, 2011. *Id.* She advised Dr. Williams that she was in severe pain and was scheduled for surgery on February 10, 2011. *Id.* She asked Dr. Williams to write a note for work. *Id.* Dr. Williams wrote the note, taking Petitioner off of work until January 10, 2011. *Id.*

Petitioner also presented for treatment with Dr. Sliva on January 7, 2011. PX. 1. Petitioner completed a questionnaire at that time. *Id.* Petitioner indicated on the questionnaire that an "accident" was the cause of her pain. *Id.* According to the record from this visit, Petitioner advised Dr. Sliva that she had experienced "excellent improvement" following her nerve block injection until mid-December 2010 when she had a recurrence of her leg pain which was quite severe. *Id.* Petitioner testified that she did not tell Dr. Sliva that her pain returned in December of 2010, but rather in the fall of 2010. An MRI was taken at that time. *Id.* The MRI revealed a large disc herniation at L1-2 midline with bilateral stenosis and right greater than left radiculopathy, L1-2 foraminal stenosis, multilevel spinal stenosis at L2-3, L3-4, and L4-5, and stable isthmic spondylolisthesis at L5-21. *Id.* Dr. Sliva recommended fusion surgery. *Id.*

Petitioner underwent L1-2 lumbar fusion surgery on February 10, 2010. PX. 1. She returned for a follow-up appointment with Dr. Sliva in February and March of 2011. *Id.* The record from Petitioner's treatment visit on March 25, 2011 indicates that Petitioner had approximately one year history of low back pain following a motor vehicle accident in January of 2010. *Id.* Dr. Sliva recommended a home exercise program and physical therapy. *Id.*

Petitioner returned to treat with Dr. Sliva on May 4, 2011. *Id.* She was discharged from care as of that date. *Id.*

Petitioner testified that on April 4, 2011, she filed two (2) Applications for Adjustment of Claim. Petitioner testified that the first Application, 11 WC 12783, alleges an injury to her back following an accident on January 8, 2010. Petitioner testified that the injury reflected on this Application was a result of her motor vehicle accident. Petitioner testified that the second Application alleges an injury to her back on or around January 7, 2011.

At the request of Respondent, Petitioner was examined by Dr. Ghanayem on August 11, 2011. RX. 1. Dr. Ghanayem is a Board Certified Orthopedic Surgeon and a Professor at the Loyola School of Medicine teaching orthopedic surgery and has a joint faculty appointment in neurologic surgery. *Id.* Dr. Ghanayem testified that on the date of examination he took a history from Petitioner. *Id.* Dr. Ghanayem testified that Petitioner advised that she developed back pain and right-sided leg pain following a car accident in January of 2010. *Id.* Dr. Ghanayem testified that Petitioner told him that she underwent conservative care though did not have the relief she was looking for. *Id.* Following his discussion with Petitioner and examination of Petitioner, Dr. Ghanayem diagnosed Petitioner with a disc herniation and aggravated stenosis following her accident. *Id.*

Dr. Ghanayem testified that Petitioner advised him that she worked with special needs kids as a paraprofessional. RX. 1. Dr. Ghanayem testified that the history he obtained from Petitioner was that her injury was from a car accident. *Id.* He further testified that Petitioner did not advise him of any work injury. *Id.* Dr. Ghanayem testified that a screening sheet filled out by Petitioner indicated that her pain worsened after her injection. *Id.*

Petitioner was next examined by Dr. Coe on January 25, 2012. PX. 6. Dr. Coe testified that he is a board certified specialist in occupational medicine. *Id.* Dr. Coe testified that he took a history from Petitioner. *Id.* Dr. Coe testified that Petitioner told him that she was injured in a motor vehicle accident on January 8, 2010. Id. Dr. Coe further testified that Petitioner told him that she works as a paraprofessional for the Winnebago County Special Education Cooperative. *Id.* Petitioner advised Dr. Coe that she works with disabled children and does a lot of repetitive bending, stooping, lifting, and twisting throughout the course of her work day. *Id.* Dr. Coe testified that Petitioner told him that by December of 2010, her right leg symptoms were severe. Dr. Coe further testified that Petitioner told him she did not have any back pain symptoms prior to her accident on January 8, 2010. PX. 6.

Dr. Coe testified that the motor vehicle accident on January 8, 2010 caused an acute central and right-sided herniation of the L1-2 intevertebral disc and did aggravate some degenerative changes in her lumbar spine. PX. 6. Dr. Coe testified that Petitioner had complete resolution of her symptoms following the nerve block injection on April 6, 2010 until December of 2010. *Id.* Dr. Coe testified that eight months is a long period of time to have relief from a single nerve block. *Id.* Dr. Coe testified that Petitioner's work activities for Respondent were a factor that aggravated the pre-existing herniated disc at L1-2 and the degenerative changes in her lumbar spine, contributing to the recurrence of her right lumbar radiculopathy and back pain in December of 2010. *Id.*

Dr. Coe testified that relief from symptoms for a nerve block typically last anywhere from three to six months. PX. 6. Dr. Coe testified that sometimes a nerve blocks do not provide any relief. *Id.* He further testified that a nerve block could last two months, four months, six months, eight months, and up to ten months. *Id.* Dr. Coe testified that he was not aware of when

Petitioner worked during the interval between April of 2010 and December of 2010. *Id.* He further testified that Petitioner was not able to give him specific sizes and weights and frequencies of lifting. *Id.* He testified that Petitioner could not describe in any detail her job duties. *Id.* Dr. Coe testified that Dr. Sliva's records do not mention any symptom causation other than a motor vehicle accident. *Id.*

Petitioner testified that she last worked for Respondent in January of 2011. Petitioner testified that Respondent could not accommodate her work restrictions following her surgery. Petitioner drafted a letter to Respondent dated May 26, 2011 resigning from her position and indicating Respondent could not accommodate her work restrictions. PX. 5.

Analysis

I. (C) The Arbitrator finds Petitioner did not sustain an injury that arose out of and in the course of her employment with Respondent on January 7, 2011.

It is well-settled law that a petitioner bears the burden of proving all elements of his claim by a preponderance of the evidence in the record. *Parro v. Industrial Comm'n*, 260 Ill.App.3d 551, 630 N.E.2d 860, at 862 (Ill. App. 1 Dist. 1993). A claimant bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. *Baldwin v. Illinois Workers' Compensation Comm'n,* 409 Ill.App.3d 472, 949 N.E.2d 1151, at 1156 (Ill. App. 4 Dist. 2011). Both elements must be present in order to justify compensation. *Id.* Arising out of the employment pertains to the origin or cause of a claimant's injury. *William G. Ceas& Co. v. Industrial Comm'n,* 261 Ill.App.3d 630, 636, 633 N.E.2d 994 (1994). When determining whether an accident arose out of and in the course of a Petitioner's employment, the Commission will consider the claimant's testimony regarding accident and its consistency with what was told to medical care providers. *See Sleeter v. Industrial Comm'n*, 346 Ill.App.3d 781, 805 N.E.2d 1227, at 1229 (4th Dist. 2004); *also Hosteny v. Illinois Workers' Compensation*

The Arbitrator finds that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment on or about January 7, 2011. The Arbitrator had the opportunity to observe Petitioner when she testified and concludes that Petitioner is not a credible witness. Petitioner testified that her work responsibilities for Respondent aggravated her back pain following her return to work in the fall of 2010. Petitioner testified that she subdues children, carries them on and off of the toilet, and lifts children on and off of swing sets as part of her job duties. Petitioner further testified that she began experiencing back pain while performing these duties. However, Petitioner could not point to any specific job activity or event that caused an aggravation to her lower back pain. Petitioner even testified that she received assistance while performing these responsibilities. Petitioner further testified that she was not experiencing any back pain prior to her motor vehicle accident on January 8, 2010. She even admitted that her back pain relief following her injection ended around the time she returned to work in August or September of 2010. The Arbitrator finds that Petitioner's testimony regarding a work accident on or about January 7, 2011, is vague at best, and is insufficient to carry the burden of proving she sustained a work-related injury.

Moreover, the medical records from Petitioner's treating physicians do not support a finding that Petitioner sustained a "new injury" or aggravated an existing lower back condition on or around January 7, 2011. Petitioner testified that she first began experiencing lower back pain following her motor vehicle accident on January 8, 2010. Petitioner treated conservatively and ultimately underwent a nerve block injection on April 6, 2010. Petitioner did not seek treatment again for her lower back until January 7, 2011. Petitioner treated with both Dr. Sliva and Dr. Williams on that date. Neither the records from Dr. Williams or Dr. Sliva on this

treatment date or following this treatment date reference a work-related injury. In addition, the record from Petitioner's treatment visit on March 25, 2011 indicates that Petitioner had approximately a one year history of low back pain following a motor vehicle accident in January of 2010.

Petitioner alleges that her repetitive lifting of children caused an aggravation to her back pain when she returned to work. However, the records from Petitioner's treatment visit with Dr. Williams on January 12, 2010 indicate that she does "not do much lifting" while working for Respondent. This note directly contradicts Petitioner's testimony. Consequently, the Arbitrator finds that the medical records support a finding that Petitioner's back pain resulted from her motor vehicle accident. The Arbitrator further finds that Petitioner did not sustain any "new" injury to her lower back or any aggravation to her back condition on or about January 7, 2011, as it is not supported by any of the contemporaneous medical records from Petitioner's treating physicians following Petitioner's alleged injury date.

The reports and testimony of Dr. Ghanayem also support a finding that Petitioner sustained an injury to her lower back following a motor vehicle accident, and not while working for Respondent on or about her alleged date of injury. Dr. Ghanayem testified that on the date of examination he took a history from Petitioner. Dr. Ghanayem testified that Petitioner advised that she developed back pain and right-sided leg pain following a car accident in January of 2010. Dr. Ghanayem testified that Petitioner told him that she underwent conservative care though did not have the relief she was looking for. Dr. Ghanayem testified that Petitioner advised him that she worked with special needs kids as a paraprofessional. That said, Dr. Ghanayem testified that Petitioner did not advise him of any work injury. Dr. Ghanayem even testified that the history he obtained from Petitioner was that her injury was from a car accident.

Dr. Ghanayem also testified that a screening sheet filled out by Petitioner indicated that her pain worsened after her injection.

Petitioner relies on the report and testimony of Dr. Coe to establish that she sustained a work-related injury on or about January 7, 2011. Dr. Coe testified that Petitioner told him that she worked as a paraprofessional for Respondent. He testified that Petitioner advised that she works with disabled children and does a lot of repetitive bending, stooping, lifting, and twisting throughout the course of her work day. However, Dr. Coe testified that Petitioner was not able to give him specific sizes and weights and frequencies of lifting. He testified that Petitioner could not describe in any detail what her job duties were for Respondent. Dr. Coe even acknowledged that Petitioner sustained a lower back injury following a motor vehicle accident on January 8, 2010, and was asymptomatic prior to the accident. Regardless, Dr. Coe testified that Petitioner's work activities for Respondent were a factor that aggravated her pre-existing lumbar spine condition in December of 2010. Dr. Coe's conclusions are based solely on Petitioner's ambiguous job description of her work activities for Respondent, and as such, are not credible. His opinions are not supported by any information contained in the records from Petitioner's treating physicians, and the symptom history provided to him by Petitioner contradicts the history Petitioner provided to Dr. Ghanayem at the time of his examination.

Dr. Coe testified that Petitioner advised that she was pain free following her injection on April 6, 2010 until December of 2010. However, Petitioner herself testified that she was only free of back pain until her return to work in the fall of 2010. Dr. Coe testified that nerve block injections, such as the one provided to Petitioner, will generally provide pain relief from three to six months. Dr. Coe admitted on cross-examination that such injections may relieve pain for anywhere up to ten months. The Arbitrator finds that Petitioner's pain returned in the fall of

2010, less than five months following her injection. The Arbitrator therefore finds that Petitioner's recurring symptoms in the fall of 2010 can be traced back to her motor vehicle accident and subsequent course of conservative treatment, and were not a result of any "new" injury or aggravation of an existing injury.

The Arbitrator finds that Petitioner did not sustain an accident that arose out of or in the course of her employment with Respondent on or about January 7, 2011. Petitioner's testimony does not reconcile with the treatment records following her date of accident. Moreover, Petitioner filed two Applications for Adjustment of Claim on April 4, 2011; one alleging a lower back injury resulting from a motor vehicle accident on January 8, 2010, and the other alleging a lower back injury resulting from Petitioner's work for Respondent on or about January 7, 2011. Petitioner's multiple filings are indicative of her poor credibility and place into question her testimony regarding the source of her back pain.

II. (E) The Arbitrator finds that timely notice of the accident was not given to Respondent.

Under the Act, notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. 820 ILCS 305/6(c). The Arbitrator finds that Petitioner failed to establish through her testimony that she provided notice of a work-related accident to her supervisors. Petitioner testified that she worked with a teacher, Laura Lough, during the fall of 2010. Petitioner testified that she told Ms. Lough that her back was hurting. Petitioner testified that she believed she advised Ms. Lough that her work activities were causing her pain. Although Petitioner testified that she advised Ms. Lough that her work activities were causing her back pain, she could not testify with any certainty whether she advised Ms. Lough as to any specific work activity that was causing her back pain. She even testified that she could not remember the entire conversation with Ms. Lough.

Petitioner's testimony regarding her conversation with an unnamed "supervisor" is also ambiguous and does not establish that proper notice of a work-related accident was provided. Petitioner did testify that she spoke with a "supervisor" regarding her back pain and treatment in January of 2011. However, she testified that she does not remember telling this "supervisor" that her work activities for Respondent had caused or were causing her back pain. She even testified that she does not remember the entirety of this conversation. Petitioner could not even testify as to the name for the "supervisor" she spoke with.

Petitioner also had an opportunity to advise Respondent in writing that her back pain and work restrictions were a result of a work-related injury, and failed to do so. Petitioner drafted a letter to Respondent in May of 2010 regarding her resignation and referencing Respondent's inability to accommodate her work restrictions. However, the letter does not include any reference to a work-related injury. The Arbitrator concludes that Petitioner could not testify with any specificity that she provided adequate notice to Respondent regarding an alleged injury sustained on or about January 7, 2011, and nothing in the record suggests that a work-related injury was reported to Respondent.

III. (F) The Arbitrator finds that Petitioner's current condition of ill-being is not related to an alleged injury sustained on January 7, 2011.

The claimant in a worker's compensation proceeding has the burden of proving by a preponderance of the credible evidence that the injury arose out of and in the course of employment, and that involves as an element a causal connection between the accident and the condition of claimant. *Cassens Transport Co., Inc. v. Industrial Comm'n*, 262 Ill.App.3d 324, 633 N.E.2d 1344, at 1348 (Ill. App. 2 Dist. 1994). Whether a causal relationship exists between a claimant's work-related accident and his current condition of ill-being is a question of fact. *P.I.*

& I. Motor Exp., Inc./For U, LLC v. Industrial Comm'n, 368 Ill.App.3d 230, 857 N.E.2d 784, at 793 (Ill. App. 5 Dist. 2006).

The Arbitrator finds Petitioner's current condition is directly related to her automobile accident on January 8, 2010. This is reflected in the treatment records of Dr. Williams, Dr. Sliva, and Dr. Sturm as well as the testimony and report of Dr. Ghanayem. Petitioner presented for treatment with both Dr. Williams and Dr. Sliva on her alleged date of injury. Neither the records from Dr. Williams nor the records from Dr. Sliva contain any information indicating a work accident on or about January 7, 2011, or any information that Petitioner's current back pain was at all related to her work activities for Respondent. Although Petitioner testified that she informed Dr. Sliva that she hurt her back while performing her work duties, her testimony is not credible and conflicts with the information contained in the treatment records. Dr. Sliva's March 25, 2011 record indicates that Petitioner's back pain stemmed from an automobile accident one year prior. Petitioner herself testified that she believed any information contained in the reports of Dr. Sliva would be accurate.

Petitioner also failed to mention to Dr. Ghanayem that she began to experience back pain as a result of her work activities. Dr. Ghanayem testified that Petitioner completed a pre-examination form where she mentioned that her back pain was a result of an automobile accident. Dr. Ghanayem further testified that he personally took an injury history from Petitioner, and she only mentioned the motor vehicle accident as the cause for her back pain. The Arbitrator finds that Petitioner's failure to mention any work-related injury to Dr. Ghanayem demonstrates that her need for back treatment and subsequent surgery were a result of her motor vehicle accident.

The Arbitrator finds the testimony of Dr. Coe to lack credibility in light of the treating medical records and testimony of Dr. Ghanayem. Dr. Coe testified that Petitioner's work activities for Respondent were a factor that aggravated her pre-existing lumbar spine condition in December of 2010. However, Dr. Coe admitted on cross-examination that Petitioner did not provide him with any specific work activities that had caused her pain. Dr. Coe further testified that Petitioner experienced complete relief from her pain symptoms from the nerve block injection until December of 2010. Petitioner testified at trial, however, that she began experiencing pain again around the time she returned to work in the fall of 2010. Dr. Coe testified that relief from a nerve block could last from two to ten months. Dr. Coe's testimony, taken with Petitioner's trial testimony, clearly indicates that Petitioner had initial pain relief following her injection, and the pain relief wore off in the fall of 2010. The Arbitrator therefore finds that the nerve block provided Petitioner a period of relief from April 6, 2010 until the fall of 2010, when the pain returned. The Arbitrator also finds that Petitioner's condition following her motor vehicle condition had not stabilized, and any return in symptoms and need for treatment are related to her motor vehicle accident.

IV. (J) The Arbitrator finds that medical services provided to Petitioner were not related to Petitioner's alleged accident on January 7, 2011.

Under the provisions of Section 8(a) of the Act, the employer is required to pay for all necessary medical, surgical, and hospital services that are reasonable required to cure or relieve the effects of an accidental injury sustained by an employee and arising out of and in the course of the employment. 820 ILCS 305/8(a); *Zarley v. Industrial Comm'n*, 84 Ill.2d 380, 418 N.E.2d 717, at 721 (Ill. 1981). However, the employee is only entitled to recover those medical expenses which are reasonable and causally related to her industrial accident. *Id.* The claimant has the burden of proving that the medical services were necessary and the expenses reasonable.

Homebrite Ace Hardware v. Industrial Comm'n, 351 Ill.App.3d 333, at 337 (Ill. App. 5 Dist. 2004).

The Arbitrator finds that Petitioner's back treatment was not causally related to an alleged accident on January 7, 2011, and therefore finds that Respondent is not responsible for payment of the medical bills resulting from Petitioner's back treatment. As mentioned above, Petitioner did not prove that her injury arose out of and in the course of her employment. She consequently failed to prove her back condition or need for treatment were related to her work for Respondent. Rather, the need for treatment was related to her motor vehicle accident on January 8, 2010. This conclusion is supported by the histories contained in the records from Petitioner's treating physicians as well as the testimony of Dr. Ghanayem. The Arbitrator finds that, as a result, Respondent is not responsible for coverage of these services or payment of the resulting bills.

V. (K) The Arbitrator finds that Petitioner is not entitled to TTD benefits.

The claimant bears the burden of proving all the elements of his case in order to recover benefits. *Ingalls Memorial Hospital v. Industrial Comm'n*, 241 Ill.App.3d 710, 609 N.E.2d 775, at 780 (Ill. App. 1 Dist. 1993). In order to recover TTD benefits, a claimant must prove by a preponderance of the evidence that the injuries arose out of and in the course of his employment and that claimant had a resultant incapacity to work. *Kieffer and Co., Inc. v. Industrial Comm'n*, 263 Ill.App.3d 294, 636 N.E.2d 7, at 10 (Ill. App. 2 Dist. 1994).

The Arbitrator finds Petitioner failed to carry the burden of proving that her injuries arose out of and in the course of her employment with Respondent. There is no mention in the treatment records following Petitioner's alleged date of accident to indicate a work-related injury. The records from Dr. Williams and Dr. Sliva contain a detailed history of symptoms and

their cause following the motor vehicle accident on Jaunary 8, 2010, though inexplicably contain no history relating Petitioner's back pain to her work for Respondent following her alleged accident date of January 7, 2011. Dr. Ghanayem also testified that Petitioner advised him during her examination that her back problems were related to her motor vehicle accident. The Arbitrator finds that based on the medical records and testimony of Dr. Ghanayem, Petitioner's injury did not arise out of or in the course of her employment for Respondent. Therefore, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits.

VI. (O) The Arbitrator finds that Petitioner is not entitled to vocational rehabilitation services.

The claimant bears the burden of proving all the elements of his case, including the extent and permanency of injury, in order to recover benefits. *Ingalls Memorial Hospital v. Industrial Comm'n*, 241 Ill.App.3d 710, 609 N.E.2d 775, at 780 (Ill. App. 1 Dist. 1993). Entitlement to rehabilitation is generally established when there has been a reduction of earning power due to an employment-related injury and such rehabilitation will increase claimant's earning capacity. *Freeman United Coal Min. Co. v. Industrial Comm'n*, 318 Ill.App.3d 170, 741 N.E.2d 1144, at 1152 (Ill. App. 5 Dist. 2000).

The Arbitrator finds that Petitioner has failed to establish that she suffered an injury on or about January 7, 2011 that arose out of and in the course of her employment, and is therefore not entitled to vocational rehabilitation benefits. Again, there is nothing in the medical records at or around the date of the alleged accident to indicate. Moreover, according to the testimony of Dr. Ghanayem, Petitioner advised that she was experiencing lower back pain as a result of a motor vehicle accident. Petitioner's testimony does nothing to establish that she suffered a work-related injury, as it is vague and not reflected in the histories contained in the records from her treating physicians. Petitioner's testimony at trial that her work activities for Respondent were

the cause of her back pain also directly contradict the report and testimony of Dr. Ghanayem As Petitioner did not establish that she suffered an employment-related injury, the Arbitrator finds that Petitioner is not entitled to vocational rehabilitation benefits.

Conclusion

The Arbitrator concludes Petitioner did not provide sufficient proof that an accident arose out of and in the course of her employment. Petitioner's testimony cannot be reconciled with the information in the medical records from the date of her alleged accident. Petitioner specifically testified at the time of trial that she began experiencing back pain while restraining children, lifting them on and off of toilets, and lifting them on and off of swing sets. However, these activities and their relation to Petitioner's back pain are inexplicably absent from the treatment records following her alleged date of accident. In fact, the first time Petitioner's job activities and their connection to her back pain are mentioned in any medical record are in the examination record from Dr. Coe, over a year following her alleged accident date.

Petitioner's multiple Application filings further place into doubt her credibility and the source of her back pain. Again, Petitioner filed two Applications for Adjustment of Claim following on April 4, 2010. The first Application alleges a back injury resulting from a motor vehicle accident on January 8, 2010. Petitioner's second Application alleges a back injury resulting from her work for Respondent on or about January 7, 2011. Petitioner was examined by Dr. Ghanayem over four months following the filing of both Applications. The filings clearly indicate that Petitioner was cognizant of her allegations at the time of her examination with Dr. Ghanayem. Petitioner had the opportunity to advise Dr. Ghanayem that her current back pain was a result of her work activities for Respondent, and failed to do so. Based on the foregoing, the Arbitrator finds that Petitioner did not prove that her back injury and subsequent treatment

was a result of her alleged work injury on January 7, 2011. The Arbitrator therefore finds that Petitioner is not entitled to TTD or indemnity benefits, reimbursement for medical services provided, or vocational rehabilitation benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeremy Scott,

Petitioner,

15IWCC0354

vs.

NO: 12 WC 31636

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, temporary total disability, causal connection, 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 December 10, 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.

15IWCC0354

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,000.00. 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: MAY 19 2015

DLG/gaf
O: 5/7/15
45

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

15IWCC0354

SCOTT, JEREMY
Employee/Petitioner

Case# **12WC031636**

DAVIS STAFFING
Employer/Respondent

On 12/10/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

2573 MARTAY & MARTAY
DAVID W MARTAY
134 N LASALLE ST 9TH FL
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

15IWCC0354

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Jeremy Scott
Employee/Petitioner

v.

Davis Staffing
Employer/Respondent

Case # **12** WC **31636**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **October 1, 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 _____

15IWCC0354

FINDINGS

On **August 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 $**13,450.32**; the average weekly wage was $**258.66**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner $253.00/week for 38 weeks of permanency at the rate of $253.00 or $9,614.00, as provided in Section 8(e) of the Act, because the injuries sustained caused 10% loss of use of each hand.

Respondent shall pay to Petitioner temporary total disability benefits for 20/3/7 weeks; that has accrued from 9/24/12 through 2/14/13, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner for medical bills of $6,268.00 owed to Dr. Gary Kronen at MidAmerica Hand to Shoulder Clinic; $2,163.00 owed to Advocate Occupational Health and $3,846.00 owed to Advocate South Suburban Hospital, pursuant to Sections 8(a) and 8.2 of the Act.

Respondent is not obligated to reimburse the Blue Cross Blue Shield lien, in the amount of $3,144.89.

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

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

15IWCC0354

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEREMY SCOTT	)	
	)	
Petitioner,	)	
vs.	)	
	)	**No. 12 WC 31636**
DAVIS STAFFING	)	
	)	
Respondent.	)	

FINDINGS OF FACT

Petitioner, Jeremy Scott, was a 39-year-old married man with no children under the age of 18; and employed by Davis Staffing on August 26, 2012. Petitioner testified he was employed by Respondent as a general laborer and had been working in that capacity for Respondent for two and a half months. He had been outsourced to a company called Landauer for two months, in a full duty capacity, with no restrictions. Petitioner also testified he was ambidextrous. *See,* Tr. pgs. 10-28.

Petitioner testified he worked for Landauer in shipping and receiving and that his specific job duties varied, but involved unloading mailbags from trucks three to four hours a day; sorting through the mailbags, filling tote bags and bringing those bags to the second floor of the warehouse. *See,* Tr. pgs. 11-14.

He testified he unloaded 20 to 50 mailbags weighing anywhere from 10 to 60 pounds each. The bags were filled with badges related to radiation detection. He would then place the badges in totes and put them on a conveyor belt up to the second floor warehouse. He testified the conveyor belt broke after a few weeks, so he would have to load the totes on a dolly and physically take them up to the second floor. The filled totes weighed between 10 and 60 pounds and he testified that the dolly plus the totes weighted approximately 70 to 80 pounds. He testified the second floor was up about 30-60 stairs and he had to significantly maneuver the dolly. The Arbitrator further notes that the petitioner's testimony seems to be exaggerated as he testified that he would sometimes fill a tote to between forty (40) to sixty (60) pounds, then load up to six totes on a dolly. If this were true, the dolly weight would have been between two hundred forty (240) to three hundred sixty (360) pounds, which is incredulous. Petitioner further testified that he had to move the totes approximately 600 feet to the stairs, then up 30, 50 or 60 stairs; and then another 25 feet. Petitioner further testified that he performed this task nine to ten times per hour. He also testified that he used the dolly for 30 days. *See,* Tr. pgs. 11-19 & 34-38.

Petitioner testified that on or about August 16, 2012, he was having bilateral hand pain from the work he was performing at Landauer. Petitioner presented to Advocate Occupational Health ("Advocate") in Hazel Crest on August 22, 2012, complaining of bilateral hand pains from repetitive overuse of his hands at work. X-rays of his cervical spine were ordered and performed at South Suburban Hospital, on the same date. Petitioner followed-up at South Suburban Hospital on September 5, 2012 and an EMG was ordered. He followed-up at Advocate on September 7, 2012 and was advised to attend physical therapy and return to work with no lifting over ten (10) pounds' no overhead work; and no repetitive use of his hands. *See*, Tr. pgs 23-24 & PX 3 & 5.

An EMG was performed at South Suburban Hospital on September 10, 2012 and revealed bilateral carpal tunnel syndrome. Petitioner returned with the results of the EMG to Advocate on September 21, 2012; and was advised to see Dr. Gary Kronen at MidAmerica Hand to Shoulder Clinic ("MidAmerica") and remain off work. *See,* PXs 3& 5.

Petitioner presented to Dr. Kronen on September 24, 2012, with complaints of numbness and tingling in his hands due to overuse at work. After a physical examination was performed and the EMG was reviewed, Dr. Kronen diagnosed Petitioner with bilateral carpal tunnel syndrome. He recommended Petitioner proceed with surgery. *See,* PX1 pgs. 19-2.

Petitioner underwent a decompression of the right median nerve on October 11, 2012, performed by Dr. Kronen. Petitioner followed-up with Dr. Kronen on October 18, 2012 and was advised to remain off work and start occupational therapy. He saw Petitioner again on November 8, 2012 and recommended Petitioner continue occupational therapy. Petitioner presented to Dr. Kronen again November 26, 2012. Surgery was recommended for the left hand and Petitioner was to remain off work. *See*, PX 1, pgs. 15-19.

Dr. Kronen performed a decompression of the left median nerve on December 6, 2012. Following surgery, Petitioner followed-up with Dr. Kronen on December 20, 2012 as well as January 10, 2013 and advised to attend occupational therapy. Petitioner was released to return to work with restrictions of no lifting over fifty to sixty (50-60) pounds with the left hand, at a visit with Dr. Kronen on January 31, 2013. Dr. Kronen released Petitioner to return to work in a full duty capacity and discharged him from care on February 14, 2013. *See*, PX1, pgs. 19-21; & Tr. pgs. 26.

At the request of Respondent, Dr. Michael Vender did a records review IME and produced a report regarding his findings, on November 1, 2012. Dr. Vender opined a mail sorter does not perform repetitive work and specifically the job was not forceful, repetitive work to the point he could attribute it causing carpal tunnel syndrome. He further testified he reviewed Petitioner's job duties and that an empty tote weighed five (5) pounds, while a full tote weighed nineteen (19) pounds. Dr. Vender never examined Petitioner and did not speak to him regarding his job duties. *See*, RX1, pgs. 6-14.

Petitioner testified he continues to suffer from bilateral hand pain. He testified his hands are tender in the center and that he has a jerking feeling when he holds things. He said his left hand is a bit worse than his right hand. He struggles with pulling activities like tying his shoes. For treatment, Petitioner testified that he takes 500mg of Tylenol a few times a week. *See,* Tr. Pgs. 27-29.

Testimony of Ms. Melissa Dziedzic

Respondent presented Ms. Melissa Dziedzic as its witness. She was a staffing supervisor for Davis Staffing and started that job in July 2012. She testified Petitioner began working at Landauer in June 2012, sorting mail. Ms. Dziedzic testified Petitioner did have to manually move tote bags, weighing approximately eighteen to twenty (18-20) pounds per bag when full, up and down stairs. She testified that she personally observed this work being done at Landauer over the course of a day; however not by Petitioner. She also testified the conveyor broke on August 8, 2012 but testified that this information was not from personal knowledge but came from Respondent. She further testified that the job, as she observed it, involved moving the totes sporadically, for approximately two to three hours per shift, as the person was performing other tasks besides this one. *See,* Tr. pgs. 62-71.

The Arbitrator notes that there is conflicting testimony regarding when the conveyor belt broke, either in late July or on August 8th of 2012; and that the longest time the petitioner would have had to manually cart the totes up stairs, would have been approximately three (3) weeks. There is also conflicting testimony as to the number of stairs, which had to be transcended. Had the Respondent's witness actually observed the petitioner in the performance of his job, the matter would be one of credibility of the witnesses. In this case, the Arbitrator has no visual evidence of the flight of stairs used by the petitioner and therefore does not have adequate evidence regarding the totality of Petitioner's job duties.

CONCLUSIONS OF LAW

15IWCC0354

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

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

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

Petitioner testified that he was performing forceful, repetitive work over the course of the few months he worked at Landauer. Respondent's witness testified that he was manually moving the tote bags, transporting them from one floor of the building to another with a hand truck, which required him to go up and down stairs.

Ms. Dziedzic testified that the totes, when full, weighed eighteen to twenty (18-20) pounds and Petitioner would take them up approximately twenty (20) stairs. He would also load two-three (2-3) totes on the dolly, which meant the dolly would weigh approximately sixty (60) pounds. She testified she saw, in her one day at Landauer, people doing that task for roughly two to three (2-3) hours; however she never observed the petitioner working.

The Arbitrator finds that Dr. Kronen's opinions are more persuasive than those of Dr. Vender. Dr. Kronen personally treated Petitioner throughout much of his medical care including performing both surgeries. Dr. Kronen opined, to a reasonable degree of medical and surgical certainty, that there was evidence of repetitive activity with forceful gripping, which led to his conclusion that Petitioner's work contributed to the development of bilateral carpal tunnel syndrome. During cross-examination, Dr. Kronen further elaborated the carrying of the dolly with the boxes up the stairs caused a vibration-like banging, up and down the stairs, which further contributed to Petitioner's bilateral carpal tunnel syndrome.

Dr. Vender did not see Petitioner for an examination; rather he performed a records and job description review, provided by Respondent. Dr. Vender opined Petitioner's job, as it was explained to him through Respondent's job description, would not have been a contributing factor to the development of carpal tunnel syndrome and that the petitioner's weight and body mass was a major factor in the development of Petitioner's hand condition. Dr. Vender was not provided any information from Respondent regarding Petitioner's working conditions, once the conveyor belt broke.

Upon cross-examination, it was brought to Dr. Vender's attention Petitioner used a dolly or hand truck as part of his duties for Respondent. He opined, "A loaded dolly would be exertional I would think; and then it's a matter of just how exertional it is, you know, is it a 30 pound pull versus an 85 pound pull". Petitioner, as testified to by Ms. Dziedzic, would have had to pull approximately sixty (60) pounds with three loaded tote bags.

As for Petitioner's prior work history of working as a push press operator, Respondent did not provide adequate evidence or medical records to show that Petitioner suffered from hand pains prior to working for Respondent, other than Dr. Kronen's supposition that this type of work could attribute to or aggravate a carpal tunnel condition. While it may be logical to suppose that the previous job contributed to Petitioner's hand condition, it must be proven, by a preponderance of the evidence; otherwise the employer takes the petitioner in the physical condition in which he finds him.

The medical evidence confirms that Petitioner suffered from chronic bilateral carpal tunnel syndrome, which was either caused or exacerbated by multiple hours of using a dolly while working for Respondent. The Arbitrator finds Petitioner has proven, by a preponderance of the evidence, that his bilateral carpal tunnel syndrome 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?

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

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar*

Tractor Co. v. Industrial Comm'n., 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

It is well settled that an employee need only show that some act of employment was a causative factor, not the sole or, principal cause, of his injury. *See, Alderson v. Select Beverage, Inc.*, 06 I.W.C.C. 0095, 01 W.C. 33435 (2006).

As the Arbitrator has found that Petitioner did suffer from bilateral carpal tunnel syndrome, which arose out of and in the course of his employment by Respondent, his current condition of ill-being is causally related to his repetitive work injury. There is no evidence of a history of bilateral hand issues prior to Petitioner working for Respondent. To correct his injuries he underwent bilateral medial nerve decompression surgeries.

Petitioner testified he continues to suffer from bilateral hand pains. He testified his hands are tender in the center and he has a jerking feeling when he holds things. He said his left hand is a bit worse than his right hand. He struggles with pulling activities such as tying his shoes. For treatment, Petitioner testified he takes 500mg Tylenol a few times a week.

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

Petitioner suffered work-related injuries while employed by Respondent. He sought medical care with Dr. Kronen, Advocate Occupational Health and Advocate South Suburban Hospital. No evidence was presented which states the medical care provided Petitioner was not reasonable and necessary. Dr. Vender even opined the medical care Petitioner received was reasonable and necessary.

The totality of the evidence suggests all of the medical care Petitioner received was reasonable and necessary in order to relieve him from pain from his work injury. Respondent shall be responsible for medical bills of $6,268.00 owed to Dr. Gary Kronen at MidAmerica Hand to Shoulder Clinic; $2,163.00 owed to Advocate Occupational Health; and $3,846.00 owed to Advocate South Suburban Hospital. The bill totals listed above shall be paid to Petitioner per the statutory medical fee schedule. Respondent is not responsible for reimbursing Blue Cross Blue Shield's lien, in the amount of $3,144.89, as it is not one of Petitioner's medical bills.

K. What temporary benefits are in dispute?

Petitioner was authorized off work or released to light duty from September 24, 2012 through February 14, 2013. Respondent did offer Petitioner light duty work, but Petitioner declined the work, because he claims it required repetitive use of his hands, which violated Dr. Kronen's work restrictions.

Since Petitioner did suffer from repetitive work injuries, which resulted in him being off work for 20 3/7th weeks, Petitioner is owed temporary total disability benefits ("TTD") for this period while he was off work, utilizing Petitioner's TTD rate of $253.00.

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

Petitioner testified he continues to suffer from bilateral hand pains. He testified his hands are tender in the center and he has a jerking feeling when he holds things. He said his left hand is a bit worse than his right hand. He struggles with pulling activities like tying his shoes. For treatment, Petitioner testified he takes 500mg Tylenol a few times a week.

The Arbitrator finds Petitioner sustained a permanency loss of 10 % loss of the use of the right hand and 10% loss of the use of the left hand pursuant to Section 8(e) of the Act.

15IWCC0354

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
12WC31636
SIGNATURE PAGE

Signature of Arbitrator

December 10, 2013
Date of Decision

DEC 10 2013

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Sibrava,

Petitioner,

15IWCC0355

vs.

NO: 11 WC 32887

Hoist Lift,

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

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

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

15IWCC0355

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: MAY 19 2015

David L. Gore

DLG/gaf
O: 5/7/15
45

Stephen Mathis

Mario Basurto

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

15IWCC0355

SIBRAVA, RONALD
Employee/Petitioner

Case# **11WC032887**

HOIST LIFT
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:

0365 BRIAN J McMANUS & ASSOC LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MICHAEL D SPINAZZOLA
210 W ILLINOIS ST
CHICAGO, IL 60654

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)

15IWCC0355

Case # 11 WC 32887

Consolidated cases: _____

Ronald Sibrava
Employee/Petitioner

v.

Hoist Lift
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 **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. ☒ 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 _____

15IWCC0355

FINDINGS

On the date of accident, **July 25, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned $; the average weekly wage was **$960.80**.

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and **$10,792.19** for other benefits, for a total credit of **$10,792.19**.

ORDER

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Fees and Penalties:

A failure to pay because of a good faith belief that no payment is due will not warrant a penalty. Respondent's actions are consistent with the Act, Respondent's nonpayment, underpayment, or delayed payment cannot be deemed vexatious or without just cause, and Section 19(k) and 19(l) penalties are denied.

Respondent has acted in accordance with the Act, it should not be held liable for Petitioner's attorney's fees in his effort to establish otherwise, and Section 16 fees 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.

Deborah L. Simpson
Signature of Arbitrator

June 20, 2014
Date

ICArbDec19(b)

JUN 23 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Sibrava,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 32887**
	)	
Hoist Lift,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on July 25, 2011, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner' average weekly wage was $960.80 and pursuant to Section 8j of the Act Respondent is entitled to a credit of $10,729.19.

At issue in this hearing is as follows: (1) Did Petitioner sustain accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of his employment with the Respondent; (2) Did the Petitioner give the Respondent notice of the injury within the time limits of the Act; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is the Respondent liable for the unpaid medical bills in Petitioner's Exhibit #11; (5) Is Petitioner entitled to TTD from July 26, 2011 through June 13, 2013; and (6) Is the Petitioner entitled to penalties and attorney's fees under Sections 16 and 19 of the Act.

STATEMENT OF FACTS

The Petitioner has been employed by the Respondent since November of 1994. Petitioner works on a "CNC" machine, which Petitioner explained is a "Computer Numeric Control" machine cutting alloys and steel for car parts. Petitioner is responsible for both running and maintaining the machine. On a daily basis, Mr. Sibrava's job entails wrenching, lifting, setting up the machines to run the parts, etc. The physical part of running a "CNC" machine entails performing a lot of grinding, wrenching, Allen wrenching, lifting parts, installing parts, and installing tools into the machines.

Petitioner testified that he never had a work injury while employed by the Respondent other than the one that occurred on July 25, 2011. Petitioner's personnel file contains an "Employee Performance Review", which was performed by Petitioner's supervisor, Sebastian Kowal, on April 29, 2011 grading Petitioner as an employee. (PX 14) Petitioner was rated as

excellent in honesty, productivity, cooperation and communication skills. In addition, he was rated as good in terms of work quality, technical skills, work consistency, enthusiasm, attitude, initiative working relations, creativity, punctuality, dependence, and attendance. (PX 14) The Arbitrator notes this review was taken three months before Petitioner's work injury.

Petitioner testified that on July 25, 2011 while moving a part which resembled a hockey puck of steel, while lifting and twisting the part began to teeter and when Petitioner was trying to gain control of the part it pulled him over causing pain in his back and neck. At the end of the lifting and securing process, Petitioner stated that he noticed pain and radiation on his right side.

Petitioner testified that he did not tell anyone from work about the accident on July 25, 2011, rather he finished out his day. The accident occurred around 1:30 pm and as the day progressed Petitioner said his symptoms became worse.

According to the Petitioner, the night between July 25, 2011 and July 26, 2011 caused him a lot of tossing and turning in bed as well as increased neck and back pain. Petitioner said that he went into work on July 26, 2011 but was probably only able to work an hour or two. On July 26, 2011, Petitioner claims he told Sebastian Kowal about his July 25, 2011 accident. At 6:30 p.m. on the night of July 26, 2011 Petitioner claims he sent Marty Flaska a text to the effect that "I injured myself and I had numbness and tingling in my right side from my toe up through my hand." The Arbitrator notes that the U.S. Cellular records introduced via subpoena in Petitioner Exhibit #9 verify that a text message was sent by the Petitioner to Mr. Kowal, however the contents of the text message were not available. (PX 9)

Petitioner also testified that on July 26, 2011 at around 11:30 a.m. he left a voicemail message for Marge Gatz, Respondent's human resources manager, about the work injury.

Petitioner was seen by Dr. Lebo at MacNeal Hospital on July 15, 2011 for a CT sinus screening. On July 19, 2011, a letter from Dr. Kurtzman to Dr. Tong reports Petitioner claiming upper respiratory problems related to inhaling of fluids at his job. His examination that day was unremarkable and he was told to follow up in 3-4 weeks. He was then seen on July 22, 2011 by Dr. Richmond, which was memorialized in a letter to Dr. Tong. Petitioner again reported using oil-based coolants at work, which he believed were causing his symptoms. (PX 1)

Petitioner testified he was injured on July 25, 2011, when his right arm was pulled due to a piece of steel falling out of the chock he was loading it into. The piece of steel allegedly teetered in the chock and pulled Petitioner's arm down as it fell out. He testified he felt an immediate onset of back and neck pain at that time. He claimed this injury occurred at approximately 1:30pm and he did not report the injury to anyone at that time. Petitioner claimed he worked the remainder of his shift.

Petitioner claimed to return to work on July 26, 2011 and "punched in" for the day. He claimed that he punched in at 6:00 a.m. and worked "an hour or two". At that time, he claimed he told Sebastian Cowl of his injury.

Petitioner reported to Dr. Tong of Riverside Family Practice on July 28, 2011 with complaints of "tightness" in his right forearm for two weeks. He complained of numbness and tingling which were worse at night in bed. The office note indicated Petitioner recalled no injury

which caused his symptoms. (PX 1) Petitioner claimed on cross-examination that he did not report this history to Riverside Family Practice. He was given Celebrex, wrist splints and a tennis elbow strap. On July 30, 2011, Petitioner called Riverside and reported the Celebrex was intolerable. The note from that date suggests a steroid injection for epicondylitis. He was supposed to follow up in two weeks, there were no medical records offered to establish that Petitioner followed up as instructed. (PX 1)

On September 6, 2011, Petitioner began treating with a chiropractor, Dr. Cawley, of Avenzado Quiropractico. Dr. Cawley recorded Petitioner's history of accident as "Patient states pain occurred as a result in an attempt to[sic] at maneuver a heavy piece of machinery over 500 pounds. This is normal in his line of work. The oversized heavy piece of machinery became lose [sic] and unattached from its proper position and in attempt to hold position he experienced severe pain extending from neck. Down into right shoulder, arm and into hand." Petitioner testified on cross-examination that he did not report this history to Dr. Cawley. (PX 3)

Petitioner treated with Dr. Ring, who performed steroid injections and he attended physical therapy at Avenzado Quiropractico. He was referred to Dr. Malek for a neurosurgical consult by Dr. Ring. (PX 2, 3)

Dr. Malek examined Petitioner on February 24, 2012. Dr. Malek took a history of Petitioner picking up a steel slug from a tub. He recorded a history of three epidural injections that provided good initial response; however, did not last. Dr. Malek reviewed a cervical MRI scan, which revealed a degenerative cervical spine with osteophytes at multiple levels. (PX 4) Dr. Malek noted that Petitioner was taking an anti-inflammatory and resting, participated in physical therapy for about nine months, unfortunately his symptoms did not improve. Dr. Malek has made a cervical surgery recommendation, which Petitioner is desirous to undergo, but Respondent has not authorized. (PX 4)

On Arbitrator Exhibit #1, the Illinois Worker's Compensation Commission Request for Hearing the Petitioner alleged that he reported the alleged injury to Marty Flaska, Marge Gatz and John Gilbert. In his testimony Petitioner denied ever telling John Gilbert of the alleged injury. Instead, Petitioner testified to having told Marty Flaska, Marge Gatz and Sebastian Cowl.

On cross-examination, Petitioner confirmed he was "absolutely 100 percent positive" he was injured on July 25, 2011. He admitted he first hired Richard Volpe as his attorney and filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. This application indicates Petitioner suffered a repetitive trauma injury. The date of accident on this application is July 28, 2011. Petitioner signed this document indicating his allegations on the first application were true and correct.

John Gilbert testified that he works for Respondent as a main assembly supervisor. He has worked for Respondent for about 20 years. He testified that he worked with Petitioner for Respondent. He testified that he knew Petitioner had a second job installing carpet. Petitioner claims he never worked installing carpet. Mr. Gilbert explained Petitioner told him he installed carpet in 2010 or 2011. Mr. Gilbert had asked Petitioner to repair carpet in his home as some side work. Mr. Gilbert explained Petitioner declined the work as Petitioner did not believe he would make any money as it was too far to travel and he had other side jobs he was doing.

Mr. Gilbert explained when a work injury is reported he fills out an accident report, paperwork for the clinic and sends the injured worker to the clinic for treatment. He explained he never filled out paperwork for an injury reported by Petitioner. He never sent Petitioner to the work clinic. Petitioner admitted he did not report an injury to Mr. Gilbert.

Marty Flaska was called to testify as well on behalf of the Respondent. He is the owner of Respondent. Mr. Flaska oversees all major projects and has worked in the shop, as well as used the machine Petitioner claims to have been using when he was injured. Mr. Flaska discussed Respondent's policy for handling workers' compensation claims and explained the shop area is under surveillance, and the tapes are saved for approximately two weeks. Mr.Flaska explained that for the reporting of a normal injury, the surveillance tape would be saved to confirm the incident, the employee would give a statement and the employee would be sent to a clinic close to the factory, assuming they did not need emergency treatment. Mr. Flaska testified that Petitioner did not report the alleged lifting incident, which is why he did not save the video surveillance, fill out an accident report or send Petitioner to the local clinic. Respondent has a policy of trying to return injured workers to work as soon as possible. Mr. Flaska explained they will accommodate up to sedentary restrictions, which is the position Petitioner was eventually offered, despite the disputes over his alleged injury.

Mr. Flaska also testified about the lifting equipment available in the shop. He explained each work station has an overhead crane that has either a magnet or strap that could be used. He explained workers would load the part into the chock using the overhead crane and a strap and release the strap once the part was secured in the chock. He explained the position Petitioner was working required very little lifting due to the ability to use the overhead cranes. Mr. Flaska encourages workers to use the crane. He explained he is not sure of the exact part Petitioner was lifting, however, given the description of a "steel hockey puck" it would be either a mast roller or a chain roller. Respondent introduced pictures of the area that the Petitioner was working in when he claimed he was injured. Mr. Flaska indicated in red pen the crane over the CNC workstation. In green he indicated the actual CNC machine and explained the safety mechanisms on the CNC lathe machine.

Mr. Flaska explained Petitioner never told him of the alleged incident regarding the "steel hockey puck". He had exchanged messages with Petitioner regarding Petitioner missing time from work due to Petitioner being sick. Mr. Flaska recalls Petitioner complaining of coolants used in the shop that were allegedly making him ill. This is supported by Petitioner's medical records. Mr. Flaska asked Petitioner to bring something to substantiate his complaints; however, Petitioner never did. Mr. Flaska explained he wanted Petitioner to return to work; however, Petitioner was looking for more time off. When Mr. Flaska was not willing to allow Petitioner to take more time off of work, Petitioner began complaining of being in pain from his work, which Mr. Flaska did not take seriously because Petitioner had been missing time for allergies.

Mr. Flaska also identified Respondent's Exhibit 5, which is a screenshot of Petitioner's hours for the month of July 2011. On July 25, 2011, Petitioner worked zero hours for Respondent. The next day, July 26, 2011, Petitioner worked zero hours as well, indicating he was not at work on either day. Petitioner had claimed he worked the whole day of July 25, 2011, the day he was injured and for a couple of hours the next day. Mr. Flaska believed Petitioner would install carpet on days he was not at work. Although Petitioner denies ever working

installing carpet, Mr. Flaska explained that he worked in the CNC department with Petitioner for two years when Petitioner was hired and it was during that time he learned of Petitioner installing carpet.

Sebastian Kowal also testified on behalf of Respondent. He worked as Petitioner's supervisor for a short time. He confirmed Respondent's procedures for a work related injury. He denied ever being told Petitioner suffered an injury at work. He admitted that he filled out a performance review in April of 2011 for Petitioner, which stated Petitioner was a good and honest worker. According to Mr. Kowal, at that point in time he believed Petitioner to be honest; however, due to the allegations of a work injury, he no longer believed he was.

Mr. Kowal also explained the procedure for shop employees to clock-in and out. He explained the employees swipe their card, or enter their ID number into a computer which then logs them in the system. They also do this to clock out of the system. In each work area, employees must handwrite their time in and out for the day. This is confirmed with the computer data at the end of each shift by the area supervisor. Kowal was the supervisor working on July 25, 2011 and July 26, 2011. The handwritten sign in/out sheets were introduced into evidence at trial. (RX 8) Mr. Kowal confirmed Petitioner did not sign the handwritten sheets on either July 25, 2011 or July 26, 2011.

Kerrie Konow was also called to testifyon behalf of the Respondent, she is the payroll clerk for Respondent. She is responsible for ensuring employee's hours are logged and proper paychecks are issued. She explained pay periods run from Thursday through Wednesday, with checks being issued on Thursday. She testified that the workers in the shop clock in/out using computers and an ID card they swipe. They can also manually enter their number into the computer.

According to the payroll/time records for the pay period of July 21, 2011 through July 27, 2011, Petitioner worked 11.25 hours. On July 21, 2011, Petitioner worked 8 hours and then worked 3.25 hours on Friday, July 22, 2011. He worked no other hours that pay period. Petitioner was paid by check that was issued the following Thursday, July 28, 2011. That paystub was entered into evidence as Respondent's Exhibit 6. The cancelled check, showing Petitioner's signature on the back was introduced as Respondent's Exhibit 7. Ms. Konow indicated these accurately reflected both the hours worked by Petitioner, as well as the payroll entered for Petitioner.

According to Ms. Konow shop employees are hourly workers, whereas office staff are salaried employees. The salary based employees do not have to punch in/out as the hourly shop employees do. She explained Petitioner is currently asked to submit a handwritten sheet submitting his hours because he is working light-duty in the office, rather than in his typical shop position, where he would clock in/out. His current position does not require him to go into the shop where the computers for clocking in/out are located.

Marge Gatz testified that she is the Human Resources manager for Respondent. She handles all aspects of Respondent's human resource issues, as well as coordinating workers' compensation claims with the insurance carrier. She received an application for adjustment of claim, which was admitted as Respondent's Exhibit 2, on or about September 1, 2011. The

application is file stamped "August 23, 2011" and sets forth allegations of a work related injury that was repetitive trauma in nature. It alleged a date of accident of July 28, 2011. Ms. Gatz forwarded the application to the insurance carrier upon receipt of the same. She explained that she may have received a voicemail from Petitioner around the time of the alleged injury; however, she was not certain of the messages details. She recalled Petitioner complaining of allergy type symptoms around the same time period.

Ms. Gatz also handles unemployment claims from former employees. She testified that the Respondent disputes unemployment claims as needed, but does not dispute every allegation on the notice. The unemployment notice contained in Petitioner's Exhibit 14 states the last day worked was July 25, 2011. According to Ms Gatz 9 out of 10 times the last day worked is wrong on the notice. She explained that the last day worked is reported by the terminated Employee, not the Respondent. Notably, the notice being reported by Petitioner contradicts the Petitioner's testimony he claimed to have worked 1-2 hours on July 26, 2013.

CONCLUSIONS OF LAW

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

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).

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

The burden 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)

While it is true than an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits

when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d. 213, 46 Ill. Dec. 687, 414 N.E. 2d 740 (1980).

Did Petitioner sustain accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of his employment with the Respondent?

A workers' compensation claimant bears the burden of proving all of the essential elements of his claim by a preponderance of the evidence. *Knox County YMCA v. Indus. Comm'n,* 311 Ill.App.3d 880 (2000). For an injury to be compensable under the Workers' Compensation Act, the injury must "arise out of" and "in the course of" the employment. (Ill.Rev.Stat.1987, ch. 48, par. 138.2.) The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. *Caterpillar Tractor Co. v. Indus. Comm'n,* 129 Ill. 2d 52, 57 (1989). The Arbitrator finds Petitioner failed to prove he suffered an accident arising out of and in the course of his employment on July 25, 2011. Therefore, benefits are denied.

While it is true than an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d. 213, 46 Ill. Dec. 687, 414 N.E. 2d 740 (1980). In the present case, the Petitioner was not a credible witness and the physical evidence, the statements made by Petitioner at times other than the day of the hearing as well as the documents and records, contradict the Petitioner's testimony.

Petitioner testified he was "absolutely positive" he was injured at work on July 25, 2011. Respondent introduced payroll information that proves Petitioner's claim to be false. First, the payroll accounting printout entered as RX # 5 clearly shows no hours logged on either July 25, 2011 or July 26, 2011. Petitioner had claimed to have been injured on July 25, 2011 and going home early from work on July 26, 2011. When Petitioner testified on direct examination, he was unequivocal that he "punched in" on July 26, 2011. The evidence does not support the Petitioner's claim. When he testified on rebuttal, Petitioner attempted to claim he had to turn in handwritten time sheets on Wednesdays; however, given the multitude of other evidence, that is simply not believable. Ms. Konow explained Petitioner's claims of turning in hours as something related to his current light-duty position, not something he would have been doing in 2011.

Additionally, Respondent presented RE #8, which is the daily production sheet. Each shop employee fills this out on his shift day and the hours are verified by the supervisor versus what is recorded in the computer where employees swipe in/out. Petitioner did not fill this sheet out on either July 25, 2011 or July 26, 2011. Petitioner worked on July 21, 2011 as evidenced by RX # 5. Petitioner also signed in/out that day as evidenced by RX #8. Petitioner worked a total of 8 hours on this date, which happened to be the first day of the pay period ending on July 27, 2011. Petitioner worked the following day, July 22, 2011, as evidenced by RX # 5 and 8 for 3.25 hours. Each day for the remainder of the pay period, Petitioner failed to appear for work, as evidenced by both RX #5 and #8. Petitioner did not return to work for Respondent until

recently, when he accepted the light-duty job offer referenced in PX #8. It is hard to believe Petitioner swiped in/out on 2 days of the pay period in question and also signed the daily production sheets but then mistakenly failed to swipe in/out or sign the daily production sheet on the alleged date of accident or the day after, when he claimed to have punched in.

The Arbitrator also finds Petitioner's story to be unbelievable based on the paystub entered as RX #6 and the cancelled paycheck entered as RX #7. The paystub reflects wages paid for the two days (July 21st & 22nd) Petitioner worked during the July 21-July 27, 2011 pay period. The paystub is for 11.25 hours, which resulted in net pay to Petitioner of $186.39. This figure matches the cancelled check, RX #7 which bears Petitioner's signature on the back. It simply does not make sense that Petitioner accepted a payroll check that did not accurately reflect the hours he claimed to have worked. Furthermore, Petitioner claimed he was not paid for July 25, 2011 or July 26, 2011 because "[he] wasn't there on Wednesday to turn them in". While he may not have been at work, Petitioner's explanation does not comport with the rest of the evidence. Petitioner admitted being paid for the pay period in question. He admitted cashing the payroll check. It simply does not make sense that Petitioner would work for four days, that he was paid for two days, and failed to be paid for two other days and accept the situation rather than try to correct it at the time when everything would be fresh in people's memories. By Petitioner's accounts this payroll check would have had to be 8-10 hours short, based on Petitioner's allegations of working July 25th and July 26th of 2011, and should have been close to double the amount he was paid.

Additionally we have the contradictions contained in the medical records. Petitioner reported to Dr. Tong on July 28, 2011 and gave a history of numbness and tingling for the past two weeks. (PX 1) Dr. Tong recorded a history indicating there was "no injury recalled" by Petitioner. This was a mere three days after the alleged accident. It is simply unbelievable Petitioner would have seen his family doctor shortly after the alleged accident, made complaints about right sided pain, but then reported he did not recall an injury, if the July 25, 2011 incident had in fact occurred. After seeing Dr. Tong, Petitioner did not seek any treatment whatsoever for over a month. When asked by counsel what he was doing during time where he was not treating, Petitioner testified "Not much. I wasn't working."

Petitioner filed an application for adjustment of claim, indicating he was injured on July 28, 2011 due to a repetitive trauma injury. Petitioner testified he signed that document as true and correct. Petitioner filed an amended application for adjustment of claim in November of 2012. This application alleged a specific incident resulting in Petitioner's injuries. This incident is the alleged accident of July 25, 2011. Petitioner testified he signed this document as true and correct as well. While it is plausible Petitioner believed he suffered from carpal tunnel at one point, it is not plausible that he went from alleging a repetitive trauma injury to a specific accident he suddenly recalled well after he began treating for carpal tunnel symptoms. Dr. Tong's record makes clear Petitioner's version of events is suspect, as he made complaints that started well before the alleged accident date and indicated there was no specific injury he recalled.

Petitioner was seen by Dr. Cawley on September 6, 2011. Dr. Cawley took a history of a 500lb machine falling and Petitioner having to catch it. Petitioner denied telling Dr. Cawley a 500lb machine was falling. This is the second treating physician with whom Petitioner took issue with the history recorded. Even the history given later to Dr. Malek is not completely

consistent with Petitioner's version of events at trial. Dr. Malek's records indicate Petitioner was lifting a tub and a metal slug slid out of the tub while Petitioner was twisting. This history is more similar to Petitioner's version at trial; however, it is still not the same story.

Finally, Petitioner claimed to have told Marge Gatz, Marty Flaska and Sebastian Kowal that he was injured due to this incident on July 25, 2011. Besides Petitioner not working on that date, each of these people appeared at trial and testified Petitioner did not report this incident of loading a piece of metal into the chock. According to Mr. Flaska Petitioner had been complaining of allergies and sinus problems due to coolant used in the shop. When he asked Petitioner to bring proof of that allegation Petitioner then told Mr. Flaska that he was in pain from work. Mr Flaska admitted that he blew this allegation off; as it came after he had told Petitioner he needed him back at work or to bring a doctor's note to remain off. Ms. Gatz testified she may have received a voicemail from Petitioner; however, she did not recall the contents of that call. She learned of the alleged repetitive trauma injury allegations when she received the first application in early September of 2011. Mr. Kowal testified he was never told of an injury by Petitioner. He testified the lack of a sign-in and out time on RX #6 indicated Petitioner was not there on the alleged date of the accident. He indicated he signed the bottom of each daily sheet and cross-referenced them with the computer swipe-in/out system.

Finally, Petitioner alleges on the request for hearing form he told John Gilbert of his injury on July 25, 2011. Gilbert was present and denied ever being told of Petitioner suffering an injury at work. Petitioner admitted during his testimony that he did not tell Gilbert he was hurt at work; contradicting his allegations on the request for hearing sheet.

Taken together, the inconsistencies in Petitioner's story undermine his credibility. Further, the evidence submitted by Respondent showing Petitioner did not work on the date in question, combined with the supporting payroll evidence and multiple witnesses disputing Petitioner told them of an accident are overwhelming. Petitioner failed to prove by a preponderance of the evidence that he suffered an accidental injury arising out of and in the course of his employment on July 25, 2011.

Did the Petitioner give the Respondent notice of the injury within the time limits of the Act?

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure?

Is the Respondent liable for the unpaid medical bills in Petitioner's Exhibit #11?

Is Petitioner entitled to TTD from July 26, 2011 through June 13, 2013?

Is the Petitioner entitled to penalties and attorney's fees under Sections 16 and 19 of the Act?

The Petitioner having failed to prove that he suffered a compensable injury on July 25, 2011, the other issues raised at the hearing 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.

A failure to pay because of a good faith belief that no payment is due will not warrant a penalty. See generally, *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 302, 412 N.E.2d 470 (1980). Where Respondent's actions are consistent with the Act, Respondent's nonpayment, underpayment, or delayed payment cannot be deemed vexatious or without just cause, and Section 19(k) and 19(l) penalties must be denied. Where Respondent has acted in accordance with the Act, it should not be held liable for Petitioner's attorney's fees in his effort to establish otherwise, and Section 16 fees should be denied.

Deborah L. Simpson
Signature of Arbitrator

June 20, 2014
Date

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

Keith Tuhowski,

Petitioner,

15IWCC0356

vs.

NO: 12 WC 38310

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 2013 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: MAY 19 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 5/7/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TUHOWSKI, KEITH
Employee/Petitioner

Case# **12WC038310**

15IWCC0356

VSGI LLC
Employer/Respondent

On 12/5/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2998 MARKER & MARKER ASSOC
JASON A MARKER
4015 PLAINFIELD-NAPERVILLE RD
NAPERVILLE, IL 60564

1454 THOMAS & ASSOCIATES
MICHAEL PILLER
300 S RIVERSIDE PLZ SUITE 2330
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

15IWCC0356

Keith Tuhowski
Employee/Petitioner

v.

VSGI, LLC
Employer/Respondent

Case # 12 WC 38310

Consolidated cases: none

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **8/14/13 & 11/6/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0356

On **10/23/12**, 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 **$120,000.00**; the average weekly wage was **$2,307.70**.

On the date of accident, Petitioner was **58** years of age, ***single*** with 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.

ORDER

Denial of benefits

Because Petitioner did not sustain an injury which arose out of and in the course of his employment on 10/23/12, 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.

Carolyn J. Doherty
Signature of Arbitrator

12/3/13
Date

ICArbDec p. 2

DEC 5 - 2013

FINDINGS OF FACT

Petitioner, a construction company project manager, alleges he sustained a mild concussion and related symptoms when he was struck on the back of his head by Jonee Christenson, a co-worker, on 10/23/12. The Respondent denies that any such accident occurred.

Petitioner testified he was in the office of VSGI, LLC, a service disabled, veteran-owned construction company that day. Also present were co-workers Jonee Christenson (wife of company president, Frederick "Rick" Harbour), Mary Wright, and a new receptionist. Petitioner initially testified that he thought two other co-workers, Clay Sheller and John Mc Connaughey were present in the office that day. However, he later testified that they were not present. After a meeting near the reception desk, in which Petitioner used the term, "draws," instead of "pay apps," he turned and walked at least 10 steps back toward his desk, when he heard Jonee say, "They're called 'pay apps,'..." and he was hit or slapped on the back side of his head. He did not see who hit him. However, Christenson was to his right and behind him when he turned around.

Petitioner felt embarrassed, but did not say anything or report the incident to anyone. He just walked back to his desk. He had trouble concentrating but continued working in the office until around 1:30 p.m. when he left to go to a construction job site in Joliet. By 3:30 p.m. he left to go home, and noticed his head was hurting. He also felt pain in his neck, shoulders and spine. Despite this, he continued working at home until 6:00 p.m. that day, working a total of 12 hours according to the time sheet he completed and turned in. (Rx – 4). He did not seek or receive any medical attention that day.

The Petitioner worked 9½ hour days on each of the next two days, 10/24/12 and 10/25/12 (Rx – 4). He testified that he did not seek or receive any medical care on those days.

In his 8/14/13 testimony, Petitioner denied sending an e-mail on 10/23/12, the date of alleged accident, to both his boss, Rick Harbour, and the company's CFO, Mary Wright. In that e-mail, he called Wright a "two faced full of bullshit person," (Rx – 3). When he testified under cross-examination on 11/6/13, Petitioner then admitted that he had sent that e-mail (Rx-3), but gave no explanation why he denied sending it in his earlier testimony.

Petitioner denied having any conversations with Rick Harbour regarding his 10/23/12 e-mail or the alleged occurrence with Christenson, in the days following 10/23/12. He specifically denied a phone conversation with Harbour, who gave testimony that he phoned Petitioner to tell him that he was going to fly to Chicago from his Florida residence meet with Petitioner face to face to discuss the e-mail.

Around 3:00 a.m. on Friday 10/26/13, Petitioner sent an email to Rick Harbour and Jonee Christenson, stating that he would not come in to work that day, and would be going to the emergency room because he could not sleep, and had severe headaches and vision problems after Jonee hit him (Px-1). His first medical attention received following the alleged occurrence was that morning (10/26/12) at Edward Hospital (Px – 5). There, he reported the incident, "happened on October 16 or 17 when he was hit by a co-worker in the back of his head." (Px – 5). He reported pain in his head and neck, headaches, fading vision, and decreased sleep. He gave a prior history of panic attack(s). At the time, he provided a list of 9 prescription medications he was taking for diabetes, high blood pressure, and high cholesterol, among other unrelated health issues. After his emergency room exam, Petitioner was discharged to his home with instructions to not work, avoid driving, and follow up with a neurologist.

Petitioner never returned to work at VSGI, LLC after that date. On 10/26/12, after he left Edward Hospital, Petitioner filed a report with the Oakbrook Terrace Police Department (Rx – 5). Those records show Petitioner reported he was struck in the rear of his head or neck (reporting that he did not know which) by Christenson on October 16, 2012. He told the police that he was not sure whether it was with an open or closed hand. Petitioner reported 2 co-employees, Clay Sheller and John Mc Connaughey as potential witnesses to the incident, but the police report notes that each of them were contacted by the reporting officer and each, "was unaware of any altercation between Tuhowski and Christenson," and each, "did not witness any battery." (Rx – 5, p.3).

Both Messrs. Sheller and Mc Connaughey credibly testified on behalf of Respondent that they never witnessed the occurrence alleged by petitioner, nor ever saw Christenson touch Petitioner at any time.

In a 10/31/12 follow-up note, the reporting officer wrote that Petitioner had not followed up with a neurologist as instructed by the E.R. doctor and also, Petitioner's report of the incident had "vague details and no witnesses." (Rx – 5, p.6). The report also noted, "TUHOWSKI stated he has been working with his wife attempting to narrow down the incident date by process of elimination from e-mails he has on his computer. TUHOWSKI also stated the original witness's (sic) SCHELLER and MC CONNAUGHEY did not witness the incident as originally reported, but WRIGHT, Mary may have witnessed the battery but would be biased due to being the owner's sister." (Rx-5, p.6). The police records contain a letter from Petitioner dated 10/31/12 in which Petitioner changed the date of his alleged battery from 10/16/12 to 10/23/12, claiming he was not thinking clearly due to headaches when he initially reported that the alleged occurrence took place on 10/16/12.

In an 11/1/12 notation in the police report, the investigating officer reported that Petitioner told him, "he knows he is going to get fired." (Rx – 5). The reporting officer also noted his investigation with Respondent revealed two members of Petitioner's family previously worked for Respondent and "discontinued employment with the company via a lawsuit." Petitioner's wife also worked for Respondent but quit in August 2012. RX 5, p. 7. The police investigation was concluded with status of the "battery" allegation listed as, "unfounded." (Rx – 5, p. 7).

Petitioner testified he never suspected he would be fired until the moment he received a certified letter dated 12/12/12 from his boss Rick Harbour, terminating him because of his "unacceptable job performance and … unacceptable interpersonal relationships with co-workers and customers." (Rx – 4).

Following his 10/26/12 ER visit, Petitioner did not receive further treatment until he saw his primary care physician, Dr. Anthony Fernandez, MD, on 11/14/12. Dr. Fernandez examined and treated Petitioner that day for diabetes as well as for other ongoing medical issues. RX 7. On 11/14/12, Dr. Fernandez noted that Petitioner's diabetic control was "poor." He performed a review of systems and a physical exam, following which he reported in his office notes that Petitioner, "Denies headaches," and was in "no apparent distress," and that he "feels well otherwise." (Rx – 7, p. 77). Dr. Fernandez spent time talking to Petitioner about problems Petitioner was having with depression, working on holidays, not getting vacation time and, "now, company may lay off people,…" (Rx – 7, p. 74). Dr. Fernandez made a notation about Petitioner's stress, though nowhere in his records did he report that Petitioner told him about the alleged 10/23/12 slap on the head or any of the multiple symptoms which Petitioner claimed began shortly after 10/23/12. Dr. Fernandez, noting that Petitioner "needs vacation", increased Petitioner's prescription of Effexor and refilled Klonopin, drugs previously prescribed to Petitioner. Petitioner saw Dr. Fernandez again on 11/17/12 for a diabetes check and again there was no mention of a slap at work on 10/23/12. RX 7. Again, Petitioner denied headaches. RX 7, p. 83. The first mention of a work incident to Dr. Fernandez was on 1/17/13. PX 5.

Petitioner testified that when he saw Dr. Fernandez on 11/14/12, he told him about the alleged 10/23/12 slap to his head, as well as all of his symptoms he claimed began thereafter. He denied telling Dr. Fernandez that he "felt well" and wasn't having headaches at the 11/14/12 office visit, and claimed that Dr. Fernandez's records were inaccurate for stating otherwise.

Although Petitioner testified that he was in good health prior to 10/23/12, records admitted into evidence show that prior to that date, Petitioner had been diagnosed with and treated for diabetes, stress, anxiety, obsessive-compulsive disorder, depression and panic attacks, for which he was prescribed Clonazepam (Klonopin), as far back as 2006 (Rx – 7, pp. 3,9,12,15,18). Petitioner also likely suffered from migraine headaches, before 10/23/12, even if they were not diagnosed as such, according to Dr. Larsen. (Px – 10, pp. 65, 66).

Petitioner first saw Dr. David Larsen, MD, a neurologist, on 11/16/12. Petitioner chose Dr. Larsen because this doctor had previously treated his son. Petitioner told Dr. Larsen the occurrence was more of a slap than a punch, and with an open hand (Px – 10, p. 8). He admitted to Dr. Larsen that before 10/23/12 he had experienced "stretches of mild daily headaches" along with really bad headaches for which he'd actually have to lay down. (Px-8, 11/16/12 note, p.1). Petitioner claimed that his headaches after 10/23/12 were different (Px – 10, p.8). Dr. Larsen testified that Petitioner had a family history and predisposition to migraine headaches (Px – 10, p. 13). Dr. Larsen believed that Petitioner experienced migraine headaches before October 2012 (Px – 10, pp. 65-66). Dr. Larsen thought Petitioner suffered from a mild concussion and probably low-grade migraines as a result of the 10/23/12 alleged occurrence. (Px – 10, p. 15).

Dr. Larsen testified Petitioner has some psychiatric history with anxiety. Though Petitioner denied ever taking Clonazepam for anxiety, Dr. Larsen testified that prior to seeing him Petitioner had been taking Clonazepam, 2 milligrams, twice a day for anxiety (Px – 10, p. 16). In addition, Petitioner had also been treated for stress and hypertension (Px – 10, pp. 43, 44, 61.). Persons experiencing anxiety and stress can have tightness in their neck and head muscles, and experience headaches. (Px – 10, p. 50).

On cross-examination, Dr. Larsen admitted that other than what Petitioner described to him, and if Petitioner had been slapped on the head, Larsen had no knowledge of the force or type of trauma allegedly sustained (Px-10, p.43,60). He testified that it would be difficult to understand how much force was involved without actually seeing the slap (Px-10, p.43). In testifying that Petitioner's increased headaches and migraine condition were causally related to the reported slap on the head, Dr. Larsen opined that the small amount of force from the slap of a hand could "easily" be enough force to cause a concussion and the aggravation of Petitioner's preexisting predisposition to migraines. PX 10, p. 40,41.

Dr. Larsen agreed that the ER records from Edward hospital on 10/26/12 (Px – 5) showed that when Petitioner was seen there, he had no abnormal objective findings on physical exam except for tenderness and soreness on Petitioner's head, and possibly a decrease in his range of motion. The ER records showed an essentially normal neurologic exam, though Dr. Larsen said he would not rely upon these ER records or "the workman's comp doctors either" in performing a neurologic exam. (Px – 10, pp. 49, 53-58).

Dr. Larsen admitted there was no objective way to determine when the symptoms of which Petitioner complained, began (Px – 10, p. 59). Although Petitioner complained of trouble concentrating, Dr. Larsen testified that the neurological test he conducted for this on Petitioner was normal (Px-10, p.62).

Dr. Larsen noted that Petitioner had a lot of difficulty following directions (Px – 10, p. 62). However, other records admitted into evidence show that the Petitioner had problems following his doctors' instructions prior to 10/23/12. For example, during a 5/31/07 office visit, Dr. Dominic Costibile reported, "...I think he has

difficulty understanding instructions," (Rx – 7, 5/31/07 visit, p.11.) Also, a 12/31/05 office note reports, "...he is not checking glucoses. He is not carbohydrate counting. He is really not doing his part." (Rx – 7, p. 18).

Dr. Larsen also testified that there are other causes beside concussions, for a number of the symptoms that Petitioner alleged. Individuals who are sleep deprived could demonstrate similar symptoms, and some prescription medications that Petitioner was taking could cause confusion and blurred vision (Px – 10, p. 63). Dr. Larsen said he did not rule out other causes beside a concussion of Petitioner's blurred vision, and he admitted there could be other causes for this symptom that he may have missed. (Px – 10, pp. 63-64). Some of Petitioner's symptoms could be caused by migraine headaches. Dr. Larsen testified that patients experiencing migraine headaches often show signs of confusion and have trouble understanding words. They also have trouble talking, and have trouble if you talk too fast. (Px – 10, p. 62).

Dr. Larsen agreed that in addition to stress and anxiety, hypertension could cause headaches (Px – 10, p. 67). Petitioner had been diagnosed with all of these conditions prior to October 2012, and had been prescribed medications for each of them. Other than what Petitioner reported to him, Dr. Larsen said there was no way to determine when Petitioner's dizziness first developed. (Px – 10, p. 69).

Dr. Larsen depended on Petitioner to give him an accurate history of the frequency and severity of his headaches (Px-10, p. 66). Dr. Larsen's diagnosis of a mild concussion was based largely upon Petitioner's description of the force of the slap and his subjective complaints that Petitioner related (Px – 10, p. 70). He also acknowledged that the symptoms of which Petitioner complained, "certainly could have" been present prior to October 2012 and that the symptoms could have worsened without an instigating concussion or trauma given Petitioner's age and physical history. (Px – 10, p. 71,72).

Finally, Dr. Larsen testified that if, in fact, Petitioner had not been struck in the head or touched at all, or if he had exaggerated or made up his symptoms, there could be other explanations for the symptoms of which Petitioner complained, though he did not think those likely. Some of the other causes could include: weather changes, weight gain, increased stress, and even changes in the prescription medications that Petitioner had been taking, including Effexor. (Px – 10, p. 73). Dr. Larsen thought the slap was more likely the cause of the increased headaches given Petitioner's lack of prior treatment for headaches. PX 10, p. 75.

On behalf of Respondent, Frederick Harbour testified that he is the President of VSGI, LLC; that prior to 10/23/12 the Petitioner did not get along well with Mary Wright, the company's Chief Financial Officer; and that he received an e-mail from Petitioner dated 10/23/12 (Rx – 3) in which Petitioner was disrespectful or inappropriate to Wright. Harbour testified that after he received that e-mail, he called and spoke to Petitioner by phone, telling him he was flying up to Chicago to meet with him to discuss it. He testified that he had planned to fire Petitioner. Harbour testified that, during his phone call with Petitioner, Petitioner made no mention of the alleged 10/23/12 incident with Christenson.

Mr. Harbour further testified that prior to 10/23/12, he had told Petitioner to stay away from the Hines VA Hospital work site because of that customer's complaints about him, but that Petitioner had ignored that order. Because Petitioner never returned to work after 10/25/13, Harbour eventually had to terminate Petitioner by sending him the letter dated 12/12/12, in which he stated the reasons for the termination (Rx-4).

Jonee Christiansen testified for Respondent. She testified that Petitioner often incorrectly used the term, "draws," instead of the correct name, "pay apps." She often had to correct him about this. She did not get angry when he used the wrong term; she would remind him of the correct term. She denied ever slapping, hitting or touching Petitioner on 10/23/12, or on any other date.

Mary Wright, CFO of VSGI, LLC, testified for the Respondent. She testified that Petitioner was often disrespectful to her prior to 10/23/12 and he had been previously warned by Rick Harbour to stop sending sarcastic and derogatory e-mails to her (Rx – 2). She was in the office on 10/23/12 but she never observed Jonee Christiansen hit or touch the Petitioner on that or any other date.

As noted above, both Clay Sheller and John Mc Connaughey each testified for Respondent that they never observed Jonee Christiansen strike or touch Petitioner on any date. On 10/23/12, both of these employees reported to Petitioner as their supervisor.

CONCLUSIONS OF LAW

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

IN SUPPORT OF THE ARBITRATOR'S FINDING RELATING TO "C," DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes numerous inconsistencies between Petitioner's testimony and the other testimony and records presented at trial. Aside from Petitioner's own reports to his employer, his treaters and the Oakbrook Terrace police, there is no evidence corroborating his claim of being slapped on the head on 10/23/12. Petitioner's credibility is therefore paramount in proving his claim. Petitioner did not see who allegedly struck him because he was struck from behind. He testified that he was struck on the back of his head by Jonee Christiansen and that he assumed he was struck by her hand as he did not see Jonee holding anything when he turned around. However, Petitioner's testimony regarding this occurrence, including the date of the occurrence, was contradicted by 4 other witnesses, his initial treating records and the police reports.

Regarding the alleged occurrence itself, Jonee Christiansen testified and denied slapping or even touching Petitioner at any time. The three witnesses whose names Petitioner reported to police (Mary Wright, Clay Sheller and John Mc Connaughey), each credibly and pointedly testified and denied observing any such occurrence or touching by Christenson.

Petitioner's testimony regarding other issues beside the alleged slap is important in evaluating his credibility. Initially, Petitioner denied he was told by Harbour to stay away from the Hines VA jobsite, but in later testimony Petitioner admitted this. He initially denied sending the 10/23/12 e-mail, but then changed his testimony and admitted it. Petitioner testified that Harbour never called him and told him he was flying in to meet with him after receiving the e-mail. This was denied by Harbour, who testified that he did.

Petitioner first reported to the emergency room of Edward Hospital and to the Oakbrook Terrace police that the alleged occurrence took place on 10/16/12. He later changed the date of the alleged occurrence to 10/23/12. The Arbitrator finds Petitioner's testimony that he struggled with the date due to his head condition unpersuasive in light of the other contradictory testimony offered at trial.

Petitioner testified that he never suspected that his job was in jeopardy any time before 12/12/12, the date he received a termination letter. This is contradicted by his 11/14/12 admission made to Dr. Fernandez and found in his records, that his employer "may lay off people," (Rx – 7, p. 74), and by the 11/1/12 police report note in which Petitioner reportedly said, "he knows he is going to get fired." (Rx – 5, p.7).

Petitioner testified he never received treatment for anxiety or sleep issues before October 2012. This is contradicted by records showing such treatment (Rx – 7, pp. 3, 9, 12, 15, 171 – 174), as well as by Dr. Larsen's testimony that Petitioner had prior psychiatric history of anxiety (Px – 10, p. 16), for which he had been taking Clonazepam, a medication which could cause symptoms if the dosage was changed (Px – 10, pp. 16, 73). Dr. Fernandez increased Petitioner's Effexor, another anxiety medication, on 11/14/12 (Rx – 7, p. 77). The Arbitrator finds Petitioner's testimony that his medications were for claustrophobia unpersuasive in light of the medical evidence presented.

Petitioner claims he told Dr. Fernandez on 11/14/12 about the alleged 10/23/12 occurrence and his subsequent headaches and other symptoms, but this in not corroborated by Dr. Fernandez's records of that date, which contain no mention of the alleged occurrence or of new or worsening symptoms. Rather, Dr. Fernandez noted, 22 days after the alleged occurrence, that Petitioner denied headaches, was in "no apparent distress," and that he "feels well otherwise." (Rx – 7, p. 77). Petitioner testified that Dr. Fernandez's records are incorrect.

Considering all of the evidence as a whole, the Arbitrator does not find the Petitioner to be a credible witness. The Arbitrator places greater credibility and weight on the testimony of Frederick Harbour, Jonee Christiansen, Mary Wright, Clay Sheller and John Mc Connaughey, who each testified that the incident never occurred. Dr. Larsen's opinion that Petitioner suffered a mild concussion and increase in migraine headaches was largely predicated on Petitioner's report which the Arbitrator does not find credible. Accordingly, the Arbitrator finds Dr. Larsen's testimony to not be persuasive or supportive of Petitioner's claim.

From the testimony and demeanor of all the witnesses testifying at trial, the tenor of Petitioner's email exchanges and of Petitioner's notes to the police department, the Arbitrator has little doubt that the work environment was less than then optimum for all employees. However, based upon the totality of the evidence presented at trial, the Arbitrator finds that Petitioner has not met his burden to show by a preponderance of the credible evidence that a work related accident occurred on 10/23/12.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATING TO "E," WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified he notified Rick Harbour and Jonee Christenson of his alleged accident via a 10/26/12 e-mail he sent, stating that he was going to seek medical care as a result of being hit by Jonee (Px-1). Respondent offered no contrary evidence.

The Arbitrator finds that Petitioner did report an alleged incident to the Respondent within the time required by the Act. However, as noted above, the Arbitrator finds that Petitioner did not suffer a work-related accident on 10/23/12.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATING TO "F," IS THE PETITIONER'S PRESENT CONDITION OF ILL BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding on the issue of accident, the issue of causal connection is moot. The Arbitrator notes, however, that even if accident were found, there is no causal connection for Petitioner's current condition of ill-being. In so finding, the Arbitrator notes that Dr. Larsen agreed that if, in fact, Petitioner was never struck by Christiansen as he alleged, there could be other explanations for his symptoms. Dr. Larsen

agreed that his opinions were largely based upon the presumed accuracy of what Petitioner told him regarding his history, description of the alleged occurrence and alleged symptoms (Px – 10, pp. 62-65).

Dr. Larsen testified that he was sure that Petitioner experienced migraine headaches before October 2012, even if they weren't diagnosed or treated as such (Px – 10, pp. 65-66). Dr. Larsen admitted that there was no objective way for him to testify that the migraine headaches Petitioner experienced after 10/23/12 were more severe after 10/23/12, because he had not seen him before that date (Px – 10, p. 69). Likewise, there was no way for him to determine the date when Petitioner's dizziness issues first developed (Px – 10, p. 69). Many of the prescription medications which Petitioner took before 10/23/12 could produce dizziness as a side effect. Though unlikely, Dr. Larsen agreed that had Petitioner not been struck or touched, there were a number of other possible causes that could explain many of his symptoms becoming worse after 10/23/12 (Px – 10, pp. 71-74). Finally, even if Petitioner had sustained a mild concussion, which the Arbitrator does not find, Dr. Larsen noted on 8/8/13 that "It is resolved completely." (Rx-6). There is no current condition of ill-being for which any award is required.

Taking all of the evidence as a whole, the Arbitrator finds no causal connection between Petitioner's alleged condition of ill-being and an alleged 10/23/12 work accident.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATIVE TO "J," WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY, AND, HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's findings on the issues of accident and causal connection, the issue of medical expenses is moot and no finding or award of medical expenses is made.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATIVE TO "K," WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's findings on the issues of accident and causal connection, the issue of temporary total disability is moot and no finding or award of TTD is made.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATIVE TO "L," WHAT IS THE NATURE AND EXTENT OF INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's findings on the issues of accident and causal connection, the issue of permanent partial disability is moot and no finding or award of PPD is made.

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

Kathy Sanders,

Petitioner,

vs.

NO: 14 WC 133

15IWCC0357

State of Illinois DHFS Child Support Division,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 14, 2014, is hereby affirmed and adopted.

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

15IWCC0357

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: MAY 19 2015
TJT:yl
o 5/11/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

SANDERS, KATHY
Employee/Petitioner

Case# **14WC000133**

SOI/DHFS CHILD SUPPORT DIVISION
Employer/Respondent

15IWCC0357

On 10/14/2014, 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 0.04% 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:

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

OCT 14 2014

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

15IWCC0357

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)

Kathy Sanders
Employee/Petitioner

v.

SOI/DHFS, Child Support Division
Employer/Respondent

Case # **14** WC **00133**

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 D. McCarthy**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **September 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 9, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,091.00**; the average weekly wage was **$1,097.91**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $731.94/week for 39 2/7 weeks, commencing 12/10/13 through 9/10/14, as provided in Section 8(b) of the Act.

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the medical treatment recommended by Dr. Gornet, including but not limited to surgery.

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. Byron McCarthy
Signature of Arbitrator

October 8, 2014
Date

ICArbDec19(b)

OCT 14 2014

FACTS

Petitioner is employed by the State of Illinois Healthcare and Family Services, Division of Child Support Services. (T.12). Her current job title is Child Support Specialist 1, a position which she has held for almost 2 years. She started with Corrections in 1999 and transferred to Child Support Services in June or July of 2000. Prior to December 9, 2013, Petitioner filed one workers' compensation claim in 2004 or 2005, where she hit her knee on the bottom part of a desk. However, her claim was denied and she took it no further.

In 2011, Petitioner experienced non-work related left shoulder pain. Her family physician, Dr. William Hays, tried to treat her with muscle relaxers, pain pills, and physical therapy. She underwent an MRI and was referred to Dr. Lyndon Gross at the Orthopedic Center of St. Louis. Dr. Gross saw Petitioner on October of 2011, and reviewed the MRI which he believed showed a labral tear. He noted that Petitioner had been seen in April of 2011 with similar pain after falls on her shoulder while riding horses. She candidly admitted to left sided neck pain, as well as radiating pain in her left shoulder and arm. She was diagnosed with left shoulder pain secondary to the labral tear and then referred for an MRI of her cervical spine. This was done on April 7, 2011, which showed C5-6 and C6-7 disc bulges with foraminal stenosis. Petitioner underwent physical therapy and medication. She also received epidural injections into her neck.

She returned to see Dr. Bayes on September 6, 2011, stating that her neck pain had greatly improved with her epidural injections and was now ready to proceed with treatment for her posterior shoulder pain. She underwent surgery for her left shoulder on October 28, 2011 in the form of a left-shoulder arthroscopy. Dr. Gross found a tear of the anterosuperior labrum, repaired the tear, and Petitioner returned to work. There was no workers' compensation claim presented. As of her last visit with Dr. Gross in January of 2012, she showed improvement with regard to her shoulder. She was placed on a home exercise program and told to return on an as-need basis by Dr. Gross' P.A.

Prior to the date of accident, Petitioner was seen several times by her family physician, Dr. Hays. Her symptoms included hypertension, allergic rhinitis, congestion, urinary frequency and a cyst behind her left ear. On several occasions she reported neck pain. On November 16, 2012, she was positive for neck pain. On April 13, 2013, when being seen for a cold, she told Dr. Hays she had joint aches including in the back and neck. She was prescribed Vicodin ES &.5 milligrams. Petitioner was prescribed no other medication, given no treatment or referred for anything regarding her cervical spine. She continued to work full duty without restrictions. Prior to her accident, there had never been a surgical recommendation for Petitioner's neck.

On December 9, 2013, Petitioner was looking for a file. She sent out an e-mail to her coworkers to ask if anyone had it. By 2:00 in the afternoon, no one responded so she went back to the closed file room to search. The boxes in the closed file room are in rows of 10-12 stacked 5-6 files high and are alphabetized. (T.16). She found the file in the fourth box from the bottom and moved the top three boxes. The boxes were shown in the picture which was entered into evidence and resemble banker's boxes. (RX7). In the boxes are closed files with heavy legal/non-legal material in closed storage. While stooping on the balls of her feet, she flipped open the lid on the box and started looking for the file she needed. While doing so, the banker's box on top of the row to her right fell directly on her head. While she was attempting to push it off, the box on the left row fell also. She estimated that these boxes weighed 20 to 30 pounds. These boxes knocked her down to the floor, where she sat for a few minutes. She pulled the file out of the box, set it to the side and organized the files back in their original position.

She testified:

> Well, I was stunned. There was, you know, a little pain from being stricken in the head. My adrenalin was flowing. I thought I was okay, and I proceeded to walk back to my office and sit down, and once I relaxed, I immediately started getting a very bad headache at the top of my head, and my neck kind of stiffened up. (T.20).

She mentioned this to her co-worker, Cynthia Frey, continued working and continued to have pain. Because she was concerned about possible bleeding, she had her co-worker take a picture with a camera phone. She then went to her Regional Manager Sherrie Runge. She was told to get on the InfoNet and fill out a workers' compensation claim, which she did immediately. She also filled out an incident report, which was entered into evidence by both Petitioner and Respondent, which give a history consistent with Petitioner's testimony. The Supervisor's Report of Injury or Illness, which was also entered into evidence, also corroborates Petitioner's testimony.

The next day, Petitioner presented back to Dr. Hays and gave the same consistent history of the injury. This time, Dr. Hays' examination was markedly positive with objective significant spasm and discomfort in the trapezius muscles. Dr. Hays' assessment was:

> I'm going to have her get x-rays of her cervical spine with obliques, right upper extremity and right elbow. I've advised her to stay off work until this can be assessed. She will most likely of [sic] no fracture exists required [sic] several weeks of physical therapy and pain management. The concern is her pre-existing injury may be significantly aggravated by this injury.

She returned on December 18, 2013, and once again, Dr. Hays noted limited range of motion, tenderness and muscle spasm. Dr. Hays kept Petitioner off work and recommended a MRI and x-

rays. The x-ray was remarkable for loss of normal cervical curve, thought to be due to muscle spasm.

On January 3, 2014, Petitioner went to the Orthopedic Center of St. Louis, where she had treated in 2011. She saw Dr, Gornet, an orthopedic surgeon at her attorney's direction. Dr. Gornet also took the consistent history of the injury, noted that Petitioner had been given muscle relaxers and a cervical collar and taken off work. Dr. Gornet noted that Petitioner readily admitted to a history of previous symptoms and noted that previous treatment by his partners Dr. Gross and Dr. Bayes. He also noted that Petitioner had no right sided symptoms from her earlier injury. However, now her symptoms were worse and causing radiating pain into her right arm. Dr. Gornet reviewed the MRI from April 7, 2011, and directly compared it to a new MRI scan. He noted on his initial visit that the disc pathology appeared to be larger at both levels with what now appeared to be an obvious right side new foraminal herniation at C6-7, which correlated with Petitioner's symptoms. He also noted foraminal stenosis and a herniation at C5-6, but noted that it was not significantly changed. Dr. Gornet stated that he believed Petitioner's symptoms were causally connected to her work accident.

Respondent had Petitioner examined by Dr. David Robson on April 15, 2014. He likewise took the identical history of the injury. He noted Petitioner's prior shoulder injury, and noted that Petitioner's symptoms had improved following epidural injections in 2011. At the time of his initial examination, Dr. Robson did not have the previous MRI done on April 7, 2011, and stated, "I cannot determine what type of injury was sustained on December 9, 2013 until I have the MRI from April 7, 2011." His report was entered into evidence and Dr. Robson stated repeatedly he could not determine what injury Petitioner had sustained because he did not have the prior MRI film.

Dr. Robson authored a supplemental report on May 20, 2014 after he reviewed and compared both sets of MRI's. He testified that the films, which he viewed side by side, were very similar.(RX 13 at 21) Because there appeared to be no new structural change, the doctor opined that the accident resulted only in a temporary exacerbation of Petitioner's symptoms and was not causally related to her curre3nt condition. (Id at 15)

Respondent also had Petitioner examined by Dr. James Emanuel on April 24, 2014. Dr. Emanuel reviewed the most recent MRI and noted foraminal edema of the cervical spine. Dr. Emanuel did not believe Petitioner sustained any injury to her right shoulder as a result of the December 9, 2013 incident. He stated that Petitioner emphatically told him that the box did not strike her shoulder, but rather struck the back of her head and rolled off the right shoulder. Dr. Emanuel specifically stated:

> The injury the patient sustained on 12/9/13 was a contusion to the back of her head and a cervical neck strain and aggravation of some pre-existing

degenerative changes within the cervical spine. In my medical opinion the injury provided and aggravation [sic] that appears to be a permanent aggravation accelerating the patient's degenerative changes beyond normal progression. Dr. Gornet, in his medical records, indicate review of both MRI scans, one prior to and the other following the injury of 12/9/13 suggesting that there was worsening of the disk herniation at C6-7. On my physical exam today the patient has significant loss of motion in the cervical spine with pain at the extremes of motion but was neurologically intact with normal muscle strength and reflexes in the upper extremity. In my medical opinion the alleged, unwitnessed work injury of 12/9/13 is causally related to a substantial aggravation of some underlying pre-existing changes within the cervical spine that are unresponsive to conservative treatment. The patient has had two trials of epidural steroid injections that had previously worked for the patient prior to the injury of 12/9/13. I am not a spine surgeon and would defer to a spine specialist with regards to possible surgical intervention. Currently the patient should be under physical restrictions of no lifting greater than 10 pounds. If she can limit her current job to no lifting files, and perform sedentary office type work, the patient would be capable of performing her job. I do not believe the patient has reached maximum medical improvement with regards to the cervical spine as a result of the 12/9/13 injury. The patient did not sustain an injury to the right shoulder as a result of the 12/9/13 injury.

Petitioner also called four witnesses who appeared at Respondent's request.

Cynthia Frey. Ms. Frey is a Child Support Specialist Trainee who works in the office with Petitioner. She admitted taking pictures of Petitioner's neck following the accident at the Petitioner's request on December 9, 2013 immediately after the Petitioner told her she had been injured when files fell on her neck. When asked about Petitioner's condition prior to the December 9, 2013 accident, she testified that Petitioner told her she was kicked in the neck by a horse. However, she also acknowledged preparing a report on December 27, 2013, 18 days after the accident, in which nothing is stated about Petitioner injuring her neck and being kicked by a horse. The report states the Petitioner reported tripping after a horse ran after her and that she was very sore over a few places on her body. (RX 5) Further, Ms. Frey sent a text to the Petitioner early after the injury acknowledging that the Petitioner was off work receiving worker's compensation benefits. (PX 11)

Jacqueline Haney. Ms. Haney is a Child Support Services employee who works with Petitioner. She acknowledged being present on the date the accident happened but did not speak with the Petitioner on that date. She testified that she had spoken with the Petitioner some three to four weeks prior to the accident. At that time the Petitioner told her shed been kicked by a horse in the posterior aspect of her right trapezius. She later filled out a statement on December

31, 2013 concerning the incident. In it she said that the Petitioner told her she was in a lot of pain after being kicked by the horse, but there is no mention as to where the pain was located. (RX 6)

Sherrie Runge. Ms. Runge testified that she was the Petitioner's supervisors supervisor. She acknowledged preparing the Supervisor's Incident Report where Petitioner stated she got hurt, which was consistent with Petitioner's testimony. She also said that the Petitioner was a good employee.

Barbara Bandy. Ms. Bandy also works for the Respondent in the Division of Child Support. She was present in the office on December 9, 2013, and after Petitioner's accident, went in the office to see if there was a mess to be cleaned up. She said that there was no mess and that she did not know whether the Petitioner or someone else had cleaned them up.

On rebuttal, Petitioner testified that she had never been kicked in the neck by a horse and that she did not say that to any of the witnesses.

CONCLUSION

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

The Arbitrator finds that the incident as described by Petitioner constitutes an accident under the Act. Petitioner was injured unexpectedly while trying to retrieve a work file from closed storage during the work day. Two boxes full of files fell striking here head, neck and right shoulder. Petitioner was a very credible witness. She promptly reported the injury on the same day and consistently reported the mechanism of injury to Respondent and all of her physicians. Since the occurrence of the incident is well documented and there is no solid or credible rebuttal evidence to refute the actual occurrence of the incident, the Arbitrator finds that the work accident did occur.

Respondent disputed the occurrence of the accident based on an incident that allegedly occurred shortly before Petitioner's work accident. Petitioner testified that on November 27, 2013, she went out early in the morning before she left for work to feed the horse. The horse bared his teeth and pawed at her, at which time she took two steps back and tripped over some buckets and caught herself with her left hand. Petitioner testified that the water spilling from the buckets drove the horse into his stall. Petitioner then locked the horse in its stall, drove back to her house and changed her clothes, and while upset over the incident, called in to work to let request time off to speak with her father about getting rid of the horse. There was no injury except a bruise on the back of her leg.

Respondent contends that she injured her neck in the incident However, none of the witnesses who appeared at Respondent's request provided testimony consistent with their written reports completed shortly after the work accident to substantiate that contention.

Cynthia Frey's report indicates that a horse ran after Petitioner, Petitioner tripped and fell over a barrel, and that she (Ms. Frey) could not recall whether Petitioner stated that the horse kicked her. (RX5). She could only remember Petitioner stating that she was sore in a few places. (RX5). She concluded, "I wish I could remember specifics but she talks to everybody in the office about her business so somebody might know." (RX5).

Ms. Haney's report indicates that the horse incident occurred 3-4 weeks prior to December 9, 2013 accident. (RX6). Ms. Haney reported that Petitioner told her that one of the horses got spooked and kicked her. *Id.* She also reported that Petitioner said she was sore and in a lot of pain. There is nothing in this report indicating that the affected area was the neck, back or shoulder. *Id.*.

Ms. Sherri Runge reported that Ms. Haney reported to her that Petitioner was ***trampled/kicked*** by a horse recently. (RX7). Ms. Runge indicated that Ms. Frey reported to her that she saw no red marks or injury on Petitioner's back the day of the incident involving the boxes. *Id.*

Finally, whatever happened to the Petitioner in the horse incident did not require her to seek medical attention. Records from Dr. Hays, the Petitioner's family physician, subpoenaed by the Respondent, contain no entries of treatment after October 15, 2013, when she was treated for headaches. If she had injured her neck to the extent claimed by the Respondent, she likely would have gone to her family doctor for treatment.

Petitioner is the only witness with adequate factual knowledge and a consistent memory of the incident, and Petitioner's account of the incident is the only account substantiated by logic. Even Dr. Robson testified that he found Petitioner to be "very credible" and testified that he had no problems in his discussions with her. (RX13, p.30). It is also apparent that Dr. Emanuel believed Petitioner's account of her work injury despite being provided with the witness reports by Respondent. (RX14).

Based upon the foregoing, the Arbitrator finds that Petitioner credibly established that she sustained accidental injuries that arose out of and in the course of her employment with Respondent.

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

Accidental injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Land & Lakes Co. v. Indus. Comm'n*, 359 Ill. App. 3d 582, 592, 834 N.E.2d 583, 592 (2005). 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. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-73 (2003). If the accidental injury aggravated or accelerated the preexisting condition, it is compensable. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 672-73 (2003). A causal connection between work duties and a condition may be established by a chain of events including [P]etitioner's ability to perform the duties before the date of the accident, and inability to perform the same duties following that date. *Darling v. Indus. Comm'n of Illinois*, 176 Ill. App. 3d 186, 193, 530 N.E.2d 1135, 1140 (1988).

The evidence in the record shows that Petitioner was working full duty without restrictions prior to the work accident on December 9, 2013. The day following the accident, however, Petitioner had to be taken off work by her family physician and has not been able to return. (PX3, 12/10/13; PX5).

Dr. Gornet reviewed the MRI from April 7, 2011, and directly compared it to a new MRI scan. He noted on the initial visit that the disc pathology appears to be larger at both levels with what now appeared to be an obvious right side new foraminal herniation at C6-7, which correlated with Petitioner's symptoms. (PX5; PX9). He whole-heartedly expressed his belief by way of deposition that Petitioner's current condition of ill-being was related to her work accident on December 9, 2013, and further testified that her need for surgery was also directly related to same. (PX9, p.12-13). He testified that Petitioner suffered an aggravation of her underlying condition as well as new disc herniation at C5-6 and C6-7 which were clearly shown on the MRI and had "changed definitively from the objective findings on 4-7-11." *Id.* at 13.

Dr. Emanuel believed that Petitioner sustained a permanent aggravation of her cervical spine which "accelerat[ed] the patient's degenerative changes beyond normal progression." (RX14). Although Dr. Robson believed that the need for surgery existed prior to Petitioner's work accident, he acknowledged that Petitioner was working full duty without restrictions on December 9, 2013, he acknowledged that the reported injury of boxes falling on her head and shoulders was consistent with Petitioner's symptoms and the type of accident that could cause disc herniation to occur or become more symptomatic, and he further acknowledged that there is no other indication of any other event in the medical records besides Petitioner's work accident that would account for her change in symptoms. (RX13, p.21-22, 27).

The Respondent's argument that an aggravation means there has to be a structural change in the Petitioner's neck as evidenced by the MRI's is not required by our Act. The fact that the Petitioner was performing her job on a regular basis prior to being injured without any ongoing medical care while having consistent symptoms despite having received a variety of conservative treatments since the accident is enough. Moreover, the Arbitrator relies on the credible causation opinions of Dr. Gornet, Dr. Emanuel, and Dr. Hays, which were substantially corroborated by the reports and/or testimonial concession of Dr. Robson. The Arbitrator especially notes that the physician to whom Respondent provided the witness reports concerning the alleged equestrian attack, Dr. Emanuel, gave no substantial credence to the alleged incident in terms of causal connection. Given the above findings, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident of December 9, 2013.

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

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

No physician disputes that Petitioner requires surgery. Based upon the above findings regarding accident and causal connection, the Arbitrator finds that Petitioner is entitled to past and prospective medical benefits under the Act. Respondent is therefore ordered to pay the medical expenses, pursuant to the fee schedule, contained in Petitioner's group exhibit, and to authorize and pay for the surgical treatment recommended by Dr. Gornet.

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

Petitioner was taken off work by her family physician, Dr. Hays, on December 10, 2013, the day following the incident, and has been unable to return to work since. (PX3; PX5). Respondent shall therefore pay temporary total disability benefits from December 10, 2013 to the date of the hearing, September 10, 2014.

This award shall in no instance 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.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS BREYTS,

Petitioner,

vs.

NO: 13 WC 02448

ELMER & SONS LOCKSMITHS,

15IWCC0358

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 expenses, prospective medical treatment, benefit rates, temporary total disability benefits, and penalties and attorneys' fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found Petitioner established a causal connection between the January 3, 2013 motor vehicle accident and the treatment he sought at the Emergency Department the same day. Further, the Arbitrator awarded Petitioner certain medical bills, per the fee schedule, that Petitioner incurred while at the Emergency Department.

The Commission awards Petitioner the additional medical bill for his first visit to Dr. Brechner. The Emergency Department physician wrote it was important for Petitioner to follow up with his primary care physician as an outpatient. Therefore, Petitioner's first visit to Dr. Brechner, his primary care physician, was ordered by the Emergency Department, which was found to be causally connected to the motor vehicle accident. However, Petitioner's continued

15IWCC0358

treatment with Dr. Brechner is not causally connected, as explained by the Arbitrator, and those medical expenses are not awarded.

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 $2,034.00 for medical expenses per the 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,100.00. 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: MAY 19 2015
TJT: kgg
R: 3/24/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

BREYTS, THOMAS
Employee/Petitioner

Case# **13WC002448**

ELMER & SONS LOCKSMITHS
Employer/Respondent

15IWCC0358

On 2/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1455 BOZICH, BRUCE M
118 CIRCLE RIDGE DR
BURR RIDGE, IL 60527

1454 THOMAS & ASSOCIATES
KELLY JOHNSON
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

15 IWCC0358

☐ 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)

Thomas Breyts
Employee/Petitioner

v.

Elmer & Sons Locksmiths
Employer/Respondent

Case # **13** WC **2448**

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 27, 2013 and January 24, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ 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 **evidentiary ruling – admissibility of photographs**

15IWCC0358

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 was less than credible and failed to establish causation as to his claimed current conditions of ill-being. The Arbitrator finds it was reasonable, however, for Petitioner to seek Emergency Room care on the day of the accident. The Arbitrator awards Petitioner the following medical expenses in connection with that care, subject to the fee schedule: 1) Dr. Malik, 1/3/13, EKG-related charge, $25.00; 2) Imaging Associates of Indiana, 1/3/13, $1,142.00; 3) St. Francis Medical Group, 1/3/13, $717.00; and 4) St. Anthony Health, 1/3/13, $150.00. PX U.

The Arbitrator finds that Petitioner failed to establish entitlement to temporary total disability benefits. Based on that finding, the Arbitrator views the issues of average weekly wage and claimed TTD underpayment as moot. The Arbitrator makes no findings as to those issues.

For the reasons set forth in the attached decision, the Arbitrator declines to award penalties and fees, as requested by Petitioner.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$20,547.58** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,547.58**. Arb Exh 1.

Respondent is entitled to a credit of **$26,662.92** under Section 8(j) of the Act. Arb Exh 1.

ORDER

Petitioner was less than credible. While he met his burden of proof on the issue of accident, he failed to establish causation as to his claimed current conditions of ill-being. Nevertheless, the Arbitrator finds it was reasonable for Petitioner to seek Emergency Room care on the day of the accident. The Arbitrator awards Petitioner the following medical expenses in connection with that care, subject to the fee schedule: 1) Dr. Malik, 1/3/13, EKG-related charge, $25.00; 2) Imaging Associates of Indiana, 1/3/13, $1,142.00; 3) St. Francis Medical Group, 1/3/13, $717.00; and 4) St. Anthony Health, 1/3/13, $150.00. PX U.

Petitioner failed to establish entitlement to temporary total disability benefits. The Arbitrator thus views the issues of average weekly wage and claimed TTD underpayment as moot. The Arbitrator makes no findings as to those issues.

The Arbitrator exercises her discretion and overrules Petitioner's relevancy objection to the photographs offered into evidence by Respondent. The Arbitrator emphasizes, however, that the photographs played no role in her decision-making.

For the reasons set forth in the attached, the Arbitrator declines to award penalties and fees, as requested by Petitioner.

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

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

2/27/14
Date

FEB 27 2014

Thomas Breyts v. Elmer & Son Locksmith
13 WC 2448

15IWCC0358

Arbitrator's Findings of Fact

Petitioner was 56 years old as of the hearing. T. 12. He testified he worked as a service technician for Respondent for 16 years prior to his claimed accident of January 3, 2013. His duties include replacing hardware, making keys, changing locks and hanging doors. Some of the doors were metal and weighed up to 80 pounds. T. 12-14.

Petitioner claims an average weekly wage of $997.48. Arb Exh 1. Petitioner testified he earned $18.50 per hour and worked at least 44 hours per week before the accident. T. 14. He generally worked 8 to 9 hours per day, Monday through Friday, and 4 hours each Saturday. T. 14. He was required to work on Saturdays. He earned time and a half on Saturdays. T. 15. Petitioner further testified he entered into a wage-related oral agreement with Harvey Sass, Respondent's owner [hereafter "Sass"], 5 or 6 years before the accident. Per this agreement, he received a 5% commission on his gross monthly total. He testified he received commissions in the amount of $9,540.95 in 2012. T. 16.

Petitioner testified he worked as a freelance locksmith on his own time between 2001 and the accident. He performed freelance jobs about once or twice a month during this period. T. 22-23.

Petitioner denied working in any capacity after the accident. T. 23.

Petitioner testified he was in "pretty good health" before the accident. T. 16. During the three years before the accident, he regularly took a sleep aid along with thyroid and hypertension medication. He denied taking any pain medication during this period. T. 17. He always refilled his prescriptions at a CVS pharmacy in DeMotte, Indiana. T. 17, 19-20. He offered into evidence print-outs of prescriptions he filled at CVS pharmacies in DeMotte and Wheatfield, Indiana between 2008 and 2013. These print-outs show that Dr. Brechner prescribed Tramadol on May 11, 2010 and January 27, 2011. PX E.

Petitioner denied having any cognitive problems or pain in his neck, back or shoulder during the three years before the accident. He denied undergoing any treatment for cognitive problems, headaches, dizziness, back pain, knee pain or shoulder pain during the three or four years prior to the accident. T. 17-18. When he lost time from work during the three or four years preceding the accident, it was due to routine sicknesses such as colds. T. 19. At no time during that period was he unable to perform his job due to a medical condition. T. 19.

Petitioner acknowledged injuring his left knee at work in 2008. He underwent a left knee arthroscopy following this injury. He did not file a workers' compensation claim because two co-workers who had filed claims had been "released" by Respondent. T. 62-63.

Petitioner testified he was operating a 1997 Ford van at the time of the January 3, 2013 accident. Respondent assigned this van to him and he had driven it for 12 years. T. 20. Petitioner testified the van was in poor condition as of and prior to the accident. The driver's and front passenger seat had been "swapped out" at some point, leaving the driver's seat with a non-functioning seatbelt. The van also had a "major gas leak." T. 21. Petitioner testified he complained about these problems to Sass on many occasions during the two years before the accident. He told Sass he was concerned about getting ticketed or getting hit. Sass would respond by saying, "I'll take that chance." T. 22.

Petitioner testified he began working at 8 AM, his usual start time, on January 3, 2013, a Thursday. T. 23, 37. The accident occurred at about 1:30 PM that day, after he dropped off a job bid at a business in Homewood. He believed he was on his way to an assignment in Matteson. He could not recall the nature of the assignment. T. 24-25. He was operating his customary company van at the time. He brought the van to a complete stop at a red light at the intersection of Flossmoor Road and Governors Highway. T. 24-25. As he was sitting at the light, he checked his rear view mirror and saw two vehicles "approaching too quickly" behind him. He knew he was about to get hit but he had no chance to take any preventive action. T. 26. The rear of his van was struck twice. The first impact caused him to be "thrown out of the seat and into the steering wheel and dashboard." When asked whether any part of his body struck any part of the steering wheel, he answered, "yes, my mid-section." He then indicated his left arm was on the steering wheel when the first impact occurred. T. 27. He did not testify as what, if anything, he felt when the second impact occurred.

Petitioner testified he felt "stunned" after the accident. He was concerned about the possibility of a fire since he had put gas in the van earlier that day. T. 27-29. He got out of the van. The van was not on fire. T. 29. At that point, he felt "woozy." He also noticed pain in his neck, back and left elbow. His knees "were hurting a little" but he was primarily concerned about his head and neck. T. 29. The paramedics and police arrived. He refused treatment because the paramedics indicated they were going to "strap him down" and transport him to South Suburban Hospital. T. 30. Since he lives in Indiana, he felt he would prefer to be somewhere closer to home if he had to go to a hospital. T. 30.

Petitioner testified the van was operable after the accident. T. 30-31. He drove the van to Respondent's warehouse in Steger. It took him about 15 to 20 minutes to get there. On arrival, he told Sass he was going to go to an Emergency Room in Indiana and asked where the bill should be sent. Sass said, "I don't know" and directed Petitioner to his secretary, who told him to put the bill on his own insurance. T. 32-33.

Petitioner testified he then drove to St. Anthony Medical Center. This hospital is about half an hour away from his residence. The trip took about half an hour longer than usual because he was "confused" and made wrong turns along the way. T. 33-34. He testified he arrived at the hospital at 3:30 PM. T. 33-34.

Petitioner testified he complained of pain in his head, neck, back, elbow, shoulder and knee at the Emergency Room. T. 35.

The St. Anthony Emergency Room records (PX A) reflect an arrival time of 3:30 PM. They also reflect that Petitioner was accompanied by a family member. [PX A, p. 5.] At 4:11 PM, the Emergency Room physician, Dr. Kanagy, recorded the following history:

> "Pt is a 55 y.o. male that presents via wheelchair to the ED post MVA, 2 hours prior to arrival. Pt was at a complete stop. A drunk driver hit the car behind him, causing the car behind him to rear-end him. He was unrestrained, no airbag deployment. The speed limit was 35 MPH and he was in a van. The car was drivable after the accident. He was ambulatory at the scene. He denies any head trauma or LOC. He is complaining of neck pain, abdominal pain, back pain, right knee and left elbow pain. He felt disoriented after the accident. Disorientation has since improved but not resolved. Pt is alert and oriented x3 and his pain seems out of proportion to his physical exam. The pt is on Coumadin."

PX A, p. 7. On examination, Dr. Kanagy noted a full passive range of neck motion "without pain," no head abrasions or contusions, generalized abdominal tenderness, tenderness of the left elbow and right knee, with no swelling noted in either body part, and "pain to palpation to entire upper back, thoracic, lumbar spine" with "no point tenderness to any one vertebra." Dr. Kanagy described Petitioner as alert and oriented.

At Dr. Kanagy's direction, Petitioner underwent lab work, an electrocardiogram (which showed normal sinus rhythm) and various radiographic studies. A CT scan of the chest, abdomen and pelvis showed evidence of the prior appendectomy and "slight bony deformity of the left anterolateral second, third, fourth and fifth ribs," with the radiologist describing this as a "chronic finding." PX A, p. 11. The scan also showed arthritic changes of the thoracic and lumbar spine. A cervical spine CT scan showed a chronic ossification, arthritic changes and a "possible small disc herniation at C3-C4." A head CT scan was negative. PX A, p. 13. Chest and left elbow X-rays were negative. Right knee X-rays showed severe degenerative joint disease. Thoracic and lumbar spine X-rays showed no fractures or dislocations and mild to moderate degenerative disc disease. PX A, pp. 13-15.

Dr. Kanagy prescribed Norco and Flexeril, to be taken as needed. [At the hearing, Petitioner denied taking either of these medications on a regular basis before the accident. T. 35-36.] He instructed Petitioner to seek follow-up care within two days. He also instructed Petitioner to continue taking his regular medications, which included Alprazolam, also known as Xanax, and Temazepam, a sleep aid. PX A, pp. 61-62. He did not restrict Petitioner's activities.

A discharge note reflects that Petitioner was "ambulatory [and in] no distress" when he left the Emergency Room at about 9:03 PM. PX A, p. 17.

Petitioner saw his family physician, Dr. Brechner, on Monday, January 7, 2013. T. 36-37. The doctor's note of that date reflects that Petitioner was rear-ended at a stop light four days earlier. The note also reflects that Petitioner complained of an acute onset of non-radiating upper, mid- and lower back pain after the accident. Petitioner also complained of neck pain and left shoulder pain that "radiates to the right shoulder." The note also states: "doesn't think he hit his head, not wearing seatbelt due to seatbelt not functional, company vehicle (Ford van)."

Dr. Brechner noted complaints of abdominal pain and nausea, right knee pain, numbness in both hands, dizziness with head movement, left elbow pain, constant headaches, difficulty with memory and concentration, reduced hearing in the left ear, left elbow and shoulder pain, neck pain and "paralyzing shooting pains, some right shoulder and right knee."

Dr. Brechner noted that Petitioner had previously undergone an appendectomy, a small bowel resection and four right knee arthroscopies. He also noted a history of hypothyroidism, hypertension, "generalized anxiety disorder" and hyperlipidemia. He indicated Petitioner had been involved in a motorcycle accident in 2001.

On examination, Dr. Brechner noted the presence of a ventral and umbilical hernia and decreased range of motion in neck forward flexion, extension, lateral flexion and rotation, left shoulder abduction, left elbow extension, wrist flexion and extension and bilateral knee flexion and extension. On neurologic examination, the doctor noted "hypoesthesia in bilateral median nerve, bilateral ulnar nerve and bilateral hands distribution." He indicated that Petitioner "seems to be in severe pain" but exhibited an appropriate affect and demeanor.

Dr. Brechner injected Depo-Medrol into Petitioner's lower back. PX B.

Petitioner testified that Dr. Brechner told him he was "off work" on January 7,.2013. The doctor's note of January 7, 2013 is silent as to Petitioner's work capacity. On January 8, 2013, Dr. Brechner issued a note indicating Petitioner was to be excused from work from January 3rd forward and until further notice. PX H is a letter dated January 9, 2013 from Petitioner's counsel to Respondent referencing and attaching this note.

Petitioner returned to Dr. Brechner on January 14, 2013, with the doctor noting complaints of neck pain radiating to the shoulders, left shoulder pain, low back pain, "nausea and dizziness from head concussion," headaches, decreased concentration and memory, photophobia, "anxious and emotional" and dizziness. He also noted that Petitioner complained of severe, incapacitating fatigue, unintentional weight loss and blurred vision.

Dr. Brechner described Petitioner's presentation as follows: "appears ill, seems to be in pain, lethargic." He prescribed a head CT scan and prescribed Zofran. He indicated he switched Petitioner to Skelaxin to avoid sedation. He did not comment as to work capacity. PX B.

Petitioner testified he underwent the recommended head CT scan. The CT scan report is not in evidence. A radiology bill in PX U reflects Petitioner underwent CT scans of the head and brain on January 14, 2013.

Petitioner returned to Dr. Brechner on January 16, 2013. The doctor described the head CT scan as "negative for hemorrhage." He noted that Petitioner complained of lower back pain, neck pain radiating to the shoulders (with associated symptoms including "headache, dizziness, numbness and tingling in hands and fingers and freezing cold feet") and left shoulder pain. The doctor also noted complaints of severe, incapacitating fatigue, unintentional weight loss, blurred vision, photophobia, nausea, memory loss and weakness.

Dr. Brechner described Petitioner's general appearance as follows: "appears ill, seems to be in pain, lethargic." On examination, he noted a decreased range of motion in the neck, shoulders, back and knees. He diagnosed post-concussion syndrome, low back pain, neck pain and shoulder pain. He referred Petitioner to Dr. Teodori, a neurologist, and Dr. Moffitt, an orthopedic surgeon. PX B.

On January 28, 2013, Petitioner filed an Application for Adjustment of Claim. The Application reflects a claimed average weekly wage of $1,080.00. Arb Exh 2.

PX I is a letter dated January 29, 2013 from Petitioner's counsel to Natasha Hawkins [hereafter "Hawkins"], a senior claim representative from Chartis Claims seeking authorization for an appointment with Dr. Moffitt and a neurologist in Munster, Indiana.

Petitioner first saw Dr. Moffitt on February 7, 2013. Petitioner testified that Dr. Moffitt told him he treats shoulder and knee problems but "d[oesn't] do necks and backs." T. 40. The doctor noted the referral from Dr. Brechner. He indicated that Petitioner "stated he was rear-ended by two different drivers in his company's work van" on January 3, 2013. He noted that Petitioner "specifically denies significant head injury" but provided a history of migraines and headaches.

Dr. Moffitt noted that Petitioner complained of pain in his left shoulder, left elbow, neck, back and both knees secondary to the accident. He also noted a complaint of dizziness.

Dr. Moffitt indicated that Petitioner had previously undergone left shoulder surgery.

On left shoulder examination, Dr. Moffitt noted tenderness at various areas, including the rotator cuff. He indicated he could not conduct range of motion testing secondary to pain.

On cervical spine examination, Dr. Moffitt noted tenderness and spasm in various areas. He indicated he could not conduct range of motion testing secondary to pain. He described abduction, thoracic outlet syndrome, traction and Valsalva testing as negative.

On bilateral knee examination, Dr. Moffitt noted tenderness in multiple areas, no swelling, effusion or ecchymosis, patellofemoral compression pain and crepitus and tightness of the lateral retinaculum. He made the same findings as to both knees. He indicated he could not perform range of motion or compartment testing secondary to pain.

Dr. Moffitt noted no neurological or vascular abnormalities.

Dr. Moffitt indicated he reviewed the previous right knee, left arm, spinal and left shoulder X-rays, along with the cervical spine CT scan.

With respect to the left shoulder, Dr. Moffitt indicated the differential diagnoses included "rotator cuff tear, cervical disc disorder and labral tear." With respect to the cervical spine, his impression was myofascial pain syndrome, idiopathic cervicalgia and possible radiculopathy. With respect to both knees, his impression was internal derangement and possible torn menisci.

Dr. Moffitt prescribed MRIs of the left shoulder and both knees.

Dr. Moffitt's records include a report concerning a shoulder MRI performed on February 14, 2013. At the top of the report, the left shoulder is mentioned but the "impression" section of the report refers to the right shoulder. The radiologist interpreted the MRI as showing a high grade full-thickness insertional tear of the supraspinatus tendon which measures 1.4 centimeters in anteroposterior with a 1.7-centimeter gap and underlying severe supraspinatus tendinosis. The radiologist also noted mild infraspinatus and subscapularis tenderness, mild to moderate intra-articular tendinosis of the long head of the biceps and moderate to severe acromioclavicular osteoarthritis. PX D.

Petitioner also underwent bilateral knee MRI scans on February 14, 2013. The right knee MRI showed "severe tricompartmental osteoarthritis with complete cartilage denudation within the medial and lateral compartments [with] no evidence of acute injury," numerous large intra-articular bodies, a "chronic complete ACL tear" and a "chronic injury of the posterior cruciate ligament." The left knee MRI showed "medial meniscal degeneration without a discrete tear," mild lateral femorotibial and patellofemoral compartment arthrosis and "ACL degeneration without evidence of recent injury." PX D.

PX J is a letter dated February 11, 2013 from Petitioner's counsel to Hawkins indicating Petitioner had recently received a temporary total disability check in the amount of $412.00 and alleging an underpayment based on a claimed average weekly wage of $881.33.

At Respondent's request, Petitioner saw Liana Palacci, D.O. for a Section 12 examination on February 13, 2013. Dr. Palacci noted that Petitioner told her his mother drove him to the appointment.

In her report of February 13, 2013, Dr. Palacci indicated she reviewed a First Report of Injury or Illness, an Illinois Motorist Report, six photocopied photographs of a Respondent panel van rear bumper, one photocopied photograph of the front bumper of a Toyota, notes from Natasha Hawkins and medical records from Winfield Family Medicine (Dr. Brechner's office) and St. Anthony Medical Center. The Arbitrator notes that the First Report of Injury or Illness and the Illinois Motorist Report are not in evidence.

Dr. Palacci recorded the following history of the accident:

> "On January 3, 2013, while driving his work van, [Petitioner] stopped at a red light when he was rear-ended by a sedan, which, according to [the] Illinois Motorist Report on January 3, 2013, was driven by Ms. Bonnie Goodwin. Ms. Goodwin's car was also rear-ended by a 'drunk driver.' [Petitioner] was not wearing his seatbelt because he states it 'wasn't working.' Upon the impact, he alleges that his abdomen and knees hit the steering wheel and dashboard. He denied any head trauma or loss of consciousness. At the scene of the accident, [Petitioner] states that the 'car that hit him was totaled' with the 'whole front end wiped out,' even though Ms. Goodwin's airbags did not deploy. When EMT and police arrived, [Petitioner] told them that he was hurt 'in the neck and back.' [Petitioner] states that he drove himself back to work and notified his employer of his injuries immediately but refused to go to the hospital in Illinois."

Dr. Palacci reviewed the medical treatment rendered to date. She noted that Petitioner had been off work since the accident. She indicated that Petitioner complained of 9/10 neck pain radiating down his spine with occasional numbness of all fingertips, tinnitus, constant 9/10 headaches, occasional nausea and photophobia, constant 9/10 thoracic and lumbar pain, "tightening" between his shoulder blades and 8/10 bilateral knee pain.

Dr. Palacci described Petitioner's past orthopedic surgical history as significant for three prior right knee surgeries, a left knee arthroscopy and a left shoulder arthroscopy.

Dr. Palacci noted that Petitioner wore sunglasses throughout her entire interview and examination. She also noted that Petitioner used both of his hands to unzip his jacket while in her waiting room but used only his right hand to unbutton his shirt during her examination.

On examination, Dr. Palacci noted that Petitioner refused certain range of motion testing of his shoulders, complaining of neck pain, and his lumbar spine and hips. She described Petitioner's gait as somewhat antalgic.

Dr. Palacci interpreted the Emergency Room records as showing a past medical history of anxiety, for which Petitioner was taking Temazepam and Alprazolam. She also concluded that the Emergency Room medication list showed Petitioner was already on Flexeril and Norco prior to the car accident. She described Petitioner's refusal to perform certain range of motion tests and his "exaggerated response to pain" as suggestive of possible symptom magnification. She opined that "while Mr. Breyts does have tenderness to palpation of the paraspinal muscles of the cervical, thoracic and lumbar spine, which is most likely associated with muscle strain and possibly spasm, this was not the result of his car accident." She further commented: "while he does exhibit muscle strain, especially of the cervical and thoracic spines, which is a likely contributor to chronic headaches, one cannot demonstrate with any degree of medical certainty that this occurred from the light impact from the vehicular collision on January 3, 2013." [Earlier in her report, Dr. Palacci had concluded the impact was light based on her review of the photographs and Illinois Motorist Report.] She indicated Petitioner's bilateral knee complaints were "more likely from his pre-existing arthritic condition."

Dr. Palacci indicated that Petitioner needed treatment, including therapy and possibly injections, for his knees and conservative measures, such as physical therapy, for his "muscle strain." She opined that "it would be difficult for [Petitioner] to return to full duty work as a service technician" but indicated Petitioner could "perhaps . . . return to work in a light duty capacity with restrictions including no driving, bending or squatting." She indicated Petitioner would require such restrictions "until completion of a formal course of physical therapy, which may take 4-8 weeks or more." RX 4.

PX K is a letter dated February 14, 2013 from Hawkins to Petitioner's counsel acknowledging the claimed temporary total disability underpayment and indicating she calculated the average weekly wage to be $740.00.

On February 20, 2013, Petitioner filed a Petition for Penalties and Fees alleging he remained temporarily totally disabled and was not receiving benefits. PX G.

On February 21, 2013, Dr. Palacci issued an addendum, after reviewing additional records, including an investigation report. Dr. Palacci reiterated that Petitioner "did not sustain any work-related injuries" on January 3, 2013 but might have pain and headaches secondary to pre-existing degenerative neck and back conditions, referencing the Emergency Room X-rays. Dr. Palacci again indicated Petitioner might require home exercises or therapy for those conditions. RX B.

PX O is a letter dated February 22, 2013 from Petitioner's counsel to Hawkins stating:

"This is to acknowledge my client's receipt of your request

> to return to work on light duty. Please be advised that my client has not been released by his physician. In addition, he is on two medications, Flexeril and Hydrocodone, which prevent him from driving an automobile. He is scheduled to see his primary physician on Tuesday, February 26th. Until such time as he is released, he will not be returning on either light duty or regular duty."

PX O.

PX P is a letter dated February 25, 2013 from Hawkins to Petitioner's counsel stating:

> "This letter is to advise that your client's weekly TTD benefits have ceased with payment thru 2/14/13. As you are aware, the IME doctor released your client to light duty work and light duty work was offered to your client and he was expected to return Monday 2/25/13 and has refused to report."

On February 26, 2013, Petitioner returned to Dr. Brechner. The doctor noted complaints relative to the neck (with pain radiating to "arms and throat"), head, left shoulder, low back and both knees. He also noted that Petitioner complained of nausea and dry heaves.

Dr. Brechner described Petitioner as "tired-appearing" and seeming to be in moderate pain. On examination, he noted a decreased range of neck motion. He ordered cervical and lumbar spine MRIs, referred Petitioner to Dr. Kuch, an orthopedic surgeon, and instructed Petitioner to continue seeing Dr. Moffitt for his shoulder. He noted that Petitioner was still awaiting a neurological evaluation. He indicated Petitioner was "not cleared for work yet due to severe pain, dizziness, nausea/vomiting and decreased memory and focus." PX B.

PX R is a letter dated February 26, 2013 from Petitioner's counsel to Hawkins and Mary Ann Randell, R.N., a case manager with Health Direct. The letter references the following enclosures: Dr. Brechner's February 26, 2013 "off work" note and his prescription for MRIs of the cervical and lumbar spine secondary to "neck pain, low back pain after MVA."

PX S is a letter dated February 26, 2013 from Hawkins to Petitioner's counsel referencing Dr. Palacci's addendum IME and indicating that no further benefits would be paid and that no further treatment would be authorized. PX S.

Petitioner underwent MRIs of the cervical and lumbar spine at St. Mary Medical Center on March 3, 2013. The radiologist interpreted the cervical MRI as showing multi-level degenerative spondylosis, worst at C4-C5 and C5-C6. He interpreted the lumbar MRI as showing degenerative changes and diffuse disc bulging at L4-L5 and L5-S1. PX B1.

Petitioner saw Dr. Abu-Aita, a neurologist, on March 5, 2013. Dr. Abu-Aita noted the referral from Dr. Brechner. He recorded the following history:

> "[Petitioner] is a 56-year-old right-handed male who told me that on January 3rd of this year his stopped work van at a light was rear-ended by 2 other cars and he didn't have seatbelt on, he possibly lost consciousness for a few seconds. He was alone when he was dazed. He went back and forth with no significant injuries except he had some bruises in the knees and sore abdomen. Since the accident he's complaining of neck and back pain as well as headaches, ringing in the ears, being dizzy at times, numbness in the hands and arms, his memory Is not good, he can't focus well and stay on task, he feels weak, he lost some weight. He denied any bladder control problems."

Dr. Abu-Aita described Petitioner's past medical history as remarkable for "hypertension, deep venous thrombosis in the left, anxiety and post-traumatic stress syndrome occasionally," with Petitioner indicating the post-traumatic stress syndrome "started when a friend died in his hands in motorcycle accident years ago."

Dr. Abu-Aita indicated Petitioner complained of pain in his neck, back, shoulders and knees as well as "moderate headache with some dizziness but no vertigo" and "ringing in the ears but no nausea or vomiting."

On examination, Dr. Abu-Aita noted some neck and low back tenderness with some increased pain with motion. He described his neurological examination as unremarkable. He described Petitioner as "walk[ing] slowly with stooped posture he says from the back pain and stiffness."

Based on Petitioner's history of briefly losing consciousness, Dr. Abu-Aita found it likely that Petitioner "had some kind of concussion with post-concussion symptoms." He recommended physical therapy. He indicated Petitioner might need to see a psychiatrist at some point or undergo a neuropsychological examination "if his symptoms persist to include memory problems, concentration, etc.," based on the past history of anxiety and post-traumatic stress disorder. He indicated he planned to see Petitioner in follow-up in two months "or earlier if needed otherwise." He did not impose any restrictions but noted Petitioner had been off work since the accident. PX C.

On March 7, 2013, Petitioner returned to Dr. Brechner. The doctor summarized Petitioner's complaints as follows: "having trouble with words and gait unsteady – wife says he's not right." He described Petitioner's general appearance as follows: "seems to be in moderate pain; tired-appearing." On examination, he noted a decreased range of neck and shoulder motion and pain over the cervical paraspinal muscles. He described Petitioner's affect

as appropriate and his speech pattern as normal. He assessed Petitioner as having post-concussion syndrome. He prescribed physical therapy, a graduated exercise program and ice therapy. He referred Petitioner to Dr. Hydar for a "herniated cervical disc." PX B1.

Petitioner testified that Dr. Brechner continued him off work on March 7, 2013. T. 43. Dr. Brechner's note of that date is silent as to work capacity. PX B1.

On March 12, 2013, Petitioner began a course of therapy at Select Physical Therapy. T. 43. The therapist described Petitioner as presenting "post MVA/concussion with extreme neck pain and headaches as well as back pain." PX Z.

Petitioner returned to Dr. Moffitt on March 13, 2013. The doctor's examination findings were unchanged.

Dr. Moffitt noted the left shoulder and bilateral knee MRI results. He prescribed a repeat left knee MRI, to be performed with contrast. PX D. It does not appear Petitioner ever underwent this MRI.

On March 26, 2013, Petitioner saw Dr. Chuman, a neurosurgeon. [See Dr. Chuman's note of September 24, 2013, indicating he first saw Petitioner on March 26, 2013]. Dr. Chuman's note of March 26, 2013 is not in evidence.

On March 27, 2013, Petitioner was discharged from physical therapist, with the therapist noting that Petitioner was seeing a specialist, Dr. Chuman, and would be going to pain management. PX Z.

On March 30, 2013, Petitioner underwent a bone scan. The bill is in evidence (PX U) but the corresponding report is not.

Petitioner testified he underwent EMG/NCV testing in April of 2013, at Dr. Chuman's direction. T. 45. Dr. Abu-Aita performed this testing on April 12, 2013. He interpreted the results as "mildly abnormal," noting electrodiagnostic evidence of mild bilateral carpal tunnel syndrome. He found no evidence of polyneuropathy, myopathy or active cervical or lumbar radiculopathy. PX C1.

Petitioner saw Dr. Cha at the Centers for Pain Control on April 29, 2013. T. 46. Dr. Cha wrote to Dr. Chuman the same day, referring to Petitioner as "your patient." Petitioner testified it was Dr. Chuman who referred him to the pain clinic. The Arbitrator notes that the only treatment record of Dr. Chuman in evidence is the doctor's note of September 24, 2013 (see below). Dr. Cha indicated he was seeing Petitioner "for further evaluation and treatment of neck pain" at Dr. Chuman's request.

Dr. Cha noted that Petitioner had been experiencing neck pain for four months and that this pain began with a motor vehicle collision.

Dr. Cha noted that, in addition to neck pain, Petitioner complained of intermittent weakness in both arms. The doctor indicated this weakness was "not suggestive of focal neurologic deficit" but "more consistent with antalgic behavior." He noted that pain medication and therapy had provided no benefit.

On examination, Dr. Cha noted "moderate to severe pain with palpation and moderate pain with range of motion maneuvers of the cervical spine." He reviewed the cervical spine MRI, noting a herniation at C3-C4.

Dr. Cha attributed Petitioner's neck pain to "a combination of facet arthropathy/arthritis, degenerative disc disease and disc bulging/herniation." He recommended a cervical epidural steroid injection, noting that Petitioner declined surgery. He performed this injection on May 9, 2013. PX X. T. 47.

On May 10, 2013, Petitioner saw Dr. Dolitsky, an orthopedic surgeon affiliated with Pronger Smith Medical Care. Petitioner testified he saw Dr. Dolitsky instead of Dr. Moffitt because Dr. Moffitt referred him to a doctor "who refused to take the case." T. 47. Dr. Dolitsky noted a referral from "Dr. Markus." No records from Dr. Markus are in evidence.

Dr. Dolitsky noted that Petitioner complained of pain in his left shoulder and both knees. He noted a history of the January 3, 2013 accident. He also noted that Petitioner had previously undergone three right knee surgeries, one left knee surgery and left shoulder surgery. He indicated that "before his recent injury," Petitioner "was complaining of only mild right knee pain" and now complained of "crunching" and worse pain. He indicated that Petitioner reported "feelings of giving out" in his left knee. He indicated that, while Petitioner had previously undergone left shoulder surgery, he "did not have any pain until recent injury."

On left shoulder examination, Dr. Dolitsky noted active abduction to 90 degrees and tenderness over the distal clavicle. On right knee examination, he noted a range of motion of 7 to 90 degrees, well-healed scars, no laxity and negative MCL, LCL and anterior drawer testing. On left knee examination, he noted a normal range of motion and no laxity.

Dr. Dolitsky interpreted the left shoulder MRI as showing a supraspinatus tear with 1.7 centimeters of retraction and "severe DJD of AC joint." He interpreted the right knee MRI as showing "severe DJD with chronic anterior cruciate ligament and PCL injuries with multiple loose bodies." He interpreted the left knee MRI as showing "mild DJD" with "no meniscal or ligament" tears.

Dr. Dolitsky indicated he would consider operating on Petitioner's left shoulder, with the knees to be addressed after the shoulder had healed. He indicated arthroscopy was an option for the left knee but that the right knee was unlikely to benefit from surgery. With respect to the right knee, he recommended injections. He viewed knee replacement as a "last resort."

Dr. Dolitsky opined that the left rotator cuff tear was "probably caused by the injury in January '13," based on Petitioner's statement that he had no symptoms before that injury. He further opined that the January 2013 accident "probably triggered or exacerbated" Petitioner's "severe DJD right knee symptoms." PX W.

Petitioner returned to Dr. Cha on May 24, 2013. Petitioner testified he told the doctor that the cervical epidural steroid injection "didn't do much good." T. 49. The doctor noted that Petitioner experienced no pain relief following the injection. On examination, he noted "moderate to severe pain with flexion and extension of the cervical spine." He recommended diagnostic cervical medial branch blocks "in order to determine whether or not his ongoing headache pain and neck pain is secondary to facet damage from his recent auto accident that occurred in January." Dr. Cha administered an initial block on June 18, 2013. In his report concerning this procedure, he indicated that, if the block resulted in at least 80% relief of Petitioner's usual pain for an appropriate duration of time, it could be concluded that degenerative arthritis of the cervical facet joints is the primary source of the pain. On June 25, 2013, Petitioner reported that the block helped him rotate his head more easily but that his pain returned within one day. The doctor recommended a second diagnostic block. Petitioner underwent this procedure on July 10, 2013. On July 12, 2013, Petitioner reported near complete resolution of his pain for "at least 1-2 hours after the procedure." Based on Petitioner's reported responses to the two blocks, Dr. Cha concluded that "the primary etiology of [the] pain is, in fact, facet arthropathy." He recommended a radiofrequency ablation, which he performed on July 12, 2013. Petitioner testified he derived more sustained pain relief following the ablation. T. 52.

At Respondent's request, Dr. Palacci re-examined Petitioner on July 16, 2013. In her report of that date, Dr. Palacci indicated she reviewed a number of medical records and accident-related documents. There is no indication that Dr. Palacci reviewed any records from Dr. Chuman.

Dr. Palacci indicated that Petitioner complained of 9/10 neck pain, radiating up and down the spine, 9/10 left shoulder pain, constant 10/10 headaches, 9/10 thoracic and lumbar spine pain and 8/10 bilateral knee pain.

Dr. Palacci noted that Petitioner grimaced in pain while performing active range of motion testing of the cervical spine and "refused to perform flexion and extension with complaints of neck pain." The doctor also described Petitioner as refusing to allow certain left shoulder and spinal range of motion tests.

Dr. Palacci commented that Petitioner's "exaggerated response to pain and inability or perhaps unwillingness to perform some range of motion testing, similar to the last IME, despite daily pain medication use, may suggest possible symptom magnification." Dr. Palacci found no causal relationship between Petitioner's various complaints and the January 3, 2013 accident but indicated Petitioner might benefit from various types of treatment. She addressed work status as follows: "While none of Mr. Breyts' multiple complaints are causally related to the

work accident of January 3, 2013, and he should be able to return to work as he is at maximum medical improvement, Mr. Breyts' non-work-related personal conditions, however, could prevent him from performing his job duties as a full-duty service technician due to his sensitivity to pain." RX C.

On July 25, 2013, Petitioner returned to Dr. Cha and reported reduced left-sided neck pain but still complained of right-sided neck pain. Dr. Cha recommended a diagnostic block "of the medial branch nerves that correspond with the sclerotomal distribution of" Petitioner's pain. He performed this block on July 30, 2013. After noting a report of 4-6 hours of pain relief following this block, Dr. Cha recommended and performed another diagnostic block on August 13, 2013. PX X1.

On August 5, 2013, Petitioner saw Dr. Tarin at CarePointe Ear, Nose and Throat. Dr. Tarin's history states: "pt states he was involved in auto accident in Jan. Still having tinnitus, difficulty hearing and dizziness." The doctor indicated he was not able to complete a mirror examination due to Petitioner's gag reflex. He described Petitioner's hearing as "normal to conversational and whispered speech and to tuning fork tests." He assessed Petitioner as having dizziness and unspecified hearing loss and tinnitus. He recommended that Petitioner undergo yearly audiograms. PX AA.

On September 4, 2013, Dr. Cha issued a note stating: "[Petitioner] cannot return to work until further notice." PX BB. On September 10, 2013, Petitioner filed a Section 19(b) petition listing his providers and attaching Dr. Cha's note. PX F.

Petitioner returned to Dr. Cha on September 13, 2013 and complained of "ongoing pain in his neck and limitation in range of motion." The doctor noted that Petitioner "also complains of other non-specific symptoms including loss of balance as well as difficulty with focus which he attributes to a post-concussion syndrome." The doctor recommended ongoing medication management and follow-up in two months. PX X2. T. 55.

Dr. Brechner examined Petitioner on September 16, 2013, in anticipation of left shoulder surgery. On examination, he noted a decreased range of motion in the neck and shoulder. He cleared Petitioner for surgery, with recommendations concerning Petitioner's Coumadin usage, and prescribed an electrocardiogram. He indicated Petitioner was to remain off work until further notice. PX B2. PX BB. T. 55-56.

On September 18, 2013, Dr. Abu-Aita issued the following note:

> "[Petitioner] may not return to work from a neurological standpoint. He states he is still experiencing chronic neck and back pain and goes to pain clinic. He is being evaluated by neuropsychologist for poor concentration and memory problems and ENT for dizziness."

On September 24, 2013, Petitioner returned to Dr. Chuman, having previously seen him on March 26, 2013 and May 7, 2013 [Petitioner's attorney elected not to offer the earlier records into evidence.] T. 57. The doctor noted that Petitioner complained of headaches, nausea, difficulty lifting his head, neck pain and "burning" in his entire back, from his head to his sacrum. He also noted a history of a "pineal cyst found in 2001." Petitioner indicated he had undergone care at pain clinics but stated this was "not helping."

On examination, Dr. Chuman noted cogwheel weakness. His impression was "pineal cyst and multiple symptoms brain, head, spine." He obtained flexion-extension X-rays. The films showed no fractures or subluxations and mild degenerative changes most prominent at C4-C5 and C5-C6.

Dr. Chuman recommended that Petitioner "try Neurontin and lumbar epidural" as well as a soft neck collar. He noted that Petitioner's "lawyer needs note to not RTW." He wrote out a note indicating he saw Petitioner "for neck pain and pineal cyst" and Petitioner was unable to return to work. PX V1. PX BB.

At Dr. Abu-Aita's referral, Petitioner saw Kathleen Pueschel, Ph.D., a clinical neuropsychologist, for evaluation on September 17, 18 and 20, 2013. On September 27, 2013, Dr. Pueschel issued a report concerning her findings.

Dr. Pueschel's report reflects that Petitioner was stopped at a light on January 3, 2013, when he was struck in the rear "by a vehicle reportedly proceeding at about 35 MPH." According to Petitioner, this vehicle was then struck by another vehicle and "was again pushed into" Petitioner's van. Petitioner reported he was not wearing a seatbelt because the seatbelt apparatus did not work.

Dr. Pueschel described the effect of the impact as follows:

> "While Mr. Breyts reports to have felt 'stunned,' he denies awareness of a loss of consciousness. Mr. Breyts states that he was knocked out of his seat by the force of the impact and hit both knees on the dashboard. He also added that he drives with his left hand gripping the steering wheel and subsequently has experienced left elbow pain."

Dr. Pueschel noted that Petitioner indicated he had been unable to work since the accident. She also noted that Petitioner claimed multiple injuries involving his head, neck, back, shoulders and knees. She indicated that, as of her evaluation, Petitioner complained of "pain all over but most notably involving his head, neck and back." Petitioner also complained of

ringing in his ears since the accident. Petitioner further reported having become nauseated during a recent eye examination, when the doctor directed a bright light toward his eyes.

Dr. Pueschel indicated that, with regard to cognitive difficulties, Petitioner complained of occasional slurred speech along with problems with memory, attention and concentration. She also indicated that, whereas Petitioner felt like a "take charge kind of person" before the accident, he was now "turning everything over to his wife, including the driving."

Dr. Pueschel indicated she separately interviewed Petitioner's wife. The wife reported that Petitioner had previously been a leader but now said "okay to anything." The wife indicated that Petitioner could now become confused with regard to scheduling.

Dr. Pueschel noted that, while Petitioner "initially denied any history of psychological difficulties, upon further inquiry he acknowledges the occurrence of flashbacks and anxiety-based phenomena, which he labeled as 'post-traumatic stress disorder.'" The doctor indicated that Petitioner developed these symptoms a couple of years after a 2001 motorcycle accident in which his best friend, with whom Petitioner had been riding, died. Petitioner indicated these symptoms "led to treatment with Xanax as prescribed by his primary physician."

Dr. Pueschel noted that Petitioner "ambulated independently but in a hunched over and slowed manner, most often taking but small steps." She also noted that Petitioner "engaged in a wide range of pain-like behaviors when ambulating or when arising, sitting or changing position." She indicated Petitioner "did not freely engage in casual conversation." She noted that, during testing, attention and concentration "appeared quite difficult," with "much repetition and redirection" needed. The evaluation extended over three days due to Petitioner's "slowed response rates and apparent significant fatigability." Petitioner "did appear to put forth reasonably good effort."

Dr. Pueschel noted that language-related testing revealed "a pattern of weakness within the realms of receptive, expressive and integrative language functioning." She commented as follows with respect to the origin of the weakness: "the nature of noted weakness suggests that Mr. Breyts' performance may reflect the impact of difficulty within the realm of attention/concentration and cognitive fluency/efficiency **in contrast to an identifiable neurocortically based impairment residual to concussive injury or TBI."** [emphasis added]. Dr. Pueschel made similar comments with respect to visual memory testing, which again revealed weakness:

> "Although such a weakness could reflect compromise in right posterior hemisphere functioning, the noted pattern of weakness is more of a nature as may reflect more longstanding, possibly developmental weakness. Deficits within the realm of cognitive efficiency and cognitive fluency appear to be such as to significantly impact overall level of cognitive and behavioral

functioning. Such deficits may reflect residual to concussive injury; however, persistent chronic pain and/or emotional/affective factors may also be playing a significant role."

In the conclusion section of her report, Dr. Pueschel again noted that "the observed pattern of visual/spatial and nonverbal reasoning weaknesses may reflect more of a longstanding, possibly developmental, weakness in contrast to an identifiable effect of traumatic brain injury and/or concussive injury." She stated that Petitioner "demonstrated heightened levels of anxiety and depression." She recommended continued medical follow-up and "referral to a comprehensive pain management program that includes a strong psychological/behavioral component."

At no point in her report did Dr. Pueschel indicate she reviewed any of Petitioner's treatment records. PX CC.

Petitioner testified he saw several other Indiana physicians in September 2013 in connection with his application for Social Security disability benefits. On October 7, 2013, he was awarded these benefits. PX DD. He testified the benefits were awarded in connection with the injuries that form the basis of his workers' compensation claim. T. 69-70. The award letter in evidence is silent as to the conditions underlying the award. The benefits were awarded beginning July 2013, not January 3, 2013. PX DD.

Dr. Dolitsky operated on Petitioner's left shoulder at MetroSouth Medical Center on October 3, 2013. The surgery consisted of a rotator cuff repair, an acromioplasty and a distal clavicle resection. PX W1. T. 58.

On October 11, 2013, Petitioner saw Dr. Dolitsky at Pronger Smith. The doctor removed the surgical staples. He instructed Petitioner to continue using a sling and start passive range of motion exercises. He recommended that Petitioner return to him in three weeks and start formal therapy at that point. PX W1. The record does not contain any additional treatment notes from Dr. Dolitsky. Records in PX 21 reflect that Petitioner underwent left shoulder therapy per Dr. Dolitsky between November 6 and November 22, 2013. A bill in PX U reflects Petitioner returned to Pronger Smith on December 6, 2013 for treatment of "osteoarthrosis, lower leg."

At Respondent's request, Petitioner saw Nancy Landre, Ph.D., for a neuropsychological evaluation on December 10, 2013. In her report, Dr. Landre indicated she based her history on her interview of Petitioner as well as her review of the medical records and vehicle photographs. She indicated Petitioner "denied loss of consciousness" but felt "stunned" after the accident.

Dr. Landre's report mentions various providers and evaluators but contains no mention of Dr. Chuman.

Dr. Landre expressed criticism of Dr. Peuschel's evaluation, noting that Dr. Peuschel "failed to include any symptom or performance validity measures." Dr. Landre indicated that such measurements are "now considered mandatory by all of the professional neuropsychological associations." Dr. Landre indicated that Dr. Peuschel listed a number of cognitive deficits. She stated this listing was "of questionable validity, secondary to the fact that validity testing was not completed."

Dr. Landre described Petitioner's medical history as significant for various conditions, including migraines. She indicated that Petitioner told her he likely sustained several head injuries while playing football as an adolescent. She described Petitioner's psychiatric history as significant for post-traumatic stress disorder dating back to a motorcycle accident in 2004 in which Petitioner's close friend "died in [Petitioner's] arms." She noted that Petitioner reported sporadically using Xanax since this accident.

Dr. Landre noted that Petitioner's wife accompanied him to the evaluation. Dr. Landre described Petitioner as non-distressed, polite and cooperative.

Dr. Landre indicated she administered a variety of validity tests to Petitioner "to determine whether he was providing sufficient effort during testing." She indicated that Petitioner's performance on nearly all of these tests was abnormal. She noted that Petitioner "obtained a significantly elevated score on a self-report measure that was specifically developed to identify malingering." Based on this, she described the cognitive test results as "not valid for interpretation." She nevertheless went on to note that Petitioner exhibited severe bilateral impairment on a fine motor fingertip-tapping test, mild impairment as to phonemic fluency, mild impairment as to the ability to reproduce increasingly complex geometric designs, mild impairment in immediate and delayed recall on a "story memory task," moderate impairment as to word recognition and a mildly elevated score on an anxiety screening.

Dr. Landre described Petitioner's level of performance on standard cognitive indices as "improbably low, at a level typically only seen in patients with severe brain injuries or advanced dementia." She found the test results and history to be "most consistent with a conclusion of probable malingering." She opined that Petitioner did not require additional care and could immediately resume full duty. RX D.

Petitioner testified he was still attending shoulder therapy twice weekly as of the hearing. He had not returned to Dr. Dolitsky since October 11, 2013. [As noted previously, a bill in PX U reflects Petitioner went back to Pronger-Smith on December 6, 2013 for treatment of "osteoarthrosis, lower leg."] He testified he was scheduled to return to the doctor in February 2014. T. 60-61. Since the accident, no treating doctor has released him to work. T. 63, 73. He is currently taking Norco and Flexeril. He never started taking Neurontin. T. 63-64. Dr. Palacci examined him twice, at Respondent's request. On February 13, 2013, Dr. Palacci spent about 30 to 45 minutes with him. The doctor devoted about half of that time to asking

him questions about the accident. T. 64. She also asked him to perform certain range of motion exercises. He "gave it [his] best" but was not able to perform certain maneuvers due to pain. T. 65-66. On July 16, 2013, Dr. Palacci spent about 30 minutes with him. During that time, she again questioned him about the accident. She also indicated she wanted to examine his back "to see it she could make it spasm." Petitioner testified he refused to allow her to do this "because it hurt." T. 65. He did not tell Dr. Palacci he was taking any pain medication as of the accident. T. 68. Petitioner testified he also saw Dr. Landre at Respondent's request. His visit to this doctor lasted 2 to 3 hours. The doctor interviewed him for 10 to 15 minutes and then had an assistant conduct certain psychological tests. He put forth his best effort while undergoing these tests. T. 67. He did not refuse to perform any of the tests. T. 67.

Petitioner testified he has incurred various medical bills in connection with the January 3, 2013 accident. He submitted some of these bills to his group carrier. Other bills remain unpaid. PX U consists of a group of unpaid bills. T. 68-69. Workers' compensation has refused to pay certain of his bills. T. 69.

Petitioner testified he experiences neck pain that gets worse with extended sitting. He also experiences nausea when he exerts himself. He rated the neck pain he was experiencing during the hearing at 7-8/10. The pain eases somewhat when he is completely inactive. T. 71. He has experienced headaches every day since the January 3, 2013 accident. He takes Flexeril and Norco for the headaches. He is also experiencing low back pain, rated 7-8/10. His operated left shoulder hurts a lot with movement. He is still undergoing therapy to increase his range of motion. The therapy is painful. When he is not attending therapy, he spends his time sitting in a recliner, watching television. He "tr[ies] to stay as inactive as possible." T. 73. He is still experiencing pain in both knees, worse on the right. He would rate his right knee pain at 7-8/10. That pain level increases when the right knee "locks up." He would rate his left knee pain at 5-6/10. His left knee also locks up occasionally. T. 72-73.

Under cross-examination, Petitioner testified he does side jobs but "does not really" own or operate a business. In the 1980s, he operated a business called "Larry's Lock and Key Service." He purchased this business. T. 74-75. During the time he worked for Respondent, he would use his own vehicle and equipment when he did side jobs. He has not performed any locksmith duties since the January 3, 2013 accident. T. 75. On a typical workday at Respondent, he would pick up his van, go to the office, pick up his service call tickets and head out to perform service calls. Sass assigned the service calls. Respondent provided the locksmiths with communication devices. T. 76-77. Petitioner testified that, early on, he worked about 50 hours a week for Respondent. In the last couple of years, Sass cut some overtime and reduced the hours from nine to eight per day. T. 76. Petitioner testified that the front seats in his assigned van were "swapped out" because the driver's seat wore out. After the "swap" occurred, he was sitting on what had originally been the front passenger seat. His seatbelt was thus on the wrong side of the seat. T. 79. The van was in this condition for about two years before the accident. T. 79. When he came to a stop at the red light, before the accident, there was a large box truck stopped "a good distance in front of" him. He stayed well behind this truck so he could see the light. T. 80. He believes the speed limit in the area was 35 MPH. T.

80. The accident occurred around 1:30 PM. A Toyota was behind his van. T. 81. After the Toyota struck his van, his airbags did not deploy. T. 81. After the accident, he got out of the van. He could not recall whether he checked to see whether the back of the van was damaged. He was concerned about fire, not damage. He "glanced at" the Toyota. He observed damage to both the front and rear of the Toyota. The front damage looked "like the extension of the vehicle had been turned downward." T. 82. The rear of the Toyota had a lot of damage. T. 82-83. The Flossmoor police "chased" the third vehicle (i.e., the vehicle that struck the rear of the Toyota), but that vehicle did not get very far. He believes the driver of that vehicle was arrested. T. 83. After looking at photographs marked as Group Exhibit H, Petitioner testified that one photograph showed his assigned van. He could tell this because the photograph showed the license plate. He could not say whether the photograph accurately depicted the post-accident damage. T. 86.

Linda Odom testified on behalf of Respondent. Odom testified she currently works as a senior field investigator for AIG. She first worked for AIG in 1982. T. 98. She has conducted many investigations for AIG over the years. T. 99-100. An adjuster asked her to inspect the van that Petitioner was operating at the time of the January 3, 2013 accident. She inspected this van on February 6, 2013. The van was in a garage behind Respondent's facility. T. 101. She did not observe any damage to either the interior or the exterior of the van. There was no evidence of airbag deployment. T. 102-103. RX H is a photograph that accurately depicts the van as it appeared on the day of her inspection. T. 103. RX G is a photograph of the 2005 Toyota that was also involved in the accident. T. 104-105.

Odom testified she interviewed Petitioner on March 5, 2013. During the interview, she asked Petitioner whether he worked for any entity other than Respondent. Petitioner told her he owns a locksmith company called JB Lock Service. Petitioner described himself as "freelancing" through this company. T. 107. Odom testified she performed a background check on JB Lock Service and learned it is located at 10451 North U.S. Highway 231 in Wheatfield, Indiana. Petitioner is listed as the owner of this company. T. 108.

Under cross-examination, Odom testified Petitioner told her he freelanced two to three times per month. Petitioner did not indicate whether he had freelanced since the accident. T. 108-109. She reviewed Petitioner's written statement prior to the hearing and brought it to the hearing. T. 109. When she did her inspection on February 6, 2013, she looked underneath the van at the rear bumper. She did not take any measurements to determine whether or not the bumper had been pushed in. T. 110. She has not undergone any professional training in assessing vehicular damage. T. 110-111. She went into the van but did not go into the back of the van. T. 111. She did not see a work bench in the rear of the van. T. 112. She looked at the driver's seat. That seat had a "non-functioning" seatbelt. T. 112. She did not inspect the van for any gas leaks. T. 113. She never saw any photographs of the rear of the Toyota. T. 114. She is aware the accident involved a three-car collision. T. 114. She asked to inspect the Toyota but did not inspect it. T. 115. Petitioner cooperated with her. Petitioner had no legal obligation to give her a statement. T. 115. She would not expect airbag deployment in a rear-end collision. T. 115.

In addition to the exhibits previously summarized, Respondent offered into evidence a lengthy print-out of Petitioner's hours and earnings during the period January 1, 2012 through December 31, 2012. The earnings are broken down into various categories: regular, overtime, sick pay, vacation pay, holiday pay, personal pay and commissions. The print-out reflects that a commission was paid mid-month in each of the months during the year in question. The commissions are in varying amounts totaling $9,450.95. Overtime was paid weekly, in slightly varying amounts, totaling $7,402.39. The print-out shows total 1976 regular hours, 266.75 overtime hours and gross earnings of $55,423.34.

[CONT'D]

Arbitrator's Credibility Assessment

The Arbitrator had problems with Petitioner, credibility-wise.

Petitioner denied taking any pain medication during the three-year period preceding January 3, 2013. T. 17. His CVS prescription print-out reflects that Dr. Brechner, his family physician, prescribed Tramadol on May 11, 2010 and January 27, 2011. PX E. Petitioner did not offer any of Dr. Brechner's pre-accident treatment records into evidence.

Petitioner, a longtime employee of Respondent, claimed he checked for fire but not for damage after his assigned company van was rear-ended on January 3, 2013. When asked whether he looked at the back of the van after the accident, he said, "I don't recall." T. 82. That response was evasive at best.

Petitioner testified that, after he dropped off the van and told Respondent's owner he planned to go to a hospital, it took him longer than usual to drive from Respondent's Steger warehouse to the Emergency Room. He attributed the delay to confusion and making wrong turns. He did not indicate he made any stops along the way yet the Emergency Room records reflect he arrived with a family member.

The Emergency Room physician, Dr. Kanagy, noted that Petitioner's pain seemed out of proportion to his physical examination. PX A.

Petitioner testified he has experienced headaches since the accident yet he did not testify he struck his head or jerked his neck. He testified that the first impact caused him to be thrown forward, with his abdomen striking the steering wheel. He did not testify as to any contact resulting from the second impact. He did not testify that either impact caused the van to move forward. He did not claim that either impact caused any damage to the rear of the van.

Dr. Kanagy, the first physician to see Petitioner following the accident, noted that Petitioner denied head trauma and loss of consciousness. PX A. Several days later, Dr. Brechner also noted that Petitioner did not recall striking his head. Two months later, however, Dr. Abu-Aita relied on Petitioner's history of briefly losing consciousness in concluding that Petitioner "likely had some kind of concussion with post-concussion symptoms." PX C.

Petitioner also claims injuries to both knees and his left shoulder. When asked what part(s) of his body he struck at the time of impact, however, he mentioned only his abdomen. T. 27. He did not testify to having struck either knee. He testified his left arm was on the steering wheel before the first impact but he did not testify that the arm was struck or pulled in

any way as a result of either impact. He testified he complained of his left shoulder to Emergency Room personnel but the Emergency Room records make no mention of this specific body part. Nor do they mention complaints relative to the left knee. PX A. Petitioner did complain of his left elbow and right knee at the Emergency Room but Dr. Kanagy did not recommend any care relative to these body parts. PX A.

At Dr. Brechner's direction, Petitioner underwent a repeat head CT scan on January 14, 2013. The report concerning this scan is not in evidence. At Dr. Brechner's referral, Petitioner saw Dr. Chuman, a board certified neurosurgeon, on March 26, 2013. The doctor's treatment note of that date is not in evidence. Petitioner underwent a bone scan of his entire body four days later, at Dr. Chuman's direction. Petitioner claims bills relating to this scan [PX U] but failed to offer the bone scan report into evidence. Petitioner returned to Dr. Chuman on May 7, 2013. Petitioner's counsel marked this note as an exhibit but ultimately decided not to offer the note into evidence. These omissions are glaring, given the bearing Dr. Chuman's specialty has on this case and the large volume of records submitted to the Arbitrator. On September 24, 2013, Dr. Chuman noted a history of a pineal cyst dating back to 2001. He also noted cogwheel weakness. He kept Petitioner off work secondary to "neck pain and pineal cyst." PX V1, BB. At no point did Dr. Chuman attribute the disabling neck pain and/or the pineal cyst to the accident. The Arbitrator has not been provided with any explanation as to the interplay between the pineal cyst and Petitioner's claimed symptoms and disability.

Deferred Evidentiary Ruling

Respondent offered into evidence photographs (purportedly taken after the accident) of the van Petitioner was driving and the Toyota that struck the van. RX G-H. The Arbitrator deferred ruling on Petitioner's relevancy objection to the admission of these photographs. T. 160-161. The Arbitrator exercises her discretion and admits the photographs into evidence but emphasizes that the photographs played no role in her decision-making.

Did Petitioner sustain an accident on January 3, 2013 arising out of and in the course of his employment by Respondent?

Petitioner testified his accident occurred during a regular workday, after he dropped off a bid to one Respondent customer and while he was on his way to his next assignment. Petitioner further testified he was operating an assigned company van at the time of the accident. No one contradicted Petitioner's testimony on these points.

The Arbitrator finds that the motor vehicle accident of January 3, 2013 arose out of and in the course of Petitioner's employment by Respondent.

Did Petitioner establish a causal connection between the accident of January 3, 2013 and his various claimed conditions of ill-being? Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator finds that Petitioner established a causal connection between the motor vehicle accident of January 3, 2013 and the need for the Emergency Room treatment he sought on that date. The Arbitrator acknowledges that Petitioner refused treatment at the scene of the accident and did not immediately drive to a hospital near his home. Nevertheless, the Arbitrator finds it reasonable for Petitioner to have sought an Emergency Room work-up following the accident. Petitioner was rear-ended while stopped in traffic. Petitioner testified he struck his abdomen against the steering wheel.

The Arbitrator finds that Petitioner failed to establish causation as to the need for the lengthy and complex treatment he underwent following his January 3, 2013 Emergency Room visit. Petitioner's complaints "mushroomed" after that visit. He began to include more body parts and symptoms as time went on. In some instances, his complaints bordered on the bizarre (e.g., "freezing cold feet"). By mid-January 2013, Dr. Brechner was diagnosing a post-concussion syndrome even though he noted, at the outset, that Petitioner denied hitting his head. There is no evidence indicating that any of the treating physicians who commented on causation in this case reviewed the Emergency Room records to see what Petitioner's initial complaints were. The few causation-related comments that appear in the treatment records are not well-explained. No depositions were taken. On September 24, 2013, Dr. Chuman took Petitioner off work in part due to a pineal cyst. Petitioner did not offer any opinion from Dr. Chuman explaining the role that this cyst played in Petitioner's disability. Dr. Pueschel, Petitioner's evaluating neuropsychologist, appeared to rely solely on Petitioner's self-reporting as to the injuries he sustained in the accident. She expressed no awareness of the pineal cyst. She took it on faith that Petitioner suffered a head injury and post-concussion syndrome. Even then, she did not clearly link Petitioner's various language- and memory-related weaknesses to a traumatic event. Rather, she indicated that Petitioner's presentation was consistent with a developmental disorder.

In finding causation only as to the need for the Emergency Room work-up, the Arbitrator reiterates that she has given no consideration or weight to the photographs offered into evidence by Respondent.

Petitioner identified PX U as a group of his unpaid medical bills. The Arbitrator, having found that Petitioner established causation only as to the need for the Emergency Room work-up performed on January 3, 2013, awards Petitioner the following bills, subject to the fee schedule: 1) Dr. Malik, 1/3/13, EKG-related charge, $25.00; 2) Imaging Associates of Indiana, 1/3/13, $1,142.00; 3) St. Francis Medical Group, 1/3/13, $717.00; and 4) St. Anthony Health, 1/3/13, $150.00.

Is Petitioner entitled to temporary total disability benefits?

Petitioner testified he has not returned to work of any kind since the accident. He claims temporary total disability benefits from January 3, 2013 onward. Arb Exh 1.

Based in part on the foregoing credibility- and causation-related findings, the Arbitrator declines to award temporary total disability benefits in this case. The Arbitrator also notes that Dr. Kanagy, the Emergency Room physician, did not impose any restrictions on Petitioner's activities. PX A. Subsequent treating physicians kept Petitioner off work but their "off work" notes [PX BB] contain no mention of the January 3, 2013 accident. Respondent's examiners noted inconsistencies on examination, with Dr. Lange indicating that malingering was a likely diagnosis.

Petitioner has been found eligible for Social Security disability benefits (PX DD) but failed to produce any credible evidence linking the award of those benefits to the accident.

Having declined to award temporary total disability benefits, the Arbitrator views the issues of average weekly wage and alleged TTD underpayment to be moot.

Is Respondent liable for penalties and fees?

The Arbitrator has found in Petitioner's favor on the issue of accident and has awarded several bills relating to care Petitioner underwent on the day of the accident. The Arbitrator declines, however, to award penalties and fees on those bills. While Respondent disputed accident in this case, it paid a substantial amount of medical and temporary total disability benefits along the way. Arb Exh 1. RX F.

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 Notice	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Grazyna Marciniak,

Petitioner,

vs.

NO: 13 WC 05446

Mid City Plaza,

15IWCC0359

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, date of accident/manifestation date, notice, causation, medical expenses, temporary total disability (TTD), prospective medical treatment and Petitioner's request to remand the case to enter additional evidence, and being advised of the facts and law, reverses the Decision of the Arbitrator with regard to notice and denies Petitioner's request for additional evidence, as stated below, and remands the matter back to the Arbitrator with instructions to make findings with regard to all remaining issues.

The Commission affirms the Arbitrator with regard to the finding that the proper accident date in this case is September 1, 2012. The Commission finds that the Petitioner sustained a specific accident on that date, which involved pulling wet laundry from a commercial washing machine. This is supported by the medical histories provided to Dr. Nowak, Dr. Verma and Dr. Karlsson. The Petitioner's testimony in this regard is admittedly equivocal. However, we find that in total it supports our finding of a specific accident. The following colloquy occurred between Petitioner and Respondent's attorney (Tr. 79-81):

"Q: Now when you saw Dr. Nowak on September 1st 2012, do you recall giving him a history?

A: Yes

Q: Do you recall telling him that you had severe right shoulder pain working pulling heavy wet bed linen from a washing machine a few days ago?

A: Yes

Q: So is it your testimony that you had a specific incident two or three days before September 1st when you felt right shoulder pain?

A: No, not two or three days before.

Q: How many days? Was this wrong then what the doctor wrote, a few days ago?

A: One, maybe two weeks.

Q: So there was a specific event, one specific time when you were pulling –

A: No.

Q: So this statement would be wrong then?

A: No.

Q: So it's correct then that you had right shoulder pain pulling heavy linen a few days ago? . . . .

A: Yes.

Q: She did have a specific incident?

A: No, I just felt pain when I was pulling wet laundry.

Q: A few days ago prior to when you first saw Dr. Nowak?

A: It hurt - - the pain increased gradually and gradually."

The Commission believes that, despite the presence of an interpreter, the Petitioner still had some misunderstanding about exactly what she was being asked. She was later asked again if she sustained a specific accident, and denied that she had (Tr. 81). Nevertheless, based on the

preponderance of the evidence, we find that her answers indicate that she developed right shoulder pain due to a specific incident wherein she was removing heavy linens from a commercial washing machine. While she may have had some level of right shoulder pain prior to this incident, it is clear to the Commission that something relatively significant occurred while she was performing this specific activity and that this significantly impacted her right shoulder condition. We acknowledge that there may be a repetitive aspect to the Petitioner's claim as well, but nevertheless find that the greater weight of the evidence reflects a specific September 1, 2012 accident.

The applicable portion of 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 that 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. Additionally: "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).

The Commission finds that the Petitioner reported her injury to her supervisor, Anna Bartusiak, within 45 days of September 1, 2012. She testified that she developed symptoms in late August, 2012. She initially sought treatment with Dr. Nowak on September 1, 2012. She testified that at some point prior to seeking treatment she was talking to Ms. Bartusiak by the washing machines and reported bilateral shoulder and arm pain. After receiving the results of her September 11, 2012 right shoulder MRI, Petitioner testified she told Bartusiak, with manager Wanda Szymutko possibly also being present, that she had a torn ligament in her shoulder. Additionally, Petitioner testified that she began to develop left shoulder pain as a result of having to favor the painful right shoulder while continuing to work for Respondent. At the end of September, 2012 she reported the condition to Szymutko, testifying that she did so speaking Polish, while Szymutko translated into English for an office worker who was writing down the information.

Ms. Bartusiak testified that she was told the Petitioner was seeking medical treatment, but that Petitioner did not say that it was for a work related problem. Petitioner told her that she was having pain in her shoulders, but she wasn't sure when this occurred. She noted that she and the Petitioner would talk generally about "aches and pains" they had, and that this may have occurred in September 2012. Ms. Szymutko was not called to testify.

15IWCC0359

While there may have been a defect in the notice in terms of whether the Petitioner specified that the condition was related to her work, based on the case law cited above, for such defect to be considered fatal to Petitioner's case the Respondent must show that it was unduly prejudiced by the defective notice. We find that the Petitioner's testimony is more credible than that of Ms. Bartusiak, and the failure of Respondent to call Ms. Szymutko to testify negatively impacted the credibility of Respondent's defense.

The Commission denies the Petitioner's request to remand the matter to the Arbitrator to take additional evidence with regard to the applicability of Section 8(j) to this claim. First, the parties had every opportunity to present evidence regarding this issue at hearing. There is nothing that has been indicated by the parties on review which shows that the evidence required to prove the applicability of Section 8(j) was unavailable at the time of hearing. While Petitioner has provided case law in support of the Commission's ability to remand the case to the Arbitrator to take additional evidence, Section 19(e) makes clear that the legislature did not intend for the Commission to utilize the ability to remand to simply get around the rule prohibiting the submission of additional evidence on review. It is our view that a remand to take additional evidence is an extraordinary measure, and the parties have provided no argument, in the discretion of the Commission, that such an extraordinary measure would be proper in this case.

Further, the Commission rejects the Petitioner's offer of proof. An offer of proof is only applicable where evidence has been offered at hearing and excluded. As noted, there was no attempt to enter evidence into the record at hearing regarding the applicability of Section 8(j) to this case, and the Request for Hearing (Arbitrator's Exhibit 1) does not reflect Section 8(j) as an issue. As such, an offer of proof regarding Section 8(j) is not proper in this case.

Because no benefits have been awarded on this case at this point, an appeal bond is not applicable. Additionally, based on our determination that there was sufficient notice to the Respondent in this case, and our remand to the Arbitrator for further findings, this decision is interlocutory and not subject to appeal at this time. Respondent has the opportunity to preserve any issues regarding this decision on review from the Arbitrator's decision on remand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed, and the Petitioner's request to take additional evidence is denied, as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings consistent with this Decision.

15IWCC0359

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

DATED: MAY 19 2015
TJT: pvc
o 3/24/15
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Simpson's findings are both thorough and well reasoned. This decision is correct and should be affirmed

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

☒ 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

Melvin Wilder,

Petitioner,

vs.

NO: 12 WC 2119

15IWCC0360

Swanson Trucking 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, 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 October 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.

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

DATED: MAY 19 2015
TJT:yl
o 5/12/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILDER, MELVIN
Employee/Petitioner

Case# **12WC002119**

12WC002107

SWANSON TRUCKING INC
Employer/Respondent

15IWCC0360

On 10/14/2014, 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 0.04% 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:

1097 SCHWEICKERT & GANASSIN LLP
SCOTT GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

3150 JAMES M KELLY LAW FIRM
4801 N PROSPECT RD
SUITE 832
PEORIA HEIGHTS, IL 61616

15IWCC0360

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

Melvin Wilder
Employee/Petitioner

v.

Swanson Trucking, Inc.
Employer/Respondent

Case # **12** WC **2119**

Consolidated cases: **12** WC **2107**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 31, 2014**. 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

15IWCC0360

FINDINGS

On **January 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 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 **$39,000.00**; the average weekly wage was **$750.00**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that his current left arm condition of ill being is causally related to an alleged repetitive trauma injury at work manifesting on January 2, 2012. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

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

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

Signature of Arbitrator

October 7, 2014
Date

OCT 14 2014

15IWCC0360

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Melvin Wilder
Employee/Petitioner

v.

Swanson Trucking, Inc.
Employer/Respondent

Case # **12** WC **2119**

Consolidated cases: **12** WC **2107**

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's above-captioned cases. Arbitrator's Exhibit[1] ("AX") 2; AX1. The issues in dispute in this case include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability from January 13, 2012 through March 29, 2012, the nature and extent of Petitioner's injury subsequent to his accident at work on January 2, 2012, and whether penalties and fees should be imposed on Respondent. AX1. The parties have stipulated to all other issues. AX1.

Background

Petitioner was employed by Respondent beginning January 2, 2011 as a truck driver hauling tankers over-the-road. He was originally assigned to a truck for a couple of months with which he testified he had no operating or mechanical problems. He then received a brand new Peterbilt truck with which he had no problems, but was then in an accident in this truck. On cross examination, Petitioner testified that he had no problems with the mechanical operations of the trucks that he had while working for Respondent from January 2, 2011 through October 3, 2011.

August 27, 2011

Petitioner was then involved in an accident at work on August 27, 2011. The circumstances of Petitioner's right hand and thumb and left elbow condition and August 27, 2011 claim are addressed in the concurrent decision issued in Case No. 12 WC 2107.

On August 27, 2011, Petitioner testified that he was going to R.E.G. in Danville, Illinois. He picked up a Peterbilt truck to haul a tanker at Respondent's facility in Ohio, Illinois. He was then involved in an accident while driving on Illinois Route 39 at approximately mile marker 62 near LaSalle/Peru, Illinois. Petitioner testified that he had a drink of coffee that caused him to choke and pass out.

Petitioner explained that he typically drove with his left hand on the steering wheel and his right hand either on the gear shift or free to hold a coffee cup. He testified that he next recalled someone helping him out of the truck. Petitioner testified that he was driving the speed limit and when he saw the truck it was destroyed and laying on its side. Petitioner was taken by ambulance to Illinois Valley Community Hospital ("IVCH"). PX5.

[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 medical records reflect Petitioner's reports of right wrist and left elbow pain. PX5; RX11. He underwent x-rays of his chest and right wrist, which were normal. *Id.* After an examination, Dr. Kim diagnosed Petitioner with a right wrist contusion and left elbow abrasion. *Id.* He was prescribed an antibiotic and muscle relaxant. *Id.* He was instructed to follow up with the IVCH Occupational Health Department and that he had continued symptoms in his right wrist, right thumb, and left elbow.

On August 29, 2011, Petitioner returned IVCH Occupational Health for a follow-up appointment. PX5; RX10. At that time, he complained of continued pain, swelling and decreased range of motion in his right wrist. *Id.* He also reported difficulty sleeping. *Id.* A physical examination of the right wrist revealed snuff box tenderness, diffuse dorsal right hand edema and limited flexion and extension. *Id.* His right hand grip strength (dominant) was less than the left. *Id.*

Petitioner was diagnosed with right wrist pain and strain/rule out occult fracture, and a left elbow abrasion following a motor vehicle accident. *Id.* He was restricted to left handed work only. *Id.* Petitioner was also provided with a custom fit, molded right posterior thumb splint. *Id.* Repeat right wrist x-rays were ordered to rule out an occult fracture and he was referred to see Dr. Michael Shin, an orthopedic surgeon. *Id.*

Petitioner returned to IVCH Occupational Health on September 2, 2011. PX5; RX9. He reported that his general body aches after the accident had resolved, but noted continued right wrist tenderness. *Id.* A repeat x-ray of the right wrist was negative. *Id.* However, on examination Petitioner had pain and limitation with right wrist extension along with tenderness to palpation over the snuffbox. *Id.* Petitioner was instructed to continue wearing his splint and using over-the-counter pain medication as needed. *Id.* His work restrictions were maintained and a right wrist MRI was ordered. *Id.*

Petitioner then saw Dr. Shin at Valley Orthopedics and Sports Medicine on September 7, 2011. PX6; RX8. He reported pain in the right snuffbox as well as lost range of motion in the right wrist and thumb. *Id.* He described the pain as dull and throbbing in nature and explained it was at a pain level of 3/10 at a baseline, increasing to 8/10 with any use of the right hand. *Id.*

On examination, Dr. Shin noted slight swelling over the right wrist, snuffbox region and thumb. *Id.* Palpation and grind testing produced mild-to-moderate pain at the right snuffbox and pinch strength testing caused pain at the snuffbox region. *Id.* Moderate pain was noted in the dorsal wrist capsule along with slight pain in the DRUJ shuck region. *Id.* Dr. Shin also noted a slight decrease in right thumb range of motion. *Id.*

Dr. Shin diagnosed Petitioner with right wrist pain and a sprain and right thumb pain and a sprain. *Id.* He ordered a right wrist MRI to rule out an occult scaphoid fracture and a removable brace. *Id.* He also ordered occupational therapy three times a week for four weeks and placed Petitioner off work due to his pain and restrictions. *Id.*

On September 14, 2011, Petitioner returned to Dr. Shin reporting no pain while wearing the splint and pain at a level of 8/10 following a lot of use of his right hand for tasks such as writing with pain localized mainly to the right thumb. PX6; RX7. He also reported that the recommended MRI was not approved by the insurance carrier. *Id.* Dr. Shin noted minimal right-sided snuffbox tenderness with persistent pain in the CMC and proximal phalanx regions. *Id.* He also noted limited right wrist tenderness in the dorsal capsule, minimal pain but fairly normal ranges of motion in MCPs, PIPs, DIPs, wrist flexors and wrist extensors, and minimally

positive Finkelstein testing. *Id.* Because the MRI was not approved, delayed x-rays of Petitioner's right wrist were taken to rule out a possible occult scaphoid fracture. *Id.* On review of these x-rays, Dr. Shin found no evidence of fracture and permitted him to return to light-duty work with a five pound lifting restriction. *Id.*; RX7 (the x-ray report states "lateral and scaphoid views show no fractures or evidence of bony reabsorption in the scaphoid region.") Dr. Shin instructed Petitioner to continue wearing the brace and ordered continued therapy. *Id.*

An occupational therapy note dated September 26, 2011 reflects that Petitioner "has made excellent progress with decreased pain. He has achieved all goals except increased wrist extension. [Petitioner] feels he is able to return to full employment." RX6.

Petitioner returned to Dr. Shin on September 28, 2011 and reported doing well in physical therapy and pain typically at a level of 2/10 around the thumb and wrist region. PX6. He also reported discontinuing use of his brace a week prior and no swelling or bruising present, but a noticeable small dorsal ganglion cyst on the right side that developed. *Id.* Petitioner testified that Dr. Shin noted the ganglion cyst and discussed forms of treatment with him, including putting pressure on it. Petitioner testified that eventually the ganglion cyst reduced in size after 3-4 weeks. The medical records reflect Dr. Shin released Petitioner back to full duty work. *Id.* At the hearing, Petitioner testified that he was off work from date of accident through October 2, 2011.

October 3, 2011 through January 2, 2012

The circumstances of Petitioner's right hand and thumb and left elbow condition and August 27, 2011 claim are addressed in the concurrent decision issued in Case No. 12 WC 2107. As relevant in this case, Petitioner testified that he had no further problems or symptoms in the left elbow, right hand, or right thumb after October 3, 2011.

Petitioner then testified about his return to work on October 3, 2011. He testified that he was not given a new truck by Respondent; rather, he received an old red Greatliner approximately 5-6 years old that had over 600,000-700,000 miles. He testified that he operated this truck five days per week and estimated that he traveled approximately 3,000 miles every five days.

Petitioner explained that he would drive with both hands on the steering wheel all the time and that the truck would shake and rattle. He testified that he told Mr. Debruhl about this every time he came to the yard, but that Mr. Debruhl told him that the truck would get fixed. Petitioner testified that he understood that he should report any mechanical issues to Mr. Debruhl, but he testified that he did not fill out any reports requesting repairs before January 2, 2012. According to Petitioner, the issues that he verbally reported were never fixed.

He later testified on cross examination that he reported problems with his truck in shop reports between October 3, 2011 and January 2, 2012. Petitioner testified that shop reports/maintenance reports required that the trucks be properly repaired. These logs would include Petitioner's mileage, pre-trip details, etc. He testified that the shop reports were maintained by Respondent, not him. No such reports were submitted into evidence.

Petitioner then testified that from October 2011 through the last day of work in January 2012 he continued to use the old Greatliner truck. On cross examination, Petitioner testified that he returned to drive Peterbilt in October 2011, not a Greatliner.

He also acknowledged that his duties included driving a tanker truck during this period of time hauling non-hazardous liquid. He did not need to physically move freight, handle a jack, etc. Petitioner further acknowledged that, subject to traffic and the time of day, he did not always have to shift gears in the truck. He could drink coffee and use one hand on the wheel. If his hands got tired, he could switch hands on the wheel sometimes. Petitioner also testified that he could take stops as needed for bathroom breaks or stiffness. Aside from pre-trip inspections, Petitioner testified that he was primarily driving.

Petitioner testified that he worked full duty from October 3, 2011 through January 2, 2012, but he also acknowledged that he took some time off over the holidays. He was off over Thanksgiving from November 20, 2011 through November 26, 2011, Christmas from December 23, 2011 through December 27, 2011, and the New Year holiday from December 30, 2011 through January 1, 2012.

Petitioner testified that he developed discomfort in his left hand and left elbow, which started just before or around the Thanksgiving holiday in 2011. Petitioner testified that he experienced pain and numbing in his hand, and in the 4th and 5th fingers. Petitioner did not undergo any medical treatment from October 3, 2011 through January 1, 2012.

He testified that he notified a secretary of his symptoms in December 2011 or January 2012 and he understood that she went to Mr. Debruhl. He also testified that his first day back at work thereafter was on January 2, 2012.

On cross examination, Petitioner testified that he could not recall telling Mr. Debruhl, Jackie or others in the office that he had to go to the emergency room on January 2, 2012 because he felt he was having a heart attack. He acknowledged that he did not indicate to anyone in the office at this time that his steering wheel or truck was causing him to have symptoms in his left arm causing him to go to the emergency room.

January 2, 2012

On January 2, 2012, Petitioner went to Perry Memorial Hospital. He testified that he did not know whether he was having heart issues or arm problems. He testified his numbness went into 4th and 5th digits, and this is the reason he went into the hospital. Petitioner explained that he felt symptoms in his left arm and he did not know what was wrong with it so he went directly to the emergency room.

The emergency room triage notes reflect Petitioner's report that he had numbness in two fingers on the left hand ever since Thanksgiving, and was experiencing numbness from his left hand to the elbow at that time. PX4; RX5. The emergency room physician noted Petitioner's report of an onset of mild, constant symptoms in the 4th and 5th fingers one month prior. *Id.* The physician diagnosed Petitioner with left cubital tunnel syndrome and he was discharged with instructions to take Tylenol/Advil for pain and to follow up with Dr. Sompalli in the next two days. *Id.*

On cross examination, Petitioner acknowledged that he did not tell the emergency room doctor on January 2, 2012 that his truck caused his problems. He explained that this is why he went to a doctor and that he told the doctor that he could not think of an event that caused problems to his left arm.

Petitioner then returned to see Dr. Shin on January 13, 2012. PX6. He reported developing numbness and tingling in his left ring and small fingers over the past month which had progressed up the ulnar side of the forearm to the medial side of the elbow. *Id.* Petitioner also reported feeling that he lost strength in his left hand,

weakness in the hand, and a dull, constant pain that was worsening. *Id.* Petitioner rated his pain level at a baseline of 4-5/10 that increased to a 6/10 with certain motions. *Id.*

On physical examination, Dr. Shin noted mild tenderness at the cubital tunnel on the left, positive flexion and pronation testing, and a moderately positive Tinel's sign. *Id.* He also noted slightly reduced grip strength and mildly decreased left ulnar nerve function. *Id.* Dr. Shin diagnosed Petitioner with left elbow pain, left hand numbness and left cubital tunnel syndrome. *Id.* He ordered an EMG/NCV to evaluate the elbow. *Id.* Petitioner also reported that he felt that he could not drive a commercial vehicle and Dr. Shin indicated that he trusted Petitioner's word and placed Petitioner off work for a month through February 13, 2012. *Id.*

Petitioner returned to Dr. Shin on February 13, 2012 with continued complaints of generalized numbness from the left elbow through his hand, throbbing, constant pain at 6/10, and fingers that tended to curl and flex on their own. PX6; RX2-RX3. Dr. Shin reiterated his order for an EMG/NCV and kept Petitioner off work due to pain and weakness. *Id.* In response to Petitioner's inquiry, Dr. Shin indicated that Petitioner's condition may be related to his truck driving. *Id.*

Petitioner also saw Dr. Blair Rhode for a second opinion on February 16, 2012. PX7. Petitioner reported left elbow pain and that his symptoms were secondary to an injury while at work. *Id.* He reported that he developed medial-sided left elbow pain with numbness and tingling to the ring and little finger around Thanksgiving 2011, but that his symptoms became precipitously worse on January 2, 2012. *Id.* Petitioner gave a work history that he was a truck driver for approximately 27 years and "[h]e is currently been driving an old truck with poor suspension. He states that he primarily hold the steering well with his left. His ulcer required to pull all his. He drives a tanker. He also is required to climb ladders. He also has a history of a rollover truck accident August 22, 2011. He sustained an injury to his cervical spine at that time. He has been treating with Dr. Shin at St. Margaret. Dr. Shin has recommended no specific treatment and told him that he is going to wait 6 months prior to determining a treatment course. The patient feels this is unacceptable due to the fact that he wants to get back to work and currently is unsafe as a truck driver. He is scheduled for an EMG today. The patient denies a history of diabetes or thyroid dysfunction. [sic]" PX7.

On examination, Dr. Rhode noted ulnar clawing, pain at the medial epicondyle, a half-grade strength loss in finger abduction, a positive Tinel's sign, and a positive cubital tunnel sign producing parasthesias in the distribution of the ulnar nerve. *Id.* He prescribed Meloxicam, an anti-inflammatory and prescribed a night splint. *Id.* Dr. Rhode also noted that Petitioner demonstrated evidence of work-related cubital tunnel syndrome that appeared advanced given his ulnar clawing. *Id.*

Petitioner underwent the recommended EMG/NCV with Dr. Lisa Snyder at the Institute of Physical Medicine and Rehabilitation ("IPMR") on February 16, 2012. PX2; PX6; RX4. Petitioner reported some numbness and tingling in the 4th and 5th digits of the left hand since about Thanksgiving of 2011 following by a visit to the emergency room in early January 2012 when he awoke with severe pain. *Id.* Petitioner reported that the "only trauma that he can think of was that he was in a motor vehicle accident in August of 2011 that involved a rollover." *Id.* Dr. Snyder's impression was of severe left ulnar nerve compression neuropathy at the elbow (cubital tunnel syndrome) and very mild radial and medial sensory neuropathies in the left upper extremity. *Id.*

Petitioner returned to Dr. Shin on February 27, 2012. PX6. After reviewing Petitioner's EMG/NCV, Dr. Shin noted that it showed severe ulnar nerve compression, mild median and radial sensory neuropathies, and denervation of the interoosseous muscles. *Id.* He recommended a cubital tunnel release given the rapid

progression of Petitioner's symptoms and prescribed Norco for pain. *Id.* He also kept Petitioner off work through March 19, 2012. *Id.* Following this visit, Petitioner treated exclusively with Dr. Rhode. PX6-PX7.

On cross examination, Petitioner acknowledged that he did not tell any doctor about vibration in the steering wheel until he saw Dr. Rhode. He did not recall telling Dr. Shin about vibration in the steering wheel. The Arbitrator notes that Dr. Rhode's February 16, 2012 notes do not reflect any report of vibration in a steering wheel.

Petitioner returned to Dr. Rhode on March 1, 2012. PX7. Dr. Rhode maintained his diagnoses and also recommended a cubital tunnel release. *Id.* He kept Petitioner off work. *Id.*

On March 20, 2012, Petitioner underwent surgery with Dr. Rhode. PX7. Pre- and post-operatively, he diagnosed Petitioner with cubital tunnel syndrome and he performed a left open cubital tunnel release. *Id.*

Petitioner returned to Dr. Rhode on March 29, 2012 and reported that his hand clawing was already improving. PX7. Dr. Rhode released Petitioner to light duty work including no lifting/carrying over 20 pounds and no loading or unloading of his truck. *Id.* Petitioner was authorized to drive. *Id.*

Petitioner did not return to Dr. Rhode and had no further medical care.

Records Review – Dr. Crandall

At Respondent's request, Dr. R. Evan Crandall performed a records review and rendered opinions in a report dated July 27, 2012. RX1. He reviewed medical records from Orland Park Orthopedics, IPMR, St. Margaret's Health, IVCH, and Perry Memorial Hospital. *Id.*

Dr. Crandall referenced the EMG/NCV report of Dr. Snyder concluding that Petitioner had severe ulnar neuropathy. *Id.* He agreed with Dr. Snyder's assessment and indicated that, in his experience, "it takes 5 to 10 years to develop that level of ulnar neuropathy. That is not a new finding. It does not reflect that the ulnar neuropathy began in January and it does not reflect that it began that year." *Id.* He also noted Dr. Rhode's March 1, 2012 chart note that Petitioner's symptoms were secondary to an injury at work, but Dr. Rhode did not indicate when that injury occurred. *Id.*

Dr. Crandall specifically opined that the mechanism of injury occurring on August 27, 2011 "would not be able to cause cubital tunnel syndrome." *Id.* He noted that the medical records showed that Petitioner sustained a left elbow abrasion at that time, and he did not complain or treat for ulnar neuropathy in the months following the accident. *Id.* He also noted that Petitioner's cubital tunnel syndrome could not be an aggravation of a pre-existing condition; otherwise he would have had symptoms close to the time of his August 27, 2011 accident. *Id.* He also opined that Petitioner's ulnar neuropathy was not caused as a result of a work accident or because of his employment. *Id.* Dr. Crandall stated that "[t]ruck driving does not cause ulnar neuropathy. *Id.*

Additional Information

Petitioner testified that he was off work for a short period of time and then found employment. Petitioner testified that he now continues to work as an over-the-road truck driver.

Regarding his current condition, Petitioner testified that his left little finger is still numb whereas before the surgery, Petitioner had pain and numbness in the 4th and 5th fingers radiating up through to his left elbow.

Brooks Debruhl

Respondent called Mr. Debruhl as a witness. He testified that he hired Petitioner in 2011. Mr. Debruhl is currently the owner of the company and has been for the past six to seven years. Previously, he was a dispatcher for 16 years or so. Mr. Debruhl testified that his duties as a dispatcher included assigning drivers their pickups and drop-offs every day. He testified that he is still responsible to assign pick-ups and drop-offs every day.

Mr. Debruhl testified that Petitioner's job was as an over-the-road truck driver hauling no-touch freight. *See also* RX12. Generally, drivers are gone most of the week. Mr. Debruhl gives the drivers their pick-ups and deliveries every day. Sometimes they are also required to hook-up hoses, but most of the job entails open driving.

Regarding procedures, Mr. Debruhl testified that there was usually a check-in call in the morning or at the end of the day. Sometimes updates were required during the day as needed. He testified that this was the protocol while Petitioner was employed by Respondent.

Regarding accidents or mechanical difficulties, Mr. Debruhl testified that drivers are told to report any accidents or incidents. He also testified that mechanical issues are reported to Mr. Debruhl or someone else in his absence as well as to the mechanics. If a truck needed to be taken out of service, and another truck was available, Mr. Debruhl testified that it would be assigned to the driver. Mr. Debruhl testified that the regular maintenance routine through January 2, 2012 was that trucks were brought in on a weekly basis and examined by Respondent's mechanics. If a problem was reported by the driver to the mechanic, the issue was repaired.

Mr. Debruhl testified that he did not become aware of any reports of vibrating steering wheel problems with the truck to which Petitioner was assigned from October 3, 2011 through January 2, 2012. He testified that when Petitioner returned to work on October 3, 2011 he was assigned to drive a Peterbilt with air-ride suspension/cab/seat, sleeper cab, etc. The particular Peterbilt truck was purchased new by Respondent. He added that the truck did have 600,000 miles, but testified that this was relatively low mileage. He testified that there was more life expectancy left on a truck with 600,000 miles; there are trucks with over a million miles.

Mr. Debruhl also testified that Petitioner never reported problems with the steering wheel to him. Petitioner's testimony at the time of hearing was the first time that Mr. Debruhl heard of any report of a vibrating steering wheel. Mr. Debruhl further testified that Petitioner did not complain about his left upper extremity bothering him or in relation to any mechanical difficulty with his truck from October 3, 2011 through January 2, 2012.

On January 2, 2012, Mr. Debruhl testified that Petitioner came in to speak with him. He testified that Petitioner talked to Jim and told him that he went to the emergency room and thought he was having a heart attack. There was no mention to Mr. Debruhl's knowledge on that day about any relation between the truck and the medical treatment.

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 2011). The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006) (*citing Three "D" Discount Store*, 198 Ill. App. 3d 43, 49 (4th Dist. 1989)).

Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529 (1987)). The Illinois Supreme Court went on to highlight its *Peoria County* decision stating that "To deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (*citing Peoria County*, 115 Ill. 2d at 529-30).

An employee claiming that he suffered a repetitive-trauma injury must still point to a date within the statutory limitations period on which both the injury and its causal link to his work became plainly apparent to a reasonable employee. *Durand*, 224 Ill. 2d at 65 (*citing Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 209 (1st Dist. 1993)); *see also Peoria County*, 115 Ill. 2d at 531. "[B]ecause repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work." *Id.*, (*citing Oscar Mayer v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (4th Dist. 1988)).

In this case, Petitioner testified that he felt left arm pain that woke him up in the middle of the night on January 2, 2012. He did not know what the pain was, but testified that he went to the hospital to determine the source of the pain. Petitioner asserts that he had a defective truck with a vibrating steering wheel after he returned to work on October 3, 2011 which caused his left cubital tunnel syndrome to manifest on January 2, 2012. In light of the totality of the evidence, the Arbitrator disagrees.

Between the time of his return to work on October 3, 2011 and January 1, 2011, Petitioner testified that he did not have any symptoms in the left arm. There is no evidence that he had any cubital tunnel or left arm complaints prior to Thanksgiving 2011, with the exception of complaints and treatment for a left arm abrasion sustained in the rollover accident on August 27, 2011. In the Arbitrator's view, the inquiry given the parties' arguments then is whether Petitioner's job duties after October 3, 2011 through January 1, 2012 caused left cubital tunnel syndrome or whether Petitioner's job duties at some point aggravated a pre-existing, but asymptomatic, left cubital tunnel syndrome condition manifesting on January 2, 2012.

The record contains various inconsistencies notable in Petitioner's testimony which are also contradicted in certain respects by the testimony of his former employer, Mr. Debruhl, and other record evidence.

Petitioner initially testified that when he returned to work for Respondent on October 3, 2011, he was given an old Greatliner truck. On cross examination, Petitioner testified that he returned to drive Peterbilt in October 2011, not a Greatliner. Petitioner testified that the truck had poor suspension. Mr. Debruhl testified that the truck had an air-ride suspension, cab and seat. Both agreed that the truck had about 600,000 miles, but disputed whether this amounted to a new or an old truck given industry standards.

Petitioner also testified that he reported various problems with this truck to Mr. Debruhl after returning in October 2011 and did so daily in reports and orally. He further testified that the steering wheel in this truck vibrated, rattled and shook. He testified that he reported that problem to Dr. Rhode. Mr. Debruhl refuted Petitioner's testimony and Dr. Rhode's records do not reflect any report by Petitioner of a problem with vibration, rattling or shaking in the steering wheel of his truck regardless of brand or age.

Moreover, Dr. Rhode's notes at the time of Petitioner's initial visit reflects Petitioner's report that he injured his neck at the time of his rollover in August 2011, which is not documented in any treatment records thereafter. Dr. Rhode also notes Petitioner's report that Dr. Shin told Petitioner that he would not provide treatment for six months for his cubital tunnel syndrome. This is contrary to Dr. Shin's records recommending surgery just three days earlier.

Indeed, on February 13, 2012, Dr. Shin indicated that Petitioner's condition may be related to his work, but he did so in response to Petitioner's inquiry and he provided no specific information on what related the work to Petitioner's condition. Three days later when Petitioner went to see Dr. Rhode for a second opinion Dr. Rhode noted that Petitioner's symptoms were secondary to an injury while at work, also without further explanation.

It is undisputed that Petitioner has been a truck driver for decades. He began employment for Respondent as a truck driver hauling no-touch non-hazardous tankers over-the-road since January 2011. Petitioner was involved in a rollover accident while employed with Respondent on August 27, 2011 at which time he sustained injuries to his right hand and thumb, and an abrasion to his left elbow. Petitioner reported no symptoms in the left elbow after a couple of weeks of medical treatment. He made no complaints of any left elbow or left hand conditions prior to Thanksgiving 2011. Petitioner was off work over this holiday from November 20, 2011 through November 26, 2011. Petitioner was also off work an additional six days over Christmas from December 23, 2011 through December 27, 2011 and the New Year holiday from December 30, 2011 through January 1, 2012. Petitioner did not seek medical attention for any reason until January 2, 2012.

The EMG/NCV performed by Dr. Snyder on February 16, 2012 shows that Petitioner had severe left cubital tunnel syndrome. Dr. Crandall agreed with Dr. Snyder's assessment and further opined that Petitioner's left cubital tunnel syndrome had developed over a long period of time, years. Notably, the first time that Petitioner noted any left arm complaints was while he was off work over Thanksgiving 2011. He did not seek medical treatment for symptoms that he reported occurred from that time until January 2, 2012 when his pain was so severe it woke him from sleep. Petitioner admittedly did not drive for Respondent for approximately 12 days over that five week period.

The medical records are also devoid of any reference to a vibrating steering wheel as alleged by Petitioner. Petitioner also switched treating physicians shortly after Dr. Shin provided an equivocal opinion that his condition may be work-related and he continued seeing Dr. Rhode who opined at his initial visit that Petitioner's condition was related to an injury at work. However, Dr. Rhode did so without indicating whether it was the rollover accident on August 27, 2011 or some specific mechanism of repetitive trauma that caused severe left cubital tunnel syndrome to manifest on January 2, 2012. He simply concluded based on Petitioner's

history that his cubital tunnel syndrome was work related, but he did not delineate the basis for that opinion including whether it was the motor vehicle accident or simply driving a truck with poor suspension.

In light of all of the foregoing, the Arbitrator finds that the opinions of Dr. Crandall are more reflective of a plausible onset of cubital tunnel syndrome than those of Dr. Rhode or Dr. Shin. Moreover, Petitioner's testimony that his condition resulted from a vibrating steering wheel in an old truck after several weeks of work in the winter of 2011 is controverted by his reports to his treating physicians as well as the testimony of Mr. Debruhl .

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to prove that he sustained a compensable accident that arose out of and in the course of his employment with Respondent on January 2, 2012 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott A. Morris,

Petitioner,

vs.

NO: 14 WC 3751

15IWCC0361

Wal-Mart Stores, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 2014, is hereby affirmed and adopted.

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

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

15IWCC0361

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,600.00. 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: MAY 19 2015
TJT:yl
o 5/12/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORRIS, SCOTT A
Employee/Petitioner

Case# **14WC003751**

WAL-MART STORES INC
Employer/Respondent

15IWCC0361

On 10/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1909 ACKERMAN LAW OFFICES PC
ACKERMAN, JAMES W
1201 S 6TH ST
SPRINGFIELD, IL 62703

0560 WIEDNER & McAULIFFE LTD
MATTHEW J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

15IWCC0361

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Scott A. Morris
Employee/Petitioner

v.

Wal-Mart Stores, Inc.
Employer/Respondent

Case # 14 WC 03751

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on August 20, 2014. By stipulation, the parties agree:

On the date of accident (manifestation), May 31, 2013, 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 $26,000.00; the average weekly wage was $500.00.

At the time of injury, Petitioner was 44 years of age, single, with 0 dependent child(ren).

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

Respondent shall be given a credit of $1,478.94 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,478.94. The parties stipulated at trial that all TTD benefits and medical had been paid in full.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $300.00 per week for a period of 70 weeks, because the injuries sustained caused a 14 % loss of use of the body as a whole as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

October 10, 2014
Date

OCT 17 2014

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged an accident (manifestation) date of May 31, 2013, and that Petitioner sustained an injury to his left shoulder and neck as a result of overhead lifting. The parties stipulated that all medical and temporary total disability benefits had been paid in full and that the only disputed issue was the nature and extent of disability.

Petitioner testified that he worked for Respondent as a tire/lube technician (Department Manager) and that his job duties included changing tires, batteries, oil changes, etc. Petitioner's job required a significant amount of lifting, in particular, lifting tires which Petitioner said could weigh 60 to 70 pounds.

On May 31, 2013, Petitioner completed an Associate Incident Report in which he reported experiencing pain and numbness in the neck, left shoulder and left hand which radiated down the left arm when lifting freight. In this report, Petitioner stated that he first began experiencing these symptoms in March, 2007 (Respondent's Exhibit 1). Petitioner subsequently completed an Associate Statement on July 11, 2013, and noted that his complaints progressed over time and that there was no single incident (Respondent's Exhibit 2).

Petitioner initially sought medical treatment from Dr. Marshall Hale on July 11, 2013. At that time, Petitioner informed Dr. Hale that he had neck, left shoulder and left arm pain with some numbness in the second and third fingers of the left hand. Dr. Hale diagnosed a left shoulder strain and cervical radiculopathy at the C6 nerve root. Dr. Hale ordered an x-ray of the cervical spine which was performed on July 11, 2013, which revealed some mild degenerative changes (Petitioner's Exhibit 2). Dr. Hale also ordered an MRI scan of the cervical spine which performed on July 31, 2013, which also revealed mild degenerative changes of the cervical spine (Petitioner's Exhibit 3).

Petitioner was again seen by Dr. Hale on August 14, 2013. At that time, Petitioner complained primarily of left shoulder pain, a "popping" sound in his left shoulder and that his left shoulder felt "out of place." Dr. Hale diagnosed Petitioner with a left shoulder strain with impingement. Petitioner also had numbness in the left hand. Dr. Hale recommended physical therapy for the shoulder and that nerve conduction studies be performed to evaluate of the hand symptoms. (Petitioner's Exhibit 4).

Petitioner received physical therapy from August 22, 2013, through September 25, 2013. On September 4, 2013, Petitioner had nerve conduction studies performed which were positive for bilateral carpal tunnel syndrome but negative for cervical radiculopathy (Petitioner's Exhibit 4).

Petitioner was examined by Dr. Darr Leutz, an orthopedic surgeon, on October 9, 2013. At that time, Petitioner still had left shoulder and radicular pain. Dr. Leutz ordered an MRI scan of the left shoulder which was performed on October 21, 2013. The MRI revealed a tear in the posterior/superior glenoid labrum with associated small paralabral cyst. It was also noted that the

paralabral cyst had a narrow neck communication with a septated cyst in the spinoglenoid notch (Petitioner's Exhibits 3 and 4).

Dr. Leutz saw Petitioner on November 6, 2013, and recommended arthroscopic surgery on the left shoulder. On November 22, 2013, Dr. Leutz performed arthroscopic surgery and the procedure consisted of superior labral repair using suture anchors, decompression and debridement of spinoglenoid cyst, biceps tendon release with endoscopic biceps tendonesis and subacromial decompression. Petitioner remained under Dr. Leutz's care subsequent to the surgery and received physical therapy (Petitioner's Exhibit 4).

Because of Petitioner's continued neck symptoms, Petitioner was seen by Dr. Paul Smucker, an orthopedic surgeon, on February 5, 2014. At that time, Petitioner complained of pain in his neck which radiated down his left arm, in particular, when he coughed or turned his head to the left. Dr. Smucker opined that Petitioner had persistent cervicalgia and left upper extremity paresthesia and possible cervical radiculopathy. He recommended Petitioner have an EMG/nerve conduction studies performed (Petitioner's Exhibit 5).

On February 19, 2014, Dr. Smucker performed EMG/nerve conduction studies which revealed findings consistent with left C6 radiculopathy. He recommended Petitioner have an epidural steroid injection which he gave Petitioner on February 25, 2014. Dr. Smucker again saw Petitioner on March 14, 2014, and Petitioner advised that the steroid injections did not relieve any of his neck/arm symptoms. Dr. Smucker recommended Petitioner undergo another injection (Petitioner's Exhibit 5).

Dr. Leutz saw Petitioner on February 26, 2014, and he subsequently released Petitioner to return to work without restrictions; however, the records of those visits were not received into evidence at trial. However, Petitioner did testify that he was able to return to work without restrictions on or about April 30, 2014.

At the direction of Respondent, Petitioner was examined by Dr. Bernard Randolph, an orthopedic surgeon, on July 18, 2014. The purpose of this examination was to obtain an AMA impairment rating. In connection with his examination of Petitioner, Dr. Randolph reviewed medical records provided to him by Respondent. Dr. Randolph opined Petitioner sustained a strain injury to the left shoulder with a SLAP tear that subsequently caused the development of a paralabral cyst. He also opined Petitioner sustained a cervical strain and while the diagnostic studies indicated C6 radiculopathy, he opined that the diagnostic criteria for radiculopathy were not met (Respondent's Exhibit 4).

Dr. Randolph opined that Petitioner was at MMI and that Petitioner could work without restrictions. For both the shoulder and cervical injuries, he opined that there was an AMA impairment rating of five percent (5%) of the whole person (Respondent's Exhibit 4).

At trial, Petitioner testified that while he worked for Respondent he was promoted to Department Manager. This promotion occurred several months before the manifestation date of May 31, 2013. Petitioner's promotion did not change his duties in the shop. When Petitioner returned to work on or about April 30, 2014, he continued to work at his regular job until he resigned his

position with Respondent on June 16, 2014. Petitioner left the employment of Respondent because he obtained a better job with the State of Illinois (Respondent's Exhibit 3).

Petitioner testified that he still has pain in his neck that goes into his left arm, in particular, when he turns his head to the left. Petitioner also stated that his left arm is weaker than it was before and that he is unable to lift as much as he did previously. He agreed that he was able to lift 70 pounds or so but that he had to use both arms. Petitioner presently works for the State of Illinois as an Office Assistant for the Department of Revenue. Petitioner is required, on occasion, to lift containers of papers that weigh five/ten pounds up to 30 pounds.

Conclusions of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 14% loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

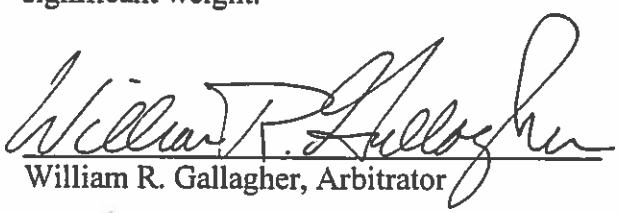
Dr. Randolph opined that, for both the shoulder and cervical injuries, Petitioner had an AMA impairment rating of five percent (5%) of the whole person. The Arbitrator gives this factor a moderate amount of weight.

At the time of the manifestation of the injuries, Petitioner worked as a tire/lube technician and while he was the Department Manager, Petitioner still performed a significant amount of lifting. The Arbitrator gives this factor a moderate amount of weight.

Petitioner was 44 years old at the time of the manifestation of the injuries and he will have to live with the effects of the injuries for the remainder of his working and natural life. The Arbitrator gives this factor of moderate amount of weight.

There was no evidence tendered that the injuries will have any effect on Petitioner's future earning capability. As a matter of fact, Petitioner left the employment of Respondent for a "better job." The Arbitrator gives this factor no weight.

Petitioner sustained an injury to his left shoulder which required arthroscopic surgery that involved both the left shoulder and biceps tendon. Further, Petitioner sustained a cervical strain with C6 radiculopathy that was treated conservatively with a steroid injection. Petitioner's complaints were consistent with the injuries he sustained. The Arbitrator gives this factor significant weight.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Warlick,

Petitioner,

vs.

NO: 09 WC 16417

State of Illinois Alton Mental Health Center,

15IWCC0362

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 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 June 27, 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/Order of the Arbitrator.

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

DATED: MAY 19 2015
TJT:yl
o 5/11/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
)
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
ORDER

LINDA WARLICK
Employee/Petitioner

v.

ALTON MENTAL HEALTH CENTER
Employer/Respondent

Case # 09 WC 16417

15IWCC0362

Petitioner's claim was dismissed for want of prosecution, and Petitioner filed a Motion to Reinstate her claim. The matter came before the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, on **May 21, 2014**, in the city of **Collinsville**. After hearing the parties' arguments, reviewing briefs, and due deliberations, I hereby ***grant*** Petitioner's Motion to Reinstate her claim. A record of the hearing ***was*** made.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner's claim is hereby reinstated. See the Memorandum of Decision of Arbitrator, attached hereto and made a part of this Order, for Findings of Fact and Conclusions of Law.

Unless a *Petition for Review* is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

Signature of arbitrator

06/27/2014
Date

JUL 3 - 2014

15IWCC0362

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
MOTION HEARING DECISION

LINDA WARLICK
Employee/Petitioner

v. Case # 09 WC 16417

ALTON MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Linda Warlick, initially hired the law firm of Reed & Bruhn to represent her in the present claim. A substitution of attorneys was granted, and Petitioner was subsequently represented by attorney Lance Mallon. (PX C). Attorney Mallon passed away on or around November 11, 2010, and attorney Keith Short subsequently purchased the deceased's law practice. (See Arb. Exh. 2). After the law firm purchase, Attorney Short filed an appearance of representative on behalf of Petitioner on April 20, 2011. (PX A). The Illinois Workers' Compensation Commission (IWCC) database never reflected either the substitution of counsel from Reed & Bruhn to Attorney Mallon, nor the subsequent change of counsel to Attorney Short. On October 20, 2012, Petitioner's claim was dismissed for want of prosecution. (RX 3). Attorney Short never received notice from the IWCC of this dismissal, as the IWCC's records were never updated to reflect him as Petitioner's attorney of record. However, Respondent, the Alton Mental Health Center, through counsel, sent via facsimile transmission to Attorney Short a copy of the dismissal order. (See Arb. Exh. 2). Attorney Short filed a Motion to Reinstate Petitioner's claim, however said motion was filed more than 60 days upon his receiving the dismissal order via facsimile from Respondent. (Arb. Exh. 1; RX 4). Respondent in turn filed a Response to Petitioner's Motion to Reinstate, asking for a denial of Petitioner's Motion. (Arb. Exh. 2).

CONCLUSIONS OF LAW

There are two primary arguments in this matter. The first is about notice and timeliness, while the second is about the burden to the parties.

I. Notice and Timeliness

The IWCC failed to update the attorney of record when Petitioner substituted attorneys from Reed & Bruhn to Attorney Mallon. This in turn made the substitution of attorneys from Attorney Mallon to Attorney Short difficult. It is undisputed that Respondent was aware of the deficiency of the IWCC on this matter.

Respondent argues that Petitioner never filed a Stipulation to Substitute Counsel, and that Respondent only received an Appearance of Representative and Attorney Representative Agreement. Respondent also argues that Petitioner did not file the Motion to Reinstate the claim within the 60 days of notice as per Rule

7020.90(a) of the Rules Governing Practice Before the IWCC.

There is no dispute that both parties were aware of the deficiencies in registering the initial substitution of counsel. There is also no dispute that matters were complicated even more in this case after the death of Lance Mallon, the second attorney. Furthermore, there is no dispute that Respondent was aware of the representation by Keith Short, especially considering the fact that Respondent received an Appearance of Representative and Attorney Representative Agreement. This matter is highlighted even more by the fact that Respondent filed a Motion to Determine Attorney of Record. (See PX C).

Petitioner appropriately filed an Appearance of Representative and Attorney Representative Agreement according to Rule 7020.30(b). The Substitution of Counsel was impossible to produce under Rule 7020.30(c), as the notice would require the signatures of "the attorney of record, the substituted attorney and the client," and Attorney Mallon was deceased. The error of the IWCC created the question of the attorney of record. Retrieving a signature from Reed & Bruhn seems inappropriate as well considering the IWCC file-stamped Stipulation to Substitute Attorneys, and a similar signature from Mr. Mallon was impossible. Furthermore, according to oral arguments, the IWCC was accepting Appearance of Representative and Attorney Representative Agreements as sufficient documentation for the transfer of attorneys in other cases.

In any event, it appears that the Substitution of Counsel under 7020.30(c) is intended to provide notice to the IWCC and the other party. In this case, it appears that, despite errors, the IWCC had sufficient notice because of the attempts to correct the issue, and it is also clear that the other party knew of the substitution because of the admitted knowledge of the course of events and because of the receipt of the Appearance of Representative and Attorney Representative Agreement.

The error also created an issue for proper notice. According to the above discussion, it is clear that Respondent knew or should have known that the IWCC would improperly serve any notice upon Petitioner. Despite the properly filed Appearance of Representative and Attorney Representative Agreement, the IWCC did not correct its error, meaning that the IWCC would have the incorrect information under 7020.30(a) for the service of any notice to Petitioner.

Respondent knew or should have known that notice was not properly provided to Petitioner under 7020.10(b). Despite this knowledge, Respondent argues that the Motion to Reinstate was untimely filed by Petitioner.

Under 7020.90(a), Petitioner had 60 days to file a Motion to Reinstate. However, Respondent argues that the improper notice of the facsimile transmission to Petitioner should constitute receipt of notice, instead of a notice served by the IWCC under 7020.10(b) to the contact information registered under 7020.30(a).

Perhaps Respondent's argument is that the 60 days should begin at the time when Petitioner knew or should have known about the dismissal, but this argument is unpersuasive due to improper notice, the cumulative disadvantage placed on Petitioner from the original IWCC error, and Respondent's complicity despite knowledge of the error.

Respondent should not receive procedural leniency on the notice component of the 60-day filing requirement when Petitioner has received none in the effort to establish selected counsel as the attorney of record.

II. Burden

For the reasons stated above, Respondent knew about all issues pertaining to the representation of Petitioner. Furthermore, Respondent knew that Petitioner did not properly receive the dismissal order as the order should have included a list of the parties to whom copies have been sent under 7020.10(b), and because Petitioner requested a copy of the order from Respondent. With this knowledge, Respondent should have anticipated a Motion to Reinstate the claim and because of this should not experience any additional burden if Petitioner's claim is reinstated.

Respondent did not cite any specific burden or prejudice that would arise out of a reinstatement of the claim, but this is not always necessary given the contemplation of such disadvantages in the drafting of the specific regulations. Petitioner does identify the preservation of all relevant testimony and medical evidence, however, and Respondent does not contest that assertion.

Petitioner also identifies the deprivation of Petitioner's right to her "day in court" as the burden Petitioner will bear, and identifies Petitioner's continued burden to establish Respondent's liability. Petitioner also identifies Respondent's burden as a mere inconvenience. Although Respondent's burden is no doubt minimized, Petitioner's identification of this unbalanced scale is persuasive.

Petitioner's burden in a denial of the Motion to Reinstate exceeds Respondent's burden in a grant of this petition.

In summary, Respondent should not receive procedural leniency on the notice component of the 60-day filing requirement when Petitioner has received none in the effort to establish selected counsel as the attorney of record. Additionally, a denial of this petition would burden Petitioner much more than a grant of this petition would burden Respondent. Petitioner's Motion to Reinstate her claim is hereby granted.

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

FRED CARR,

Petitioner,

15IWCC0363

vs.

NO: 96 WC 54795

AMERICAN PASSENGER RAIL 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, causal connection, medical expenses, temporary total disability benefits, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons specified below.

Findings of Fact and Conclusions of Law

1) Petitioner testified he began working for Respondent in 1995, as welder/detailer of nonferrous metals, stainless steel mostly, for passenger rail cars for Amtrak. (T7-9). Petitioner testified that on August 06, 1996 he was working at the old Pullman Factory, under the roof of a train car, in confined space without exhaust systems in place, performing tungsten inert gas (TIG) welding of stainless steel. (18-20). Petitioner testified that while he was welding under a train car roof, he felt a mounting headache, was unstable on his feet, and passed out. Petitioner testified two co-employees carried him out to the nurse's station, at which time he was disoriented, experienced heart palpations and shortness of breath, and was given oxygen. (T26-29).

2) Petitioner testified he sought treatment at Trinity Hospital on the date of accident, at which time he noticed that he could not raise his left arm, that his head went to his left side, and that he

was stuttering and stammering. Petitioner denied any similar problems prior to working for Respondent, and testified that following his discharge from Trinity Hospital his symptoms failed to improve, with an inability to lift his arm, a lack of strength in his left hand, left-sided weakness, and non-decipherable handwriting. (T26-32).

3) Petitioner's Exhibit 3, the treating records from Dr. Manzoor Hussain, contains the only medical evidence of treatment rendered at Trinity Hospital immediately following the August 06, 1996 work-related injury. That exhibit contains only an August 12, 1996 discharge summary, authored by Dr. Manzoor Hussain, and no other medical records concerning Petitioner's admission, history, or inpatient treatment. The discharge summary notes that Petitioner was admitted to the hospital on August 06, 1996, that he was a known patient of arthritis, that he was status post right hand surgery, that he was taking Ecotrin 2 tablets daily, and that he was seen in the emergency room with complaints of dizziness and blurred vision. It was further noted Petitioner had inhaled fiberglass fumes, complained of chest pain, mostly substernal and left sided, that his pain was gradual in onset and intermittent, that it became progressively worse, and was associated with shortness of breath but no orthopnea or any paroxysmal nocturnal dyspenea. Dr. Hussain noted Petitioner was admitted, underwent routine lab work, an EKG and stress test, and was discharged with the following diagnoses: chest pain; unstable angina; myocardial infarction ruled out; and, arthritis by history. Petitioner was noted to be alert, oriented, and in stable condition upon discharge. At the time of discharge Dr. Hussain recommended physical activity as tolerated, Provenil and Prednisone, and that Petitioner follow up with him in four days. The discharge summary fails to reflect a history of Petitioner being overcome by fumes causing him to pass out, working in a confined space, an inability to lift his arm, a lack of strength in his left hand, left-sided weakness, or non-decipherable handwriting. (PX3).

4) Petitioner admitted on cross examination that following his discharge from Trinity Hospital he was diagnosed arthritis, chest pain and angina, that a myocardial infarction was ruled out, and that he was advised to follow up with Dr. Hussain, who treated him during the course of his hospital admission, and with his personal physician, Dr. Prakash. Petitioner admitted Drs. Hussain and Prakash released him to return to work as a welder thereafter, but he testified that he was advised he was prohibited from welding in a restricted area. Petitioner testified he recalled undergoing a methacholine challenge test with Dr. Prakash on October 08, 1996, but that he did not recall the doctor advising him the test was negative for bronchial hyperactivity and that he could return to work regular duty without restrictions as of that date. Petitioner further denied that on October 09, 1996, Dr. Hussain advised him that he had no asthma or any significant lung disease, or that he could return to regular work as of that date. (T64-68).

5) On October 08, 1996, Dr. Rajal Prakash issued a "To Whom It May Concern" report indicating Petitioner had a normal spirometry test on August 22, 1996, and that Petitioner's methocholine challenge test of September 19, 1996, was negative for bronchial hypereactivity. Dr. Prakash opined Petitioner was capable of returning to work without restrictions. (RX2).

6) On October 09, 1996, Dr. Manzoor Hussain Shah issued a note indicating that Petitioner had been treated for acute fumes inhalation with hyperactive reactive airway disease, and that the condition had resolved with treatment. The doctor further indicated Petitioner had no asthma or any significant lung disease and was released to return to regular work as of October 09, 1996. (RX1).

7) On October 17, 1996, Petitioner filed an Application For Adjustment of Claim, alleging a date of injury of August 06, 1996, and "exposure to welding fumes from fiberglass wood."

8) Petitioner testified he sought additional care at Cook County Hospital for his continuing symptoms, and that he attempted to return to work but that he was terminated by Respondent on October 01, 1996. Petitioner testified he was unable to perform welding again for quite some time after that, that he began working as a handyman through a temporary employment agency. Petitioner testified that in 1997 he began a welding job, but that he was only capable of performing that job for two or three days, after which he was hospitalized at Cook County for complaints of chest pains and constant pressure on his brain. Petitioner testified he had those symptoms since his date of injury, and they progressively worsened. (T35-37).

9) Petitioner testified that in October of 2010 he worked for 24 Carat Gold Welding as a welder, off and on, that he was unable to perform the calculations required of him in that job, and that he had no problem with calculations prior to his accident. Petitioner testified he subsequently worked during the summer doing landscaping, but after two or three days would start having palpations and unstableness on his feet. Petitioner testified he continued working that job but was eventually was let go as he was only was able to work three days a week and was taking time off to go to hospital. Petitioner testified he last employer was 24 Carat Welding, that he still wanted to work after that but he was unable to do so. (T37-42).

10) On cross examination, Petitioner admitted he worked various job from 1997 to 2000, including work in 1997 for Unique Checkout, performing layout and set up of machinery. Petitioner also admitted he subsequently worked numerous labor jobs including manufacturing boxes while working for Pro Temp Labor Service. Petitioner admitted that in 1998 he worked for Pump Company, where he was responsible for lay out and detailing for welding company. Petitioner also admitted that in 1999 and 2000 he worked for Tool & Die Company, performing a minor amount of welding and teaching other welders. Petitioner also admitted that in 2001, he began receiving Social Security Disability benefits. (T68-75).

11) Following Dr. Manzoor Hussain's October 09, 1996 release to return to full duty, and finding that Petitioner's hyperactive reactive airway disease and resolved with treatment, the record is void of any evidence of additional medical treatment/testing until March 15, 1997, when Petitioner underwent a chest x-ray, which was noted to be normal, and an ECG which was noted to reflect mild aerobic impairment, but was otherwise normal. (PX4). On May 06, 1997, Petitioner presented to the Fantus Health Clinic of Cook County Hospital, with a complaint of struggling for breath for the last year, since March of 1996. Petitioner also complained of chest

tightness, light headedness, and a feeling like he was going to pass out. Petitioner also complained of a feeling in his left arm with exertion and lifting for two to three minutes, and some occasionally unclear thoughts when he wakes from sleep. Petitioner further reported a history of his August 1996 hospitalization for difficulty breathing, and reported a history of working as welder since 1962, with exposure to Argon gas in restricted area, stainless steel fumes, and acetylae gas through the present. The impression at the time of Petitioner's May 06, 1997 office visit was a history of arthritis, and a history of significant steel and argon gas exposure. Petitioner was referred for an evaluation of his shortness of breath and lightheadedness, and testing was ordered to rule out a myocardial infarction. Petitioner's May 06, 1997 chest x-ray indicated mild degenerative disease of the thoracic spine but was otherwise normal. A May 27, 1997 ECG was also interpreted as normal, when compared to his prior testing of March 16, 1997.

12) Petitioner was next seen at the Fantus Clinic on October 07, 1997, with complaints of chest pain, shortness of breath, and dizziness, which he related to his 1996 exposure to fiberglass fumes while performing overhead welding at work. Petitioner reported his chest pain radiated to his left arm. A diagnosis of chest pain, possibly stable angina pectoris based upon his history, was made. Petitioner's stress test performed on that date was normal, Isordil was prescribed, and a referral to a cardiology clinic evaluation was recommended, as was a CT for possible welders' pneumoconiosis. On November 10, 1997 Petitioner underwent a cardiology consultation at Cook County Hospital, at which time Petitioner complained of exertional chest pain relieved by rest and nitroglycerin. Petitioner was advised to continue his medications and undergo a cardiac catheter to rule out coronary artery disease. On November 19, 1997 Petitioner presented to the requesting his unemployment papers be completed, authorizing him to return to work. Petitioner was given an authorization to return to work with no exposure to dust/fumes at that time. On December 09, 1997 Petitioner was seen with complaints of tiredness after walking 3-1/2 blocks, but that his Isordil was helping. Petitioner was diagnosed with chest pain, was advised to continue his medication, undergo a sleep study. At that office visit, he PFT was noted to show shows restriction, with possibility of welders' pneumoconiosis. Petitioner's January 24, 1998 chest x-rays indicated no active disease, and an elevated right hemi-diaphragm, either acute or chronic. (PX4).

13) Petitioner continued to follow up at the Fantus Clinic on monthly or bi-monthly basis from January 1998 through August 1, 1999, with continuing complaints of difficulty breathing, check pain, medicine refills, and his diagnosis of stable angina. On September 19, 2000, Petitioner was seen in the Cook County ER for general anxiety disorder, with history of being out of his medications for 6 weeks. His ECG was found to be normal, he was discharged, and advised to continue his medications. (PX4).

14) Petitioner's Exhibit 5 contains the records of Mount Sinai Medical Center. On September 28, 2000, Petitioner was seen in the Mount Sinai Medical Center for complaints of depression and anxiety, which he attributed to a sudden breathing attack and loss of consciousness that he had had six years prior at work. Petitioner was admitted, underwent EEG,

and MRI of the brain, cognitive testing, and additional testing. Upon discharge his diagnosis was major depression with anxiety, panic attacks, and hypertension. Petitioner was advised to follow up with Dr. Mirkin and take Lorazepam and Paxil. (PX5). Petitioner was seen in follow up at Sinai Family Health Centers for anxiety, depression, hypertension, shortness of breath, unstable angina, and prostate cancer from November 15, 2000 through August of 2008. On August 01, 2001 Petitioner was seen by Dr. Adams for a cardiology consult, at which time he was noted to have stable angina. On June 20, 2003, Petitioner was admitted for depression and anxiety. On February 24, 2004 Petitioner underwent an angioplasty and stent placement. Petitioner was admitted for major depression, anxiety, and unstable angina on May 18, 2004, for major depression on August 24, 2004, for unstable angina on July 11, 2006 and October 25, 2006, and for depression on February 05, 2007. (PX5).

15) On September 13, 2006 Petitioner resumed treatment at Cook County Hospital, providing a history of treating for reactive airway disease since 1996, after inhaling toxic fumes as welder at work. Petitioner reported his shakiness began on the day he was exposed to fumes in accident at work in 1996. The assessment rendered on September 13, 2006 was chronic tremors at rest, but not typical of Parkinsons. Blood serum levels of magnesium, lead, and chromium was recommended, as well as obtaining treating records from Trinity Hospital, input from a neurology, and better compliance w/ hypertension medication. (PX4).

16) From September 27, 2006 through September 05, 2007, Petitioner sought treatment with Dr. Onur Melen, a neurologist, for evaluation and management of Parkinson's like syndrome. Petitioner provided a history of tremors in his left arm and voice, shaking in his hands and legs, face tightness, and weakness on his left side. Petitioner further reported all his symptoms started in 1996 and progressed since. Petitioner underwent MRI studies of the brain and neuropsychometric testing. On March 14, 2007 Dr. Melen opined Petitioner's diagnosis was Bradykinetic/ left hemiparetic state, and he further noted he "suspected this may well be primarily psychogenic." On September 05, 2007, Dr. Melen opined Petitioner's Parkinson's like syndrome was to some degree "psychogenic," and held a questionable relationship to welding. Dr. Melen recommended continue psychiatric treatment, home physical therapy, increase in Sinemet, and follow up in four months. Dr. Melen's records fail to reflect Petitioner followed up with his office after September 05, 2007. (PX8).

17) On October 18, 2006 Petitioner was seen in the Occupational Medicine Clinic at Cook County Hospital, at which time Dr. Francis Song, an occupation medicine resident, recorded a detailed history of Petitioner's occupation, including exposure to numerous gases while welding. Dr. Song's assessment, was based upon Petitioner's work in the welding industry for 34 years, he developed L arm tremor, and that the "Parkinsonism like syndrome is believed to be related to long-term exposure to PIG, MIG and Arc welding, but we do not have enough evidence to prove it at this moment." Dr. Song recommended follow up with a neurologist to rule out idiopathic Parkinson disease or other causes of Parkinson's like syndrome. Dr. Song requested an opportunity to review Petitioner's September 2006 MRI results, as well as the Mt. Sinai and Trinity Hospital records. On November 29, 2006 Petitioner presented to Dr. Song to ask for a

letter regarding his left hand and leg tremor. Dr. Song's assessment was that Petitioner worked in the welding industry for a long time, that he had an accident in railcar, and that his neurologist's report and neuropsychologic report showed he was suffering from Parkinson's syndrome. Dr. Song opined that "combined with his working history and the incident of welding fumes caused intoxications, the Parkinson's syndrome is attributed to long term exposure to magnese and the accident." On December 20, 2006 Petitioner was again seen by Dr. Song, to obtain a summary of his occupational and exposure history per his attorney. Dr. Song again opined Petitioner's diagnosis was Parkinson's syndrome, related to his magnese exposure. On December 21, 2006 Dr. Song issued a narrative report, at Petitioner's attorney's request, with an extensive work history provided by Petitioner, based upon Petitioner's report that his shakiness started in 1996 after he sustained a metal fume accident at work, and based upon his review of treating records/testing: August 1996 normal spirometry; negative Methacholine challenge test; normal EEG of September 29, 2000; October 02, 2000 MRI of the brain showing a small vessel disease of ischemic etiology. Dr. Song's report fails to reflect he reviewed any other treating records/testing. Dr. Song opined Petitioner suffers from Parkinson's related to long-term work exposure to metal fumes, particularly Manganese. He recommended Petitioner follow up with a neurologist, and opined that Petitioner was unable to work in sustained employment in a competitive work environment because of his condition. (PX4).

18) On April 19, 2007 Petitioner was admitted at Michael Reese Hospital for complaints chest pain for one hour, slow and slightly slurred speak, weakness on left side, and a fall at work the week prior. Petitioner further provided a history of falling since a cardio vascular accident in 1996, when he was diagnosed with manganese induced Parkinson's syndrome. Petitioner was discharged April 23, 2007, with diagnoses of: chest pain- resolved; dizziness-improved; HTN-controlled; CVA- continue meds. He was advised to follow up with Dr. Gidea and Dr. Narh, his personal physician, after discharge. (PX1).

19) Petitioner's Exhibit 7 contains the treating records of Dr. Raymone Narh, Petitioner's personal physician, who treated Petitioner for hypertension and depression from October 21, 2005 through March 31, 2008. (PX7).

20) On May 03, 2007, Dr. Song issued a supplement narrative report, noting Petitioner had provided him with a large amount of medical records from Mount Sinai Hospital and Trinity Hospital. Dr. Song noted that upon his review of these documents he had not found a detailed occupational history or medical record regarding the diagnosis and treatment of the Parkinsonism-like syndrome. Dr. Song recommended a neurologist evaluation to rule out idiopathic Parkinson's or other causes of Parkinson's like syndrome. He also requested an opportunity to review Petitioner's MRI of the brain from September of 2005. Dr. Song opined that "only after we obtain all the necessary information, we are able to give him a report about his movement disorder and occupational hazardous exposure." (PX4).

21) Dr. Jerrold Leiken, board certified in internal medicine, emergency medicine, and medical toxicology, conducted several record reviews at the request of Respondent, dated August

02, 2007, December 04, 2009, March 15, 2010, and March 16, 2010. Dr. Leiken testified he reviewed the medical records from Trinity Hospital, Cook County Hospital, along with radiology and laboratory records and consultations. Dr. Leiken testified Petitioner's medical history was remarkable for myocardial infarction in 1997, hypertension in 2000, a CVA in 2004 with subsequent left hemiparesis, degenerative joint disease to the spine, stable angina, prostate cancer with radiation in 2000, and reactive airway disease. Dr. Leiken testified he reviewed the report from the October 2006 MRI of the brain, which failed to show any basal ganglia or midbrain lesions. He testified that Petitioner's October 2006 neuropsychological testing was consistent with dysfunction in the "frontal networks" but it did not really address this aspect. He opined that it was unlikely that Petitioner's neurological complaints were ascribable to manganese toxicity for various reasons: the lack of medical findings, specifically at the time of exposure or even predating that; the cognitive/dementia complaints which were not consistent with a pattern for manganese induced Parkinsonism; and, the lack of symptoms at the time near to the height of the suspected exposure. He opined Petitioner did not require any special treatment for manganese toxicity and that he was at maximum medical improvement. (PX11, T8-15). Dr. Leiken opined manganese did not play a role with regards to the event in question or the sequelae in this way. Dr. Leiken testified that manganese toxicity, especially that causes Parkinsonism type of symptoms, is usually very specific, does not involve the entire brain, and very specific as far as anatomic location overall. He further testified that an anoxic brain injury causes global brain issues in general, and that no significant anoxic brain injury is documented in Petitioner's medical records. Dr. Leiken testified that when an anoxic brain injury presents, an EEG will typically show it, and that it was his understanding Petitioner's EEGs in 2000 and in 2009 were normal. Dr. Leiken opined the neuropsychological testing done at Northwestern did not show a diagnosis of anoxic brain injury or of manganese exposure either. He further testified that manganese causes a very specific lesion in the brain, and it is bilateral not unilateral. (PX11, T15-23).

22) Dr. Peter Orris, board certified in internal medicine and occupational environmental medicine, testified Petitioner was seen by a number of his colleagues at the Internal Medicine and Occupational Environmental Department at Cook County Hospital, and that he prepared the final report for their group. Dr. Orris testified that he reviewed the Trinity Hospital records from August 06, 1996 and other treating records in reaching his conclusion. He testified Petitioner had an acute injury in August 1996, and that Petitioner very specifically ascribed his condition of shakiness in his left hand and leg for 10 years to the event on that date, when welding in a confined area and passing out, and prior repeated welding in confined spaces causing occasions of lightheadedness and needing oxygen. He opined that Petitioner had repeated and significant exposure to welding fumes, in a confined space, and that he suffered anoxic brain damage during that time. (PX10, T5-13). Dr. Orris testified Petitioner's chronic anoxic problem with a lack of oxygen over time caused his situation as documented on his MRI study. (PX10, T 13-14). On cross examination, Dr. Orris admitted on cross that he first saw Petitioner in his clinic 10 years after the date of injury, and that the information he obtained about Petitioner becoming overcome by fumes, the lack of oxygen, and him passing out for several minutes, all came from speaking to Petitioner. He further admitted that he would not dispute Petitioner's 2001 diagnosis of

Parkinson's made by neurologist at Northwestern, that Parkinsonism may have been part of the picture. He admitted Petitioner's diagnoses of PTSD, reactive airway disease, and depression all came from Petitioner and Petitioner's histories in his medical records. Dr. Orris further opined that Petitioner's working in confined space contributed in part to his current condition, as did Parkinsonism, aging, prior stroke in 2004, and cerebral vascular disease would have also contributed to his condition of ill-being. (PX10, T17-34);

Although the Arbitrator found Petitioner had failed to meet his burden of proof with regard to the issue of accident, the Commission finds otherwise. Petitioner testified unrebutted that on August 06, 1996 he was working under the roof of a train car, in a confined space, welding stainless steel, when he began to experience a mounting headache, was unstable on his feet, and passed out. Petitioner testified un-rebutted that his co-employees carried him out to the nurse's station, at which time he was disoriented, experienced heart palpations and shortness of breath, was given oxygen, and transported to Trinity Hospital, at which time he was hospitalized until August 12, 1996. Although the complete set of treating records from his admission are not contained within the record, the discharge summary from Trinity Hospital reflects that Petitioner was seen in the emergency room on August 06, 1996 with complaints of dizziness and blurred vision, that Petitioner provided a history of inhaling fiberglass fumes, complained of chest pain, mostly substernal and left sided, and associated with shortness of breath but with no orthopnea or any paroxysmal nocturnal dyspenea. Although, as the Arbitrator notes, Petitioner's testing at the time of his admission was normal per the discharge summary, and the discharge diagnoses were chest pain, unstable angina, myocardial infarction ruled out, and, arthritis by history, Petitioner was seen in follow up thereafter. In follow-up, Petitioner underwent additional testing and treatment with Dr. Manzoor Hussain, who treated Petitioner during the course of his hospital admission, for "acute inhalation with hyperactive reactive airway disease" which improved with treatment. The Commission finds Petitioner met his burden of proof with regard to accidental injuries arising out of and in the course of his employment, through his unrebutted testimony and the contemporaneous treating medical records documenting an acute inhalation with hyperactive reactive airway disease.

However, with regard to the issue of causal connection, the Commission finds Petitioner failed to prove his condition of ill-being subsequent to October 08, 1996 is causally related to his August 08, 1996 work-related injury, and specifically that Petitioner failed to prove the anoxic brain damage diagnosed by Dr. Orris is causally related to his work-related injury. Petitioner alleges he sustained anoxic brain damage caused by a lack of oxygen in 1996, relying on the causal connection opinion of Dr. Peter Orris, rendered in 2007. The Commission finds significant that the record fails to contain the initial treating medical records documenting Petitioner's initial hospitalization on the date of injury, or the treating records immediately following his discharge from the hospital- his follow-up treatment with Dr. Manzoor and Dr. Prakash, and the lack of a causal connection opinion with regard to an anoxic brain damage due to repeated and significant exposure to welding fumes rendered by any of Petitioner's treating physicians prior to Dr. Orris's rendering of such opinion on April 19, 2007.

The Commission finds significant that this causal connection opinion with regard to anoxic brain damage was not rendered until April 19, 2007, more than 10-1/2 years after Petitioner's work related injury. Also significant is the lack of medical evidence in the record to support Dr. Oriss' conclusion that Petitioner suffered from left-sided predominant tremors within hours of his loss of consciousness in 1996, or that he passed out for several mintues. Dr. Oriss admitted the information he obtained about Petitioner becoming overcome by fumes, the lack of oxygen, and him passing out for several minutes, all came from speaking to Petitioner. (PX10, T17-19). Instead, the record reflects that Petitioner was diagnosed with and treated for "acute inhalation with hyperactive reactive airway disease," which as of October 08, 1996 had improved with treatment such that Petitioner was released to return to work full duty. The record fails to reflect that Petition sought any additional follow up treatment with his primary care physician or with Dr. Hussain thereafter. While Petitioner underwent a chest x-ray and EEG on March 15, 1997, other than mild aerobic impairment on his EEG, the testing was found to be normal. Petitioner subsequently sought treatment for shortness of breath, chest tightness on May 06, 1997 at Fantus Health Clinic of Cook County Hospital, he again underwent chest x-rays and an EEG, unchanged from his prior March 15, 1997 studies.

Although Dr. Song initially opined that Petitioner suffered from Parkinson's syndrome attributed to long term exposure to magnese and his work-related accident, he issued a May 03, 2007 supplemental report, after reviewing a large amount of medical records from Mount Sinai Hospital and Trinity Hospital, and noted the records were void of a detailed occupational history or medical record regarding the diagnosis and treatment of the Parkinsonism-like syndrome, and he recommended a neurologist evaluation to rule out idiopathic Parkinson's or other causes of Parkinson's like syndrome, and he requested an opportunity to review Petitioner's MRI of the brain from September of 2005. Dr. Song further noted in order to render an opinion on Petitioner's movement disorder and occupational hazardous exposure, he required additional necessary information. The record is void of any supplemental report from Dr. Song.

In further support of the finding that Petitioner failed to prove that his current condition of ill-being is causally related to his work related injury, the Commission relies upon the testimony of Dr. Jerrold Leiken, board certified in internal medicine, emergency medicine, and medical toxicology. Dr. Leiken conducted four record reviews at the request of Respondent, from 2007 through 2010, which included review of the initial treating medical records from Trinity Hospital, records from Cook County Hospital, and the radiology and laboratory records and consultations. Dr. Leiken stated that it was unlikely that Petitioner's neurological complaints were ascribable to manganese toxicity for various reasons: the lack of medical findings, specifically at the time of exposure or even predating that; the cognitive/dementia complaints which were not consistent with a pattern for manganese induced Parkinsonism; and, the lack of symptoms at the time near to the height of the suspected exposure. He opined Petitioner did not require any special treatment for manganese toxicity and that he was at maximum medical improvement. Dr. Leiken testified that an anoxic brain injury causes global brain issues in general, and that no significant anoxic brain injury is documented in Petitioner's medical records. Dr. Leiken testified that when an anoxic brain injury is present, an EEG will

show typically show evidence of this, and that it was his understanding Petitioner's EEGs in 2000 and in 2009 were normal. Dr. Leiken opined the neuropsychological testing done at Northwestern did not show a diagnosis of anoxic brain injury or of manganese exposure either.

For the reasons stated above, the Commission finds Petitioner sustained accidental injuries arising out of and in the course of his employment on August 06, 1996, but that his condition of ill-being subsequent to October 08, 1996 is not causally related to same.

With regard to the issue of medical expenses, the Commission finds Petitioner is entitled to $9,623.08 for necessary medical expenses under Section 8(a) of the Act, for services rendered by Trinity Hospital for services rendered from August 06, 1996 through August 12, 1996, (PX12), relying on its finding of accident and causal connection herein. Based upon Petitioner's failure to prove a causal connection between his-work related injury and his condition of ill-being subsequent to October 08, 1996, Petitioner's claim for medical expenses after October 08, 1996 is hereby denied.

Based upon the Commission's finding of accident and causal connection, the supporting medical records, and the off work authorizations, the Commission finds Petitioner was temporarily totally disabled for a period of 9-4/7 weeks, from August 07, 1996 to October 08, 1996, at the rate of $311.13 per week. On October 08, 1996, Dr. Rajal Prakash, Petitioner's personal physician, authorized Petitioner to return to his regular work occupation without restrictions. On October 09, 1996, Dr. Manzoor Hussain Shah, who treated Petitioner on an in-patient basis and in follow-up, concurred that Petitioner was capable of returning to work without restriction, noting that Petitioner's acute fume inhalation with hyperactive reactive airway disease had resolved.

Based upon the Commission's finding that Petitioner reached maximal medical improvement as of his October 08, 1996 release by Dr. Prakash, Petitioner's claim for temporary total disability benefits and medical benefits subsequent to October 08, 1996 is denied.

With regard to the issue of permanent partial disability, the Commissions finds Petitioner sustained permanent partial disability to the extent of 5% of the person as a whole under Section 8(d)2.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 03, 2013 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the related medical expenses incurred in the amount of $9,623.08 for treatment rendered from August 06, 1996 through October 08, 1996, by Dr. Manzoor Hussain Shah, Dr. Rajal Prakash, and Trinity Hospital under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $311.13 per week for a period of 9-4/7 weeks, from August 06, 1996 to

October 08, 1996, 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 $280.02 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 use of the man as a whole to the extent of 5%.

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 $19,700.00. 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: MAY 19 2015
KWL/kmt
O-03/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARR, FRED
Employee/Petitioner

Case# **96WC054795**

15IWCC0363

AMERICAN PASSENGER RAIL CAR COMPANY
Employer/Respondent

On 9/3/2013, 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:

0969 RITTENBERG & BUFFEN
STEVEN R SAKS
309 W WASHINGTON ST SUITE 900
CHICAGO, IL 60606

1454 THOMAS & ASSOCIATES
JOSEPH FITZPATRICK
300 S RIVERSIDE PLZ SUITE 2330
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

15IWCC0363

Case #96 WC 54795

FRED CARR
Employee/Petitioner

v.

AMERICAN PASSENGER RAIL CAR COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on July 24, 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. ☒ 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 6, 1996, 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.
- At the time of injury, the petitioner was 56 years of age, *married* with one child under 18.

ORDER:

- The petitioner failed to prove that he sustained an accident on August 6, 1996, arising out of and in the course of his employment with the respondent.

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

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

Robert E. Williams

Robert Williams

9/3/13

Date

SEP 3 - 2013

FINDINGS OF FACTS:

On Aug. 6, 1996, the petitioner, a welder, received emergency care for dizziness, blurred vision and left-sided chest pains at Trinity Hospital and was hospitalized through August 12th. Except for the discharge summary, the treating records are not in evidence. The petitioner reported he inhaled fiberglass fumes and had a gradual onset of intermittent pain that progressively worsened and associated with shortness of breath. An EKG was normal but showed a normal sinus rhythm with frequent ventricular fusion complexes. A myocardial perfusion imaging study at a sub maximal level of exercise was negative for ischemia. A ventilation/perfusion scan showed no evidence of pulmonary embolism. A chest x-ray was negative for cardiopulmonary disease. His neurological exam revealed no focal deficit and his electrolytes and chemistries were normal except for albumin and alkaline phosphatase levels. Their discharge diagnosis was chest pain and unstable angina. On October 8, 1996, Dr. Prakash indicated that the petitioner's spirometry test on August 22, 1996, was normal. He released the petitioner to regular work. On October 9, 1996, Dr. Hussain noted that the petitioner had no asthma or lung disease and released him to regular work.

He had repeat chest x-rays and ECGs from March 15, 1997, through May 6, 1997, at Cook County Hospital. On May 6, 1997, it was noted at Cook County that the petitioner complained of shortness of breath and chest tightness/pain. He followed up at Cook County on the May 27th and October 27th and received more stress tests and chest x-rays. His stress tests and chest x-rays were unremarkable. He followed up periodically for chest pain at Cook County Hospital and sought emergency care on June 9, August 1 and September 19, 1999.

The petitioner received emergency care at Mount Sinai Hospital on September 28, 2000, for anxiety. An EEG on September 29, 2000, was normal. An MRI of his brain on October 2, 2000, revealed moderate diffuse cerebral and cerebella atrophy and periventricular white matter changes consistent with ischemic etiology. He was treated with radiation for prostate cancer in May 2001. An MRI of his brain on May 15, 2001, was normal except for asymmetric appearance of the right insular region.

The petitioner filed for social security disability on July 6, 2001. The petitioner saw a cardiologist for chest pain at Mount Sinai Hospital on August 1, 2001. He sought care for depression at Mount Sinai Hospital on June 20, 2003, and was hospitalized for depression from May 18 through 25, 2004. He saw Dr. Manzoor Hussain on August 23, 2004. A combined plethysmograph report on August 30, 2004, showed mild obstructive patterns. A chest x-ray the same day revealed mild degenerative osteoarthritis, a mildly dilated aorta and no infiltrates or effusions.

The petitioner sought care at Cook County Hospital on September 13, 2006, for shakiness of his arms and legs and reported a ten-year duration. Dr. Onur Melen evaluated the petitioner on September 17, 2006, and noted a bradykinetic and somewhat rigid syndrome. A brain scan on October 10, 2006, revealed a generalized cortical volume loss with ventricular enlargement and chronic micro vascular ischemic changes within deep hemispheric white matter. Dr. Melen noted on March 14, 2007, that the petitioner's brain MRI showed mild atrophy and deep WM signals, presumed micro vascular ischemic in nature and a neuropsych test showed minimal F network dysfunction. His impression was that the petitioner's bradykinetic/left hemi paretic state was primarily psychogenic. Mount Sinai Hospital treated the petitioner in October and

November 2006 for depression. Dr. Frances Song at Cook County Hospital saw the petitioner on December 21, 2006, and noted on May 3, 2007, that his review of a large amount of medical records of Mount Sinai Hospital and Trinity Hospital did not detail an occupational history, medical diagnosis or treatment of a Parkinsonism-like syndrome.

The petitioner received emergency care for chest pain at Mount Sinai Hospital on April 19, 2007. Dr. Peter Orris at Cook County Hospital saw the petitioner on November 9, 2009, and opined that the petitioner suffers from anoxic brain damage caused by a lack of oxygen in 1996. He opined further that the petitioner's progressive left-sided predominant tremors began within hours of his loss of consciousness in 1996 and his previous assessment of Manganism in 2006 was not precise.

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 6, 1996, arising out of and in the course of his employment with the respondent. The medical evidence does not support a causal relationship with the inhalation of fiberglass fumes with his complaints of a gradual onset of intermittent, progressive, left-sided chest pain and associated shortness of breath. The series of tests performed on the petitioner at Trinity Hospital - an EKG, electrolytes, chemistries, myocardial perfusion study, ventilation and perfusion scan, chest x-ray and neurological examination - were all normal. Their assessment was unstable angina.

FINDING REGARDING THE AMOUNT OF WAGES:

The petitioner's earnings from August 6, 1995, through December 28, 1995, were $9,469.13 and from December 29th through August 6, 1996, were $14,799.04. In the year

preceding the injury, the petitioner earned $24,268.17; the average weekly wage was $466.70.

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 failed to prove that his current condition of ill-being is causally related to the work injury. Trinty's treating records are not in evidence and their discharge summary reveals only complaints of a gradual onset of intermittent, progressive, left-sided chest pain associated with shortness of breath. There is no medical evidence of a loss of consciousness or shakiness of his hands. Moreover, the conclusion of Dr. Orris that a loss of consciousness would be due to anoxia is speculative and is not consistent with the medical evidence. The opinion of Dr. Orris is conjecture. The petitioner's claim for benefits is denied.

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

Shane Chomko,

Petitioner,

15IWCC0364

vs.

NO: 13 WC 15039

Cassen Transport Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 14, 2014 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,200.00. 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: MAY 19 2015
KWL/vf
O-5/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0364

CHOMKO, SHANE
Employee/Petitioner

Case# **13WC015039**

CASSENS TRANSPORT COMPANY
Employer/Respondent

On 10/14/2014, 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 0.04% 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:

0252 HARVEY & STUCKEL CHTD
J KEVIN WOLFE
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PEORIA, IL 61602

0445 RODDY LAW LTD
FRANCIS J O'BYRNE
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0364

Case # 13 WC 15039

Shane Chomko
Employee/Petitioner

v.

Cassens Transport Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **8/15/14**. 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

15IWCC0364

FINDINGS

On the date of accident, **February 26 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**69,947.04**; the average weekly wage was $**1225.51**.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**817.01**/week for **35 4/7** weeks, commencing **December 10, 2013** through **August 15, 2014**, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay the reasonable, necessary and causally related expenses associated with the costotransversectomy recommended for the Petitioner by Dr. Fardon and Dr. Phillips.

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

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

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

Arbitrator Anthony C. Erbacci

October 8, 2014
Date

13 WC 15039
ICArbDec19(b)

OCT 14 2014

FACTS:

On February 26, 2013 the Petitioner was employed by the Respondent as a car hauler, having been so employed since 2011. The Petitioner testified that on that date he was delivering a load of cars to a dealership in Peoria, Illinois and he was pulling out the "skids" which were necessary to unload the cars from his truck. The Petitioner described that "skids" as being made of heavy aluminum, approximately 6 feet long and as wide as a truck tire. The Petitioner testified that the skids had become stuck in the retracted position due to an accumulation of snow and ice and that as he was pulling on one of the skids with both arms he felt a pop in his back and then pain into his waist and around to his sternum and up and down his back. The Petitioner testified that despite his pain, he was able to complete the delivery and drive his truck back to the Respondent's terminal. The Petitioner testified that he reported the incident and was directed to obtain medical treatment at the Provena St. Mary's facility in North Aurora.

The Petitioner was seen and treated at Provena St. Mary's where he was prescribed medications and physical therapy. The Petitioner testified that he had difficulty performing the physical therapy due to pain in his pain which he described as being in his mid-back radiating to his sternum. The Petitioner testified that he then sought treatment with Dr. David Fardon at Rush Orthopedics.

The medical records and reports of Dr. Fardon and Midwest Orthopaedic at Rush were admitted into the record as Petitioner's Exhibit 1, without objection. On June 12, 2013 the Petitioner saw Dr. Fardon and gave a history of injury on February 26, 2013 "when he was having to vigorously pull and jerk, skids and (*sic*) the course of his job is (*sic*) a car hauler. He said it was snow and the equipment was stuck and he felt a crack in his back and had an extreme pain. He says that he managed to drive his truck back home, though in grueling pain." The Petitioner denied previous trouble with his back, and after exam and review of x-rays and MRI, Dr. Fardon diagnosed the Petitioner with a thoracic and lumbar strain sprain, and a possible disk herniation at T10-11. Dr. Fardon recommended blood antigen testing and a thoracic MRI.

The Petitioner returned to Dr. Fardon on August 20, 2013 and Dr. Fardon ordered a CT of the chest which was performed on September 24, 2013. Dr. Fardon reviewed the CT scan with the Petitioner on October 31, 2013, discounted pulmonary involvement and felt at that point the T8-9 costovertebral articulation on the left looked arthritic. Dr. Fardon suggested a bone scan and continued to hold Petitioner off work.

At the request of the Respondent, the Petitioner was examined by Dr. Carl Graf on October 9, 2013. Dr. Graf noted a consistent history of injury and the Petitioner's subsequent treatment with Dr. Panuska and then Dr. Fardon. Dr. Graf reported that it was possible that the Petitioner suffered a thoracic and lumbar strain and he opined that the medical treatment the Petitioner had received was reasonable. Dr. Graf further reported that he was unable to substantiate the Petitioner's subjective complaints of pain and he opined that the Petitioner had reached maximum medical improvement and was not in need of any further treatment.

Dr. Graf opined that the Petitioner could return to full duty work without restriction.

On November 26, 2013 the Petitioner returned to Dr. Fardon with complaints of increasing severe left thoracic pain with radiation around the rib. Dr. Fardon again reviewed the Petitioner's radiographic studies and felt that a lesion at the 8th rib of the costovertebral articulation which could be arthritic, traumatic or neoplastic was the cause of the pain. Dr. Fardon indicated that he assumed it was traumatic until proven otherwise. Dr. Fardon suggested a thin cut CT scan and bone scan and kept the Petitioner off work until these were completed.

On January 2, 2014 Dr. Fardon saw the Petitioner again and reviewed the December 5, 2013 report prepared by Dr. Carl Graf. Dr. Fardon indicated that the Petitioner's bone scan demonstrated slight increased uptake in the region of the left costovertebral joints and the midthoracic spine, while the CT scan showed evidence of comminuted fracture at what Dr. Fardon felt was the left T8 costovertebral joint. Dr. Fardon also noted that there was evidence of post traumatic arthropathy. Dr. Fardon's assessment was persistent midthoracic back pain that was "largely owing to post traumatic arthropathy of his T8 costovertebral joint that is visible on fine-cut CT scan examination as well as the bone scan. It is likely that this is the root cause of his problem. ... The tenderness and symptoms he has completely correlates with this diagnosis." Dr. Fardon recommended injections, therapy and medication.

On February 19, 2014, Dr. Fardon saw the Petitioner again and continued to keep him off work for an additional six weeks. On March 19, 2014 Dr. Fardon referred the Petitioner to Dr. Frank Phillips for a surgical consultation and restricted him from work. Dr. Fardon's assessment at that time was T9-T10 costovertrebral pain secondary to trauma.

In a supplemental report dated February 27, 2013, Dr. Graf reported that he had reviewed additional medical records and continued to be of the opinion that he was unable to substantiate the Petitioner's subjective complaints of pain, that the Petitioner had reached maximum medical improvement, was not in need of any further treatment, and could return to full duty work without restriction.

On April 1, 2014, the Petitioner was seen by Dr. Phillips, who, after reviewing the history of injury, performing an examination and reviewing the December 20, 2013 CT scan, noted that it appeared that the Petitioner sustained an injury to the costovertebral articulation around T9, resulting in axial pain as well radicular pain. Dr. Phillips noted that performing a costotransversectomy had been discussed and he indicated that the Petitioner's pain seemed to be related to intercostal nerve irritation and removing the bony elements could effectively decompress the nerve. Dr. Phillips noted that the Petitioner, after hearing the risk and benefitsof such a surgery, wished to proceed.

On January 29, 2014, Dr. Fardon authored a letter report to the Petitioner which was admitted into the record, without objection, as Petitioner's Exhibit 2. In that letter Dr. Fardon addressed Dr. Graf's reports and also provided a narrative of the studies and examinations he performed or reviewed. Dr. Fardon, reported that he reviewed the September 24, 2013 CT

scan done of the Petitioner's chest and felt that it demonstrated an abnormality around the 9th thoracic rib region of the spine. Dr. Fardon noted the Petitioner's antigen blood test, which was a test for specific types of arthritis, was negative. Dr. Fardon reported that he reviewed the December 20, 2013 CT scan and indicated that he agreed with the radiologist that the 10th rib articulation with the vertebrae at T10 was the most abnormal. There were similar abnormalities but less severe at T9. There were also arthritic changes. Dr. Fardon reported that it was his opinion that the abnormalities represented a post traumatic change that was consequent with the injury of February 26, 2013. Dr. Fardon opined that even if this was an arthritic condition, or if it was present prior to the injury, the injury aggravated it. Dr. Fardon also clarified the naming of the level of the abnormality, noting that at different points in the record the abnormalities had been considered at the T8, 9 or 10 level. Dr. Fardon noted this was a difficult area to localize, and he opined that "*there is no doubt that the abnormality is at the 10th thoracic rib and transverse process and that there are also minor similar changes at the 9th just above it. It is my opinion there is no abnormality of the 8th and the previous references to the 8th were simply due to error in counting the ribs. The naming of the rib has not been important to your clinical care. The injection that Dr. Fetzer did was guided by x-ray, where he could put the needle at the site of the pathology regardless of what name was not attached to it.*" Finally, Dr. Fardon reported that his current diagnosis was post traumatic arthritis from injury to the transverse process and rib of the 10th and to a lesser extent 9th thoracic vertebrae on the left side which he opined was related to the Petitioner's February 16, 2013 work accident.

The Petitioner testified that he currently continues to have the same pain as he has had since the time of his injury and that he is taking Norco every other day for that pain The Petitioner testified that because the majority of his pain is the pain in his mid-back which radiates to the sternum, he desires to have the surgery suggested by Dr. Phillips.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that on February 26, 2013 he was performing the regular duties of his employment as a car hauler and was pulling on a skid which had become stuck in position due to an accumulation of snow and ice. The Petitioner testified that as he was pulling the skid with both arms he felt a pop in his back and then pain into his waist and around to his sternum and up and down his back. The Petitioner reported his injury and was directed by the Respondent to seek medical treatment.

There is nothing in the record to dispute or to refute the Petitioner's description of the incident. The incident is consistently reported in both the records of the Petitioner's medical treatment and the reports of the Respondent's medical examiner. The Respondent did not

dispute notice of the injury and offered no testimony or other evidence which in any way contradicted or rebutted the Petitioner's testimony. As there is no conflicting testimony, the description of the incident is consistent with a finding of an accident which arose out of and in the course of Petitioner's employment.

The Arbitrator finds that on February 26, 2013 an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner's treating physician, Dr. Fardon, opined in his medical treatment records and his letter report that the Petitioner's condition of ill-being was causally related to his February 26, 2013 work injury. Dr. Graf, the Respondent's examining physician reported that it was possible that the Petitioner suffered a thoracic and lumbar strain that he was unable to substantiate the Petitioner's subjective complaints of pain. Dr. Graf opined that the Petitioner had reached maximum medical improvement from his work injury, was not in need of any further treatment, and could return to regular unrestricted work.

While the Arbitrator notes the opinions of Dr. Graf, the Arbitrator notes that Dr. Graf provided little basis for his findings other than he was unable to substantiate the Petitioner's subjective complaints of pain. In his records and his letter report, Dr. Fardon provided specific detail as to the exact nature of the injury sustained by Petitioner. He described the blood antigen test which ruled out specific types of arthritis as causing the Petitioner's difficulties and the CT scan which ruled out any chest abnormalities as causing the Petitioner's problems. He reviewed the Petitioner's CT scans and nuclear bone studies and opined that the abnormalities noted at the Petitioner's 10th, and to a lesser extent, the 9th thoracic vertebrae on the left side, represented a post traumatic change that was consequent with the injury of February 26, 2013. The Arbitrator finds the opinions of Dr. Fardon to be more persuasive in the instant matter than the opinions of Dr. Graf. The Arbitrator further finds that the opinions of Dr. Fardon are sufficiently reliable and persuasive so as to satisfy the Petitioner burden of proof.

Based upon the forgoing, the Arbitrator finds Petitioner has established a causal connection between the work accident of February 26, 2013 and the post traumatic arthritic injuries to the transverse process and rib of the 10th and to a lesser extent the 9th thoracic vertebrae on the left side as set forth by Dr. David Fardon and Dr. Frank Phillips.

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The only definitive treatment that has been suggested for the Petitioner is the surgery recommended by Dr. Phillips. Dr. Phillips noted that it appeared that the Petitioner sustained

an injury to the costovertebral articulation around T9, resulting in axial pain as well radicular pain and opined that performing a costotransversectomy could effectively decompress the nerve and relieve the Petitioner's pain. Dr. Phillips noted that there were risks the surgery might not be successful but he indicated that it did offer an opportunity to alleviate the Petitioner's pain and that the Petitioner, after hearing the risks and benefits of such a surgery, wished to proceed. While Dr. Graf opined that the Petitioner had reached maximum medical improvement, he did not specifically comment on the reasonableness of the specific suregery recommended by Dr. Phillips.

Based upon the forgoing, and having considered the totality of the credible evidence adduced at hearing, The Arbitrator finds that the costotransversectomy recommended for the Petitioner by Dr. Phillips is reasonable and causally related medical treatment which the Respondent is obligated to provide.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner, apparently having received appropriate Temporary Total Disability benefits from the date of injury through December 10, 2013, has claimed to be entitled to Temporary Total Disability benefits from December 10, 2013 through the present time. Dr. Fardon has, throughout the course of the Petitioner's treatment, restricted the Petitioner from working. As of March 19, 2014 the Petitioner remained under the care of Dr. Farden and was unable to participate in heavy lifting, bending, twisting or exercise. Dr. Fardon has continued those restrictions on the Petitioner through the present time. The Petitioner's job, detailed in his testimony, does require lifting, pulling and bending which is not supported by the restrictions put in place by the Petitioner's treating physician.

The Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from December 10, 2013 through August 15, 2014, the date of hearing, a period of 35 4/7 weeks.

In Support of the Arbitrator's Decision relating to (.), Should penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

Despite finding Petitioner is entitled to prospective medical care and temporary total disability benefits, Respondent has provided contrary opinions in support of its position, and penalties as requested are not warranted, and as such 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

Pat Brandonisio,
Petitioner,

15IWCC0365

vs.

NO: 13 WC 34012

City of Chicago,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue 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 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: MAY 19 2015
KWL/vf
O-5/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0365

BRANDONISIO, PAT
Employee/Petitioner

Case# **13WC034012**

12WC028571

CITY OF CHICAGO
Employer/Respondent

On 9/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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0113 CITY OF CHICAGO ASST CORP COUNSEL
STEPHANIE LIPMAN
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0365

Case # 13 WC 34012

Consolidated cases: 12 WC 28571

Pat Brandonisio
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **6/6/14**. By stipulation, the parties agree:

On the date of accident, **10/9/13**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**70,408**, and the average weekly wage was $**1,354**.

At the time of injury, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$721.66**/week for a further period of **20** weeks, as provided in Section **8** of the Act, because the injuries sustained caused **a loss of 4% man as a whole**.

While the petitioner was test driving an ambulance, the vehicle was hit from behind. He was diagnosed with a cervical and lumbar strain. He lost no time from work and his treatment was minimum. He is represented in a third party claim against the driver that struck the ambulance. He is back to his usual and customary position with the respondent.

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

9/3/13
Date

SEP 3 - 2014

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAT BRANDONISIO,
Petitioner,

vs.

CITY OF CHICAGO,
Respondent.

15IWCC0365

Case No.: 13 WC 34012

ADDENDUM TO ARBITRATION DECISION

FINDINGS OF FACT

Petitioner filed two claims which were consolidated: 12WC028571 for an accident of September 23, 2011 and 13WC034012 for an accident of October 9, 2013, two separate decisions have been issued as each claim concerns a different part of Petitioner's body.

Petitioner has been employed by Respondent as a motor truck driver since 1993. In 1995, Petitioner sustained a work injury to his left leg and was off work approximately sixteen (16) weeks. That matter eventually settled for 22½% loss of use in claim 95WC37441. After his return to work, Petitioner continued to work as a motor truck driver until he had a back injury on December 16, 2008. Petitioner treated with the City doctor for three visits and never filed an Application for Claim at the Commission. After the 2008 back injury, Petitioner continued to work full time, full duty, until September 23, 2011, where he sustained injuries to his right foot and ankle while coming down off his truck.

On October 9, 2013, Petitioner testified he was test driving an ambulance when he was involved in a collision. Petitioner was transported to St. Anthony Hospital where he was diagnosed with a cervical and lumbar strain. Petitioner was discharged and given pain medication as well as lumbar support device. (PX. 5).

On November 4, 2013, Petitioner underwent an initial physical therapy evaluation at Athletico where it was noted that he presented with reduction in cervical and lumbar mobility with pain post motor vehicle accident. Petitioner was uncomfortable with

prolonged positioning and had to stand and move frequently during his evaluation. (PX. 6).

On November 27, 2013, Athletico physical therapy records indicate that Petitioner presented with significant improvements although it was noted that Petitioner continued to have mild pain with lumbar flexion ROM at end range. The records further indicate that Petitioner's strength had improved although he continued to take pain medication frequently. (Id.).

On February 5, 2014, Petitioner was discharged from physical therapy. (Id.).

Petitioner is under no active treating medical care today related to injuries sustained on October 9, 2013.

Petitioner does use lumbar support when necessary and takes OTC pain medication when needed.

Petitioner has had no new back injury since the accident at issue and continues to work for respondent as a motor truck driver.

Neither Petitioner nor Respondent offered on AMA rating, however, the Arbitrator still considered Section 8.1(b) of the Act and the factors contained therein. The Arbitrator considered Petitioner's age, 60 years old; the fact that he is still a motor truck driver; the wages and future earning capacity of Petitioner; and the evidence of disability to Petitioner's back which is corroborated by the various medical records and reports.

Based on a careful review of the evidence, the Arbitrator finds Petitioner suffered 4% loss of use of a person as a whole pursuant to section 8(d)(2)or 20 weeks disability at the rate of $721.66 per week which Respondent shall pay to Petitioner.

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

Yolanda Brito,

Petitioner,

vs.

15IWCC0366

NO: 11 WC 44038

Wal-Mart Associates, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 2014 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 19 2015
KWL/vf
O-5/12/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0366

BRITO, YOLANDA
Employee/Petitioner

Case# **11WC044038**

WALMART
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:

BROWN & BROWN
DAVID J JEROME
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HTS, IL 62208

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

TT 5

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)

15IWCC0366

Yolanda Brito
Employee/Petitioner

v.

Walmart
Employer/Respondent

Case # **11** WC **044038**

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**, on **3/25/14**. 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 _____

15IWCC0366

FINDINGS

On the date of accident, **10/8/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $; the average weekly wage was **$257.33**.

On the date of accident, Petitioner was **22** 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 **$31.43** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$31.43**.

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

ORDER

Respondent shall pay temporary total disability benefits of $220.00/week for 23-1/7 weeks, commencing September 5, 2012 through February 13, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $10,630.60, as provided in Section 8(a) of the Act, pursuant to the medical fee schedule.

Respondent shall authorize medical care consistent with the recommendations from Dr. Corey Solman, as provided in Section 8(a) and 8.2 of the Act.

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

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

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

Carl Lee
Signature of Arbitrator

5/12/14
Date

ICArbDec19(b)

MAY 15 2014

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On October 8, 2011, Petitioner was working for Respondent as a deli worker preparing deli foods behind a counter. On the date of accident, Petitioner was cleaning dishes in a nearby sink when she slipped on a wet floor. When Petitioner fell, she tried to catch herself with her left arm but ended up falling to the ground landing on her left arm and buttocks.

Petitioner advised her supervisor of the work injury. She was unable to complete her work shift and left work early. The next day, Petitioner called off sick and advised her supervisor that she was taking off due to ongoing problems stemming from the work accident.

On October 11, 2011, Petitioner was seen by her family doctor, Dr. Lebeau, where she advised her family doctor of this work injury. Dr. Lebeau recommended further workup including an MRI, medications, and an off-work status but refused to provide such treatment since this was a workers' compensation case. As a result, Petitioner was seen at St. Elizabeth's emergency room on October 14, 2011 due to ongoing problems.

Petitioner advised her employer of this medical care and off-work status. Shortly thereafter, Respondent referred her over to Midwest Occupational Medicine who first saw her on October 21, 2011. Medical records from this facility confirm this work injury. Following examination, Petitioner was sent for physical therapy that was completed at Collinsville PT. Eventually, Midwest Occupational Medicine referred Petitioner to Dr. Khan for a physiatrist consultation. On November 29, 2011, Petitioner was seen by Dr. Khan who recommended further physical therapy which continued at Collinsville PT.

However, by December 16, 2011, physical therapy was stopped due to Respondent refusing to authorize any further physical therapy. Thereafter, on December 21, 2011, Dr. Khan indicated that he could no longer treat Petitioner as he was unable to obtain any approval for any of the treatment that he was recommending. As a result, Dr. Khan returned Petitioner back to Dr. Gorton at Midwest Occupational Medicine.

On February 17, 2012, Dr. Gorton noted that Petitioner was continuing to have problems with her left shoulder, low back, and neck. Dr. Gorton recommended that Petitioner be seen by a different doctor for purposes of an "independent medical examination." Dr. Gorton also referred Petitioner to her family doctor for further medical treatment. At the time of this last visit, Dr. Gorton released Petitioner to return to work full duty.

Petitioner testified that while she was undergoing this medical treatment with Dr. Gorton and Dr. Khan, her employer continued to work her as a cashier since it was much easier on her left shoulder than the deli job. Petitioner noted that she was able to complete these work activities albeit with difficulty.

However, after being released full duty by Dr. Gorton, Petitioner attempted to return to work in the deli department. When she attempted to perform the activities of sweeping,

mopping, lifting of meats, and lifting of trash bags, she had a dramatic increase in the problems in her left shoulder. Following one day in this position, Petitioner described a dramatic flare-up to the point that she was seen at Anderson Hospital emergency room. At that time, the emergency room doctor discussed with her a possible MRI and recommended that she follow up with her family doctor to obtain a script for this testing.

Petitioner testified that while she was trying to obtain authority for this MRI, she had been calling off work because of the problems that she had in completing the work activities in the deli department. Petitioner testified that she had spoken with an assistant manager who had indicated that they were working to move her back to a cashier position so that she could complete these activities without causing further problems with her shoulder. However, instead of providing her with this alternate position, Respondent terminated Petitioner citing her excessive absenteeism as being the basis for termination.

On April 23, 2012, Petitioner was seen at Anderson Hospital where she underwent an MRI of her left shoulder. At that time, she was diagnosed with having a partial torn supraspanitus tendon. Dr. Lebeau again recommended physical therapy and pain medications but this treatment was never approved so she was unable to move forward in that manner.

On September 5, 2012, Petitioner was seen by Dr. Corey Solman for an orthopedic consultation. Dr. Solman initially recommended an MRI of the cervical spine which was read as being normal. Dr. Solman completed this test in order to negate any issues associated with her neck. Thereafter, Dr. Solman provided Petitioner with work restrictions associated with her left shoulder and subsequently recommended surgery on this shoulder. Petitioner last saw Dr. Solman on December 13, 2013. At that time, Dr. Solman reiterated his continued recommendation of surgery on her left shoulder to correct a torn supraspinatus tendon. Dr. Solman testified that at the time of the original visit, he would have provided her with work restrictions to protect the shoulder from further injury.

Petitioner testified that she began working again for the State of Illinois – Department of Rehabilitative Services on February 14, 2013. Petitioner testified that she worked approximately 20 to 30 hours per week as a personal assistant taking care of an individual who was home bound because of a disability. Petitioner testified that she had a great deal of problems completing these activities due to the issues with her left shoulder. As a result, she last worked there on September 15, 2013 due to the fact that she could no longer perform lifting activities with her left arm that were required for this position.

Shortly thereafter, Petitioner began working as an in-home nanny where she has continued to work up to this date. Petitioner noted that she continues to have problems completing the work activities that would involve picking up the children or lifting heavy weights because of the problems associated with her left shoulder.

On June 11, 2013, Respondent sent Petitioner to Dr. Craig Byer for a Section 12 medical evaluation. Dr. Byer concluded that Petitioner's left shoulder problems were not related to the work accident but instead were related to incidents that occurred in 2005, 2008, and 2011.

In 2005, Petitioner was involved in a motor vehicle accident when she was 16 years old. At that time, Petitioner struck a telephone pole and was seen at Anderson Hospital for problems associated with her cervical spine, lumbar spine, and thoracic spine.

Petitioner testified that she had no problems with her left shoulder at the time of that accident. Further, she did not follow up with any doctors associated with that motor vehicle accident. Petitioner also testified that following the emergency room visit and normal healing, she had no ongoing problems associated with her cervical, lumbar, or thoracic spine.

In 2008, Petitioner was involved in a motor vehicle accident when she was rear ended. At that time, Petitioner was seen at Anderson Hospital and was noted to have problems with her neck, low back, and left shoulder. X-rays were taken of Petitioner's low back and left shoulder which were read as being normal. The emergency room diagnosed Petitioner with having a cervical strain and a muscle strain post motor vehicle accident.

Petitioner testified that following this single emergency room visit, she obtained no further medical care following this motor vehicle accident. Additionally, by approximately one month post motor vehicle accident, she was having no ongoing problems associated with her cervical spine, lumbar spine, or left shoulder.

Petitioner was treated for alternate medical conditions through either the emergency room or her family doctor. During those medical visits, there was no mention of any ongoing problems associated with Petitioner's left shoulder.

On August 2, 2011, Petitioner was seen at Anderson Hospital due to abdominal problems. During that medical visit, Petitioner testified that she had low back and arm pain due to an injury that she had sustained at Walmart the previous week. Following an examination, the doctor had recommended testing for carpal tunnel syndrome.

Petitioner testified that when she was seen in the emergency room on August 2, 2011, she was having low back problems due to her working at a new job which was causing pain in her low back. As for the arm condition, Petitioner testified her symptoms and treatment were for her right hand and not her left shoulder as she believed that she had developed right carpal tunnel syndrome. Petitioner testified that she was prescribed testing and treatment for her right hand but was having no problems with her left shoulder.

Petitioner was seen by her family doctor, Dr. Lebeau on August 5, 2011. At that time, she was diagnosed with having possible lupus as she was having pain in all of her joints. Dr. Lebeau eventually ruled out lupus and Petitioner noted that the joint soreness went away leading up to the work injury.

As a result, of the work accident, Petitioner continues to have pain in her shoulder that is a 7 out of 10 that increases when she attempts to use it with lifting or overhead work activities. She uses over the counter medications three to seven times per week as well as ice and heat to reduce her symptoms. Petitioner noted that when her left shoulder hurts, it causes symptoms down the arm into all of the fingers of her left hand.

Petitioner entered into evidence medical bills surrounding the treatment of her work injury. Petitioner is seeking to have the workers' compensation carrier pay these medical bills.

Dr. Solman testified on behalf of Petitioner. Dr. Solman diagnosed Petitioner with having left shoulder pain with possible biceps tendon pathology or subluxation. Following an injection into the shoulder, he had recommended that she undergo a left shoulder arthroscopy to address the biceps tendon problem. Dr. Solman related this injury to the work accident of October 8, 2011. Dr. Solman noted that when Petitioner fell, she imparted a great amount of strain on the shoulder which strained the rotator cuff, biceps, and labrum. He noted alternatively she could have sustained a partial dislocation or full dislocation of her shoulder that popped back into place. These different mechanisms occurred with the type of fall that Petitioner had described on the date of accident and caused the medical condition for which he recommended surgery.

Dr. Craig Byer testified on behalf of Respondent. Dr. Byer concluded that Petitioner's condition was not related to the work injury based upon his belief that the current symptoms were simply a continuation of chronic musculoskeletal problems that had predated the date of accident. Dr. Byer reported that he believed that her symptoms of neck, back, and left shoulder problems had been present since 2005 and 2008. Dr. Byer also concluded that Petitioner had left upper extremity symptoms in August of 2011, two months before the alleged injury.

CONCLUSIONS

Issues (C) and (F): 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; in this regard, the Arbitrator makes the following conclusions:

On October 8, 2011, Petitioner sustained a work injury when she slipped on a wet floor and landed on her left arm and low back. Petitioner's testimony was not refuted by any fact witnesses and was fully supported by the medical records. Respondent initially directed medical care relating to this work accident.

Immediately following this accident, Petitioner was seen by her family doctor as well as Dr. Gorton at Midwest Occupational Medicine. Dr. Gorton attempted conservative treatment as well as a referral to a physiatrist. This treatment was unilaterally stopped by Respondent without explanation. Respondent's own doctor, Dr. Gorton had recommended at his last visit that Petitioner continue to follow up with her family doctor as well as obtain an "independent medical evaluation." Recorded in all of these medical records is the same description of accident as described by Petitioner at trial.

In addition, Dr. Corey Solman, Jr. testified that based upon the history provided by Petitioner, the mechanism would be consistent with the biceps tendon pathology and subluxation that he was looking to surgically correct. Further, Dr. Solman testified that in reviewing the prior medical records, there did not appear to be any similar types of symptoms in Petitioner's

shoulder until after this work injury. As a result, the doctor attributed Petitioner's medical condition and need for surgery to the work accident.

Alternatively, Respondent brought forth the medical opinion of Dr. Craig Byer. Dr. Byer concluded that Petitioner's condition had predated the date of accident based upon his reading of emergency room visits of 2005, 2008, and 2011. Dr. Byer concluded that these medical records show an ongoing chronic level of symptoms in Petitioner's left shoulder.

However, consistent with the medical records and Petitioner's testimony at trial, Petitioner sustained no injury to her left shoulder in the motor vehicle accident in 2005. Further, the motor vehicle accident of 2008 contained an x-ray of the left shoulder which was read as negative. Petitioner testified to no ongoing problems following that emergency room visit. Respondent offered no additional medical records showing any ongoing problems between 2008 leading up to the work injury on October 8, 2011.

Further, Dr. Byer testified at length regarding Petitioner's lack of credibility given the fact that she did not advise him of an alleged left shoulder problem six weeks prior to the date of accident. However, review of the medical records specifically refutes Dr. Byer's conclusions in this regard. The medical records from Anderson Hospital reveal that Petitioner had sustained injury to her right hand for which she had been referred for further testing of potential carpal tunnel syndrome. Additionally, Petitioner testified that in the months leading up to the date of accident, she had no problems with her left shoulder and had been working full duty.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained a work injury on October 8, 2011. The medical records confirm that Petitioner's condition of ill-being remains causally related to this work accident. Dr. Solman's opinion is deemed credible whereas Dr. Byer's conclusion is not deemed credible as Dr. Byer made incorrect factual assertions based upon his misreading and misinterpretation of prior medical records. Further, Petitioner's description of her work injury is consistent with the ongoing left shoulder problems that were seen throughout the medical records.

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

Petitioner introduced Petitioner's Exhibit 9, a package relating to medical bills as well as a medical bill summary. Petitioner testified that the bills shown in the exhibit were incurred as a result of this work injury. Respondent denied this claim and therefore denied liability for the payment of these medical bills. The charges are as follows:

Provider	Total Charges
Midwest Emergency Services	$390.00
Radiology Consultants of Mid America	$105.00

Southern IL Healthcare Dr. David LeBeau	$1,015.00
St. Elizabeth's Occ Med Dr. Byron Gorton	$371.82
Dr. Anwar Khan	$355.00
Collinsville PT & Wellness	$1,195.00
Anderson Hospital	$4,070.35
Maryville Radiology	$362.00
Elite Imaging of Fairview Heights	$2,320.94
Dr. Corey Solman	$430.00
Walgreens	$15.49
Total	**$10,630.60**

The Arbitrator orders Respondent to pay $10,630.60 for medical bills, as set forth above and provided in Section 8(a) of the Act. These bills are to be paid pursuant to the medical fee schedule, Section 8.2 of the Act.

Respondent argues that Petitioner exceeded her choice of doctors by going choosing more than two providers. However, review of the medical records confirms that Petitioner did not violate this provision and remained within her two choices of doctors. Petitioner was originally seen by Dr. Lebeau who refused to provide medical treatment since this was a work injury. Subsequently, Petitioner sought emergency medical treatment at St. Elizabeth's Hospital. Emergency medical care is not considered a choice or provider. Dustin Cashmer v. Kelly Temp Services, 2006 Ill.Wrk.Comp. LEXIS 967 (Commissioners Pigott, DeMunno and Lindsay) and Patty Barnhill v. K-Mart, 2009 Ill.Wrk.Comp. LEXIS 687 (Commissioners Gore, DeMunno and Basurto).

Thereafter, Respondent sent Petitioner to Midwest Occupational Medicine who in turn referred her for physical therapy and to Dr. Khan for a physiatrist consultation. Dr. Gorton thereafter referred Petitioner back to Dr. Lebeau for further medical care. This treatment was at the choosing of Respondent and therefore does not constitute Petitioner's choice of medical care provider.

Finally, Petitioner chose Dr. Solman for an orthopedic consultation after Respondent's doctors were provided no further authority. Dr. Solman constitutes Petitioner's second choice of physician. As a result, Petitioner remained within her two choices of medical care providers.

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

Following this work injury, Petitioner was released to return to work full duty. However, when she attempted to return to the deli, she had increased problems with her shoulder. Petitioner advised the assistant store manager who told her that they would attempt to find her a new position. During the pendency of this relocating her to a new position, Petitioner was terminated due to her absenteeism. Petitioner testified that she had continued to call in to her supervisor leading up to her termination.

On September 5, 2012, Petitioner was seen by Dr. Corey Solman who provided Petitioner with light duty restrictions. Petitioner remains on these light duty restrictions but was able to obtain employment on February 14, 2013 and has continued to work regularly since that time.

As was noted by the Supreme Court of Illinois:

> "Whether an employee has been discharged for valid cause, or whether the discharge violates some public policy, are matters foreign to workers' compensation cases. An injured employee's entitled to TTD benefits is a completely separate issue and may not be conditioned on the propriety of the discharge."

Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n, 236 Ill.2d 132; 923 N.E.2d 266; 337 Ill. Dec. 707 (2010)

As a result, the Arbitrator orders Respondent to pay lost-time benefits from September 5, 2012 to February 13, 2013, totaling 23-1/7 weeks at $220.00 per week for a total of $5,091.43. Petitioner has not yet been released at maximum medical improvement and remains on light duty thereby obligating Respondent to pay lost-time benefits.

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

Dr. Corey Solman testified that Petitioner was in need of surgery to correct the biceps injury that occurred as a result of the work injury. Dr. Solman recommended that Petitioner undergo a shoulder arthroscopy with either a biceps tenotomy or tenodesis. Dr. Solman indicated that the procedure would help Petitioner to be able to perform all of her activities without having the pain that the biceps tendon was causing her.

Alternatively, Dr. Byer recommended differential injections to sort out from where the pain was coming. However, Dr. Byer did not believe that Petitioner needed surgery to correct the biceps tendon.

Based upon the foregoing, I find the medical conclusions of Dr. Solman to be more credible than Dr. Byer and more consistent with Petitioner's symptoms. The Arbitrator orders Respondent to authorize medical care consistent with Dr. Solman's recommendations.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cecil Runyon Jr.,
Petitioner,

15IWCC0367

vs.

NO: 10 WC 45760

Pinckneyville Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanenr partial disabilit 8(j) credit, exhibits 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 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.

DATED: MAY 19 2015
KWL/vf
O-5/12/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0367

RUNYON JR, CECIL
Employee/Petitioner

Case# **10WC045760**

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 7/3/2014, 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:

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

JUL 3 - 2014

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

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

15 IWCC0367

Cecil Runyon, Jr.
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # **10** WC **45760**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon, IL**, on **May 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **Admissibility of Petitioner's Exhibits 12, 14-24**

FINDINGS

On **11/22/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**78,646.50**; the average weekly wage was $**1,512.43**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **3** dependent children.

Respondent is not liable for any medical services.

Respondent is entitled to a credit for all payments made by group under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on November 22, 2010 that arose out of and in the course of his employment with Respondent or that his bilateral carpal tunnel syndrome was causally related to his employment with Respondent. Petitioner's claim is denied. No benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

July 1, 2014
Date

JUL 3 - 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This case proceeded to arbitration on May 7, 2014. Petitioner alleges that he sustained injuries to his right and left hands and right and left arms/elbows as a result of repetitive duties while working for Respondent, Pinckneyville Correctional Center. (AX 2) Petitioner alleges an accident date of November 22, 2010. The issues in dispute are: accident; notice; causal connection; medical bills; nature and extent; credit for prior awards; and the admissibility of PX 12 and PX 14 through 23.

The Arbitrator finds:

According to the medical records admitted into evidence Petitioner presented to Dr. David M. Brown at the Orthopedic Center of St. Louis on November 22, 2010, for evaluation and treatment of a problem with both of his upper extremities. Petitioner completed a "New Patient Questionnaire" in which he reported that he was referred to Dr. Brown by his attorney. Petitioner reported that he was there for a work-related injury, and he was represented by an attorney for this problem. Petitioner's activities included lifting weights and riding motorcycles. Petitioner reported heart problems, high blood pressure, and a thirty year smoking history. With regard to his upper extremities Petitioner reported numbness and tingling and aching in his wrists and fingers to both wrists. Petitioner denied any prior treatment. The history outlined in Dr. Brown's November 22, 2010, note is as follows:

> Cecil [Petitioner] is a 50 year old right hand dominant correctional officer for the Illinois Department of Corrections at Pinckneyville. He presents for evaluation and treatment for a problem with both his upper extremities. He explains to me he's worked at Pinckneyville since 1984. He works eight hours a day, forty plus hours a week. His job entails locking and unlocking cell doors, turning a key. He does this for 85% of his shift. He will also lock and unlock padlocks, office doors among other activities. He presented with a typewritten job description, which is included as part of the medical record.
>
> Cecil explains to me that he has about a year history of numbness and tingling in both his hands associated with some volar wrist pain. He was treated with wrist braces with no improvement in his symptoms. He could recall no specific traumatic event. (PX 3)

Petitioner's past medical and surgical history was remarkable for a history of heart disease, high blood pressure, emphysema and a left ulnar nerve transposition in 2003 or 2004. Petitioner explained that he was smoker for thirty years but quit smoking about a year and a half ago.

Petitioner's physical examination revealed good active range of motion of both extremities. He had a scar over his left elbow from a previous surgery. Petitioner exhibited a negative Tinel's over the ulnar nerve at the right cubital tunnel. Direct compression test induced some discomfort. Elbow flexion test was negative. Petitioner had a negative Tinel's over the scar at the left cubital tunnel. Direct compression/elbow flexion test was negative. Petitioner had a positive Tinel's over the right and left carpal tunnels. Direct compression test/Phalen's test was positive bilaterally. Two point discrimination

was 5 to 6 mm in the digits of both hands. There was no intrinsic muscle atrophy in either hand. Grip strength was noted as: three trials right 107, 120, 82; three trials left 83, 90, 106. Key pinch: three trials right 19, 20, 21; three trials left 26, 25, 24. (PX 3)

Dr. Brown opined that Petitioner had symptoms and findings on examination consistent with bilateral carpal tunnel syndrome and possibly a component of an ulnar neuropathy. Dr. Brown recommended detailed nerve conduction studies of both upper extremities. Once those were done, Dr. Brown would review and contact him with the results. In the meantime, Petitioner was given bilateral Titan wrist splints to wear over both wrists at night and bilateral, elbow splints to wear over both elbows. Dr. Brown also recommended a nonsteroidal anti-inflammatory medication. Based on Petitioner's job description, combined with his own understanding of those job activities, Dr. Brown opined that Petitioner's work for the Illinois Department of Corrections would be considered, in part, an aggravating factor in the need for further evaluation and treatment for carpal tunnel syndrome and/or cubital tunnel syndrome. (PX 3)

That same day, Petitioner saw Dr. Daniel Phillips at the Neurological & Electrodiagnostic Institute, Inc. of St. Louis on a referral from Dr. David Brown for electrical diagnostic studies to evaluate his bilateral upper extremity pain and numbness. Petitioner completed a "Patient Questionnaire/Health History" in which he reported his fingers were numb, they tingled, and his wrists hurt. He reported his symptoms began one year earlier and was gradual in onset and occurred with "lifting, overuse, [and] incident at work." Petitioner reported that since the onset, his symptoms had gotten worse. He denied any similar problems in the past. Petitioner described the nature of his pain/symptoms as throbbing, aching, and constant. He reported that as the day progressed, his symptoms stayed the same. He reported night awakening only when changing positions. He reported pain/stiffness upon getting out of bed in the morning. Petitioner reported a one-year history of gradually progressive aching throbbing bilateral wrist pain with numbness preferentially involving the first three fingers. Petitioner acknowledged that about 5 years earlier he had undergone a left ulnar nerve transposition. Right elbow pain was not described. Cervical radicular pain was not described. Petitioner was noted to have a past medical history of hypertension and a social history of quitting smoking in 2009. Petitioner was 5'8" and weighed 225 lbs. Dr. Phillips' impression of the nerve conduction study was relatively moderate sensory motor median neuropathy across the right carpal tunnel and milder median sensory neuropathy across the left carpal tunnel. (PX 4)

On November 22, 2010, Dr. Brown authored an addendum which noted that Petitioner had undergone nerve conduction studies by Dr. Daniel Phillips which revealed findings consistent with bilateral carpal tunnel syndrome. Petitioner was assessed with bilateral carpal tunnel syndrome. Dr. Brown noted that Petitioner had tried wrist splints in the past with no improvement in his symptoms. Petitioner's symptoms were chronic. Dr. Brown felt Petitioner was a candidate for carpal tunnel release. (PX 3)

Petitioner signed his Application for Adjustment of Claim in this case on November 24, 2010. (AX 2)

On November 29, 2010, Petitioner completed a document entitled "CMS Workers' Compensation Employee's Notice of Injury." Petitioner reported the date of incident as November 22, 2010. Petitioner

reported repetitive use as a cell house lieutenant at Pinckneyville Correctional Center. Petitioner described the injury as "pain and numbness in both left and right hands." (PX 9; RX 2)That same day Petitioner and Major Bebout, Petitioner's supervisor, completed an Incident Report (RX 6) in which Petitioner stated he saw Dr. Brown on November 22, 2010 and was informed that he had carpal tunnel syndrome bilaterally and it was the result of my 27 years of repetitive duties as an employee of the Illinois Department of Corrections.

On December 1, 2010, Major Bebout completed a document entitled "CMS Supervisor's Report of Injury or Illness." The description of the injury was "refer to DC 434". The description of the injury was both right and left hands. It was noted that Major Bebout received written notice on November 29, 2010, from Lt. Runyon. (PX 9; RX 3)

On December 1, 2010, Major Bebout completed a document entitled "CMS Demands of the Job." Major Bebout reported that the average daily job demand of Lt. Cecil Runyon was zero to two hours per day for use of hands for gross manipulation (grasping, twisting, handling) and zero to two hours per day for use of hands for fine manipulations (typing, good finger dexterity). (PX 9; RX 5)

On December 3, 2010, Dr. David Brown completed the CMS Initial Workers' Compensation Medical Report. (RX 4)

On October 5, 2011, Petitioner presented to Dr. George A. Paletta, Jr. at The Orthopedic Center of St. Louis. Petitioner reported that up until August 31, 2011, he had worked as a correctional officer for the Illinois Department of Corrections at the Pinckneyville Facility. He presented for evaluation of intermittent numbness and tingling into his right and left hands as well as pain at the wrist. He reported a two-year history of these symptoms. While Petitioner's chief complaint was both of his hands, he felt the right hand was a little bit worse than the left hand. He reported intermittent numbness and tingling involving the first, second, and third fingers. It was confined mainly to the tips of the fingers. He complained of some wrist pain. Petitioner reported that he retired on August 31, 2011 but things had not improved significantly. Petitioner reported that particularly in the last few years, his job involved a lot of continuous computer work. He typically worked eight hours a day and averaged at least 40 hours if not more a week. His job entailed all the typical duties of correctional officer including locking and unlocking cell doors, turning keys, cuffing and uncuffing inmates, and restraining inmates when necessary. He would lock and unlock pad locks and office stores among other activities. He stated that this was the majority of his shift. Physical examination revealed no evidence of cubital tunnel syndrome. Examination of both wrists revealed full unrestricted pain-free range of motion including the wrist, MCP, PIP, and DIP joints. Petitioner had a positive Tinel's sign over the right carpal tunnel and a negative Tinel's over the left carpal tunnel. He had positive direct compression test bilaterally. Phalen's test was positive on the right, negative on the left. Distal neurovascular exam was grossly intact. Dr. Paletta noted "EMG and nerve conduction studies were available for review. These were compared to the previous nerve conduction studies[1] done in November 2010." Dr. Paletta commented that Dr. Phillips had noted that "this" was a cold hand study so it was difficult to interpret the latencies accurately.

[1] Exactly what studies were being compared is unclear as the record only contains the 11.22.10 emg/ncs.

However, Dr. Phillips felt there was unequivocal evidence of right carpal tunnel syndrome with more equivocal evidence of left carpal tunnel syndrome. Dr. Paletta's impression was 1) chronic right carpal tunnel syndrome with positive electrophysiologic findings; and 2) clinical findings of carpal tunnel syndrome on the left with equivocal electrophysiologic findings. Dr. Paletta strongly recommended a carpal tunnel release on the right wrist. Dr. Paletta opined that Petitioner's activities as a correctional officer were an aggravating factor with regard to his peripheral compressive neuropathy. Dr. Paletta noted that Petitioner had no evidence of underlying systemic risk factors for peripheral compressive neuropathy. (PX 6)

On October 6, 2011 Petitioner presented to his primary care physician, Dr. Christopher Reyes, for the purpose of undergoing an EKG pre-surgery. According to the doctor's note, "The patient came in. He just needs a preop and EKG. He is going to have carpal tunnel surgery. This is workman's comp." The EKG looked "okay." Attached to the office note is an information sheet in which Petitioner was asked to identify the date of accident. He wrote, "recurring from 2009 -- 11/22/10." (PX 7)

On October 11, 2011, Petitioner underwent a right carpal tunnel release performed by Dr. George A. Paletta, Jr. at Frontenac Surgery & Spine Care Center. (PX 6; PX 8)

On October 31, 2011, Petitioner was seen by Dr. Luke Choi for follow-up. Petitioner felt that his paresthesia had improved. Petitioner was to begin post-operative physical therapy and return in four to six weeks. (PX 6)

On November 15, 2011, Petitioner underwent a left carpal tunnel release performed by Dr. George A. Paletta, Jr. at Frontenac Surgery & Spine Care Center. (PX 6; PX 8)

On December 15, 2011, Petitioner returned to see Dr. Paletta. His only complaint was some soreness at the incision site on the right wrist. (PX 6)

On January 23, 2012, Petitioner again returned to see Dr. Paletta. Petitioner was noted to be doing quite well. He noted dramatic improvement in his symptoms. He reported no residual numbness or tingling, no pain, and no nocturnal symptoms. He reported a little bit of tenderness at the incision sites if direct pressure was applied. Dr. Paletta noted that Petitioner had an excellent outcome. Dr. Paletta reassured Petitioner that the tenderness at the incision sites would resolve over time. Petitioner had complete resolution of his carpal tunnel symptoms. Petitioner was released from care full duty, no restrictions. Petitioner was to return on an as needed basis. Dr. Paletta noted that Petitioner did not need any additional treatment. (PX 6)

At the request of Respondent Petitioner was examined by Dr. James Williams on April 18, 2012. Thereafter the doctor issued a written report in which he discussed the records he had reviewed, his examination of Petitioner, and his opinions on causation. Dr. Williams reviewed Petitioner's treating medical records and various job descriptions. He wrote that he had spoken with Petitioner and when reviewing the job descriptions noted that he, himself, had performed some of Petitioner's job duties noting he did not feel they would require repetitive forceful impact or vibration and did not lack significant rest in between the activities. He also felt Petitioner's nerve studies were almost normal

when looking closely at the numbers. Dr. Williams stated his belief that Petitioner's history of smoking for over thirty years could have contributed to his development of carpal tunnel syndrome and both his hobby of weight lifting (which involved repetitive forceful gripping) and his hobby of motorcycle riding (vibratory) were risk factors for compression neuropathies. Dr. Williams did not feel that any of Petitioner's job duties would lead to carpal tunnel syndrome. (RX 8)

The deposition of Dr. James Williams was taken on behalf of Respondent on August 29, 2012. Dr. Williams testified that he is an orthopedic surgeon who holds a certificate of added qualification in hand surgery. He performs approximately 200 surgeries annually for carpal tunnel syndrome. Dr. Williams testified that he reviewed Petitioner's medical records, the Corvel Job Analysis reports and DVDs for both a correctional officer and a correctional lieutenant at Pinckneyville Correctional Center, key estimation study by Lt. Jason Thompson, job descriptions (including a typewritten job description filled out by Petitioner), and had toured Pinckneyville Correctional Center. Dr. Williams fully acknowledged that he did not examine Petitioner and that the reference within his report to speaking to Petitioner to inform him that no physician/patient relationship was formed was a transcription error made by staff. (RX 9)

Dr. Williams testified that he has used small keys and larger Folger Adams keys to turn locks; cuffed and uncuffed another officer; opened and closed a chuckhole; lifted a property box; and toured all areas of Pinckneyville Correctional Center. Dr. Williams explained that the pinch grip force required to open doors at Pinckneyville Correctional Center with a Folger Adams key was "not something one sustains for a long period of time, something that doesn't require a great deal of force, and then you just close the key—it's not something you have to turn the key back to lock it, to close it shut." Dr. Williams described the type of activity of opening cell doors as a light to medium type activity. Dr. Williams believed Petitioner's diagnoses were bilateral carpal tunnel syndrome on the right side which was mild and even milder on the left. (RX 9)

Dr. Williams noted that Petitioner had the following risk factors for the development of carpal tunnel syndrome: increased body mass index, history of hypertension, motorcycle riding, lifting weights, and smoking for 30 years. Based upon the information, his knowledge and expertise, Dr. Williams opined to a reasonable degree of medical certainty that Petitioner's job duties were neither contributory nor aggravating for bilateral carpal tunnel syndrome. Dr. Williams testified that if Petitioner were to testify at trial that he generally performed job duties associated with a correctional officer, Dr. Williams still did not believe the job duties of a correctional officer at Pinckneyville Correctional center would cause or aggravate carpal tunnel syndrome. Dr. Williams explained that this was based upon his own knowledge of the job duties of which he performed, from the videos; as well as the key turning analysis, which were performed at Pinckneyville Correctional Center; the two site visits, which were done by Corvel at Pinckneyville Correctional Center; the job videos, which were done; and his own firsthand visit to Pinckneyville Correctional center and the activities which he performed. Dr. Williams explained that the key turning as utilized in the cuffing and uncuffing of inmates; the opening of cell doors and chuckholes was not causative or aggravating for carpal tunnel syndrome because it was done for a short period of time with sufficient rest in between, and a low magnitude of force required in pinching and/or gripping to perform those activities. Dr. Williams testified that it would be significant if Petitioner had retired and

his symptomatology in his hands continued. He explained that with a patient such as Petitioner having very mild, stated by his nerve examiner himself, as well as based on his numbers, you would think that if something being an aggravating factor were removed, that his symptoms should also resolved. He further testified that "[w]hen something is mild, it's simply an irritation that can be resolved with the removal of the inciting cause." (RX 9)

Dr. Williams acknowledged while the job duties of bar rapping at Pontiac Correctional Center was something that involved vibration and could contribute to compression neuropathies. However, Dr. Williams testified that he would be surprised if it would take 12 years to manifest itself. In addition, he opined that it would be hard to say it would take 12 years to develop, especially when the carpal tunnel was graded as mild. Dr. Williams opined that if Petitioner's symptoms began at Pontiac Correctional Center where Petitioner last worked in 1998, he would think that if it had been going on for 12 years, it should have been at least moderate or severe it should not be in the mild category. He also did not understand why Petitioner would not state to his own doctor that work at that facility (Pontiac Correctional Center) was something that he felt contributed to this. Dr. Williams also testified that typing is neither causative nor aggravating to a condition of carpal tunnel syndrome. (RX 9)

The deposition of Dr. George Paletta, Jr. was taken on behalf of Petitioner on April 5, 2013. Dr. Paletta is a board certified orthopedic surgeon primarily focused on upper extremities and knees. Dr. Paletta testified that he compared two nerve conduction studies from Dr. Phillips, one dated November 22, 2010, and the other dated September 28, 2011. (PX 11, p. 7) Dr. Palettta testified that Petitioner had electrophysiologic evidence of right carpal tunnel syndrome and more mild findings of left carpal tunnel syndrome in November 2010. On repeat studies in September of 2011, Petitioner had evidence of right carpal tunnel syndrome, but the study was equivocal for left carpal tunnel syndrome. (PX 11, p. 8) Dr. Paletta was asked about Dr. Phillips' notation of a "cold hand study" and Dr. Paletta testified that EMG and nerve conduction studies are done with temperature correction because temperatures can affect the results of the studies. If it's a cold hand study, it meant the patient was cold at the time which can affect the results as it makes the study more difficult to interpret and less reliable. As for whether a cold hand study tends to make the results more positive or negative, Dr. Paletta indicated one would need to ask Dr. Phillips. (PX 11, pp. 8-9)

With regard to his care and treatment of Petitioner, Dr. Paletta testified consistent with his office notes.

Dr. Paletta testified that Petitioner had non-work-related risk factors for the development of bilateral compression neuropathy such as carpal tunnel syndrome to include hypertension, body mass index over 30, and a history of smoking. Dr. Paletta also testified that Petitioner's hobbies of riding motorcycles and lifting weights could also be non-work-related risk factors for the development of compression neuropathy such as carpal tunnel syndrome. Dr. Paletta explained that motorcycles cause vibration, and vibration has clearly been correlated with a potential risk for carpal tunnel syndrome. Dr. Paletta also testified that lifting requires heavy gripping, so that could potentially be a factor. (PX 11)

Dr. Paletta testified that he was not familiar with the jobs at Pontiac Correctional Center and had not reviewed the job site analysis or DVDs for a correctional lieutenant at Pinckneyville Correctional Center.

Dr. Paletta testified that he did not know how many job assignments there were for a correctional lieutenant at Pinckneyville Correctional Center; did not know what job assignments Petitioner had; did not know how many cell doors Petitioner would lock and unlock each day; did not know how often Petitioner turned keys as a correctional lieutenant; did not know how many times Petitioner would cuff or uncuff inmates on his shift as a correctional lieutenant; did not know how often he would restrain inmates; did not know how often Petitioner would lock or unlock padlocks or office doors; did not know which type of key was used to open a cell door at Pinckneyville Correctional Center; did not know how often Petitioner was using each of his arms for the activities; did not know which shift Petitioner worked; did not know the days of the week Petitioner worked; did not know whether Petitioner worked in segregation or general population or both; did not know the differences between the key-turning activities in segregation and general population at Pinckneyville Correctional Center; did not know the number of hours per day Petitioner was forceful pinching or gripping; did not know how often Petitioner would lift something at Pinckneyville Correctional Center; did not know the rest time between turning keys. (PX 11)

Dr. Paletta testified that he does not hold a special certificate in hand surgery. He testified that prior to 2010, he only performed 6-10 carpal tunnel surgeries per year, less than two percent of his practice. Dr. Paletta testified that Petitioner informed him he spent about 10% of his day typing on a computer. Dr. Paletta testified that the literature now indicates that there is no correlation between typing or keyboard use and the development of carpal tunnel syndrome. (PX 11, pp. 33-34) Dr. Paletta testified that Petitioner did not indicate any symptoms when weight-lifting or riding his motorcycle. (PX 11)

At the arbitration hearing Petitioner testified that he is a fifty year old, right-hand dominant correctional lieutenant. Petitioner testified that he began his employment with the Illinois Department of Corrections in 1984 beginning at Pontiac Correctional Center where he worked from 1984 until 1998. He was a correctional officer from 1984-1988; a correctional sergeant from 1988-1989; and a correctional lieutenant from 1989-1998. Petitioner then transferred to Pinckneyville Correctional Center (Respondent herein) as a correctional lieutenant where he worked from 1998 until his retirement in 2011. Petitioner also testified that he was the assistant warden of programs at Pinckneyville Correctional Center for a few months.

Petitioner testified that while he worked at Pontiac he was required to engage in bar rapping and the locking and unlocking of "old-time" sliding metal cell doors using a Folger Adams key, a "big key" requiring Petitioner to move his wrists, pinch, and grip. Once the door was unlocked Petitioner would have to "tug" at the doors to open them which also required a lot of pressure. Petitioner further testified that he had to cuff and uncuff inmates and often times he would encounter difficult inmates who would try to tear away, causing twisting and pain to his wrists. Petitioner testified that while at Pontiac he was often assigned to the segregation unity where contact was made with inmates through "chuck holes." This required Petitioner to use a Folger Adams key, thereby involving his wrists. Petitioner also participated in shakedowns which involved all parts of his body, including his hands and wrists.

Petitioner testified that he has been an officer, a lieutenant, and a sergeant. According to Petitioner these jobs do not vary in their duties despite the different titles. Petitioner testified that his job duties

as a lieutenant were no different that those of a correctional officer because, as a lieutenant, he was ultimately responsible for the officers getting their jobs done so he might have to perform some of the duties.

Petitioner testified that after fourteen years at Pontiac, he transferred to Pinckneyville Correctional Center, which, at that time, was a "state of the art facility" with brand new locks and keys and an excellent locking system compared to that of Pontiac.

Petitioner testified that his job duties at Pinckneyville included bar rapping on a daily basis. He also had to lock/unlock cell doors but the ones at Pinckneyville were not as difficult unless one was in the segregation unity. There were also chuck holes which required a key similar to that of a Folger Adams. Petitioner worked at Pinckneyville until he retired in 2011. When Petitioner first began at Pinckneyville he was a "receiving and segregation lieutenant" responsible for all incoming and outgoing inmates. He then went to receiving followed by a transfer to the housing units where he would walk the galleries, pulling on all the cell doors to guarantee none were open. Petitioner also opened cell doors to perform shakedowns, something Petitioner claimed he did about every day. Petitioner testified that he subsequently returned to receiving and segregation for the next 4 1/2 years. He then took over "Property". According to Petitioner all of his activities required the use of his hands and arms.

Petitioner testified that he injured his left elbow in 2002 while aiding a fellow officer with an inmate. Petitioner then had another incident where his left arm went completely numb and he eventually underwent left elbow surgery. Petitioner also had a traumatic injury to a left knuckle as a result of an altercation with an inmate. Petitioner testified that prior to this claim being filed he had never undergone a nerve conduction study.

Petitioner also testified that he had reviewed videos showing an officer and a lieutenant working at Pinckneyville, a work history and demands of the job form provided by the State of Illinois, a jobsite analysis for a correctional lieutenant performed by Corvel, a job site histories and a key estimation study performed by Lt. Thompson, and Petitioner's Exhibits 14 through 23 (various depositions). Petitioner testified that as a correctional lieutenant he performed some of the same job duties discussed in those exhibits/depositions. With regard to the videos, Petitioner did not feel they showed all of his work activities and did not accurately reflect his job. He felt they were staged.

Petitioner testified that while he was performing his job duties as a lieutenant at Pontiac he began to develop symptoms of numbness and tingling in his hands. Petitioner noticed his hands were getting tired and tingled in the fingers. According to Petitioner, gripping became increasingly difficult. Petitioner also testified that he noticed his symptoms would go away when he got home and rested. When asked why he didn't go to a physician during that time period Petitioner testified he didn't do so because "they" told "us" to go back to work no matter what. Petitioner testified he continued to work and continued to have trouble but waited to do anything about it until he couldn't stand it anymore.

Petitioner testified that his symptoms did not resolve after retiring from Respondent. Petitioner testified that from 2002 to the present, he has put 100,000 miles on his Harley-Davidson motorcycle, which was 1450 cc. Petitioner testified that he has ridden motorcycles most of his life. Petitioner

admitted that he experienced the same symptoms of numbness and tingling in his hands when riding his motorcycle due to the vibration before he had the surgeries. Petitioner testified that he used his right hand to key and his left hand to pull on the doors. Petitioner testified that he had symptoms at Pontiac Correctional Center, but he did not report them. He testified that he agreed with the key estimation study performed by Lt. Jason Thompson and the CMS Demands of the Job with regard to fine and gross manipulation.

Petitioner testified that he presented to his family physician, Dr. Reyes, prior to seeing his attorney, Mr. Rich. He testified that he did not know how long before seeing Mr. Rich or Dr. Brown that he presented. He testified that his family physician told him that he had something wrong with his hands and that he needed to see a specialist. Petitioner testified that he knew at that time that it was work-related. Petitioner testified he next presented to his attorney who referred him to Dr. David Brown.

Petitioner acknowledged that he is not claiming any right elbow injuries, only bilateral hand injuries. During his testimony he reiterated that he first noticed his symptoms while working at Pontiac but didn't go see a doctor about them. On cross-examination Petitioner was asked how his symptoms progressed after transferring to Pinckneyville and Petitioner "guessed" it was "over time." Petitioner testified that there was less bar rapping at Pinckneyville than at Pontiac.

Petitioner did not have an explanation as to why the medical record from Dr. Reyes prior to November 22, 2010, concerning Petitioner's first visit to a doctor for his condition to his hands was not contained in Petitioner's exhibits. Petitioner was asked about the symptoms he was referring to in his history of "one year symptoms" when he was examined by Dr. Brown and Dr. Phillips. Petitioner testified he was only functioning at 50% and he just really couldn't function.

Petitioner denied being examined by Dr. Williams in Peoria.

Lt. Jason Thompson performed a key study usage estimation at Pinckneyville Correctional Center (RX 14). His deposition testimony was admitted as RX 15. Per his estimates, on the 7am-3pm shift, Petitioner as correctional lieutenant would turn 10-20 large keys and 45 small keys per shift, depending on the Zone. He was present in x-wing style housing units 3 and 4, which held 448 inmates. These are 112 cells in 2 wings, holding 2 inmates each. He saw Dr. Williams' attempt to open one key on the R3-C wing door and one handcuff key. He testified that Dr. Williams was awkward while trying to get the hand position movements, and had trouble hitting the double lock key portion of it.

When asked to explain the difficult double lock key portion, he testified:

A: Basically, with your handcuff keys, you've got the keyhole, which the key portion fits in. You turn that to unlock it. (Indicating).

Q: Yes, sir.
A: On either the side—either the edge side or on the opposite of the keyhole, you also have what's called a double-locking mechanism. (Indicating.) If it's a pin-type, you have a small pin that you press in with the non-key end of the key—of the cuff key. It's just like a pinpoint.

Q: Yes, sir.
A: And you press it in, and that double-locks the cuffs. (Indicating.) If not, you've got—it's basically a wire-type double lock, where you—also using the same end of that key, you stick it in there and you push it in, and that also double-locks the cuffs.

Q: Very good. And the reason that they're double-locked is why?
A: So they can't be compressed any further and they're harder to jimmy.

Q: Safety reasons?
A: Yes. Absolutely.

Lieutenant Thompson testified that keying cells and chuckholes, opening and closing doors, cuffing and un-cuffing inmates, turning difficult keys, opening difficult doors, pulling on bars, checking cell doors, weapons training, working mandated double shifts, performing extra duties on lock down, opening and closing chuckholes, lifting property boxes, carrying trays upstairs, restraining inmates, guiding inmates through lines, and performing various amounts of paperwork were the duties of a Correctional Officer. He further agreed that there was not a single part of the job that did not involve using one's arms, hands, or elbows. In addition, he acknowledged that these activities involved force and stress. (RX 15)

Lieutenant Jason Thompson was also present at the hearing on behalf of Respondent, but was called as a witness by Petitioner. He testified that his answers that he gave during his deposition were truthful and accurate to the best of his ability. He knows Petitioner and testified that he is a good employee. He testified that he has never worked at Pontiac Correctional Facility outside of his attendance at a one-day training session. He further testified that he did not disagree with any of Petitioner's testimony.

The deposition testimony of Melanie Welch taken on July 8, 2011 in the case of "Donna Jones v. State of Illinois, et. al., 2010 WC 38807" was admitted as PX 13. Ms. Welch is an employee of Corvel, which is a national corporation providing services to employers, third party administrators, insurance companies, and government agencies.

Ms. Welch received her training in Job Site Analysis from ErgoRehab Incorporated. This certification was obtained by mail and through the Internet, and was paid for by Corvel. (PX 13)

Ms. Welch could not remember the last time she did any work on behalf of an injured worker, did not know the age of Pinckneyville Correctional Center, did not know that during the 5 to 7 years prior to the video being shot that the facility was short staffed, and admitted that the video was edited. (PX 13)

Ms. Welch also believed that it was a requirement that 20% of the entire staff rotate every 90 days. She did not take into account overtime and she mistakenly believed that the segregation unit was contained in the video that she filmed. The video did not show any of the locks that would not open, did not show how hard the locks were to open, did not show any bending or breaking of keys, did not show any new keys which were hard to put into the locks, and did not show the heaviness or the weight of the wing doors. (PX 13)

Ms. Welch testified that she had neither seen nor lifted a property box, and was completely unaware that they contained TVs, radios, books, paperwork, computers, clothing. She further acknowledged that the video showed nothing about Correctional Officers having to carry crates filled with cartons of milk or

juice weighing hundreds of pounds up flights of steps to feed inmates. When asked whether it would be important in consider whether a Correctional Officer had to carry a milk carton and/or food tray and simultaneously open and close difficult chuckholes that often stick, Ms. Welch answered, "I don't know, I didn't try it." She also believed that restraining a combative inmate at a Respondent's Pinckneyville Correctional Center would fall in the "medium" category of job requirements. (PX 13)

She further acknowledged that there was nothing in the Job Site Analysis or video about keying and un-keying doors for moving of inmates through the housing units in passes run on any given day; nothing about the transfer box, writs, medical furloughs, medical and furlough bags. Nothing was contained in the video about keying out passes for clothing, barber shop, and commissary, or weapons and tactical training. (PX 13)

She did not videotape or observe any cell shake downs and, in fact, believed that shake downs were performed on Correctional Officers themselves when they entered the prison. She did not video tape the Correctional Officers having to push buttons and operate toggles to open doors, which required the officers to hold down the button with their thumb and toggle the switch with their little and pinky fingers at the same time. She had no idea that this happened almost 250 times in an hour and thousands of times in a day. After going through all this information, Ms. Welch testified that whether Correctional Officers are constantly and repetitively using their arms and hands in a forceful manner depended on their post. (PX 13)

A Job Site Analysis performed of a Pinckneyville Correctional Lieutenant classifies the position as a medium level job, requiring lifting up to 50lb. with frequent lifting and/or carrying up to 25lb. It also shows that the physical demands of the job require frequent wrist turning, frequent grasping, frequent pinching, and frequent finger manipulation. Frequent is defined as 2.5 – 5.5 hours per day, between 34% and 66%. (RX 10)

A Demands of the Job form created by Respondent indicates that Petitioner uses his hands for gross manipulation between 0-2 hours per day, and fine manipulation between 0-2 hours per day. This form gives no details about the extent of lifting and/or carrying Petitioner performs with rest or the number of times per day. (RX 5)

At the commencement of the arbitration hearing herein Respondent objected to Petitioner's Exhibits #12 and 14-23 on the basis of relevance. Respondent's objections were to be addressed in the Arbitrator's Decision.

The Arbitrator concludes:

1. **The Admissibility of PX 12.** Respondent objected to the admissibility of PX 12 on the basis of relevance. PX 12 is an independent causation opinion of Dr. Williams pertaining to a separate claimant in a separate case. During his deposition in this case, Dr. Williams was asked about his testimony given in "10 WC 23567, James Phillips v. Pinckneyville Correctional Center." Dr. Williams answered the questions posed to him regarding that. At that time the deposition (PX 12) was not introduced for any reason. Accordingly, the Arbitrator sees no relevance in admitting PX 12 at this time and Respondent's objection is sustained. PX 12 is rejected.

2. **The Admissibility of PX 14 - 23.** These exhibits contain deposition transcripts and videotapes of various individuals taken in "10 WC 38807, Donna Jones v. State of Illinois, Pinckneyville Correctional Center" and "10 WC 223657, Jimmy Phillips v. State of Illinois, et. al." These depositions and video depositions were not taken in the case of Cecil Runyon v. Pinckneyville Correctional Center, and are hearsay according to Illinois Rule of Evidence 804 since Petitioner did not present evidence that these witnesses were unavailable to testify in this specific case. Therefore, this is not an exception to the hearsay rule. Respondent objected to their admissibility on the basis of relevance and the Arbitrator sustains the objections. It is axiomatic that the unique facts of each case must be closely analyzed in a repetitive trauma case. Thus, the issues herein center around Petitioner and not other employees or claimants. If Petitioner wished to have the testimony of these individuals included in the record, they should have testified live at trial or, alternatively, had their depositions taken in this case. PX 14 - 23 are rejected.

3. **Accident and Causal Connection.**

Petitioner has failed to prove he sustained a repetitive trauma accident on November 22, 2010 that arose out of and in the course of his employment with Respondent. As mentioned above, in the case of a repetitive trauma claim the unique facts of each case must be closely analyzed. Furthermore, while accidents can fall into one of two broad categories (specific v. repetitive) a claimant's credibility is always central to the case and it is axiomatic that a claim may be denied if a claimant's testimony is considered not credible because it is uncorroborated by, or inconsistent with, information contained in the medical records. A case of repetitive trauma should be no different -- that is, if the claimant's testimony regarding the onset of his problems is not corroborated by the medical records, then the arbitrator should feel she can conclude the claimant was not a credible witness. Indeed, in this instance, the Arbitrator concludes Petitioner was not a credible witness. His testimony concerning the onset of his symptoms in his hands and wrists is not corroborated by the medical records and the timing of his retaining of an attorney and initiation of medical treatment is suspicious, thereby casting doubt on Petitioner's overall motivation.

When Petitioner presented to Dr. Brown in November of 2010 he gave a <u>one year</u> history of numbness and tingling in both hands. He also associated the onset of his complaints with his job duties at Pinckneyville Correctional Center claiming he had worked there since 1984. Petitioner provided the same one year history of complaints to Dr. Phillips. In contrast, Petitioner testified that his symptoms began with his job duties at Pontiac which would date back to 1984, not 2009. Petitioner also testified that he went to Dr. Reyes before he was referred to Dr. Brown. However, Petitioner offered no corroborating medical report into evidence. There is a November 6, 2011 office visit with Dr. Reyes but it doesn't corroborate Petitioner's testimony. Petitioner did not have an explanation as to why the medical record from Dr. Reyes prior to November 22, 2010 was not contained in the exhibits. Additionally, concerning, is the information provided to Dr. Reyes in November of 2011 -- ie., that his problems were

"recurring" in 2009. Except for a reference to reduced function Petitioner did not present any detailed testimony as to the significance of 2009, the significance, if any, of the year before November 22, 2010, or explanation for a "recurrence." It was all rather vague. Rather, Petitioner pinpointed all of his hand/wrist problems to his initial job at Pontiac and a gradual worsening as time went on. Such a history is not found in any of the treating medical records. Compounding this inconsistency is the fact Petitioner went to an attorney before he sought any medical treatment and then presented to physicians with an already prepared type-written summary of his job duties (albeit a not completely accurate one). Petitioner's motivation is suspicious.

The Arbitrator further concludes that Petitioner has failed to prove that his bilateral carpal tunnel syndrome was a result of his work-related duties as a correctional lieutenant for Respondent, Pinckneyville Correctional Center. The Arbitrator was not persuaded by the testimony of Dr. Paletta. The job description given to Dr. Brown and Dr. Paletta was not an accurate representation of Petitioner's jobs or duties. While Dr. Brown noted in his initial office visit with Petitioner that he was familiar with Petitioner's job duties, generally, no additional information was provided from which one might conclude his opinion was a truly informed one. Furthermore, Petitioner misled Dr. Brown from the beginning when he indicated he had been working for Pinckneyville since 1984. He also gave him the impression his problems had begun in the previous year. Additionally, Dr. Paletta's opinions are unpersuasive. He was unfamiliar with Petitioner's job duties at Pontiac and rendered his causation opinion on a hypothetical set of facts which weren't supported by the record. When asked if he knew the differences in job duties, if any, between Menard and Pontiac Correctional Center, Dr. Paletta testified that he only knew what Petitioner's attorney has told him. (PX 11, p. 43)

Lastly, the Arbitrator notes Petitioner's comments to Dr. Paletta at the time of his initial examination. Dr. Paletta noted that Petitioner had retired on August 31, 2011 and that in the last few years before then Petitioner's job involved "a lot of continuous computer work." (PX 6) On cross-examination Petitioner was asked about his paperwork duties as a lieutenant and he testified that he wasn't much of a "paperwork lieutenant" as he was a "hands-on" guy. He estimated he spent a maximum of thirty minutes a day on paperwork. He later agreed that he may have spent up to two hours a day typing as a lieutenant. Once again, the history provided to Dr. Paletta, Petitioner's treating physician, is different than Petitioner's testimony as he downplayed the role of typing in his duties. Even then, Dr. Paletta testified that keyboarding in and of itself is no longer considered a causative or contributing factor in carpal tunnel syndrome. (PX 11, p. 34)

The bottom line is that Petitioner engaged in a variety of job duties that involved the use of his hands in different ways throughout the work day and over the life of his career with the Department of Corrections. None of the doctors ever had a full, complete, and accurate understanding of Petitioner's job history and duties and/or Petitioner's history as to the onset or development of his alleged symptoms. Petitioner bears the burden of proving all of the elements of his claim, including accident and causal connection. Based upon the foregoing,

Petitioner has failed to meet his burden of proof. All other issues raised at the hearing are moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Gasca,

Petitioner,

vs.

No. 09 WC 09871

15IWCC0368

City of Palos Hills,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. The circuit court remanded the matter "for specific findings on the issue of IMRF credit, if any." The Commission, after considering the issue of credit due to Respondent for the benefits paid to Petitioner by the Illinois Municipal Retirement Fund (IMRF), concludes that Respondent cannot establish an entitlement to the credit it seeks under section 8(j) of the Workers' Compensation Act. The Commission therefore vacates its previous award of section 8(j) credit in this matter. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

On March 4, 2009, Petitioner filed an application for adjustment of claim alleging multiple accidental injuries arising out of and in the course of his employment on October 20, 2007. Following a section 19(b) hearing, the Arbitrator filed a decision on October 18, 2012, awarding temporary total disability benefits, medical expenses, prospective medical care and section 8(j) credit. Regarding the credit, the Arbitrator found:

"Petitioner testified he began working for Respondent in 1976. Under Section 5.40(b)(2) of the IMRF, a member is allowed to receive workers'

compensation benefits and a non-reduced IMRF disability benefit under the following condition:

> The member has IMRF or reciprocal retirement system credit earned during the period from October 1, 1974 through September 30, 1977. If the member had service credit earned anytime during this period in effect on the date of his or her disability, the member will receive an unreduced disability benefit even though he or she is also receiving worker's compensation benefits. (Illinois Municipal Retirement Fund, Section 5.40(b)(2))

While Petitioner may fall within this exception based on his 1976 hire date the statute does not state that Respondent is not entitled to a credit for disability funds paid into the IMRF on Petitioner's behalf therefore, Respondent is entitled to its credit or an offset of those payments made, pursuant to section 8(j) of the Act."[1]

The Arbitrator therefore ordered that "Respondent is entitled to a credit of that amount paid for disability, on Petitioner's behalf, to his retirement fund pursuant to Section 8(j) of the Act." On April 30, 2013, the Commission affirmed and adopted the Arbitrator's decision. On judicial review, the circuit court entered an order on August 20, 2013, remanding the matter "for specific findings on the issue of IMRF credit, if any."

The issue at hand involves the interplay between the Workers' Compensation Act and the Illinois Pension Code. Petitioner testified he worked for Respondent for 32 years as of October 20, 2007, mostly in the department of public works. Following the work accident, Petitioner underwent extensive treatment. In 2008, while he was off work and collecting temporary total disability benefits, Petitioner started receiving disability benefits from IMRF of approximately $2,000.00 a month. In late May of 2011, Respondent stopped paying temporary total disability benefits. In September of 2011, Petitioner started receiving Social Security disability benefits, which reduced the amount of his benefits from IMRF. Respondent sought Petitioner's release to obtain his records from IMRF. Respondent maintained it was entitled to a credit under section 8(j) of the Workers' Compensation Act for the disability benefits that IMRF paid to Petitioner. At the time of the arbitration hearing, neither party had records from IMRF.

Section 8(j) of the Workers' Compensation Act provides, in pertinent part:

> "1. In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be

[1] The reference to section 5.40(b)(2) of IMRF apparently comes from an earlier edition of a manual published by IMRF.

credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. *** This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act.

* * *

2. Nothing contained in this Act shall be construed to give the employer or the insurance carrier the right to credit for any benefits or payments received by the employee other than compensation payments provided by this Act, and where the employee receives payments other than compensation payments, whether as full or partial salary, group insurance benefits, bonuses, annuities or any other payments, the employer or insurance carrier shall receive credit for each such payment only to the extent of the compensation that would have been payable during the period covered by such payment." 820 ILCS 305/8(j) (West 2007).

Turning to the Illinois Pension Code, section 7□222 of the article governing IMRF provides, in pertinent part:

"Whenever any person is entitled to a disability or survivor's benefit under this Article and to benefits under the Workers' Compensation Act [820 ILCS 305/1 *et seq.*] or the Workers' Occupational Diseases Act [820 ILCS 310/1 *et seq.*] in relation to the same injury or disease, the monthly benefits payable under this Article shall be reduced by the amount of any such benefits payable under either of those Acts, except payments for medical, surgical and hospital services, non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this State, and for artificial members or appliances, and fixed statutory payments for the loss of or the permanent and complete loss of the use of any bodily member." 40 ILCS 5/7□222 (West 2007).

Prior to 1974, the Workers' Compensation Act contained a pension benefits reduction provision. In 1974, the legislature repealed the provision. However, in 1977 the legislature amended the Illinois Pension Code by enacting section 7□222 with respect to IMRF and similar provisions with respect to four other pension systems. In Gentry v. Illinois Municipal Retirement Fund, 182 Ill. App. 3d 494, 496 (1989), the appellate court explained: "An examination of the legislative history of section 7□222 of the Pension Code reveals the deduction clause was intended to apply to temporary disability benefits. Public Act 80□903, effective September 21, 1977, amended statutes relating to five of the State's pension systems, including the Retirement Fund (1977 Ill. Laws 2602). The purpose of the act was to avoid the double benefits then possible under the pension system and the Workers' Compensation Act. (80th Ill. Gen. Assem., Senate Proceedings, June 22, 1977, at 327 (statements of Senator Glass))." As to the employees who made pension contributions during the time period between the repeal and reenactment of the reduction provisions, the appellate court held their pensions would not be offset by the workers' compensation benefits. See Taft v. Board of Trustees of the Police Pension Fund of the Village of Winthrop Harbor, 133 Ill. App. 3d 566 (1985); Gualano v.

City of Des Planes, 139 Ill. App. 3d 456 (1985); Carr v. Board of Trustees of the Police Pension Fund of Peoria, 158 Ill. App. 3d 7 (1987).

The question of whether a municipal employer should be allowed a credit in a workers' compensation case for payments made to the claimant by the municipal pension fund was addressed under the pre-1974 statutory scheme by the supreme court in Village of Streamwood Police Department v. Industrial Comm'n, 57 Ill. 2d 345, 351-52 (1974). The court considered section 8(j)(1) of the Workers' Compensation Act and held: "We believe it is apparent that the foregoing credit provisions are inapplicable to this case, where there has been no showing that the Policemen's Pension Fund benefits are limited to occupationally related disabilities. Presumably they are not, and therefore the last sentence of the quoted language renders the entire paragraph inapplicable." Next, the court turned to the pension reduction provision, noting the provision "does not purport to establish a credit against an employer's statutory obligation to pay workmen's compensation benefits." Rather, there might be a question of reimbursing the pension fund for the benefits it paid. As that issue was not before the court, the court concluded: "[U]nder the facts of this case there is no statutory authority for allowing the [employer] credit against its obligation to claimant under the Workmen's Compensation Act."

Recently, the appellate court in Wood Dale Electric v. Workers' Compensation Comm'n, 2013 IL App (1st) 113394WC, construed section 8(j)(2) of the Workers' Compensation Act. The appellate court held an employer is not entitled to a credit for payment of "normal pension retirement benefits, wholly unrelated to the claimant's workers' compensation accident." The appellate court relied on its decisions in Tee-Pak, Inc. v. Industrial Comm'n, 141 Ill. App. 3d 520 (1986) and Elgin Board of Education School District U-46 v. Workers' Compensation Comm'n, 409 Ill. App. 3d 943 (2011). In Tee-Pak, the employer sought section 8(j) credit for the full salary it paid the claimant while he was off work. The employer's accounting manager testified the sick pay benefits were payable regardless of whether the claimant was injured at work. The appellate court reversed the award of section 8(j) credit, explaining: "Because [the employer] failed to show that these benefits are limited to occupationally related disabilities, the credit section of the Act does not apply." Tee-Pak, 141 Ill. App. 3d at 529. In Elgin, the employer also paid the claimant a full salary while she was off work. This time, the appellate court reversed the denial of section 8(j) credit, explaining: "This case is distinguishable from Tee Pak, Inc. In Tee Pak, Inc., there was evidence from which the Commission could infer that the employer intended its employees to collect *both* TTD benefits and salary payments for the same period of time. Tee Pak, Inc., 141 Ill. App. 3d at 529. In the present case there was no evidence that respondent had in place a similar policy. Thus, the limitation of section 8 imposed in Tee Pak, Inc. does not apply here." Elgin, 409 Ill. App. 3d at 954 (emphasis in original).

In the instant case, Petitioner testified he worked for Respondent for 32 years as of October 20, 2007. Petitioner asserts he belongs to the class of employees whose IMRF benefits are not reduced by the workers' compensation benefits. There is nothing in the record to the contrary. Since Petitioner has the right to receive benefits from IMRF irrespective of any recovery for a work injury (in other words, he has the right to collect both IMRF benefits and workers' compensation benefits), Respondent cannot establish an entitlement to a section 8(j) credit.

15IWCC0368

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission's previous award of section 8(j) credit in this matter 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 shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

DATED: MAY 20 2015
d-04/30/2015
SM/sk
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

Elliott Daymon,
Petitioner,

vs.

NO: 13 WC 13491

Vienna Correctional Center,
Respondent.

15IWCC0369

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

The Commission agrees with the Arbitrator's ultimate conclusion and the analysis contained within the decision and further expounds on the application of the evidence contained within the case to the proper legal theory. The Commission notes that the Arbitrator was correct in addressing the feasibility of the application of a neutral risk standard to the evidence presented to the Commission. Furthermore, the Arbitrator was correct in holding that neutral risks are compensable under the Act when an employee is exposed to either a qualitative or quantitative risk to a greater degree than the general public. Having reviewed the evidence at hand, the Commission finds that since Petitioner testified that he was filling in for someone else at the time of the incident there was no quantitative risk that subjected him to a greater exposure than a member of the general public. Additionally, since Petitioner was unable to clearly identify any alleged defect caused by employer, there was no qualitative risk as well. As such, the Commission finds that the evidence supports a finding of a non-compensable neutral risk which has no particular employment or personal characteristics. Additionally, the Commission finds that the Arbitrator only addressed Petitioner's testimony and the histories contained in the medical records and she did not address the contemporaneous incident reports consisting of the March 25, 2013 employee injury report, the March 26, 2012 Form 45 report of accident and the April 24, 2013 Application for Adjustment of claim. Having reviewed these reports along with

15IWCC0369

Petitioner's testimony and the histories contained in the medical records, the Commission finds that they only support the fact that the chair rolled out from underneath Petitioner and not the fact that the chair bound up or was defective in anyway. As such, the Commission finds that the incident should be classified as a non-compensable neutral risk.

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

No bond or summons for the State of Illinois.

DATED: MAY 2 0 2015

MB/jm

O: 4/30/15

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAYMON, ELLIOTT
Employee/Petitioner

Case# **13WC013491**

15IWCC0369

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

On 7/3/2014, 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:

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
KENTON OWENS
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

JUL 3 - 2014

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

15IWCC0369

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elliott Daymon
Employee/Petitioner

v.

State of Illinois/Vienna Correctional Center
Employer/Respondent

Case # **13** WC **13491**

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0369

FINDINGS

On **March 25, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,816.00**; the average weekly wage was **$881.07**.

On the date of accident, Petitioner was **30** 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 $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

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

ORDER

Petitioner failed to prove he sustained an accident that "arose out of" his employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

June 30, 2014
Date

JUL 3 - 2014

ELLIOTT DAYMON V. STATE OF ILLINOIS/VIENNA CORRECTIONAL CENTER, 13 WC 13491

FINDINGS OF FACT AND CONCLUSIONS OF LAW

THE ARBITRATOR FINDS:

At the time of the alleged accident, Petitioner was a 29-year-old Correctional Officer for Respondent. Petitioner testified that on March 25, 2013, he was sitting in a chair in Unit 3A supervising inmates. Petitioner testified that this was not his regular job and he was simply filling in for someone. Petitioner testified (with the aid of photographs-RX 2) that there was a desk attached to the wall on his right and a phone box above that desk at the "one o'clock position." Petitioner further testified that the phone rang and when he reached out to answer the phone and as his hands got to the phone, his chair "popped" and there was a "malfunction" in the rolling wheel of his chair, and his chair "ejected" and shot out from underneath him, with Petitioner's feet sliding up and down on the floor. Petitioner testified that he did not believe the accident would have happened if the wheel on his chair hadn't caught.

On cross-examination Petitioner acknowledged that he never got to answer the phone because of the incident. Petitioner testified that he felt immediate pain after falling but acknowledged that nothing prevented him from standing up and answering the phone; however, he just didn't. Petitioner further testified that the roller on the chair didn't catch; rather, it stopped and then it just "popped." Petitioner was unaware of a crack in the floor or any debris. Petitioner did not immediately seek attention at the healthcare unit.

Petitioner completed a Notice of Injury on March 26, 2013. According to Petitioner's handwritten statement, the phone rang and as he stretched to answer it the chair (with rollers at bottom) "got into a bind" and quickly shot out from under him. (RX 1) Petitioner listed his low back as the area of injury as he felt immediate back pain with radiating pain down his leg.

Petitioner testified that as a result of the accident, he developed chronic low back pain radiating into his left thigh and his right leg and numbness in his right foot. Petitioner testified that his right foot numbness was a new symptom, and that his back pain after the incident on March 25th was more extensive and chronic in nature than the pain he had experienced after a former back injury in 2009. Petitioner testified he required no treatment for his back from 2010 until March 25, 2013.

Petitioner sought treatment for his injuries the following day with his primary care physician, Dr. Matthew Winkleman, who noted findings of motion induced pain, decreased range of motion, and tenderness to palpation over Petitioner's lumber spine. Dr. Winkleman prescribed steroid anti-inflammatory medication and narcotic muscle relaxer, and ordered lumbar x-rays and physical therapy. X-rays were negative, but Petitioner continued to report symptoms of radicular pain with intermittent numbness in his left foot.

As of April 10, 2013 Petitioner was told to continue with his therapy and return to see the doctor in one month. In the interim, his restrictions remained in effect. (PX 3)

Petitioner signed his Application for Adjustment of Claim on April 17, 2013. (AX 2)

Petitioner began physical therapy on April 30, 2013. According to the history Petitioner hurt his back when he "had a chair roll out from underneath him." (PX 4)

On May 8, 2013, Dr. Raskas examined Petitioner. According to the history Petitioner went to reach and answer a phone while seated in a chair when the chair slid out from under him causing him to fall onto a concrete floor. (PX 5) Dr. Raskas diagnosed Petitioner with a lumbar strain and possible radiculitis and prescribed ongoing physical therapy and restrictions. Physical examination showed persistent pain limiting range of motion and tenderness to palpation in the sciatic notch. The MRI scan of Petitioner's lumbar spine revealed a small central herniated disc with an annular tear at L5-S1. Dr. Raskas recommended injections. (PX 5, 6, 7)

As of May 16, 2013 Petitioner reported no great change in his level of pain since beginning physical therapy although he was moving better and tolerating stationary position for a longer period of time. (PX 4)

Petitioner's level of pain decreased from a 6 to a 3 following the injections. Petitioner was placed at maximum medical improvement on August 9. 2013. (PX 5)

Petitioner testified at arbitration that he continues to experience chronic low back pain which intermittently radiates into his legs along with numbness in his foot. Petitioner testified that he experiences pain while engaging in his hobbies. Petitioner testified he is unable to sit or stand for prolonged periods of time without alternating his position. When standing on his feet eight hours a day Petitioner finds he must sit down multiple times. Petitioner testified that this has impacted the performance of his job duties with Respondent and his second employer. Petitioner notices immediate discomfort when he has to restrain inmates in the course of his job with Respondent. Petitioner's second job as a part-time police officer requires him to sit for prolonged periods of time during patrols. He now has to take many breaks, but did not do so before. Petitioner now experiences difficultly sleeping and can no longer lie on his stomach or right side without pain. Petitioner uses a body pillow between his knees and takes sleeping medication to get comfortable enough to sleep. According to Petitioner his ability to recreate with his young children has also been adversely affected. Petitioner takes prescription Tramadol in addition to his sleeping medication for his symptoms.

THE ARBITRATOR CONCLUDES:

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

To obtain benefits under the Act, Petitioner must prove by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment with Respondent. 820 ILCS 305/1(d). There is no dispute as to whether Petitioner was in the course of his employment while injured; rather, the analysis focuses on whether or not Petitioner's injuries "arose out of" his employment with Respondent.

An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work ***or*** that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.* Specifically, the Court has acknowledged the existence of three categories of risk: (1) risks distinctly associated with her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 290 (4th Dist. 2013). Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Id.* This increased risk may be qualitative, such as some aspect of employment that contributes to risk, or quantitative, such as the number of times they are required to encounter the risk. *Id.* Liability is also generally imposed where an injury occurs as a direct result of a hazardous condition on the employer's premises. *USF Holland, Inc. v. Industrial Commission*, 357 Ill.App.3d 798, 829 N.E.2d 810 (1st Dist. 2005).

Petitioner never clearly testified as to any alleged defect in the chair located at his work station. Petitioner agreed there was no defect or debris on the floor. In explaining what occurred Petitioner referred to a roller getting "caught," "in a bind," and/or the wheel "malfunctioning" but with no further explanation as to how it got caught, what he meant by "a bind" or how the wheel malfunctioned. Petitioner did testify that the chair "ejected" and shot out from under him. The medical records and injury report suggest the chair slid out from under him. Based upon Petitioner's description of the accident the Arbitrator could reasonably infer that as Petitioner reached (rather than stood up) to answer the phone located above the desk he may have had to stretch to do so (because he was sitting in the chair) and the chair simply rolled out from under him. Reaching is an ordinary activity of daily life. This was not Petitioner regular job as he was filling in for someone. Petitioner did not establish that he was subject to a greater risk of injury.

It is Petitioner's burden to prove that his accident "arose out of" his employment. The Arbitrator concludes that Petitioner failed to meet his burden of proof. Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Carol Riggs,

Petitioner,

vs.
Martin & Bayley, Inc. d/b/a Hucks,

NO: 10 WC 11243

15IWCC0370

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 18, 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.

15IWCC0370

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

DATED: MAY 20 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:3/25/15
43

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

RIGGS, CAROL
Employee/Petitioner

Case# **10WC011243**

15IWCC0370

MARTIN & BAYLEY INC D/B/A HUCKS
Employer/Respondent

On 9/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1312 BEMENT & STUBBLEFIELD
GARY BEMENT
PO BOX 23926
BELLEVILLE, IL 62223

0734 HEYL ROYSTER VOELKER & ALLEN
JOE GUYETTE
102 E MAIN ST SUITE 300
URBANA, IL 61801

15IWCC0370

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)

Carol Riggs
Employee/Petitioner

v.

Martin & Bayley, Inc. d/b/a Hucks
Employer/Respondent

Case # 10 WC 11243

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Nancy Lindsay, Arbitrator of the Commission, in the city of Collinsville, on July 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 _____

15IWCC0370

FINDINGS

On the date of accident, **11/27/09**, 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 **$37,492.00**; the average weekly wage was **$708.98**.

On the date of accident, Petitioner was **49** 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 $- for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

Respondent is not entitled to a general credit under Section 8(j) of the Act for any medical bills paid by its group medical plan.

ORDER

Petitioner failed to prove that her condition of ill-being in her spine after May 5, 2011 is causally connected to her work accident of November 27, 2009. Prospective medical care is denied.

Respondent shall pay the medical bills found in PX #1 which were incurred by Petitioner through May 5, 2011, subject to the Medical Fee Schedule as provided in Sections 8(a) and 8.2 of the Act. As stipulated, Respondent shall receive credit for any medical bills it has paid.

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

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

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

Signature of Arbitrator

September 14, 2014
Date

ICArbDec19(b)

SEP 18 2014

CAROL RIGGS V. MARTIN & BAYLEY, INC. D/B/A HUCKS, 10 WC 11243 (19(B))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner was involved in an undisputed accident on November 27, 2009. At the time of arbitration Petitioner was seeking prospective medical care and payment of certain medical bills. Respondent disputes liability for both based upon causal connection. Petitioner was the sole witness testifying at the hearing.

The Arbitrator further notes that PX 5 (medical records from The Orthopedic Center of St. Louis) was not included in the Arbitrator's exhibits. However, records from The Orthopedic Center of St. Louis were included in Dr. Gornet's deposition (PX 9).

The Arbitrator finds:

Petitioner sustained an accident on November 27, 2009 when she was standing on a rubber mat, turned, twisted her left ankle causing the mat she was standing on to slide and Petitioner fell against a safe with her low back hitting the safe. Petitioner left work early.

Several days later Petitioner underwent a hysterectomy and other surgery for which she was briefly off work. She then resumed working for Respondent. (PX 9, Pet. Group 2)

Petitioner underwent a physical therapy evaluation on December 23, 2009 per the recommendation of Dr. Stiehl, the doctor Petitioner was treating for due to a right shoulder injury that occurred in July of 2009. During the evaluation Petitioner also reported slipping in November at work and hitting her back on the corner of a safe. Petitioner complained of pain throbbing down her low back into her tailbone (left more than the right) as well as pinching. Petitioner also reported numbness in her hand and some initial right leg numbness. Petitioner had undergone a "NCT" but was unsure of the results, had been diagnosed with breast cancer, and undergone a hysterectomy three weeks earlier. Physical therapy was recommended on both her shoulder and low back based upon the physical examination and objective findings. (PX 6)

Petitioner returned for physical therapy on December 30, 2009 reporting improvement in her right shoulder but a lot of pain in her low back and pain radiating down into both of her legs. (PX 6)

Petitioner also presented to Dr. Zahoor on December 30, 2009, over one month after the claimed accident. (RX 1, PX 2). At that time, Dr. Zahoor recorded that Petitioner was 49 years old, complaining of "chronic lower back pain for past one month." (RX 1, PX 2). Dr. Zahoor's note does not include any reference to an accident at work or an acute onset of Petitioner's symptoms. (RX 1, PX 2). On physical examination Petitioner's lower back was tender and some spasms were noted. Straight-leg raising was positive on the right. According to the doctor's notes, Petitioner was already undergoing physical therapy but felt it was making her back worse. As part of that initial visit, Dr. Zahoor ordered an MRI of the lumbar spine. (RX 1, PX 2).

The MRI ordered by Dr. Zahoor took place on December 31, 2009. (RX 1, PX 2). It revealed facet joint degeneration at L4-5 and L5-S1 with early disc degeneration at L4-5 and L5-S1. (RX 1) The MRI did not show any disc herniation, and did not reveal any acute injuries. (RX 1) On the left side of the MRI report, Dr. Zahoor's handwritten notes indicate his impression of "arthritis," and that the study was "otherwise OK." (RX 1) Further, Dr. Zahoor noted that a referral to orthopedics could be made if Petitioner continued to have

pain. (RX 1) An additional note indicated Petitioner had been advised of the results and Petitioner wished to discuss the matter with her husband. (RX 1)

Petitioner attended physical therapy on January 6, 2010 reporting constant pain in her right shoulder but low back pain only with movement. Petitioner also reported that her MRI reported arthritis but no other injuries. (PX 6)

On January 12, 2010 Dr. Zahoor referred Petitioner to Dr. Gornet. (PX 2)

When Petitioner first saw Dr. Gornet on February 8, 2010, she completed a "medical information" form. (PX 9) On that form, Petitioner indicated that she had suffered a work-related injury on November 27, 2009. (RX 9) Further, Petitioner indicated that she fell into a safe, and that she was not currently disabled. Dr. Gornet noted her chief complaints were bilateral low back pain, bilateral buttocks pain, and radiating pain and tingling down both legs. Petitioner had reported her accident several days after it occurred as the accident occurred the day after Thanksgiving and most of her supervisors were away on holiday. She had then stopped working several days thereafter due to undergoing a hysterectomy and "other surgery." Petitioner had returned to work but noticed a constant low level of pain worse with bending, sitting and prolonged standing. Petitioner reported she had "tried three weeks of physical therapy" but this made her leg symptoms worse. She acknowledged a history of a brief period of low back pain following a fall ten years earlier. Dr. Gornet examined Petitioner and reviewed an MRI from December 31, 2009 which showed no evidence of significant disc herniation, subtle foraminal stenosis developing at L5-S1, and a suggestion of possibly an annular tear at L5-S1 centrally, but no large disc herniation noted. He recommended conservative care including steroid injections at L5-S1 and that she could continue working full duty. He felt her current symptoms were causally connected to her Novembe 27, 2009 accident. (PX 9)

Petitioner met with Dr. Boutwell on February 15, 2010 regarding her complaints of low back and bilateral lower extremity pain. Petitioner attributed her complaints to her November 27, 2009 accident when she fell into the safe and experienced immediate bilateral lower extremity and low back pain which had worsened over time. She acknowledged some low back pain ten years earlier after slipping and hitting a counter but she claimed to have fully recovered. Petitioner was continuing to work full-time for Respondent. Dr. Boutwell recommended epidural steroid injections at L4-5 L5-S1, for Petitioner's pain complaints. Petitioner was given an injection in the right L4-5 transforaminal space. (PX 4, PX 8)

Petitioner underwent a physical therapy evaluation for her right shoulder and neck on March 8, 2010. Petitioner reported she injured her shoulder and neck at work in July and November of 2009. Petitioner's shoulder pain was from mopping and in November she slipped and hit her back on a corner of a safe. Petitioner reported undergoing surgery on January 27, 2010 and that she had returned to her physically demanding job full duty. Petitioner reported pain with certain tasks but could not elaborate further. Dr. Stiehl had performed the recent surgery. No low back complaints were mentioned. (PX 6)

Petitioner signed her Application for Adjustment of Claim on March 9, 2010. (AX 2)

Petitioner underwent injections with Dr. Boutwell on March 29, 2010 and April 19, 2010 (both at L5-S1 and L4-5) (PX 8).

At her March 29, 2010 visit with Dr. Gornet, Petitioner reported improvement in her symptoms and Dr. Gornet recommended she undergo her third injection as the goal was to improve her quality of life. She was to return in six weeks. (PX 9)

Petitioner continued to undergo physical therapy and to work for Respondent. As of April 20, 2010 Petitioner was declining to perform certain exercises during therapy due to arm complaints. It was noted she was scheduled to see her surgeon on April 23rd to discuss it further. Additional therapy was stayed pending the appointment. (PX 6)

As of her May 13, 2010 visit with Dr. Gornet Petitioner had undergone the third injection and was working full duty. She reported intermittent bouts with sharp back pain and a give away sensation in her legs. Petitioner's physical exam was normal for strength and sensation, her MRI described as "really fairly benign." Petitioner was to return in two months. (PX 9)

As of July 12, 2010 Petitioner's complaints were noted by Dr. Gornet to be relatively unchanged and she was told to follow-up as needed or, if necessary, in December a new MRI scan could be done. Petitioner remained working on full duty. She continued to report significant low back pain in September of 2010 and another injection and an MRI were recommended. Petitioner was still working full duty. (PX 9)

Petitioner underwent further injections with Dr. Boutwell on September 22, 2010; October 8, 2010: and October 28, 2010 (PX 8).

Petitioner underwent a second MRI on November 1, 2010 which revealed a left herniated disc at L4-5 and a minimal disc bulge at L5-S1. (PX 7)

Dr. Gornet examined Petitioner on November 1, 2010 noting right-sided complaints but commenting that her recent MRI showed disc pathology on the left more than the right. Petitioner's complaints were right buttock, hip and leg pain. As she had responded well to her injection, he recommended ongoing conservative care. He also felt Petitioner could continue to work full duty. (PX 9)

Still experiencing problems with her right shoulder since surgery, Petitioner underwent a right shoulder arthrogram on December 21, 2010. (PX 7)

Petitioner followed-up with Dr. Gornet on March 7, 2011, approximately four months since her last visit. Petitioner had tried and failed some injections. She had noticed some relief. He wrote, "She continues to do well." Petitioner's primary complaint was intermittent low back, right buttock, and right leg pain. He felt her disc pathology at L5-S1 was left more than right but did correlate with some of her right buttock pain. He felt she should continue working full duty and be observed. (PX 9)

Petitioner returned to see Dr. Gornet on May 5, 2011. Petitioner was reporting ongoing buttock, back, (intermittent) right leg pain, and (occasional) left leg pain. He reassured her and felt that as long as she was coping moderately well, he recommended no further treatment. Petitioner was to return as needed. He kept her at full duty. (PX 9)

Petitioner underwent a cervical spine x-ray on July 5, 2011, at the request of Dr. Milne. (PX 9)

On October 24, 2011 Petitioner was attempting to reach a soda bag on a top shelf and the bag came flying out striking her on the right side of her face, neck, and right shoulder. (RX 2)

A cervical spine x-ray was taken on October 31, 2011 at Salem Family Health. It revealed degenerative changes with mild neuroformen stenosis. (PX 2)

On November 23, 2011 Petitioner returned to see Dr. Gornet. He ordered a new MRI which revealed left lateral defects at L4-5 and L5-S1 which could be iatrogene, though annular tears were suspected and facet arthropathy with some degree of foraminal narrowing at L4-5 and foraminal stenosis at L5-S1 was also noted. (PX 7)

Petitioner underwent physical therapy with Roger Young on four occasions between October 31, 2011 and December 16, 2011. (PX 2)

Petitioner received an additional seven injections from Dr. Boutwell between December 12, 2011 and June 7, 2013. (PX 8)

On April 13, 2012 Petitioner underwent an examination pursuant to Section 12 of the Act with Dr. deGrange. (RX 3) According to the written report issued thereafter, Petitioner was being seen in regard to an October 24, 2011 injury to her face, neck and right shoulder). Petitioner's complaints at the time of the exam included low back pain with right lower extremity radicular symptoms which had begun several days after the October 24th accident but weren't immediately noticeable because of her neck and shoulder problems. Petitioner reported her neck and low back symptoms ere exacerbated by activities of daily living such as mopping, sweeping, carrying, repeated bending and twisting. Petitioner was working full duty having missed only about 3-4 days since the accident. Petitioner's back was examined with findings noted. Dr. deGrange identified a number of records he reviewed; however, he had no lumbar films. He did not feel Petitioner had injured her low back in the accident as she had no direct trauma to the lumbar spine. He felt she was at maximum medical improvement and needed no further medical care. He also felt she could return to work without any restrictions. Petitioner's diagnoses included cervical and lumbar sprains. (RX 2)

Dr. deGrange issued another report on June 14, 2012 which addressed the October 24, 2009 accident and his earlier report. His report contains no discussion of Petitioner's low back. (RX 3)

Dr. deGrange issued a third report on January 8, 2014 in which he indicated that he had diagnosed Petitioner was a lumbar strain and cervical strain as a result of the October 24, 2011 accident. However, he added that she would have reached maximum medical improvement for both conditions as of early December of 2011. He further indicated that Petitioner's lumbar strain was superimposed on a pre-existing degenerative condition unrelated to the October 24, 2011 accident. Petitioner's lumbar spine complaints were not, in his opinion, causally related to any alleged accident of November 27, 2009 nor did he fell Petitioner needed any treatment or restrictions due to a November 27, 2009 accident. (RX 4)

Dr. deGrange issued another report on January 24, 2014. In it he reviewed additional records from after November 27, 2009. He wrote that when he examined Petitioner on April 13, 2012 she didn't mention a November 27, 2009 accident only a work-related accident involving her right shoulder and at that time she had no complaints referable to her lumbar spine. Dr. deGrange then stated that the records he had recently been given did not document a low back injury in November of 2009. Any injury Petitioner would have sustained to her low back on November 27, 2009 would have been, in all probability, a soft tissue strain which would have quickly resolved. (RX 5)

Petitioner underwent a CT of the lumbar spine post discogram on October 4, 2013. (PX 7)

Dr. Gornet was deposed on May 12, 2014. (PX 9). It is Dr. Gornet's opinion that Petitioner's current symptoms are causally related to the accident of November of 2009. (PX 9, p. 11) Further, Dr. Gornet testified that

Petitioner has failed conservative care, and requires a spinal fusion at L5-S1 to resolve her symptoms. (PX 9, p. 11)

Dr. Gornet testified that he had treated Petitioner from February 8, 2010 through April of 2014. (PX 9, p. 4) Dr. Gornet explained that petitioner's initial complaints included back pain to both sides, down both legs to her feet, with tingling in her legs. (RX 9 pg. 5-6). Further, Dr. Gornet explained that Petitioner's symptoms were worse on the right side than they were on the left. (PX 9 pp. 5-6) In a visit on May 13, 2010, Dr. Gornet reviewed Petitioner's MRI of December 31, 2009. (PX 9, p. 21) Dr. Gornet characterized that MRI as "benign," and testified that there were no large pathologic problems and he felt he could manage Petitioner's problems conservatively. (PX 9 pp. 21-22) Approximately two months later, in July of 2010, Petitioner left Dr. Gornet's office without any plans for further treatment. (PX 9 p. 24) Instead, Dr. Gornet told her at that time that she could return of she was continuing to have problems. (PX 9 p. 24)

A subsequent MRI reviewed by Dr. Gornet included a finding of herniation on the right at L5-S-1. (PX 9, p. 32) The most recent MRI study, from September 2013, included a finding of facet changes on the right at L5-S1. (PX 9, p. 33) The original MRI, from December of 2009, did not include any reference to any pathology on the right.

Dr. Gornet testified that Petitioner told him "that she did have a history of low-back pain in the past after a previous fall 10 years ago." (PX 9, p. 19) In addition, Dr. Gornet explained that Petitioner initially reported the 11/27/09 accident "several days" after it occurred. (PX 9, p. 5)

Dr. deGrange issued another report on June 5, 2014 in which he addressed and reviewed records and the deposition of Dr. Gornet. There were also records from Dr. Milne who treated Petitioner for carpal tunnel syndrome. Dr. deGrange found no new or medically convincing arguments in the doctor's notes or deposition relating to his request for a fusion to Petitioner's October 2011 accident. He felt she needed no further treatment as a result of an accident on November 27, 2009. (RX 6)

At the arbitration hearing, Petitioner testified that she has worked at Respondent's grocery store in Salem for 12 or 13 years. For that entire period, Petitioner has been employed as the manager of the store. As the manager, Petitioner's duties include controlling the cash and inventory, keeping the store clean, and scheduling.

At arbitration, Petitioner testified that her accident occurred while she was at the front of the store, operating a cash register. Petitioner explained she was standing on a "stress mat," when she tried to turn. Petitioner testified that the mat slipped, she twisted her ankle, and fell backward into a metal safe. Immediately after the accident, Petitioner explained that she had pain going down her right buttock and leg, down her to her right foot. As a result of that pain, she left work before the end of her shift.

Petitioner did not initially seek treatment, because she "didn't want to have to turn a case in." Eventually, as a result of the ongoing pain, she sought treatment with Dr. Zahoor. Dr. Zahoor provided pain medication and a course of therapy, but the therapy sessions aggravated Petitioner's pain complaints. Because her symptoms were not improving, Petitioner sought additional treatment with Dr. Gornet, who had previously treated Petitioner's husband. Dr. Gornet referred Petitioner for epidural steroid injections with Dr. Boutwell, and periodically saw Petitioner to address her complaints of low back pain. At the time of arbitration, Petitioner testified that she believed her problem was getting worse, instead of better.

On cross-examination, Petitioner testified that she emailed her supervisor to report her accident, immediately after it occurred. Further, she denied any prior instances of low back pain. Petitioner testified that she was not previously injured in a fall, and denied reporting any prior low back problems to Dr. Gornet.

Petitioner acknowledged that on July 29, 2009 she suffered a rotator cuff tear for which she received treatment from Dr. Stiehl. She also underwent neck surgery with Dr. Milne. Petitioner continued working full duty for Respondent after her November 27, 2009 accident except for time she may have lost due to her right shoulder injury and surgery.

The Arbitrator concludes:

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

Petitioner has failed to establish that her current condition of ill being is causally related to the accident of November 27, 2009. It is Petitioner's burden to establish this causal connection by a preponderance of the evidence, and Petitioner has failed to meet that burden in this case.

Petitioner relies upon the testimony of Dr. Gornet whose causation opinion is based upon the history provided to him by Petitioner and the absence of any intervening trauma between November 27, 2009 and the date of his surgical recommendation. The problem is that Petitioner's history to Dr. Gornet is not accurate. Petitioner gave a different history to Dr. deGrange when she was initially examined by him on April 13, 2012. Petitioner acknowledged when she was examined by Dr. deGrange that she had an accident on October 24, 2011. Indeed, that was why the doctor was examining her. At the time of her visit with Dr. deGrange she told the doctor she was experiencing low back and bilateral radicular leg pain that had begun several days after her October 24, 2011 accident. She provided no information to suggest she was experiencing low back pain prior to October 24, 2011 and one may reasonably infer from the history she provided to him that she wasn't experiencing any low back pain before that date as she used the word "began" rather than "an increase" or "worsening" of prior back pain. In addition, Dr. Gornet's office notes support this. As of March 7, 2011 Petitioner was doing well and only experiencing intermittent symptoms. She was working full duty. As of May 5, 2011 Petitioner still had intermittent and occasional complaints but she was noted to be coping moderately well. Dr. Gornet recommended no further treatment and released her to return as needed. Petitioner then sought no further treatment from Dr. Gornet until six months later on November 23, 2011 (approximately one month after the October 24th accident) and relates "increasing" buttock and right leg pain. Thus, there was another accident after November 27, 2009 and Petitioner hasn't been forthcoming with Dr. Gornet. His causation opinion is based upon incorrect information and is, therefore, unpersuasive.

Additionally, there are some inconsistencies in Petitioner's testimony and records which are troublesome.

While Petitioner testified Dr. deGrange did not examine her low back on April 13, 2012 his report suggests otherwise as she had some positive findings.

Petitioner's accident occurred on November 27, 2009, but she failed to seek any treatment for over a month. When Petitioner finally saw Dr. Zahoor, she only indicated that she was having an exacerbation of chronic back pain, without any reference to an accident at work. Dr. Zahoor attributed this back pain to arthritis, again failing to mention any accident at work. After seeing Dr. Zahoor on December 30, 2009, Petitioner did not seek any treatment with any physician until seeing Dr. Gornet over two months after the claimed accident date.

The history provided by Petitioner to Dr. Gornet is contradicted by the history she provided to Dr. Zahoor. She failed to mention any accident at work when she saw Dr. Zahoor in December, but attributed her complaints to the accident at work when she saw Dr. Gornet the following February.

Additionally, Petitioner's arbitration testimony is contradicted by the medical records and the testimony of Dr. Gornet. Petitioner testified that she immediately contacted her supervisor to report the accident, but had told Dr. Gornet that there was a delay of "several days" before she told anyone about her accident. The delay in reporting the accident would be consistent with an insignificant injury, but Petitioner testified that she was in excruciating pain. It is illogical that Petitioner would wait over a month to seek any treatment for her claimed injury, if her testimony regarding the severity of her symptoms was credible.

At arbitration, Petitioner also denied ever having prior low back pain. Dr. Gornet not only testified that Petitioner had prior low back pain, but attributed that low back pain to a specific fall ten years earlier. Petitioner testified at arbitration that she had never previously fallen, and never had any prior low back pain.

Petitioner's accident was undisputed. While there are some inconsistencies in Petitioner's records and her testimony, given that Petitioner had some other medical issues around the time of this accident and noting that the December 23, 2009 physical therapy note referenced the accident and Petitioner's pain complaints, the Arbitrator gives Petitioner the benefit of the doubt and while not concluding Petitioner's current condition of ill-being is causally connected to her accident does conclude that she established a causal connection between her back condition and her work accident through her May 5, 2011 appointment with Dr. Gornet. This determination is based upon a chain of events and Dr. Gornet's records through that date. Dr. Gornet had an accurate understanding of her work accident and her condition through May 5, 2011. By that date Petitioner's condition appears to have plateaued. Even Dr. deGrange acknowledged that any injury that might have occurred on November 27, 2009 would have been a soft tissue strain in all probability (RX 5) While Dr. deGrange's reports were insightful within the context of causal connection and the October 24, 2011 accident, he knew very little about the November 27, 2009 accident nor did he review all of the records pertinent to that accident or get a history from Petitioner as to what occurred on November 27, 2009 or immediately thereafter.

J. Were 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 her causation determination above, Petitioner is awarded any and all medical bills incurred by her through May 5, 2011 as set forth in PX 1 and subject to the Medical Fee Schedule.

K. Is Petitioner entitled to prospective medical care?

Based upon the Arbitrator's causation determination prospective medical care is denied.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jack Lingenfelter,
Petitioner,

vs.

NO: 11 WC 30578

15IWCC0371

Cloverleaf Golf Course, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employer/employee relationship, accident, causation and additional compensation and attorneys' fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that, in order to determine whether an employer/employee relationship exists, a thorough assessment of the factors that compose the same needs to be made in this claim. While there are many factors for determining employer/employee relationship, the primary factors are the right to control the manner in which the work was done. Having reviewed the evidence in this case, it indicates that Petitioner was given a set of tasks to perform during the morning and on the weekends. The morning tasks composed the majority of the tasks he performed and these tasks were performed alone, in an independent manner and with no direct supervision. While Petitioner interacted with other employees at the course, these interactions only took place on an occasional basis. Primarily, they took place in the afternoon when he washed and put away golf carts. Brian Lawson, the vice president of the course, testified that while both the volunteers and employees were placed on a schedule, there were looser guidelines in regard to the tasks the volunteer performed and the hours in which they performed them as opposed to the paid staff whose schedules and tasks were more regimented. He further testified that there were additional tasks that were performed by the paid staff that were not assigned to the volunteers. These tasks included pulling crab grass, refilling the ball washers and working alongside a supervisor in bringing in damaged golf cart. Based on this evidence, the Commission finds very little control was imposed on Petitioner by the Respondent. In terms of the method of

payment, it appears that Petitioner bartered an exchange of his time for the ability to play golf gratis. The evidence contained nothing of the normal examples of agreed employment such as an employment application, W-9s or W-2s, vacation/sick time, insurance, retirement plans and the like. Rather, the evidence demonstrates Petitioner's efforts were compensated in a non-monetary fashion similar to a barter and trade rather than through the normal monetary compensation given for one's employment. In terms of the furnishing tools, materials and equipment, the evidence clearly demonstrates this was all provided by the Respondent in this case. In regard to the right to discharge, there is no evidence provided one way or another on this issue.

Having reviewed all of the factors related to the issue of an employer/employee relationship, the Commission finds that totality of the factors weigh against a finding of such a relationship. While there are some factors that weight favorable in terms of an employer/employee relationship such as the equipment provided and being placed on the schedule, the majority factors weigh against a finding of employer/employee in that there was little evidence of the exercise of control, no formal trapping of employment and no indication whatsoever of the right to discharge. Therefore, the Commission finds Petitioner failed to prove an employer/employee relationship existed on June 26, 2011.

In terms of the concurrent employment issue, the Commission finds that the evidence clearly shows that on June 26, 2011 Petitioner was on an employment related disability leave and that he had bartered/traded his services to keep busy, pursue a hobby as an avid golfer and to ensure that he did not jeopardize his disability benefits from a separate claim through receiving monetary compensation for his services. As such, the Commission finds that no concurrent employment was evident as of June 26, 2011.

Having found Petitioner did not meet the threshold requirement of establishing an employer/employee relationship exists, the Commission finds that it need not address the issue of additional compensation/attorneys' fees.

Lastly, the Commission notes that the Arbitrator found that Petitioner was not a credible witness based on his demeanor and inflections while testifying and due to the interplay between this claim and Petitioner's unrelated 2010 right eye injury. As the trier of fact and based on the Arbitrator's first hand observation of the Petitioner, the Commission defers to the Arbitrator's assessment of credibility.

In addition to the above paragraphs, the Commission affirms and adopts the remainder of the Arbitrator's decision.

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

15IWCC0371

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

DATED: MAY 2 0 2015

MB/jm

O: 4/30/15

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LINGENFELTER, JACK
Employee/Petitioner

Case# **11WC030578**

15IWCC0371

CLOVERLEAF GOLF COURSE INC
Employer/Respondent

On 6/18/2014, 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 0.07% 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:

4488 PERICA LAW FIRM
BOB L PERICA
229 E FERGUSON AVE
WOOD RIVER, IL 62095

1256 HOLTKAMP LIESE ET AL
JOHN P KAFOURY
217 N 10TH ST SUITE 400
ST LOUIS, MO 63101

15IWCC0371

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

Jack Lingenfelter
Employee/Petitioner

v.

Cloverleaf Golf Course, Inc.
Employer/Respondent

Case # 11 WC 30578

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 22, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [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. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **No-show fee/Dr. Joan Pernoud**

15IWCC0371

FINDINGS

On **June 26, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

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

Respondent is entitled to a credit of **$0** for any medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove an employee-employer relationship existed between the parties on June 26, 2011. Even assuming an employee-employer relationship, Petitioner failed to prove he sustained an accident on June 26, 2011 that arose out of and in the course of his employment with Respondent.

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

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

Signature of Arbitrator

June 18, 2014
Date

JUN 23 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

On August 23, 2010 Petitioner was employed by Bechtal Construction at Conoco Phillips earning $32.00 per hour. On that day Petitioner sustained an injury to his right eye when a roller frame broke, fell about 30- 40 feet and struck him in the right eye. Paint also went into his right eye. Petitioner testified that he was off work thereafter until the time of his alleged accident herein (June 26, 2011). Petitioner testified that during that entire time, Petitioner never returned to work and he received temporary total disability payments of $1050.00 per week. Petitioner testified that, as a result of that accident, he sustained a massive right corneal injury and became very sensitive to light and has to wear dark glasses all the time because he is now photophobic.

According to Petitioner in October of 2010 he was walked to the gate at Bectal and asked to leave his badge and stay off the job site until his right eye got better (ie., he was released).

On November 1, 2010 Petitioner filed an Application for Adjustment of Claim against Bechtel Construction Co. with regard to the above right eye injury. Petitioner's claim was denied and a hearing was held on April 12, 2011 before an arbitrator. In a decision entered on April 28, 2011 the arbitrator found that Petitioner sustained a work-related accident to his right eye on August 23, 2010 and that Petitioner's current condition of ill-being in his eye and his inability to return to work at the time of the hearing were causally related to the accident. Petitioner was awarded temporary total disability benefits of $1005.66 per week through the date of the hearing along with medical expenses and prospective medical care. (RX 8) The decision was appealed.

At the arbitration hearing herein, Petitioner, who candidly acknowledged that he is passionate about golf, testified that he knew Brian Lawson, Respondent's vice-president. Petitioner worked with Mr. Lawson at the Conoco Phillips refinery where they would see each other frequently while working. According to Petitioner, Mr. Lawson knew that Petitioner worked at Conoco Phillips refinery as a union painter and also knew that he had been hurt on the job and was off on temporary total disability. Petitioner testified that he approached Mr. Lawson inquiring as to whether anyone was looking for help at the golf course and was told to check with "Vernon" who ran the desk at the golf course. Petitioner testified that he called out there and subsequently filled out an application, submitted it and was hired as a "ranger."

Petitioner testified that his duties as a "ranger" included: showing up early in the morning and getting the carts out and ready to go; prepping ice coolers and delivering them to the stations out on the course; taking out trash; and "cruising" the course to make sure there was no slow play or monkeying around going on. Petitioner initially testified he worked six to eight hours a day but then said it "just depended." He worked about three days a week. Petitioner usually worked the weekends so that he could play golf there during the week. Petitioner tried to play as many rounds of golf as possible. Petitioner was not paid cash; rather, he was allowed to play unlimited golf and have unlimited use of a golf cart. [1]

Petitioner further testified that on the morning of his first day of work he saw Mr. Lawson and a female and he walked up to them and introduced himself to Mr. Lawson's mother, the owner of the golf course. Petitioner further testified that "right then and there" he explained to Mr. Lawson that he wanted to be sure Mr. Lawson's mother knew he was off on temporary total disability and had been hurt working for Conoco Phillips. Petitioner

[1] Eighteen holes of golf on weekends would cost $25.00 to $27.00 and during the week, the cost was $20.00.

testified that he further told Mr. Lawson that all he wanted to do was work out there and "trade and play golf" as he just wanted to keep up with his hobby and have something to do. Petitioner explained that he was scared that he was going to take a job and jeopardize his temporary total disability benefits but he loved playing golf so he thought "trading it out" was the way to go.

According to Petitioner Respondent posted his work schedule a week in advance so Petitioner would know when he was required to report for work. Respondent also provided all of the necessary equipment that Petitioner needed to perform his job duties at the golf course as a Ranger, which included a golf cart.

Petitioner testified that he told the "folks at Cloverleaf" that he wasn't working anywhere and that he was on workers' compensation but it was his intention to return as soon as he got released.

Petitioner testified he was working for Respondent as a golf course ranger on June 26, 2011, when he was hit in his left eye by a golf ball. On June 26, 2011, there was a golf scramble scheduled. Petitioner testified that he showed up early in the morning and proceeded to follow his usual routine. The scramble was scheduled to begin at 1:00 p.m. and Petitioner went out in a golf cart between the 12th and 14th holes and sat between the trees observing play. Petitioner testified that at one point he was watching the guys tee off and he turned his head sideways and the next thing he knew he was lying on the ground by the cart with a ball right next to him.

Petitioner testified that he drove himself back to the club house where he reported the incident and was provided with some first aid by clubhouse personnel. Petitioner was asked if he wanted an ambulance or wanted someone to drive him to the hospital but he declined. Petitioner testified he then attempted to drive himself to the hospital in his Corvette because he didn't want to leave it at the golf course. Petitioner got about a mile

down the road when he realized he could not drive and so he had his wife pick him up and take him to the hospital.

At the hospital Petitioner gave a history of being hit in the left eye by a golf ball (See Exhibit #1, #5). He was diagnosed with a large corneal abrasion on his left eye.

Petitioner was treated by a Board Certified Ophthalmologist, Dr. Chen, for his left eye injury the following morning. Dr. Chen had also treated Petitioner for his right eye injury. Petitioner testified that he continued to treat with Dr. Chen through the date of the hearing.

While Petitioner remained off work and after his left eye injury he reached a settlement of his right eye case which was pending on appeal. On December 23, 2011 Petitioner signed a settlement contract in case number 10 WC 42201. The contracts were approved on January 3, 2012. According to the settlement contract, disputes existed as to whether Petitioner's condition was related to his employment and whether he was able to work. Petitioner received $190,000.00 in settlement of any and all claims resulting from his August 23, 2010 accident and "any aggravating incidents involving Petitioner's eyes [emphasis added.] to date of approval of the settlement." (RX 9)

Petitioner testified that he has a huge cataract in his left eye that will eventually have to be removed. He further testified that he is unable to focus on anything with his left eye. He has bad depth perception. He also doesn't trust himself driving but he acknowledged that he is a Corvette enthusiast, and likes to take out his antique Corvettes on Sundays or during the week and drive up the river road but he has to be careful. Petitioner testified that he takes some eye medications (Durezol -- artificial tears; Lotemax -- an antibiotic; Besivance; and Xanax). Petitioner uses a magnifying glass to read but he acknowledged not being much of a reader. The Arbitrator notes that when asked about his medications, Petitioner was provided with a plastic bag of prescription medicine bottles. Petitioner advised that he had trouble pronouncing the names of the medications.

Petitioner then held the bottles approximately less than one foot away from his eyes and clearly read each letter off the individual bottles in an effort to spell the names.

Petitioner described himself as a golf fanatic. He loves the sport, it is outdoors, it is exercise, and it kills time for him. While his vision is poor he has learned how to play golf with his limited vision and even received some specialized training, from Steven Kramer,[2] in order to do so.

Petitioner testified that his right eye had healed well enough that he told Dr. Chen he had "intentions" of returning to work on August 1st.[3] He would be unable to work up high but felt he would be able to perform groundwork. According to Petitioner, now that he has injured his left eye he cannot get certified to return to work, even at ground level.

On cross-examination Petitioner acknowledged that he received no wages from Respondent, only free unlimited golf. Petitioner did not get a W-2 from Respondent. While the stipulation sheet claims Petitioner made $78,000.00 in earnings Petitioner acknowledged he was receiving disability benefits, and didn't pay taxes on $78,000.00. Petitioner also acknowledged that he had no written contract with Respondent. Petitioner is claiming that he should be entitled to concurrent wages from both his prior job at Bechtel Construction and for his alleged compensation from Respondent.

Petitioner testified that he still plays golf "all over the place." Since injuring his left eye Petitioner has not looked for any work.

Petitioner testified that he was late for a scheduled examination with Dr. Pernoud (Respondent's examining physician) because the insurance carrier provided him with the wrong directions.

Brian Lawson testified on behalf of Respondent. Mr. Lawson is Respondent's vice-president and operations manager. It is a family owned business which he has been a part

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[2] Mr. Kramer testified at length regarding his efforts with Petitioner.
[3] Petitioner didn't say in what year.

of his entire life. Mr. Lawson testified that Petitioner was considered to be a volunteer. Respondent has both employees and volunteers. Petitioner approached him in the Summer of 2011 about becoming a volunteer. He filled out a form to volunteer and was given part-time hours as that is what is typically done with volunteers. Regular employees have fixed schedules and longer hours. According to Mr. Lawson, Petitioner played more golf than he volunteered. It was Mr. Lawson's understanding that Petitioner was off work, wanted to fill his days, and had a passion about golf so he wanted to work some shifts in return for golfing. When asked if he had any control over Petitioner's duties as a volunteer, Mr. Lawson explained that he would have been given some general, or basic, guidelines to adhere to. Volunteers aren't policed. Petitioner never requested a W-2. Petitioner usually worked the weekends when there were tournaments.

The Arbitrator concludes:

Issue B. Was there an employer-employee relationship?

At the outset, the Arbitrator notes that in determining the issues in dispute she has also considered Petitioner's credibility and in that regard, she did not find Petitioner to be a credible witness. This is partially due to his demeanor and inflections while testifying and also due to the interplay between this claim and Petitioner's 2010 right eye injury.

Petitioner was working for Bechtal Construction on August 23, 2010 when he sustained a significant eye injury. When he was escorted off the company's premises in October of 2010 he was specifically told he was not being terminated and was to return when he got a full release. At the time of approval of his settlement contract in January of 2012 Petitioner still had not returned to work for Bechtal. His case was settled for $190,000.00. Petitioner testified that as of the date of his accident on June 26, 2011 he was still off work on account of his right eye injury and receiving $1050.00 per week in TTD benefits. When seen at the emergency room after the accident Petitioner's employer

was listed as Bechtel Construction and Petitioner made no specific mention of working for Respondent when hit in the left eye.

The Arbitrator finds it very strange and highly suspicious that Petitioner, claiming he was unable to work because of his 2010 eye injury and receiving over a thousand dollars per week in TTD benefits because of that accident, is now claiming he was Respondent's employee on June 26, 2010. Such a claim flies in the face of the terms of the 2012 settlement contract which indicates it is a final settlement of any and all claims resulting from Petitioner's accident of August 23, 2010 and any aggravating incidents involving Petitioner's "eyes" (emphasis mine) to date of approval of the settlement. Accordingly, the Arbitrator concludes that there was no employer-employee relationship between the parties on June 26, 2011. Petitioner volunteered his services to Respondent in order to fulfill his desire to play golf and to avoid any problem that might be caused by being employed by anyone. In addition, it appears that Petitioner was subject to minimal supervision and control by Respondent. No W-2 was issued.

Issue C. Did an accident occur on June 26, 2011 that arose out of and in the course of Petitioner's employment with Respondent?

Even assuming, arguendo, that an employer-employee relationship existed, Petitioner failed to prove that he sustained an accident on June 26, 2010 that arose out of and in the course of his employment with Respondent. While Petitioner did get hit by a golf ball on June 26, 2011 he failed to prove that his accident arose out of his employment with Respondent. Petitioner was subject to no greater risk than that of the general public when he was hit by the golf ball.

Issue O. No-show Fee/Dr. Pernoud.

Respondent is denied any credit for a no show fee regarding the first exam with Dr. Pernoud. Petitioner's testimony regarding the first exam was unrebutted and Respondent produced no evidence that it even paid a no show fee to Dr. Pernoud.

In light of the Arbitrator's decision on employer-employee relationship and accident, all other issues are rendered moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Derek Flatt,
Petitioner,
vs.
State of Illinois/Pinckneyville Correctional Center,
Respondent,

NO: 11 WC 33055

15IWCC0372

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, permanent partial disability, notice, 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.

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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

No bond or summons for the State of Illinois.

DATED: MAY 2 0 2015

MB/mam
o:3/26/15
43

Maria Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLATT, DEREK
Employee/Petitioner

Case# **11WC033055**

ST OF IL/PINCKNEYVILLE CORR CTR
Employer/Respondent

15IWCC0372

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:

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
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG - 7 2014

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

15IWCC0372

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

Derek Flatt
Employee/Petitioner

v.

State of Illinois/Pinckneyville Corr. Ctr.
Employer/Respondent

Case # **11** WC **33055**

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 6, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Admissibility of PX 9, PX 10**

15IWCC0372

FINDINGS

On **August 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 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 **$57,594.00**; the average weekly wage was **$1,107.54**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **any amounts paid by its group medical plan for which credit is allowed** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on August 8, 2011 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his left elbow is causally connected to his work accident and employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Hendricks
Signature of Arbitrator

August 4, 2014
Date

AUG - 7 2014

Derek Flatt v. Pinckneyville Correctional Center, 11 WC 033055

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to his upper extremity(ies) with an accident date of August 8, 2011. Petitioner's original Application for Adjustment of Claim alleged right and left hand injuries; however, at the time of arbitration Petitioner orally amended his Application for Adjustment of Claim to allege only a left elbow injury. (AX 2) The disputed issues are: accident; notice; causal connection; medical bills; nature and extent; credit for a prior award; and the admissibility of PX 9 and PX10. Petitioner was the sole witness testifying at arbitration. Mr. Jason Thompson appeared as Respondent's representative.

The Arbitrator finds:

Summary of the Medical Records and Pertinent Exhibits

Petitioner filed an Application for Adjustment of Claim against the State of Illinois Menard Correctional Center on November 17, 2005 alleging an injury on September 16, 2005. Petitioner's case went to arbitration and he was awarded 30% loss of use of the left arm, along with other benefits. (RX 4)

Petitioner was involved in an altercation at work on August 20, 2009 in which he was kicked in the face. Initially Petitioner experienced primarily neck and right arm pain but low back pain began the day after the altercation. (RX 3)

Petitioner's right elbow complaints were addressed by Dr. Ahn. Petitioner underwent physical therapy, work restrictions, and a steroid injection for those complaints. Dr. Ahn's diagnosis was right medial epicondylitis. Petitioner's therapy was occurred in September, October and November of 2009. (RX 3)

During the foregoing time period Petitioner filed an Application for Adjustment of Claim with the Commission alleging injuries due to his August 20, 2009 accident. That case went to arbitration (19(b) hearing) on November 10 2009. Petitioner was awarded temporary total disability benefits from August 21, 2009 through November 10, 2009, as he had been off work since the date of accident. (RX 1)

During the time Petitioner was undergoing therapy for his right elbow, he began treating with Dr. Matthew Gornet for back complaints. In February of 2010 Petitioner underwent an anterior decompression at L5/S1, anterior lumbar fusion at L5-S1 and a subsequent laminotomy at L5-S1, posterior fusion L5-S1. Petitioner was also experiencing some cervical and thoracic/mid back pain while being treated by Dr. Gornet but the focus of attention was primarily on the low back problem. As of his June 24, 2010 visit with Dr. Gornet Petitioner was, clinically, doing very

well. He remained temporarily totally disabled and aggressive physical therapy was to begin. Petitioner subsequently underwent physical therapy at NovaCare Rehabilitation during the summer of 2010. He completed his physical therapy on August 6, 2010. At that point in time Petitioner still had not returned to work but was hoping to in the upcoming month. (RX 3)

Petitioner underwent an independent medical examination with Dr. David Brown on October 26, 2010 with regard to his right elbow. According to Dr. Brown's report Dr. Ahn had previously treated Petitioner for post-traumatic right cubital tunnel syndrome/flexor mass and a medial collateral ligament strain v. a partial tear. Petitioner had also undergone a nerve conduction study in November of 2009 that was supportive of a diagnosis of right ulnar neuropathy at the elbow. Petitioner was continuing to complain of pain in the medial aspect of the elbow, decreased strength, and numbness and tingling in the right little and ring fingers. Dr. Brown diagnosed Petitioner with chronic right cubital tunnel syndrome associated with medial epicondylitis that had failed extensive conservative treatment. He recommended surgery and opined that Petitioner's condition was due to his August of 2009 work accident. Thereafter, Petitioner treated with Dr. Brown who performed right elbow surgery on January 20, 2011. Physical therapy followed. As of February 28, 2011 Petitioner was doing very well and was released to return to full duty as of March 1, 2011 without restrictions. (RX 3)

On April 10, 2011 Dr. Williams issued a report after having reviewed a job site analysis, written job description, and video of a corrections officer at Pinckneyville Correctional Center. Dr. Williams was of the opinion the job duties there would neither contribute to nor aggravate carpal tunnel syndrome. (RX 7)

In another report dated April 18, 2011 Dr. Williams further opined the job duties at Pinckneyville would not causally relate to cubital tunnel syndrome. (RX 6)

On April 13, 2011 Petitioner's case in 09 WC 40031 proceeded to arbitration on the issues of permanency. The Arbitrator awarded Petitioner 22.5% man as a whole and 20% loss of use of the right arm. In his decision he noted that Petitioner had been released to return to work with regard to his back on November 1, 2010 and as to his elbow on March 1, 2011. The Arbitrator also noted that Petitioner testified to moderate ongoing pain with activities. Petitioner's hobbies of basketball, tennis and motorcycle riding had been curtailed. His weightlifting and running have been eliminated. Petitioner noticed right elbow symptoms at work, especially when turning keys and pushing and pulling heavy doors. Petitioner was also taking over the counter medication and occasional Hydrocodone for mid and low back complaints. (RX 2)

On August 23, 2011 Petitioner signed his Application for Adjustment of Claim in this matter alleging repetitive trauma with an accident date of August 8, 2011. According to the Application Petitioner alleged injuries to his bilateral hands. (AX 2)

On September 12, 2011 Petitioner was examined by Dr. George Paletta, Jr. In conjunction with the visit, Petitioner completed a Patient Health Questionnaire in which he stated he was being

seen that day for "numbness and pain in both hands and left elbow." Petitioner also indicated the problem began "year or 2 ago?". Petitioner's exercise routine was noted to include running, weights, and sports. (PX 3)

When examined by Dr. Paletta that day, Petitioner's main complaint was left elbow pain. Petitioner also complained of numbness and tingling extending into the fourth and fifth fingers of his left hand. Petitioner reported mild symptoms on the right side but otherwise doing reasonably well after right elbow surgery with Dr. Brown. According to Dr. Paletta's note, Petitioner was a corrections officer who had worked at Menard Correctional Facility up until about two months earlier when Petitioner transferred to Respondent's facility. Petitioner gave a history of experiencing the onset of symptoms a year or two earlier while at Menard where his job duties included bar rapping, keying cells, opening and closing cell doors, cuffing and uncuffing inmates, writing reports and tickets and restraining inmates as necessary. Petitioner's symptoms were reportedly gradual in onset but had reached a point where he had a lot of complaints including nocturnal symptoms. He also noted some symptoms with activities of daily living. Petitioner was noted to be fit and well muscled. An EMG/NCS performed that day showed electrophysiologic findings consistent with left cubital tunnel syndrome. Petitioner's examination showed tenderness along the cubital tunnel and a positive ulnar nerve compression test and Tinel's sign. Dr. Paletta diagnosed Petitioner with left cubital tunnel syndrome and recommended a night splint given the nocturnal symptoms. He also recommended conservative treatment. Dr. Paletta opined that Petitioner's condition was causally related to, or aggravated by, Petitioner's job activities. In the interim, Petitioner could continue working full duty. (PX 3)

Dr. Phillips' EMG/NCS included a history in which Petitioner, who is right handed, related an 18 month history of progressive bilateral elbow pain with intermittent numbness involving the last two fingers. Petitioner's major complaint was sharp left lateral elbow pain. On examination, Petitioner had some tenderness over the left lateral greater than medial epicondyle. A Tinel's sign was not elicited with a normal degree of pressure. Petitioner's hands were noted to be callous from weightlifting. Upon testing Dr. Phillips noted mild demyelinative ulnar neuropathy across the left elbow. (PX 3, PX 4)

On August 25, 2011 Petitioner and his supervisor, Major Pickering, completed an Incident Report. Petitioner gave an accident date of August 8, 2011. Petitioner indicated that he had contacted Dr. Paletta's office on August 8, 2011 concerning pain and numbness in both his hands and left elbow. Petitioner further indicated that he advised Dr. Paletta that he worked for the IDOC since Nov. 1977 at Pontiac CC and Menard CC where bar rapping, manually unlocking doors, manually pulling open door is part of daily duties. Dr. Paletta then advised him to have a nerve conduction test done to test for possible repetitive motion injury. That test was scheduled for 9-7-11. (PX 6)

On September 13, 2011 Major Pickering completed a CMS Supervisor's Report of Injury regarding Petitioner's complaint of pain/numbness in both hands and left elbow. Major Pickering also completed a Demands of the Job form for the job title of "Officer." (PX 6)

On October 5, 2011 Petitioner completed a CMS Employee's Notice of Injury alleging an injury to his left elbow. Petitioner indicated in the form that he notified his supervisor, Major Pickering, on August 25, 2011 about his injury. He gave an accident date of August 8, 2011. (PX 6)

On December 16,, 2011 Dr. James Williams issued a report based upon a review of records concerning Petitioner. (RX 13)

The deposition of Dr. James Williams was taken on December 28, 2011. Respondent had Petitioner's records reviewed by Dr. James Williams. He testified by way of deposition that he reviewed Petitioner's medical records, the Demands of the Job form from Pinckneyville, and Petitioner's reports of injury. On direct examination, it appeared that he believed Petitioner's notice of injury indicated his job duties as a Correctional Officer at Pinckneyville Correctional Center were the cause of his injury. He testified that he did not have a complete copy of Dr. Paletta's note of September 12, 2011, the only date of service. Dr. Williams agreed that Petitioner suffered from cubital tunnel syndrome. at 14-15.

Dr. Williams testified that he believed that bar rapping was an activity that could aggravate a condition of cubital tunnel syndrome. However, assuming the information provided to him by Respondent regarding the timeline of Petitioner's employment was correct, he did not believe it was a causative factor in Petitioner's case. He also did not believe Petitioner's job duties at Pinckneyville were aggravating or causative factors in Petitioner's left cubital tunnel syndrome. Dr. Williams acknowledged that Petitioner had no anatomical risk factors for the development of carpal tunnel syndrome. When given Petitioner's hobbies, he only felt that weight lifting and motorcycle riding were risk factors in Petitioner's condition. He agreed that the treatment recommended by Dr. Paletta was reasonable.

On cross-examination, the timeline was corrected by Petitioner's attorney. Dr. Williams testified that he was unaware of how long Petitioner worked at Menard after transferring from Pontiac Correctional Center, and that he did not visit Menard Correctional Center or have any knowledge of the similarity of the conditions between the two facilities. While Dr. Williams did not initially believe that Petitioner's job duties at Menard, such as bar rapping, were the cause of Petitioner's left cubital tunnel syndrome, he acknowledged that he did not have any information regarding the details of Petitioner's job duties at Menard Correctional Center. He did not have the JSA, DVD, or any information from the State regarding Menard Correctional Center; he was only provided with the evidence from Pinckneyville Correctional Center, where Petitioner worked only months before his injury manifested.

Dr. Williams did not know that Petitioner was engaged in frequent lifting or carrying up to twenty-five (25) pounds frequent being defined as up to 5.5 hours per day, or lifting up to 50lb.

He did not know that Petitioner was required to pull on doors up to 66% of the work day, or 200 times per day. He did not know that the doors at Menard were heavy steel doors. He was also unaware of the opinion of Dr. Sudekum, another examining physician for the State of Illinois, who had previously testified that the duties of a correctional officer at Menard could cause and contribute to the development of compression neuropathies in the upper extremities. Dr. Williams further acknowledged that his opinion could change if he had been provided with this information. Dr. Williams also agreed that opening and closing difficulty heavy steel doors would also be a significant factor in aggravating cubital tunnel syndrome. He also agreed that the effects of repetitive trauma are cumulative.

Petitioner's treating physician, Dr. Paletta, testified by deposition taken on April 3, 2014. Dr. Paletta testified that Petitioner very well may have been referred to him by his attorney. He further testified to his belief that Petitioner's job requirements were a contributing factor that either caused or increased Petitioner's cubital tunnel syndrome. He cited specific job duties or motions in which Petitioner engaged as causative factors:

> Well, basically, the ones that I – in my opinion, would contribute would be bar-rapping because of the vibration associated with that, opening and closing of cell doors, which my understanding is sometimes requires forceful flexion and extension of the arm, and keying may also play a role, and that particularly cuffing and uncuffing inmates, were at least the guards described that they sometimes have to struggle with individuals to do that. (PX 12, p. 16)

Dr. Paletta also explained that there is a latency period in repetitive trauma cases, or a lapse of time that develops between exposure or accumulation and the development of symptoms. He testified that the cumulative nature of certain stressors and the time from exposure to manifestation of symptoms is variable and dependent upon each individual human being's tolerance to those stressors.

Dr. Paletta also reviewed the evidence pertaining to Petitioner's job duties at Pinckneyville Correctional Center, and testified that the Pinckneyville Job Site Analysis describes activities that would also contribute to the development of compressive neuropathies.

On cross-examination Dr. Paletta testified that it is important to know the patient's activities because if he is doing the same activity and remains symptomatic (or increasingly so) one may modify the activities. (PX 12, p. 34) He also explained how ulnar nerve problems can be found with weight lifters and tennis players. (PX 12, p. 37) Dr. Paletta further acknowledged he was unaware of Petitioner being off from work during certain times and that if he was off work from August of 2009 through November 1, 2010 that could change his opinion with regard to the development of ulnar neuropathy at the elbow and its relationship to Petitioner's work at Menard. (PX 12, p. 52) When also given Petitioner's subsequent absence dates from January 2011 through

March 1, 2011, Dr. Paletta could only acknowledged Petitioner didn't have his dates straight. (PX 12, pp. 52-53)

On redirect examination Dr. Paletta was asked if Petitioner's missing work "a few months" would affect his causation opinion. He replied, "Does not materially affect it at this point, because he was doing those activities that, in my opinion, can contribute to it during the time preceding when I saw him." (PX 12, p. 59)

The Arbitration Hearing

Petitioner began working for the State of Illinois Department of Corrections in November of 1997. At the time of arbitration Petitioner was working at Respondent's facility. However, he began his career with the Corrections Department at Pontiac Correctional Center. Throughout his employment with Corrections, he has been a correctional officer.

Petitioner testified that while he worked at Pontiac, the entire facility was converted to segregation due to an incident that happened the year before, meaning that the inmates were on lockdown and had to be handcuffed every time they left their cell. Petitioner testified the doors of the facility were sliding doors, some of which were very difficult to open and required grip, strength and force to open.

Petitioner testified that when he turned the Folger Adams key to open doors, he was actually moving a 1.5-2 inch diameter steel rod that spans the side of the door, encased in the door frame. He testified that this pushed yet another three (3) inch long rod that reached horizontally over the door and pulled the latch up. Petitioner indicated that he then had to hold the Folger Adams key in position to keep the latch released while he opened the door. He also pulled on doors during wing checks and bar rapped, causing numbness in his arms and forearms. Petitioner testified that he was required to use both hands to perform these activities because one side would tire before he completed his assignment. Petitioner worked at Pontiac for three years and performed these activities on a daily basis. Petitioner also opened chuckholes, cuffed and uncuffed inmates who frequently resisted, performed cell shakedowns and lifted heavy property boxes. He testified that there was no part of his job that did not involve the use of his hands and arms.

In 2000, Petitioner was transferred to Menard Correctional Center. He testified that he performed the same activities at Menard Correctional Center on a daily basis as he did at Pontiac Correctional Center, such as bar rapping, opening doors with Folger Adams keys, cuffing and uncuffing inmates and shaking down cells. Petitioner worked at Menard until 2011 and testified that during his 11-year tenure, he performed these activities tens to hundreds of thousands of times, and he stated that there was no part of his job that did not require the use of his arms and hands.

Respondent created a DVD depicting the duties of a Menard Correctional Officer, which was entered into evidence by Petitioner (PX 11). Correctional Officer DVD depicts various job tasks,

assignments, areas, equipment and mechanisms demonstrated by a variety of Correctional Officers. Depictions included the armory, shakedown officer, bar rapping, double gate door, double gate walkway, opening cell doors, turning gallery cranks, receiving control house, control room, receiving door, shower door segregation, shower door, segregation unit, segregation door, chuckholes, double gate, and tower. Each area required opening and closing multiple doors and using multiple keys, mostly Folger Adams keys. These tasks were briefly shown.

Bar rapping was simulated in the DVD and the officer explained that, depending upon the shift, all open bars will be rapped for security purposes. Officers are to listen to the sound to ensure that the bar is solid and that the inmates have not tampered with the cell doors. The officer held the bar with his right hand and struck the bars approximately 60 times to demonstrate bar rapping on 1 cell (5 to 6 bars vertically in 12 separate sections, each bar struck 1 time). Bar rapping is conducted on the 7-3 and 3-11 shifts. Officers perform bar rapping at the beginning of each shift on the gallery where they are assigned. There are 55 cells per gallery. While some galleries have half solid doors and half open bars, Correctional Officers will also be assigned more than one gallery shift per day.

The Correctional Officers demonstrating these areas and job duties on the DVD used both hands to complete tasks. On one occasion, when the videographer requested a Correctional Officer to demonstrate the unlocking maneuver in slow motion, the officer tried to do so and the lock stuck. He had to turn it multiple times to get it to work and explained that the locks were difficult to turn in slow motion. Respondent stopped filming when a Correctional Officer struggled to open a cell door and yanked on it repeatedly with both hands. There appeared to be a mechanical problem. Petitioner testified that some of Respondent's doors and chuckholes were very difficult to open.

Petitioner reviewed the DVD of a Correctional Officer, and testified that it was somewhat misleading. Petitioner also noted that the officer in segregation had difficulty opening the door and testified that this difficulty is common is segregation.

Petitioner worked in segregation from 2000 until 2007. He testified that inmates in segregation were fed through chuckholes.

Petitioner submitted a The Cellhouse Post Description (PX 7) created by Respondent indicates that Petitioner, as a Gallery Officer, was to ensure that each cell is searched and bars rapped before an inmate was assigned to an unoccupied cell. He was directly responsible for random checking of all locks on his assigned gallery. He was required to pull cell doors twice to ensure that the cell doors are securely locked. He was also directly responsible for monitoring all movement of high-risk inmates and keeping proper documentation of their movement in log books. He was directly responsible for escorting all line movement off the gallery to the designated area with knowledge of the proper count within said line, and was also responsible for returning with the line and ensuring that all of the inmates were re-secured in their assigned cells.

Petitioner also submitted a Job Site Analysis obtained by Respondent into evidence, which provides a narrative description of the job duties of a Correctional Officer at Menard. It classifies the strength demand of the job as frequent lifting and/or carrying up to 25 pounds. Correctional Officers are required to frequently pull open doors from 2 ½ hours to 5 ½ hours per day, up to 66% of the time, or up to 200 times per day. This includes pulling open chuckhole doors as needed during lockdowns for dining, and cuffing and snuffing residents. Wrist turning is required 34-66% of the time, 2 ½ hours to 5 ½ hours per day, or 33 to 300 times per day. (PX 8)

Petitioner testified to sustaining an injury to his left shoulder in 2005 when he and an inmate worker were handling a food cart on the stairs and they tripped, causing Petitioner to fall to the bottom. Petitioner required left shoulder surgery as a result of this accident. He also testified that he injured his back and right elbow while responding to an altercation wherein two inmates attacked to officers. Petitioner returned to work full duty following the surgeries on his back and right elbow.

Petitioner testified that during the course of his job duties at Menard Correctional Center, Petitioner began developing symptoms of numbness and tingling in his arms and hands. On August 8, 2011 Petitioner talked to Dr. Paletta's office and advised "them" of his symptoms. He was told to make out an Incident Report because "they" believed it might be work-related. He was then given a date to come in and see Dr. Paletta and to obtain some studies.

Petitioner presented to Dr. Paletta on September 12, 2011. Petitioner testified that at the time that he made the appointment with Dr. Paletta, he was working at Pinckneyville Correctional Center. Petitioner testified that he continued to use his hands and arms for everything, but he did not bar rap and stated that the doors were different. Petitioner does not suffer from diabetes, hypothyroidism, or rheumatoid arthritis, and his weight has not substantially changed over the last five (5) to ten (10) years.

Petitioner testified that on August 8, 2011, Dr. Paletta advised him that his condition might be work-related.

Petitioner testified that he has not returned to Dr. Paletta because Respondent denied his claim. Petitioner testified that he would like to avoid surgery and live with his present condition if possible. Petitioner testified that at Arbitration that his symptoms persist. His transfer to Pinckneyville Correctional Center has brought no change in his condition. He testified that his left arm goes to sleep when bent for any length of time. Petitioner also experiences discomfort with certain activities. He takes over-the-counter medication such as Advil as needed.

On cross-examination Petitioner acknowledged that he was off work after his August 20, 2009 accident through November 1, 2010 when he was released to return to work. He then only went back to work for a few months as he then began treating for his right elbow and stopped working from January 10, 2011 through March 1, 2011.

RX 5 is a Job Site Analysis dated February 17, 2011.

RX 10 and 11 are DVDs of a corrections officer at Pinckneyville Correctional Center.

RX 8 is an "Estimation of Key Usage at Pinckneyville C.C." prepared in February of 2011.

RX 9 is the deposition testimony of Melanie Welch taken in the case of "Donna Jones, a/k/a Correctional Officer," et. al. v. State of Illinois, Department of Corrections, Pinckneyville Correctional Center, 10 WC 038807."

Petitioner offered two exhibits into evidence at the commencement of the hearing -- PX 9 and PX 10. Respondent objected to their admissibility and the issue was taken with the case to be addressed herein.

The Arbitrator concludes:

1. Issue "O" -The admissibility of PX 9 and PX 10.

Petitioner's Exhibit 9 is the report (Independent Medical Examination) of Dr. Sudekum performed on April 29, 2011 regarding the job duties performed by correctional officers at Menard Correctional Center and their causative effect, if any, on the development of "repetitive trauma injuries." (PX 9)

Petitioner took the deposition of Respondent's records reviewer, Dr. Sudekum, pursuant to a Dedimus Order. That deposition was taken on June 13, 2011 in "James Bauersachs a/k/a "Correctional Officer," et. al. v. State of Illinois/Menard Correctional Center, 10 WC 27503 et. al." (PX 10)

The Arbitrator finds that the deposition and general IME exhibits deal with cases completely separate and unrelated to the case at bar and are therefore irrelevant and inadmissible. Bradshaw v. Menard C.C., 14 I.W.C.C. 0394.

Respondent's objections to PX 9 and PX 10 are sustained. The exhibits are rejected and will travel with the record.

2.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?

Petitioner has failed to prove he sustained an accident on August 8, 2011 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his left elbow is causally related to his employment duties with Respondent. The Arbitrator is aware that Petitioner is claiming a cumulative trauma injury based upon his career with the Illinois Department of Corrections, most notably his years at Pontiac and Menard Correctional Centers. Nevertheless, Petitioner has failed to meet his burden of prove that his work activities caused his left elbow condition.

It is axiomatic that in a repetitive trauma case, the unique facts of each case must be closely scrutinized, analyzed, and considered. The Arbitrator has done so herein. According to Petitioner his symptoms in his left elbow came on gradually over a one to two year period of time preceding Petitioner's examination with Dr. Paletta. This would mean Petitioner's left elbow symptoms date back to between August of 2009 (when he had his work accident involving his back and right elbow) and August of 2011. During that time Petitioner was off work from August 21, 2009 through November 1, 2010. He was again off work from January of 2011 through March 1, 2011. None of the medical records generated during that time period suggest or even infer any type of problem with Petitioner's left elbow. Furthermore, the only time Petitioner was working during this one to two year onset period was late 2010 and early 2011. Interestingly, Petitioner began treating with Dr. Brown in October of 2010 and never mentioned any left elbow problems to the doctor at any time while he was being treated for his right elbow condition. The lack of mention of any left upper extremity complaints seems to undermine Petitioner's credibility regarding the onset of his complaints. One would reasonably think that if Petitioner were having left elbow complaints and symptoms while treating for his right elbow, he would mention same to the doctor. Petitioner didn't and the Arbitrator reasonably infers he wasn't having any left elbow complaints during that time. Even Petitioner's physical therapy records post-right elbow surgery are silent as to left elbow problems but, otherwise, reflect a strong left upper extremity (ex. grip strength testing).

The Arbitrator was not altogether persuaded as to Petitioner's credibility. To illustrate, she notes the Arbitrator's Decision in his 2009 work accident case. According to the Decision, Petitioner testified, under oath, that some of his activities had been entirely curtailed by his mid back, low back, and right elbow injuries. This included weight lifting and tennis. When examined by Dr. Paletta in September of 2011 (approximately five months after his arbitration hearing) Petitioner indicates he engages in running, weights, and sports for exercise. (PX 3) Furthermore, RX 15 suggests, at a minimum, that Petitioner, no matter what his rating, was participating in tennis in 2012. Either Petitioner had a remarkable come-back after his arbitration hearing and was able to return to the activities which had been "curtailed" by his work injury or he was not being entirely candid at times. Regardless, he provided no testimony to explain these inconsistencies. Furthermore, Dr. Phillips noted Petitioner's hands were calloused from weight lifting when he tested him in the fall of 2011. He also noted Petitioner's complaints were bilateral which was completely contrary to his testimony at arbitration.

Dr. Paletta related the condition to Petitioner's work activities because Petitioner reported to him that he noted his symptoms while he was meeting all the job requirements of a correctional officer at Menard. (PX. 3) According to Dr. Paletta, the basis for his opinion that the job activities were a contributing factor was the fact that Petitioner had correlated the onset or increase of his condition to his job. Dr. Paletta made enough concessions during cross-examination to render his causation opinion unpersuasive. He had no knowledge of the time Petitioner was off from work after his August 20, 2009 accident and that information is very important as it was during that period of time Petitioner claims his injury evolved. He further acknowledged, on cross, that such information could change his opinion. In the end, Dr. Paletta related Petitioner's left elbow injury to his job because Petitioner had performed those duties and the doctor believed such duties could contribute to it. Thus, Dr. Paletta's

opinion in this case was more generic, than specific, to Petitioner's claim. As such, it was not persuasive. Lastly, Dr. Paletta testified that it is important to know what activities a patient is engaged in because if he is doing the same activity and remains symptomatic one might modify the activities. Ironically, Dr. Paletta finds Petitioner's job duties are the cause of Petitioner's elbow condition but he allowed him to continue working full duty. His actions appear inconsistent with his testimony rendering his opinions less credible and persuasive.

Petitioner's claim for compensation is denied. No benefits are awarded. All other issues are moot.

****

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROLLAND BLAND,

Petitioner,

vs.

NO: 08 WC 30028

ILLINOIS DEPARTMENT OF CORRECTIONS,

15IWCC0373

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 expenses, prospective medical treatment and temporary total disability benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto. 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 reverses the Arbitrator and finds Petitioner proved his condition of ill being is causally connected to his work injury. The Commission awards Petitioner temporary total disability benefits, all outstanding medical expenses and prospective medical treatment for his left foot.

The Commission finds Petitioner proved his left foot and ankle issues are causally connected to his work injury. It is undisputed Petitioner slipped and fell on March 1, 2007, and

that he injured his left knee in the process. Thereafter, Petitioner immediately complained of foot and ankle pain, and had swelling and bruising in the area. Petitioner also complained of extensive knee pain. In the course of the work accident, Petitioner tore his meniscus and had surgery for the injury. While Petitioner's initial treatment focused on the left knee, he continued to complain of ankle and foot pain throughout.

The Commission also notes Petitioner was diagnosed with diabetes in 2000 but was able to work his physical job without issue and had not sought medical attention for his left foot before the traumatic accident.

Petitioner's foot pain progressively worsened to the point that his foot had essentially collapsed and surgery was necessary. It is not disputed that he sprained his ankle and foot when he fell on March 1, 2007. Petitioner immediately sought medical treatment and was initially diagnosed with an ankle sprain and tendonitis on March 7, 2007. Petitioner's ankle and foot sprains did not improve, but instead progressed and worsened over time to the point that he required surgical intervention. No other traumas were reported in the record that would cause Petitioner's current left foot issues.

On November 24, 2008, Petitioner began treating with Dr. Freedberg for his left foot and ankle. Petitioner complained that his left foot had been swollen and painful since the injury. Dr. Freedberg diagnosed Petitioner with a left LisFranc sprain with degenerative joint disease. He wrote Petitioner clearly sustained the left foot injury at the time of the work accident and he probably needed surgery. Dr. Freedberg added if Petitioner's foot was not treated, it would quickly degenerate and produce significant impairment. Petitioner continued to treat with Dr. Freedberg and on July 10, 2009, Petitioner had left food surgery. However, Petitioner continued to experience left foot pain, which had improved since surgery but had not resolved. On April 12, 2010, Petitioner followed up with Dr. Freedberg, who reviewed a recent CT scan. The impression from the CT scan was a fracture with one screw although it did not disrupt the bony structures, erosive changes and subchondral cyst formation involving the tarsometatarsal joint but no definite fusion of bony structures, and minimal subcutaneous edema of foot and fluid collection within structure below first metatarsal. Dr. Freedberg wrote Petitioner did not appear to have a complete arthrodesis as he now had two broken screws and he was not pleased with what he saw on the scan. On December 16, 2010, Petitioner reported to Dr. Freedberg that he felt something moving on the inner bottom of his foot that snaps and causes pain. Dr. Freedberg wrote it does not seem likely that Petitioner will have a good fibrous union with the recent development of moveable bone or tissue that causes crepitus and pain in the midfoot. He noted Petitioner had been given extensive time to heal and support but with the recent symptomology of palpable crepitus and pain with the motion of this possibly bony fragment, he recommended another surgery. On February 4, 2011, Dr. Freedberg performed a second surgery on Petitioner's left foot where he removed a large plantar cyst and performed exostectomy with debridement. Petitioner saw Dr. Freedberg on March 20, 2014, and reported his left foot was not doing well. Petitioner continued to have pain and swelling and does not have control over his foot. It is clear

15IWCC0373

from the medical records that Petitioner constantly and consistently complained of left foot pain. He has undergone years of treatment but his left foot issues have not resolved.

There is nothing in the record that would break the chain of causation regarding Petitioner's left ankle and foot from his accident though the present.

The Commission relies on the opinions of Dr. Freedberg, Petitioner's treating physician. Dr. Freedberg opined that Petitioner's injuries stemmed from his work accident. He explained the progression of Petitioner's accident and how his diabetes and arthritis contributed to Petitioner's foot issues but the accident was the aggravating force that significantly worsened Petitioner's foot. Dr. Freedberg clearly testified how Petitioner suffered a LisFranc sprain during his work accident, which aggravated or accelerated his Charcot arthropathy. He stated Petitioner's foot would not have deteriorated without the LisFranc fracture regardless of Petitioner's diabetes. We disagree with the opinions of Dr. Holmes, Respondent's Section 12 examiner. Dr. Holmes suggested that Petitioner's foot began to have all of these issues without any direct cause. However, Petitioner suffered an undisputed injury to his ankle and foot and continued to complain of pain and issues throughout treatment for both his left knee and foot. Additionally, Dr. Holmes admitted a Charcot foot might or could develop from the type of trauma Petitioner suffered. Based on the evidence as a whole and the opinions of Dr. Freedberg, we find Petitioner proved his left foot and ankle conditions of ill being are causally connected to his work accident.

Additionally, we award Petitioner all outstanding medical expenses and prospective medical treatment. Dr. Freedberg has recommended additional treatment for Petitioner's left foot as the first attempted fusion failed and Petitioner continues to experience pain and swelling in his foot. Even Respondent's Section 12 examiner, Dr. Holmes, stated that Petitioner needed additional medical treatment.

Finally, the Commission awards Petitioner temporary total disability benefits for 377-5/7 weeks beginning March 2, 2007 through May 27, 2014. Dr. Freedberg continually wrote Petitioner off work as a result of his work accident and has not yet released him. Petitioner testified he continues to experience issues with his foot and it is undisputed that he cannot perform his regular job duties.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $882.58 per week for a period of 377-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

15IWCC0373

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all outstanding medical expenses and prospective medical treatment for his left foot per the medical fee schedule under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

DATED: MAY 2 1 2015
TJT: kgg
R: 2/2/15
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Flores' 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
& 8(a)

BLAND, ROLLAND
Employee/Petitioner

Case# **08WC030028**

ST OF IL DEPT OF CORRECTIONS
Employer/Respondent

15IWCC0373

On 7/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0226 GOLDSTEIN BENDER & ROMANOFF
ALFRED PEFROCELLI
1 N LASALLE ST SUITE 2600
CHICAGO, IL 60602

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

5132 ASSISTANT ATTORNEY GENERAL
STACEY R LASKIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 17 2014

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

15IWCC0373

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Rolland Bland
Employee/Petitioner

v.

State of Illinois Department of Corrections
Employer/Respondent

Case # **08** WC **30028**

Consolidated cases: **N/A**

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

FINDINGS

On the date of accident, **March 1, 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 as explained *infra*.

In the year preceding the injury, Petitioner earned **$68,841.08**; the average weekly wage was **$1,323.87**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **no** dependent children.

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

Respondent shall be given a credit 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 **$117,902.41** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that his current left foot condition of ill being is causally related to his injury at work on March 1, 2007. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

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

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

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

Signature of Arbitrator

July 15, 2014
Date

JUL 17 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Rolland Bland
Employee/Petitioner

v.

State of Illinois Department of Corrections
Employer/Respondent

Case # **08** WC **30028**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills related to the left foot, Petitioner's entitlement to temporary total disability benefits from December 26, 2011 through May 27, 2014, and whether he is entitled to prospective medical care with regard to his left foot. Arbitrator's Exhibit[1] ("AX") 1.

Background

Petitioner worked for Respondent at the Sheridan Correctional Center as a stationary fireman/boiler operator. He ran all the boilers and provided maintenance during the day shift.

Petitioner underwent some medical treatment related to his left foot in January 2005 at Ottawa Community Hospital where he underwent left foot x-rays. PX6. Petitioner treated with Jeffrey Crowhurst, D.P.M. for osteomyelitis in the left foot and left second toe. *Id.*

On cross examination, Petitioner testified that he could not recall when he was diagnosed with diabetes. The medical records reflect that Petitioner has had type II diabetes for years and some form of diabetes for decades. PX2. Petitioner testified that he is able to go to Hines VA hospital for diabetes-related treatment, which includes seeing a podiatrist. Petitioner believes that last treatment for that was a couple of years ago. He testified that he received treatment for two hammer toes that were surgically treated on the right foot. Petitioner also had left foot treatment for his left foot ulcer after his accident at work.

Petitioner later recalled that he was first diagnosed with diabetes around 2000 and that he took medication to manage the condition, which was under control at the time of his accident at work. Petitioner acknowledged that he had an ulcer in the left foot about two years before the accident. He testified that his podiatrist believed that he had a bone infection, which was treated for one month or so and he was discharged from care. Petitioner had no other problems with either foot before the accident. Petitioner also testified that he applied for and received service-connected benefits related to diabetes.

Petitioner testified that he has neuropathy and that he did not have that condition since he was diagnosed with diabetes. Petitioner testified that he understood he had neuropathy in both feet and legs. Petitioner testified that he has treated for this condition since 2007.

[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.

March 1, 2007 15IWCC0373

On March 1, 2007, Petitioner testified that he parked his car in the employees' parking lot as directed by Respondent, which was open only to employees. While walking from his car to the employee entrance, he slipped on ice. Petitioner testified that it was raining that morning. His left foot stayed on the ground and his right foot went out from under him into the air. He went over the toe of his left foot, and his left foot ended up in the middle of his back. Petitioner testified that he was unable to get up on his own and had help from his boss, Rod Landreth, and an inmate school teacher, Peggy Blair. *See* RX1. In a notice of injury report, Petitioner reported "I was walking thru parking lot on way to work & slipped on patch of ice. When I feel my left leg got caught under my body causing injury to my ankle, knee, hip & tendons." *Id.* Petitioner then went home.

Medical Treatment

Petitioner sought medical attention the following day at Ottawa Community Hospital. PX6. Petitioner reported that he slipped on ice twisting his left leg and falling. *Id.* He reported that he could walk, but with pain. *Id.* On examination, Paul Toofan, M.D. noted some swelling over the lateral aspect of the left ankle and dorsum of the foot. *Id.* He noted that there was no deformity to the foot. *Id.* A left foot x-ray taken the same day showed arthritic changes present involving the joint spaces of the tarsal bones and at the tarsometatarsal joint as well as prominent arthritic changes at the second and third metatarsal phalangeal joints. *Id.* The x-ray also showed subluxation present at the second metatarsal phalangeal joint as well as the presence of a possible old fracture involving the second proximal phalanx. *Id.* No acute bony abnormality was present. *Id.* Dr. Toofan diagnosed Petitioner with a left foot sprain and a left ankle sprain. *Id.* Dr. Toofan also gave Petitioner an Ace wrap, instructed him to refrain from strenuous activity for a few days and placed him off work. *Id.* Petitioner was instructed to follow up with his doctor if pain persisted. *Id.*

Petitioner testified that he then went to see his family doctor, Dr. Harney, who prescribed pain medication and re-wrapped his foot. He testified that he was off work for about 9 days based on the hospital doctor and Dr. Harney's recommendation.

The medical records reflect that on March 7, 2007, Petitioner followed up with Michael Harney, D.O. complaining of left ankle, knee, and hip pain following a fall at work. PX2. On examination, Dr. Harney noted ecchymosis and swelling of the left ankle. *Id.* He diagnosed Petitioner with a left ankle sprain and tendonitis, and kept him off work through March 9, 2007. *Id.*

Petitioner testified that he went back to work and continued to see Dr. Harney. He was accommodated with sedentary work although Petitioner testified that he walked in to work about .25 mile every morning. Petitioner testified that Dr. Harney and the emergency room staff told him that "it" would heal. Petitioner testified that he complained to Dr. Harney about the left foot, ankle and knee and that Dr. Harney addressed his foot and ankle.

On August 28, 2007, Petitioner saw his civilian podiatrist, Dr. Crowhurst, and complained of left second toe drainage following "[t]rauma to the area occurred as a result of playing golf. … Condition has existed for 2 months." PX4. Dr. Crowhurst reviewed Petitioner's foot x-rays, which showed left 2nd proximal phalanx evidence of hammer toe deformity, left 2nd DIP joint and left 2nd distal phalanx evidence of soft tissue swelling and erosion, and left 3rd metatarsal head and left 2nd metatarsal head evidence of bony erosion. *Id.* On examination, he noted a left second toe that was distal, inflamed, serous draining, macerated, erythemous, and worsening with a Grade III diabetic ulcer. *Id.* He diagnosed Petitioner with an ulceration of the lower limb,

controlled diabetes mellitus type II with neurologic manifestations, bilateral hammertoes, and acute osteomyelitis. *Id.*

Petitioner returned to Dr. Crowhurst on September 11, 2007, for evaluation of his left ankle. PX4. At this visit, Petitioner reported that his left ankle sprain had existed for 6 months and that trauma to this area occurred as a result of an injury at work twisting his foot. *Id.* On examination, Dr. Crowhurst noted dryness and erythema[2] of the second left toe, a healed ulcer on the distal tip of the left second toe, and misalignment, swelling, and tenderness along the medial aspect of the left midfoot and left medial malleolus. *Id.* Dr. Crowhurst diagnosed Petitioner with cellulitis of the left foot as well as an ankle sprain. *Id.* He debrided necrotic tissue of the left second toe, ordered a left foot and ankle MRI, and recommended continued antibiotics. *Id.*

On October 2, 2007, Petitioner saw Dr. Crowhurst again reporting an improving left second toe condition that was worsened by walking. PX4. Dr. Crowhurst diagnosed Petitioner with a left second hammertoe and osteomylitis, and reiterated his recommendation for a left foot and ankle MRI. *Id.*

Petitioner testified that Dr. Harney eventually ordered a left foot, ankle and knee MRI. The medical records reflect that on October 9, 2007, Petitioner underwent a left ankle MRI, which showed findings consistent with mild plantar fasciitis at the attachment of the plantar aponeurosis (plantar fascia) and to the calcaneus (heel bone). PX2; PX6. Petitioner also underwent left foot MRI, which showed arthritic changes involving primarily the metatarsophalangeal and tarsometatarsal joints, plantar fasciitis, and no acute bony abnormalities. *Id.* Petitioner also underwent MRI of the left knee, which showed an oblique tear through the posterior horn of the medial meniscus. *Id.*

On November 27, 2007, Petitioner saw Paul Perona, M.D. for evaluation of his left knee pain. PX2. On December 21, 2007, Petitioner saw Dr. Crowhurst and complained of right second toe and left second toe deformity and tenderness. PX4. Petitioner stated that he wanted to have hammertoe surgery following his knee surgery. *Id.* Petitioner underwent casting for functional orthoses. *Id.*

Petitioner testified that Dr. Harney told him that he saw a torn meniscus in the knee and he referred Petitioner to a few doctors. Petitioner testified that he then saw Dr. Perona who performed knee surgery.

Left Knee & Heart Surgeries

On January 9, 2008, Petitioner underwent a left knee arthroscopy and partial medial meniscectomy and chondroplasty of the medial femoral condyle performed by Dr. Perona. PX2; PX7.

On January 21, 2008, Petitioner had a myocardial infarction and was treated at St. Francis Hospital, where he received a stent. PX2. Dr. Perona noted that Petitioner was unable to comply with a recommended physical therapy regime due to the heart attack. *Id.*

Petitioner testified that Dr. Perona was treating his leg and only looked at his foot and ankle, but did not treat it specifically. Petitioner also testified that he went to physical therapy for 4-6 weeks related to his left knee after his surgery and he received his temporary total disability benefits. After completing the knee treatment, Petitioner went to see Dr. Freedburg regarding his foot. He testified that Dr. Freedburg told him that his foot

[2] Erythema is generally defined as abnormal redness of the skin due to capillary congestion. *See* http://www.merriam-webster.com/dictionary/erythema (last visited July 15, 2014).

was broken.

Continued Left Foot and Ankle Treatment

Petitioner returned to Dr. Crowhurst on March 4, 2008 for an orthotic check and for evaluation of his hammertoes. PX4. Petitioner was instructed to return as needed for foot care. *Id.* He was also discharged from physical therapy for the knee on April 25, 2008. PX6.

On May 6, 2008, Petitioner saw Dr. Perona at St. Margaret's Hospital Family Orthopedic Center reporting lateral left foot and ankle pain when he inverts the foot, pain to the midfoot and plantar surface of the great toe, increased foot and ankle pain with weightbearing, pain at rest, and clicking and catching of the ankle. PX2; PX7. This information was provided in a letter addressed to Respondent. *Id.* On examination, Dr. Perona noted a planovalgus deformity, minimal subtalar motion, minimal inversion, and hammer toe formation of the second toe. *Id.* Dr. Perona also reviewed Petitioner's left foot and left ankle x-rays. *Id.* The left foot x-rays from St. Margaret's showed "midfoot sclerosis possibly consistent with metastatic disease or a severe diffuse osteopenia," severe degenerative joint disease and destruction of the second and third metatarsal phalangeal joints possibly consistent with avascular necrosis; the x-ray showed a normal left ankle. *Id.* With regard to the left foot, the interpreting radiologist noted that there was "complete obliteration of the second and third metatarsal phalangeal joints. There is increased sclerosis of the midfoot with what appear to be small lytic lesions consistent with a moth-eaten appearance." *Id.* The left ankle x-rays were essentially normal. *Id.* Dr. Perona diagnosed Petitioner with left foot and ankle pain consistent with a posterior tibial tendon rupture. *Id.* Dr. Perona recommended that Petitioner see an orthotist for fabrication of bilateral shoe insert orthotics with arch supports to address left foot and ankle pain. *Id.*

Left Foot Treatment – Dr. Freedburg

On November 24, 2008, Petitioner saw Dr. Freedburg for the first time. PX1; PX2. He reported left foot and ankle pain status post an injury in March 2007. *Id.* Dr. Freedburg noted Petitioner's description of the mechanism of injury as follows: "...in March 2007 when he got out of his car at work, he slipped on black ice. He fell with his left knee bent under his body." *Id.*

Petitioner reported that his left ankle was swollen and painful since his injury, an arch deformity and pain inferior and posterior to the medial malleolus, constant swelling and mild ecchymosis over the dorsal and medial aspect of the foot. *Id.* Petitioner also reported that the orthotics had not helped, that he was back at work, and that he was taking Gabapentin for neuropathic pain in his lower limbs related to his diabetes mellitus type II. *Id.* Dr. Freedburg reviewed Petitioner's x-rays taken that day noting left foot severe arthrosis and minimal ankle arthrosis. *Id.* Specifically, he interpreted the x-rays to show normal alignment of the ankle and foot with valgus deformity of the 2nd MTP, severe degenerative joint disease in the 2nd-5th DIPJ, moderate degenerative joint disease in the 4th-5th MTPJ, severe degenerative joint disease in the 2nd-3rd MTPJ, moderate degenerative joint disease in the medial cuneiform/base 1st MT, calcaneus osteophyte formation at the Achilles and plantar fascial insertions as well as multiple non-acute bone chips in the medial gutter. *Id.*

Dr. Freedburg diagnosed Petitioner with left pes planovalgus, a left LisFranc sprain with degenerative joint disease, and status post work comp injury with left knee arthroscopy. *Id.* In a narrative opinion contained in this initial evaluation note, Dr. Freedburg states the following:

> ... I also believe that the foot and ankle were involved based off the mechanism of the injury. He is very painful and

> in my opinion requires further treatment which is probably surgery. the major issue is he probably sustained a LisFranc injury that went unrecognized. that is a serious issue because it quickly degenerates the foot and produces significant impairment which he has. He will need a midfoot arthrodesis and a balancing of the hindfoot. It appears clear to me that this injury occurred at the time of the knee injury and is very problematic. The LisFranc injury is a serious problem which gives long term issues. I have told me when he [sic] clarifies the work comp difficulty he should return to discuss the appropriate next step.

PX1. On this date, as well as on May 13, 2009 and June 11, 2009, Dr. Freedburg took x-rays with similar findings and he continued to diagnose Petitioner with a left LisFranc sprain with degenerative joint disease, left pes planovalgus, and status post left workers' compensation injury with left knee arthroscopy. *Id.* Dr. Freedburg reiterated in these progress notes that there "is no question that the foot and ankle were involved based off of the mechanism of injury. my opinion was correct that he needed surgery of the Lis Franc injury. A LisFranc injury that went unrecognized is a serious issue and now has degenerated the foot and has produced significant impairment which he has. There is a question of the neuropathic foot but, I feel this is definetly [sic] post traumatic and after the fusion I will be ultra careful with him if he does have any diabetic problems with decreased sensation to the area." *Id.* He recommended a surgery consisting of a midfoot arthrodesis and balancing of the hindfoot. *Id.* Dr. Freedberg again advised Petitioner to return for treatment "when he clarifies the work comp difficulty." *Id.*

Petitioner testified that Dr. Freedburg took Petitioner him off work just before his surgery and that he has not been released yet to return to work. He also testified that between Dr. Freedburg's first recommendation for surgery and when he had the surgery on July 10, 2009, Dr. Freedburg told him that he was just waiting for the "ok" for surgery.

The medical records[3] reflect that Petitioner underwent surgery with Dr. Freedburg on July 10, 2009. Pre- and post-operatively, Dr. Freedburg diagnosed Petitioner with left foot post-traumatic degenerative joint disease of five tarsometatarsal joints with an abductor planus mid foot deformity and a left second toe inflexible hammer toe. Dr. Freedburg performed the following procedures: (1) left foot osteotomies, curettage, debridement with arthrodesis of the first through fifth metatarsal to the medial, intermediate and lateral cuneiforms and cuboid joints with arthrodesis of the cuneiforms with bone grafting; and (2) left second toe proximal interphalangeal joint arthroplasty.

In the indications portion of the operative report, Dr. Freedberg noted that Petitioner injured his foot at work and "[i]t appeared to be somewhat of a missed injury where the patient had complained about it from day 1 and yet it was untreated. The patient eventually developed this deformity. The question of his diabetes played a part in the problem and the deformity was there, but he did have an abductor planus deformity as well as he had severe pain, difficulty walking. Therefore, in spite of that, if that even plays any part in this, we needed to proceed forward with the operative intervention."

Following the surgery, Petitioner testified that his left foot was in a cast and his ankle swelled up so big the cast had to be cut off a couple of times then he was put in another boot. He testified that this surgery consisted of fusing his foot with implantation of six screws. At some point, Petitioner testified that a couple of screws broke.

The medical records reflect that from July 30, 2009 through October 1, 2009, Petitioner saw Dr. Freedburg

[3] The parties submitted a post-hearing stipulation to admit this operative report into evidence as it was not submitted with the records at the hearing.

status post left foot tarsometatarsal arthroplasty with second toe arthroplasty. PX1; PX2. He recommended continued use of the cam walker and ordered a bone stimulator. *Id.* As of October 29, 2009, Dr. Freedburg kept Petitioner non-weightbearing to be followed in two weeks by weightbearing at touch. *Id.*

On December 10, 2009, Petitioner reported that his 3rd, 4th, and 5th toes curled under when he walked causing pain. PX1; PX2. Dr. Freedburg reviewed Petitioner's left foot x-rays of the same date showing normal alignment, no evidence of dislocation or fracture, no bony or soft tissue lesions, solid arthrodesis that was improving, and a broken lateral screw with the arthrodesis consolidated and not appearing disrupted. *Id.* Dr. Freedburg found the x-ray showed that Petitioner's left foot was status post left foot LisFranc arthrodesis. *Id.* discontinued use of the cam walker to transition Petitioner into regular shoes as tolerated. *Id.*

On January 14, 2010, Petitioner returned to Dr. Freedburg wearing a normal shoe and reported some ankle swelling, but not much pain in the foot like before the surgery just some continued problems with the ankle. PX1; PX2. X-rays taken the same day showed a normal left ankle with minimal degenerative joint disease. *Id.* Petitioner' left foot x-rays remained the same from his last visit. *Id.* Dr. Freedburg recommended and ordered orthotic shoes and noted that, despite the broken screw, Petitioner's arthrodesis seemed to be healing well. *Id.*

On March 18, 2010, Petitioner presented with his new orthotic and reported that he had pain every time that he walked on the lateral aspect of the left foot. PX1; PX2. X-rays taken the same day were essentially the same as in January; however, Petitioner now had two broken screws in the left foot. *Id.* Dr. Freedburg ordered a CT scan to evaluate the consolidation of the arthrodesis and custom orthotic shoes. *Id.*

On April 12, 2010, Petitioner underwent the recommended CT scan, which Dr. Freedburg interpreted to show multiple screws about the tarsometatarsal joint due to a LisFranc arthrodesis, a fracture with one of the screws that did not appear to disrupt the bony structures, minimal subcutaneous edema of the foot, and fluid collection within a structure below the first metatarsal. PX1; PX2. Dr. Freedburg recommended several more weeks of observation. *Id.*

On May 17, 2010, Petitioner reported pain across the top of his foot when he walked a lot and some ankle soreness, but otherwise getting better. PX1; PX2. Petitioner's x-rays of the same day remained unchanged. *Id.* Dr. Freedburg recommended several more weeks of observation in spite of the two broken screws. *Id.*

On June 23, 2010, Petitioner reported continued soreness in the ankle, walking fairly normally, and that his foot flops down when he steps instead of rolling down like the other foot; he felt the tendon was still weak or stretched out. PX1; PX2. Petitioner's x-rays of the same day remained unchanged. *Id.* Dr. Freedburg recommended several more weeks of observation in spite of the two broken screws. *Id.*

On July 29, 2010, Petitioner reported that the ankle was still tender and "bothers the hell out of me." PX1; PX2. Petitioner's x-rays of the same day remained unchanged. *Id.* Dr. Freedburg noted that Petitioner still did not have the custom orthotic shoes that he ordered and that Petitioner's midfoot was collapsing which was producing problems of an abutment laterally at the peroneal tendon that he indicated could be controlled with an orthotic shoe. *Id.* Dr. Freedburg recommended several more weeks of observation in spite of the two broken screws. *Id.*

On September 2, 2010, Petitioner reported no changes since his last visit; flopping when he walks, pain on the lateral aspect of the foot and ankle, and no approval of the recommended custom orthotic shoes yet. PX1; PX2. Petitioner's x-rays of the same day remained unchanged. *Id.* Dr. Freedburg recommended several more weeks

of observation in spite of the two broken screws. *Id.*

On October 7, 2010, Petitioner reported continued pain on the lateral aspect of his foot and that it still flops when he walks. PX1; PX2. Petitioner's x-rays of the same day remained unchanged. *Id.* Dr. Freedburg again noted that Petitioner's midfoot was collapsing and the problem could be addressed by the custom orthotic shoes he recommended. *Id.* He recommended several more weeks of observation in spite of the two broken screws. *Id.*

On November 11, 2010, Petitioner reported that he had not yet received the custom orthotic shoes, that he felt something loose in his arch and a popping feeling and noise, and left knee pain. PX1; PX2. Petitioner's x-rays of the same day remained unchanged. *Id.* Dr. Freedburg recommended several more weeks of observation in spite of the two broken screws. *Id.*

On December 16, 2010, Petitioner reported that he still did not have the prescribed custom orthotic shoes and that he felt something moving on the inner bottom of his foot that snaps and causes pain. PX1; PX2. Petitioner's x-rays of the same day remained essentially unchanged; however, Dr. Freedburg now noted a non-union in the left foot on x-ray. *Id.* Dr. Freedburg reiterated that Petitioner's midfoot was collapsing and producing problems that he believed could be controlled by a custom shoe. *Id.* He also noted that the fractured screws and arthrodesis did not appear to be consolidated and that Petitioner had a palpable, movable piece of bone or tissue causing crepitus and pain in the medial-plantar foot. *Id.* Dr. Freedburg recommended a second surgery including two different approaches, and Petitioner chose to undergo the smaller procedure consisting of bony fragment removal, debridement and possible coplanning of any prominent bone knowing that this procedure would not address the arch of the foot. *Id.* Petitioner remained off work. *Id.*

Petitioner underwent the recommended second surgery with Dr. Freedburg on February 4, 2011. PX1. Pre- and post-operatively, Dr. Freedburg diagnosed status post left foot tarsometatarsal joint arthrodesis with partial nonunion and painful bony exostosis, and a plantar cyst. *Id.* He performed a removal of the large plantar cyst in the left foot and an exostectomy with debridement. *Id.*

From February 10, 2011 through May 19, 2011 Petitioner followed up with Dr. Freedburg post-operatively. PX1; PX2. Petitioner's x-rays throughout this period remained unchanged. *Id.* He progressed from use of a cam walker to weightbearing at touch to use of regular shoes. *Id.* Dr. Freedburg reiterated that Petitioner's toe and ankle symptoms were not surprising due to the extensive surgical procedure and chronicity of his injury, and again noted that the midfoot was collapsing. *Id.* He continued to recommend custom orthotic shoes. *Id.*

On June 23, 2011, Petitioner's custom orthotic shoes were approved. PX1; PX2. Petitioner picked up his shoes on July 28, 2011. *Id.* Petitioner continued to follow up with Dr. Freedburg as of September 1, 2011 who kept him off work. PX1; PX2.

Section 12 Examination – Dr. Holmes

On December 6, 2011, Petitioner saw George Holmes, M.D. for an independent medical evaluation at Respondent's request. RX4. Petitioner reported increased continued pain across the midfoot area, increased pain with walking and weightbearing activities, some increased collapse of the medial aspect of the foot, and some ankle pain. *Id.* On examination, Dr. Holmes noted midfoot collapse with loss of arch and pes planus and midfoot and forefoot valgus deformity. *Id.* Dr. Holmes noted that Petitioner did not have the strength or ability to go up on his tiptoes, that the collapse was exacerbated with weightbearing, and that the ankle was grossly

stable. *Id.* Dr. Holmes diagnosed Petitioner with midfoot Charcot arthropathy with nonunion from the previous attempted midfoot arthrodesis and there might be some incompetency of the posterior tibial tendon, although he noted that the ankle joint was free of any significant arthritic change. *Id.*

Dr. Holmes opined that Petitioner's left ankle condition was not related to his injury at work. In so concluding, he noted that the March 2007 x-rays showed no evidence of acute fracture or dislocation, but rather revealed pre-existing arthritic changes in the tarsal bones and tarsometatarsal joint but not at the ankle. *Id.* He also noted that the October 2007 MRI scans, taken approximately seven months after the work accident, showed no abnormalities other than findings consistent with plantar fasciitis. *Id.* Thus, Dr. Holmes opined that there was no occult injury that occurred after October of 2007 that would somehow be attributable to the March 1, 2007 injury at work. *Id.*

With respect to Petitioner's left foot condition, Dr. Holmes specifically opined that the "only way" that Petitioner's Charcot arthropathy could be causally related to the March 2007 work injury would be if both the March 2007 x-rays (which he did not review) and the October 2007 MRIs (which he later reviewed) had both been misinterpreted by the radiologists who completed the respective reports. *Id.*

Additional films from 2009 through 2011 were provided to Dr. Holmes and he issued an addendum report dated January 16, 2012. RX5. Dr. Holmes maintained his earlier opinion that there is no evidence of a LisFranc injury occurring on March 1, 2007 and that, if an incident is going to initiate a Charcot arthropathy, the Charcot arthropathy would be evident shortly following the accident and certainly within seven months. RX4-RX5. He noted that the records showed that as late as October 2007 there was no evidence of a Charcot arthropathy. *Id.* Dr. Holmes also opined that Petitioner had a pre-existing arthritic condition in the left foot and that his Charcot foot condition developed as a result of his diabetes, and not his accident at work. RX4.

Dr. Holmes placed Petitioner at maximum medical improvement with regard to his work-related injury sometime between March 2, 2007 and October 9, 2007. *Id.* He opined that Petitioner was not a good candidate for surgery based on his medical history and suggested a diabetic total contact cast followed by a total contact boot or the use of a steel-shank rocker-bottom-sole shoe possibly with a double upright bar and medial reinforcement to prevent collapse of the foot. *Id.* Dr. Holmes further cautioned that should Petitioner undergo surgery in the future, Petitioner would have difficulty healing due to his diabetes and could eventually require a below-the-knee amputation due to complications. *Id.*

Continued Medical Treatment

On January 19, 2012, Petitioner saw Dr. Freedburg who reviewed Dr. Holmes' independent medical evaluation report. PX1; PX2. He noted Petitioner's report that use of the custom orthotic shoes did not help the left foot. *Id.* Dr. Freedburg discontinued use of the bone stimulator. *Id.* He also noted that Petitioner continued to have two broken screws in the left foot and a non-union arthrodesis causing the foot to hyperpronate. *Id.* Dr. Freedburg noted that Petitioner did have diabetes as evident in Petitioner's difficulty healing from the first surgery and smaller second procedure. *Id.*

Dr. Freedburg indicated that he discussed Dr. Holmes' independent medical evaluation report with Petitioner and the recommendation for a total contact cast, but that Petitioner did not want that and he wanted his left foot fixed. *Id.* Specifically, Dr. Freedburg disagreed with Dr. Holmes regarding causation and stated "[a]s far as causation is concerned I disagree. [Petitioner] has absolutely had an injury and it is well documented. Therefore, the accident produced the initiation and certainly the exacerbation of the charcot foot. So I will

disagree with Dr. Holmes and I am still requesting approval for the CT scan and possible surgery." *Id.* He recommended another CT scan to view the arthrodesis likely followed by an arthrodesis revision surgery. *Id.* Dr. Freedburg kept Petitioner off work. *Id.*

On May 3, 2012, Dr. Freedburg reiterated his opinions, recommendation for a CT scan and possible surgery, and noted that the VA was making Petitioner an Arizona brace. PX1; PX2. He kept Petitioner off work. *Id.* On July 23, 2012, Petitioner reported that he was going to pick up his Arizona brace in a few days. *Id.* Petitioner continued to follow up with Dr. Freedburg for wound care and treatment of the left foot through March 20, 2014, which remained the same. *Id.* He kept Petitioner off work. *Id.*

Petitioner testified that Dr. Freedburg was recommending a surgery, which he continues to recommend and Respondent still has not approved. He also testified that Dr. Freedburg has not yet released him from care and that he continues to see Dr. Freedburg once every two months.

Dr. Holmes' Deposition Testimony

Respondent called Dr. Holmes as a witness and he gave testimony at an evidence deposition on November 8, 2012. RX6. Dr. Holmes completed his undergraduate and medical schooling at Yale University, followed by two years of general surgery at Columbia Presbyterian in New York City. RX6 at 5. He then completed his orthopedic residency at Harvard, followed by six months of chief residency at Massachusetts General Hospital in orthopedics and a fellowship in sports medicine at Children's Hospital in Boston, Massachusetts. *Id.* Dr. Holmes also completed a foot and ankle fellowship in California with a Dr. Roger Mann. *Id.* He estimated that 95% of his practice is comprised of foot and ankle patients. RX6 at 6. Dr. Holmes has also published materials regarding foot and ankle injuries, specifically including LisFranc injuries. RX6 at 7.

Overall, Dr. Holmes opined consistent with his reports that Petitioner's left foot Charcot arthropathy condition was not caused or aggravated by his March 1, 2007 accident. RX6 at 14-15. He explained that Charcot arthopathy is a joint degenerative condition that occurs more acutely in diabetic patients and manifests in three phases. RX6 at 18-20. First, the patient had a hyperemic warm phase where the foot is swollen and red and appears to have osteomyelitis that appears within a few days or weeks after an acute traumatic event like a fall or tripping accident, or an acute event of which the patient is not aware. *Id.* Dr. Holmes explained that initial x-rays can show what looks like the bones dissolving and after a few weeks x-rays will show a disorganized healing phase making the bones appear fuzzy. *Id.* Third, the bones will consolidate and try to heal. *Id.* So, Dr. Holmes testified that since no scans from March through October 2007 showed any of these three phases Petitioner's accident at work could not have initiated his Charcot arthropathy. RX6 at 20-21.

He also testified that his review of Petitioner's medical records reveal a point around May 6, 2008 indicating the initiation of Petitioner's Charcot arthropathy. RX6 at 21, 46. On that date, Dr. Perona noted that Petitioner had left foot and ankle findings consistent with a posterior tibial tendon rupture, which could itself cause additional stress to the midfoot area and be a precursor to midfoot collapse in a normal person. RX6 at 21-22. Dr. Holmes noted that this finding was important because Petitioner's October 9, 2007 did not show any posterior tibial tendon rupture; it was essentially normal with the exception of some plantar faciitis. *Id.*

Dr. Holmes indicated that Petitioner's March 2, 2007 x-ray findings related to his age, diabetic condition, and weight; genetic factors that caused certain people to be predisposed to arthritis of the foot. RX6 at 15-16. He also indicated that the findings in Petitioner's October 9, 2007 MRI were unrelated to his accident at work; that the findings indicated arthritic changes of a long-standing duration. RX6 at 16-18. Dr. Holmes disagreed with

the proposition that Petitioner had a LisFranc injury as a result of his accident at work. RX6 at 23-25. He explained that these injuries were fairly painful and that if Petitioner had such an injury it would have shown up in the March 2007 x-rays or the October 2007 MRI. RX6 at 25.

Dr. Holmes maintained that Petitioner's pre-existing arthritic condition was not exacerbated or aggravated by his March 1, 2007 accident, he reached maximum medical improvement with regard to the injury that he did sustain (which he testified on cross examination occurred, but was not significant or a structural injury to the foot) on March 1, 2007, and Petitioner's Charcot arthropathy and the surgical intervention from Dr. Freedburg was not related to his accident at work. RX6 at 26-29, 38-39. Dr. Holmes recommended a conservative course of treatment including casting for Petitioner's unrelated, but existing, left foot condition given his history of diabetes, heart attack and DVT. RX6 at 28-32. He also opined that Petitioner could work a sedentary position and, ultimately, that Petitioner's current left foot condition was not causally related to his March 1, 2007 accident. RX6 at 32-33.

On cross examination, Dr. Holmes testified that he did not believe that Petitioner sustained a LisFranc injury despite Dr. Toofan's notation on March 2, 2007 that Petitioner had some swelling over the lateral aspect of the left ankle and dorsum of the foot. RX6 at 41-42. He explained that, for example, just because someone has a headache it does not mean that they have a tumor; a patient with a foot or ankle injury and swelling could have a metatarsal fracture, a tendon rupture, etc. *Id.* Dr. Holmes added that to diagnose a LisFranc injury it would require more than just a finding that the patient had swelling in those areas, which he acknowledged could be symptoms consistent with a LisFranc injury when taken in conjunction with other symptoms. RX6 at 42-43, 51-53.

Dr. Holmes further testified on cross examination that Charcot arthropathy can be caused by trauma, but it is not possible for trauma to accelerate a pre-existing Charcot arthropathy condition; "[i]t would be like beating a dead horse to death. … [or] breaking a bone that's already broken." RX6 at 46-47.

Dr. Freedburg's Deposition Testimony

Petitioner called Dr. Freedburg as a witness and he gave testimony at an evidence deposition on September 17, 2013. PX8. Dr. Freedberg attended the University of Illinois for undergraduate and medical school. PX8 at 5. He went on to complete an internship in general surgery and a four-year orthopedic residency at the University of Illinois, Cook County, the Westside VA Hospital, and Ravenswood Hospital. *Id.* Dr. Freedburg also completed a fellowship in sports medicine in Cincinnati and an exchange fellowship which took him to France and Germany. PX8 at 5-6.

Overall, Dr. Freedburg maintained his opinion that Petitioner had an unrecognized LisFranc injury that, given Petitioner's diabetic and neuropathy conditions, caused the midfoot to break down much quicker than without those conditions. PX8 at 10. He opined that on the date of accident, Petitioner sustained an unrecognized LisFranc sprain and the foot deteriorated significantly also due to Petitioner's diabetes condition. PX8 at 13-14. Dr. Freedburg also opined that Petitioner's foot would not have deteriorated due to diabetes only; that when diabetics develop what Dr. Holmes called a Charcot foot there is usually some related trauma. PX8 at 14, 18. He specified that the caused the foot deterioration to start. PX8 at 14-15. On cross examination, Dr. Freedburg disagreed that 50% of Charcot foot cases resulted from non-traumatic degeneration in diabetics. PX8 at 18-19. Then he indicated that there is some trauma, but the patient simply does not know what the trauma was. *Id.*

Dr. Freedburg also testified that Petitioner's March 2, 2007 Ottawa hospital x-rays would not reflect the

LisFranc injury because it is a ligament, not a bone, injury. PX8 at 15. He testified that the October 9, 2007 MRI did not exclude a LisFranc injury either. PX8 at 15-16. On cross examination, Dr. Freedburg testified that the MRI in October 2007 would not have shown swelling in the foot to identify the LisFranc sprain, which would have dissipated after those several months and left only the "propagation and sequelae of the injury at hand." PX8 at 20. He also testified that the symptoms of a LisFranc sprain are mostly pain in the midfoot, swelling, and dysfunction. PX8 at 20. He added that there could be panoply of different symptoms to varying degrees including the inability to bear weight sometimes. *Id.* He then reiterated that a trauma causes Charcot foot and that diabetes and neuropathy are exacerbating factors; so the Charcot condition will develop over time, but not in two months. PX8 at 25-26.

With regard to the May 6, 2008 diagnosis of a posterior tibial tendon rupture, Dr. Freedburg disagreed with Dr. Perona's clinical diagnosis and testified that Petitioner did not have this condition when he diagnosed Petitioner with pes planovalgus stemming from the LisFranc sprain. PX8 at 23-24. He acknowledged that if Petitioner had this tendon rupture, it would cause additional stress to the midfoot, but he denied that Petitioner had such a rupture given his MRIs. PX8 at 24. Dr. Freedburg acknowledged, however, that he did not have all of Petitioner's records from after his accident. PX8 at 20-21.

Dr. Freedburg testified that both of the surgeries that he performed on Petitioner were for the midfoot region. PX8 at 21-22. He also opined that Petitioner was unable to work since he performed Petitioner's first surgery in 2009. PX8 at 13. He further opined that Petitioner could do at least sedentary work. PX8 at 26. Finally, Dr. Freedburg testified that, while Petitioner had high risk factors for surgery, his only other option would be to leave the foot the way it is; Petitioner had tried other options including use of an Arizona boot without success and Dr. Freedburg continued to recommend surgery. PX8 at 26-27.

Additional Information

Regarding his current left foot condition, Petitioner testified that he still has lots of pain and he can move the bone in the foot with his finger which he has been able to do since he fell. Petitioner testified that he has an Arizona boot from the VA podiatry department which puts a lot of pressure on the ball of the foot. He goes to the VA for diabetes-related treatment, but he no longer treats at the VA regarding the Arizona boot. He testified that he was told to wear it if it helps. Petitioner also testified that he no longer plays golf; he quit after his surgery.

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 Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being in the left foot is not causally related to the injury sustained at work on March 1, 2007 as claimed. In so concluding, the Arbitrator finds that the opinions provided by Dr. Holmes, Respondent's Section 12 examiner, to be more persuasive because they are supported by medical evidence.

Through January 19, 2012, Dr. Freedburg diagnosed Petitioner with an unrecognized LisFranc injury for which he recommended and later performed surgery. Indeed, he treated Petitioner for this diagnosis as of Petitioner's initial visit on November 24, 2008 when he also, notably, provided a narrative opinion that Petitioner's left pes planovalgus and left LisFranc sprain with degenerative joint disease were directly caused by the mechanism of injury at work described to him by Petitioner. That description was that "…in March 2007 when he got out of his car at work, he slipped on black ice. He fell with his left knee bent under his body." There is no indication of any direct trauma to the foot or midfoot, specifically. Notwithstanding, it may not be unreasonable for Dr. Freedburg to have inferred that Petitioner sustained a midfoot injury subsequent to trauma that he did not know occurred when he sustained a serious injury to the knee requiring surgery; but only if objective medical evidence supported such a finding. The Arbitrator finds that it does not.

As an initial matter, it is remarkable that Petitioner is a heavy individual with a long history of diabetes and related problems including lower extremity ulcers after his injury at work. He also had moderate-to-severe degenerative joint disease in the foot as of March 2007, a point on which interpreting radiologists, emergency room physicians, Dr. Perona, Dr. Harney, Dr. Freedburg, and Dr. Holmes all essentially agree when comparing their interpretations of the diagnostic films. With regard to the specifics of Petitioner's midfoot condition, Dr. Holmes and Dr. Freedberg both provided testimony via evidence deposition.

Interestingly, they agree that Petitioner currently has Charcot arthropathy in his left foot. They also agree that Charcot arthropathy can be caused by either significant trauma, such as a fall on ice with multiple injuries, or insignificant trauma, such as walking down stairs, of which a patient may not even be aware. However, this is not a diagnosis that Dr. Freedburg rendered (i.e., a LisFranc injury to the midfoot) or mentioned prior to when he reviewed Dr. Holmes' independent medical evaluation report. In fact, he steadfastly maintained that Petitioner sustained a LisFranc injury on March 1, 2007 at work and added, after Dr. Holmes' diagnosis, that the LisFranc injury preceded development of the Charcot arthropathy which was also due, in whole or in part, to the work accident on March 1, 2007. In considering the opinions of both physicians, the Arbitrator finds that the opinions of Dr. Holmes are supported by objective medical evidence.

Dr. Holmes was able to more reasonably explain Petitioner's present condition of ill being and the progression of his left foot condition from the date of accident through the date of his independent medical evaluation. He articulated the development of Charcot arthopathy, the symptoms to be noted on examination at different stages of progression, and (addressing Dr. Freedburg's original diagnosis) how a LisFranc injury occurs. He was further able to point to specific objective evidence (i.e., Petitioner's March 2007 x-rays and October 2007

MRIs) that lacked evidence of trauma consistent with an unrecognized LisFranc injury or any trauma for that matter that would lead to Charcot arthropathy. He noted that the first evidence of trauma that would lead to Charcot arthropathy was around May 6, 2008 when Dr. Perona noted that Petitioner had left foot and ankle findings consistent with a posterior tibial tendon rupture. However, the Arbitrator notes that Dr. Holmes was not provided with the medical records from Petitioner's podiatrist, Dr. Crowhurst.

When Petitioner first saw Dr. Crowhurst approximately six months after his injury at work on August 28, 2007, he complained of left second toe drainage following "[t]rauma to the area [that] occurred as a result of playing golf. … Condition has existed for 2 months." Dr. Crowhurst examined Petitioner noting no midfoot complaints and diagnosed him with an ulceration of the lower limb, controlled diabetes mellitus type II with neurologic manifestations, bilateral hammertoes, and acute osteomyelitis. When Petitioner returned to Dr. Crowhurst on September 11, 2007, Petitioner exhibited the first clinical findings of symptoms in the midfoot. Specifically, Dr. Crowhurst noted tenderness along the medial aspect of the midfoot. While Petitioner related the midfoot symptoms to his injury at work, there was no clinical evidence of an injury to the midfoot until after his golfing incident which is relatively consistent with the medical progression of Charcot arthropathy status post recognized or unrecognized trauma articulated by Dr. Holmes. Notably, Dr. Holmes did not appear to have reviewed Petitioner's diagnostic films himself from 2007, but Dr. Freedburg did not have the medical records of Dr. Crowhurst noting an intervening injury while golfing involving the left foot occurring approximately four months after his accident at work.

In comparing the opinions of both physicians, it is paramount to recognize that "[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)). The Court went on to specify that such opinions are "only as valid as the reasons for the opinion." *Id.*, (*citing Kleiss v. Cassida*, 297 Ill. App. 3d 165, 174, 696 N.E.2d 1271, 1277, 231 Ill. Dec. 700 (1998)).

Dr. Freedburg was ultimately unable to specifically explain how Petitioner's generally described mechanism of injury caused his midfoot condition either in whole or in part, and the Arbitrator finds that his opinions are based more on speculation or conjecture than objective medical evidence. He was unable to reasonably explain why the October 2007 MRI would not have revealed *any* indication of a midfoot injury other than in a conclusory fashion when he testified that the swelling "in the foot that would identify the LisFranc sprain would be dissipated [by the time of the October 2007 MRI] *and what you are left with is the propagation and the sequelae of the injury at hand.*" PX8 at 20 (*emphasis* added). He did not explain what this meant and no mention was made of the fact that swelling and tenderness was first noted in the midfoot after Petitioner's golfing injury by a podiatrist, Dr. Crowhurst.

When prompted, Dr. Freedburg testified generally that the symptoms of a LisFranc injury would be mostly pain in the midfoot, swelling, possibly the inability to bear weight and "dysfunction. You could have a panoply [sic] of different symptoms and to a varying degree also." *Id.* Dr. Freedburg did not specify this panoply of symptoms generally, in patients with unrecognized midfoot injuries, or specifically, in Petitioner's case. He simply indicated at one point that Petitioner was focused on his knee injury and not the foot condition. When further prompted, Dr. Freedburg also acknowledged that he did not have all of Petitioner's medical records from right after his accident and he dismissed the reliability of emergency room physicians' diagnoses or interpretation of diagnostics relating to orthopedic conditions. *Id.*, at 20-21.

Ultimately, Dr. Freedburg steadfastly maintained that his diagnoses were correct—which even includes the Charcot arthropathy diagnosis that he adopted from Dr. Holmes—and that Petitioner's left foot condition was causally related to his injury at work, in whole or in part, without providing specific explanations or citation to objective medical evidence to support his unwavering conclusions. Indeed, Dr. Freedburg causally related Petitioner's midfoot condition on the very first day he examined Petitioner and his medical records and deposition testimony are replete with conclusory opinions that Petitioner's left foot condition was causally related to his fall at work. Without an objectively and more specifically supported explanation other than Dr. Freedburg's contention that Petitioner's reported mechanism of injury of falling with his left leg bent under his body was sufficient to cause the type of midfoot—not toe, or ankle or knee—injury that he diagnosed, the Arbitrator does not find Dr. Freedburg's opinions to be persuasive.

Finally, comparing the curricula vitae and respective education and training of Dr. Holmes and Dr. Freedburg, the Arbitrator finds that Dr. Holmes has more specialized and extensive training as well as a more focused medical practice related to the foot and ankle as compared to Dr. Freedburg. In addition to Dr. Holmes' specific explanation of Petitioner's midfoot condition, its general progression, and the medical records which support his explanation, the Arbitrator finds Dr. Holmes' opinions to be more persuasive in light of his very specialized training than those of Dr. Freedburg. Thus, the Arbitrator accords significant weight to Dr. Holmes' opinions in this case.

Based on all of the foregoing, the Arbitrator finds that Petitioner's claimed condition of ill-being as to his left foot is not causally related to the injury sustained at work on March 1, 2007. By extension, all other issues related to the left foot are rendered moot and all related requested compensation and benefits 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

CYNTHIA KILBER,

Petitioner,

15IWCC0374

vs.

NO: 08 WC 045282

UNITED AIRLINES, INC.,

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 accident, medical expenses, notice and TTD and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below, which is attached hereto and made a part hereof.

Petitioner, on October 28, 2007, fell while descending a flight of stairs and claims to have sustained injuries to her left knee, left shoulder, left elbow and neck. The immediate explanation for the fall was given as her left knee giving out. The more distant explanation for the fall was Petitioner's falling to the ground on March 1, 2005, after slipping on ice while in Respondent's parking lot, an accident the Commission found to be compensable. It is this explanation that was adopted in the Decision of the Arbitrator. The Commission cannot do likewise.

"[T]the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a preexisting condition, and, thereby, caused the disability, the Commission's award of compensation must be confirmed." *Sisbro v. Industrial Commission, 207 Ill. 2d 193, 215; 797 N.E.2d 665; 2003 Ill. LEXIS 776; 278 Ill. Dec. 70 (2003).* For the Commission to adopt the finding that Petitioner's October 28, 2007, fall was causally connected to her March 1, 2005, accident, it would have to engage in speculation and conjecture.

The Commission finds the medical records of no value to explain Petitioner's October 28, 2007, fall. Subsequent to March 1, 2005, and prior to October 28, 2007, Petitioner underwent a course of physical therapy for her left knee and continued treatment of the same with Dr. Warren Jablonsky, her treating physician. Contained within their treatment records are multiple but sporadic complaints of pain to the medial aspect of her left knee. She complained of left knee pain to her physical therapist on August 22, 2005, and of a "rubber band type pull" with a significant increase of pain in her left knee to Dr. Jablonsky on August 25, 2005. In both histories, Petitioner related that the pain began with her ascending stairs on August 20, 2005. She then complained of continued pain when she was seen by Dr. Jablonsky on November 3, 2005. Slightly more than one year later, on November 27, 2006, Petitioner returned to Dr. Jablonsky with complaints of left knee pain and swelling that had been present since November 8, 2006. Dr. Jablonsky then ordered a repeat MRI of Petitioner's left knee to be taken. It showed only degenerative changes and no definitive tear. Absent from these records was any history offered by Petitioner or any finding made by either Petitioner's physical therapist or Dr. Jablonsky of any instability or weakness in her left knee. Those same records indicate only that Petitioner, for a short time in 2005, experienced pain in her left knee when ascending stairs, not descending stairs. Other than those complaints of pain, no other impediment was complained of or identified in the treatment records.

The Commission, similarly, finds the testimony fails to explain what caused Petitioner's left knee to give out on October 28, 2007. Petitioner, on direct examination, testified to falling down stairs. On cross-examination, she testified to falling down the stairs due to her knee buckling. Not elicited was an impression from Petitioner as to what might have caused her knee to buckle. Absent from her testimony was any statement of her experiencing any weakness or pain in her left knee either immediately before or simultaneous with her fall. Dr. Jablonsky testified via evidence deposition twice but on neither occasion did he offer an explanation as to what caused Petitioner's October 28, 2007, fall beyond stating that her left knee gave away. On redirect examination during the evidence deposition of February 4, 2008, Dr. Jablonsky was asked if Petitioner's knee giving out "consistent with the kind of injury she sustained [on] March 1, 2005," and he responded, "Yes." The Commission finds this testimony to be unsatisfactory as Dr. Jablonsky's answer is inconsistent with the findings he recorded in his treatment notes. As noted above, his records contain no mention of any complaints or findings of any weakness or instability in Petitioner's left knee. As such, Dr. Jablonsky's answer to the posed question is not supported by his examinations of Petitioners or by any history Petitioner provided to him prior to October 28, 2007. Dr. Jablonsky participated in a second evidence deposition on May 25, 2010. While on direct examination, he answered affirmatively that the condition for which he was treating Petitioner as of February 24, 2010, was causally connected to her March 1, 2005, accident, noting that Petitioner still complained of pain. He then, without solicitation, indicated that he wasn't quite sure and that he really wouldn't know without a new MRI. The questions posed to Dr. Jablonsky on cross-examination focused on the time immediately before October 28, 2007, and resulted in him indicating that he did not have any record of Petitioner complaining of her left knee giving away prior or of having any problems with stairs prior to October 28, 2007. The Commission finds the testimony of Petitioner and Dr. Jablonsky, like Petitioner's medical records, provide no explanation as to what caused Petitioner's left knee to give away on October 28, 2007.

15IWCC0374

Based upon the totality of the evidence, the Commission finds itself unable to award compensation to Petitioner for injuries sustained on October 27, 2008, as Petitioner failed to prove that her fall that day was causally related to her March 1, 2005, accident. As noted above, at no time after her October 27, 2008, accident did Petitioner attribute her knee giving out to any condition, let alone one related to her original accident of March 1, 2005. Furthermore, even if the Commission was to decide the claim in Petitioner's favor, it would find Petitioner failed to prove any injury to her knee on October 28, 2007, as evidenced in Dr. Jablonsky's January 31, 2008, treatment record, in which only injuries to her left shoulder, neck and arm were chronicled.

IT IS THEREFORE ORDERED BY THE COMMISSION that April 3, 2014, Decision of the Arbitrator is reversed and compensation denied.

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: MAY 21 2015
KWL/mav
O: 03/24/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0374

KILBER, CYNTHIA
Employee/Petitioner

Case# **08WC045282**

06WC054936

UNITED AIRLINES INC
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:

2226 GOLDEN LAW OFFICE
LOREN GOLDEN
2400 BIG TIMBER RD SUITE 201A
ELGIN, IL 60123

0560 WIEDNER & McAULIFFE LTD
KAREN COON
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0374

Cynthia Kilber
Employee/Petitioner

v.

United Airlines, Inc.
Employer/Respondent

Case # **08 WC 45282**

Consolidated cases: **06 WC 54936**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **September 23, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0374

FINDINGS

On the date of accident, **October 28, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**52,742.28**; the average weekly wage was $**1,014.28.**

On the date of accident, Petitioner was 44 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 $**288,163.10** for TTD, in the combined claims of **08 WC 45282** and **06 WC 54936**.

Respondent is entitled to a credit of $**54,605.35** under Section 8(j) of the Act for the combined claims of **08 WC 45282** and **06 WC 54936**.

ORDER

Please see Decision issued in companion case **06 WC 54936**.

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

4/2/14

Date

ICArbDec19(b)

APR 3 - 2014

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Kilber,

Petitioner,

vs.

United Airlines, Inc.,

Respondent.

15IWCC0374

Case No. 08 WC 45282; 06 WC 54936

FINDINGS OF FACT:

The petitioner testified that she has worked for the respondent, United Airlines, Inc., as a supervisor of interline domestic accounting for approximately 20 years. She described her position as being primarily a desk job at which she sits before a computer. However, the petitioner stated that occasionally, she would walk around to help those working under her.

The petitioner testified that on March 1, 2005, she was exiting her vehicle in the employee parking lot when she slipped and fell on black ice. She twisted her left knee and fell on her right back and hip area.

Following the accident of March 1, 2005, the petitioner was initially evaluated by Dr. Warren Jablonsky on March 10, 2005, for complaints of right hip and left knee pain. X-rays of the left knee showed lateral compartment degenerative changes. X-rays of the right hip showed evidence of a varus hip with no other bony abnormalities. She was diagnosed with a right hip and buttock contusion with evidence of a right sacroiliac joint strain, and a left knee probable medial collateral ligament sprain with a possible medial meniscus tear. An MRI of the left knee was prescribed and the petitioner was authorized to return to work at full duty.

On March 10, 2005, petitioner underwent an MRI of the left knee, which showed a low grade injury of the medial collateral ligament with increased signal intensity in the medial meniscus which did not fit MRI criteria for a tear. There was mild chondromalacia patella with a small patellofemoral joint fusion. Dr. Jablonsky suggested she might need an arthroscopy and administered an intraarticular steroid injection. Physical therapy for right SI joint and low back pain was prescribed.

On June 3, 2005, the petitioner underwent a left knee arthroscopy with medial meniscal repair and partial lateral meniscectomy performed by Dr. Jablonsky. She returned to Dr. Jablonsky on June 6, 2005 and noted no significant complaints of pain or discomfort. By June 30, 2005, she was to work up to weight bearing as tolerated. Postoperatively, she underwent physical therapy at Excel Physical Therapy beginning on July 6, 2005.

On August 22, 2005, while at physical therapy, the petitioner reported that while ascending stairs on August 20, 2005, she felt a sharp pain in the medial left knee, accompanied by throbbing pain in the area since that time. Hip pain had also reportedly kept her awake since 2:45 a.m.

On August 25, 2005, she reported to Dr. Jablonsky that she had been doing well until Saturday, when she was going up stairs and felt a rubber band-type pull with significant increasing pain. As she now had new complaints of pain radiating to the right lower leg, an MRI of the lumbar spine was prescribed.

The MRI of the lumbar spine performed on August 29, 2005 showed a small right paramedian disc herniation at L3-L4, postoperative and degenerative changes at L4-L5 with mild foraminal stenosis and a tiny left foraminal disc herniation at L5-S1. Based on the MRI results on September 1, 2005, Dr. Jablonsky recommended an epidural steroid injection.

A Section 12 examination was performed on September 22, 2005 by Dr. Babak Lami of Illinois Spine Institute at the request of the respondent. The petitioner reported post-surgery improvement of 90% in her left knee symptoms. She reported pain in her lower back and on the lateral aspect of the right leg over the greater trochanteric area. The symptoms were not radicular at that time. The petitioner was diagnosed with low back pain with a component of

right iliotibial band inflammation and possible SI joint pain and a left knee meniscal tear. Dr. Lami recommended physical therapy for her low back and right hip and injections if physical therapy was not beneficial.

Following an evaluation at the Pain Center of McHenry County with Dr. Nasaruddin on October 13, 2005, the petitioner continued with conservative care consisting of injections and physical therapy with no improvement. The petitioner returned to work on October 11, 2005 until September 21, 2006 at full duty, as was stipulated to by the parties. (AX1)

The petitioner saw Dr. Jablonsky again on November 3, 2005, reporting that her back pain had continued after the epidural steroid injection. Dr. Jablonsky agreed with the Dr. Nasaruddin's recommendation to perform a sacroiliac joint injection.

The petitioner returned to Dr. Jablonsky on February 16, 2006 describing pain of a radicular nature in the lower extremity, as well as ongoing complaints of right SI joint pain and sudden discomfort in the left medial femoral condyle region. Dr. Jablonsky provided her with the names of possible spine specialists, including Dr. Panchal, and noted she might need a lumbar discectomy.

The petitioner began treatment with Dr. Panchal, affiliated with Centegra, who recommended a myelogram and post-myelogram CT which was performed on May 19, 2006 by Dr. Nassaruddin. The exam showed advanced disc disease at L4-L5, endplate degenerative changes, stenosis at L3-L4, neuroforaminal stenosis at L3-L4 on the left, and at L4-L5.

On September 21, 2006, petitioner underwent a laminectomy at L3-L5, medial facetectomy and foraminotomy, neurolysis, and decompression of the L4-L5 nerve root.

The petitioner saw Dr. Jablonsky again on November 28, 2006, with complaints of left knee pain and swelling which began November 8, 2006 during rehabilitation for her back while on a bicycle. She reported no history of twisting or any injury. The records reflect that she had been able to ride a bicycle throughout the summer without complaints of pain or discomfort. The MRI of the left knee performed January 11, 2007 showed no evidence of a re-tear. It did show mild to moderate osteoarthritis most pronounced within the patellofemoral joint space. Dr. Jablonsky suggested possible diagnostic arthroscopy with debridement or repair as needed.

The petitioner underwent a second myelogram and post-myelogram CT of the lumbar spine on March 2, 2007. The results suggested severe degenerative disc disease at L4-5, marginal osteophytes, broad-based bulge of L3-4 and evidence of previous surgeries.

The petitioner returned to Dr. Lami for a second Section 12 examination on May 23, 2007. Dr. Lami found her condition with respect to the lumbar spine was unrelated to the work injury of March 1, 2005, as the radiculopathy did not begin until 6 months after this fall. He also noted that the petitioner's subjective disabilities and pain were out of proportion to the objective findings and he opined she would be a poor surgical candidate. Dr. Lami further opined that the petitioner was at maximum medical improvement following injuries sustained from the accident on March 1, 2005. He stated that further treatment would not be related to her work injury and recommended she return to her office job at full duty.

The petitioner sought a second opinion from Dr. Spencer on September 13, 2007. He initially opined that her back pain was not mechanical and provided her with an injection. At a follow-up appointment, she demonstrated signs of mechanical back pain and he recommended a laminectomy.

On September 13, 2007, Dr. Lami issued an addendum report. He opined that the lower extremity symptoms were not due to radiculopathy but were rather due to inflammation of the iliotibial band. He further opined that her leg symptoms and the low back surgery were therefore unrelated to the March 1, 2005 work injury.

The petitioner testified that on October 28, 2007, she fell down the stairs in her home and injured her left shoulder, left elbow and left side of her neck.

Following the October 28, 2007 occurrence at home, the petitioner saw Dr. Jablonsky on January 31, 2008. The petitioner told Dr. Jablonsky that the injury occurred as she was going down the stairs at home, her left knee gave way and she fell. Following this fall, the petitioner complained primarily of left elbow, neck, shoulder and arm pain.

The petitioner next followed up with Dr. Jablonsky on February 7, 2008, at which time they discussed the results of the February 1, 2008 MRI of the left upper extremity.

The MRI showed evidence of a C4-C5 left-sided disc herniation, as well as bilateral foraminal narrowing at C5-C6 with left paramedian protrusion at C6-C7. The petitioner advised Dr. Jablonsky that she would follow up with her spine specialist, Dr. Spencer, at Lutheran General Hospital.

Dr. Jablonsky was first deposed on February 4, 2008. He testified that the petitioner had no lumbar complaints or radiculopathy when he first saw her in March 2005. He opined that it was possible that the second injury of October 28, 2007, aggravated the petitioner's pre-existing condition. He testified that the March 1, 2005 accident aggravated the right hip area. It was his opinion that the petitioner's current knee problems, at the time of the deposition, were most likely related to the March 1, 2005 accident rather than to any biking activities in which the petitioner engaged. Furthermore, Dr. Jablonsky could not correlate the new instance of right leg radiculopathy or lumbar condition to the accident of March 1, 2005.

The deposition of Dr. Panchal was taken on April 28, 2008. At the time of his deposition, he had not seen the petitioner since July 23, 2007. Dr. Panchal testified that the MRI indicated the petitioner had undergone a prior, right-sided L4-L5 laminectomy. He opined that the fall of March 1, 2005 contributed to the petitioner's symptoms and aggravated her degenerative condition. Dr. Panchal noted that the petitioner had continued complaints after surgery and the myelogram on March 2, 2007 showed a bulging disc at L3-L4 with scarring. Dr. Panchal further opined that the March 1, 2005 fall was connected to the herniated disc, radiculopathy and surgery. On cross-examination, however, he testified that if the petitioner had absolutely no symptoms of back pain or leg pain for six months after the accident, he would find that the March 1, 2005 fall played a very little role with regard to the petitioner's condition at that time. While Dr. Panchal testified the petitioner could not work as a flight attendant, this was not her job and no opinion was offered as to whether she could work in an office setting.

On May 29, 2008, Dr. Lami testified that he had diagnosed petitioner with low back pain with a component of a right IT band inflammation and possible SI joint pain, in addition to a left knee meniscus tear. Dr. Lami deemed that these conditions were casually related to the fall of March 1, 2005.

At the time of his examination, Dr. Lami found no indication of any injury to the petitioner's L4-5 and L3-4 disks. Dr. Lami explained the difference between iliotibial band pain and diskogenic pain and testified that the petitioner had no symptoms or complaints of sciatica or radiculopathy at the time of the September 22, 2005 examination. As the petitioner developed radicular pain at least one year after falling, he was unable to relate the need for the lumbar surgery that the petitioner underwent in September to the petitioner's fall on March 1, 2005, as an injured back would not take up to one year to show signs of sciatica or radiculopathy.

The petitioner was seen by Dr. James Bresch on June 16, 2008. The petitioner filled out an intake form in which she identified October 28, 2007 as the date of injury and told him that she had a three-month history of left shoulder pain. She reported that she initially had numbness and tingling in her left hand and was evaluated by a spine surgeon, who obtained an MRI that did not demonstrate any findings consistent with her symptomatology. It was suggested by her physical therapist that she seek an orthopedic evaluation. X-rays showed good joint space within the glenohumeral joint with some slight degenerative joint disease in the AC joint with no overall source of her symptomatology. Dr. Bresch's assessment was adhesive capsulitis. He administered a corticosteroid injection in the subacromial space. The petitioner was instructed to continue with physical therapy for range of motion and strengthening activities and to return in six to eight weeks.

The petitioner saw Dr. Bresch again on June 30, 2008 and stated that the injection did not provide any relief. Dr. Bresch noted that Dr. Spencer strongly believed her complaints were not coming from her neck. Dr. Bresch prescribed an arthroscopic subacromial decompression and release of adhesions. Left shoulder surgery was performed by Dr. Bresch on September 5, 2008. The post-operative diagnoses were left shoulder impingement syndrome, profound rotator cuff tendinopathy and detached glenoid labrum.

Due to continued post-operative complaints, a second MRI of the left shoulder was performed on October 23, 2008. The study showed post-surgical changes involving the glenoid. There was a focal full thickness tear of the supraspinatus tendon without retraction of the myotendinous junction. Also seen were degenerative changes at the AC joint causing

impingement and long head of the biceps tendinitis. The petitioner underwent a second left shoulder surgery performed by Dr. Bresch on December 12, 2008 consisting of a left shoulder arthroscopy with open bicipital tenodesis for a diagnosis of chronic bicipital tendinitis.

Dr. Spencer testified in this matter on October 16, 2008. He evaluated the petitioner on what he believed to be a referral from Dr. Panchal. He initially felt the petitioner's leg pain was independent of movement of the lumbar spine. Dr. Spencer opined that as the petitioner's pain was not mechanical, a fusion would not help. He prescribed Neurontin that reduced the leg pain, leaving her back pain as the primary problem.

At the petitioner's next evaluation by Dr. Spencer, he noted that her pain was now mechanical and a revision laminectomy was prescribed.

The petitioner followed up with Dr. Spencer on February 19, 2008 and reported an accident where she fell on her elbow. With regard to causation, Dr. Spencer testified that the petitioner had early retrolisthesis, which was related to a degenerative condition and that the March 1, 2005 fall on ice contributed to her back pain. He testified that he could not say if she was still a surgical candidate as he had not seen the petitioner since September 13, 2007.

On April 6, 2009, a Section 12 examination of the left knee was performed by Dr. Brian Cole. Dr. Cole recommended an MRI and injection. Dr. Cole causally related the petitioner's condition to an aggravation sustained in November 2006 while the petitioner was in physical therapy for her low back and was riding a bike. Dr. Cole opined the petitioner's present complaints were a result of an aggravation of her pain symptomatology and not as a result of a new injury or tear.

The petitioner was seen on April 14, 2009 by Dr. Jablonsky for a new right knee injury. She reported that she was walking on April 4, 2009 when she felt a sharp pulling sensation in her right knee. X-rays of the right knee showed some mild medial compartment narrowing and proximal tibial changes of the previous bone graft site. The impression was that of right knee pain of unclear etiology due to an injury on April 4, 2009.

The petitioner underwent an MRI of the right knee without contrast on April 16, 2009. She was found to have mild chondromalacia to the lateral facet of the patella and medial joint

compartments with increased signal intensity in the posterior horn of the medial meniscus, an acute mid-grade injury of the collateral ligaments, iliotibial band syndrome, large patellofemoral joint effusion and fluid in the subcutaneous fat anterior to the patella and patellar tendon.

The petitioner was seen on April 21, 2009 to review the MRI findings with Dr. Jablonsky. The MRI showed some medial meniscal degeneration, iliotibial band syndrome and prepatellar tendon fluid. The petitioner reported that she had lateral pain along the distal IT band, lateral joint line and medial pain and Dr. Jablonsky gave her an injection at this visit.

The petitioner was seen by Dr. Jablonsky on May 5, 2009, and reported that the injection she received on April 21, 2009 provided some relief, but she still had substantial pain. The petitioner noted she was going to hold off on any surgery at the present time.

On July 2, 2009, the petitioner saw Dr. Jablonsky for left knee complaints. He had not seen her for complaints to the left knee since February 23, 2007. He noted that dating all the way back to the February 23, 2007 visit, arthroscopic debridement to the left knee, secondary to the work injury of March 1, 2005, had been discussed and future treatment options had been contemplated since that time. Dr. Jablonsky proceeded to inject the petitioner's left knee at the time of this visit.

The petitioner followed up with Dr. Jablonsky for re-evaluation of left knee pain on July 16, 2009. He noted that the left knee condition stemmed from a left knee injury on March 1, 2005. As the petitioner reported that the left knee injection she had received at the time of the July 2, 2009 visit provided little relief, Dr. Jablonsky prescribed an MRI.

On August 10, 2009, the petitioner underwent a right knee arthroscopy with partial medial and lateral meniscectomies, patellofemoral chondroplasty and medial femoral chondroplasty. Post-operatively physical therapy was instituted.

On November 5, 2009, the petitioner was given an injection to the left knee. On November 19, 2009, she reported that the injection did not provide adequate relief. Dr. Jablonsky proceeded to recommend an MRI scan of the left knee.

On December 18, 2009, the petitioner underwent an MRI of the left knee that showed tricompartmental chondromalacia, with worsening in the patellofemoral joint compared to the prior study of March 10, 2005.

The petitioner returned to Dr. Jablonsky on January 8, 2010 to review the MRI. The petitioner felt that she would like to proceed with an arthroscopic evaluation and debridement.

The petitioner returned on February 24, 2010, stating that on February 19, 2010, while walking up the stairs at home, she felt a significant crack in the left knee. She reported an onset of pain primarily in the patellofemoral region and lateral aspect of the joint. Dr. Jablonsky found she had an exacerbation of her symptoms in her left knee with somewhat different complaints of pain after the incident of February 19, 2010. The doctor recommended a repeat MRI scan to ensure there was no other evidence of increased injury or damage.

The petitioner was seen on March 18, 2010 for right knee follow up after the arthroscopy performed on August 10, 2009. On examination, she had pain radiating from the lateral aspect of her right hip all along the course of the iliotibial band and lateral aspect of her right knee.

A second deposition of Dr. Jablonsky was taken on May 25, 2010. Dr. Jablonsky testified that the petitioner's left knee complaints through February 24, 2010 were causally related to the March 1, 2005 work accident.

With respect to the right knee, Dr. Jablonsky offered no opinion as to whether the right knee surgery was related to a work accident or to the left knee condition. He also testified that it was possible that the left knee condition was a result of the November 2006 incident in therapy rather than the March 1, 2005 accident. Upon further questioning, he conceded that it was possible that the right knee may be having an adverse effect on the left knee. He was also unaware that the petitioner was treating for her left elbow, shoulder and neck.

On June 23, 2010, the petitioner underwent an MRI of the left knee that showed tricompartmental chondromalacia most severe at the patellofemoral joint, with full thickness chondral defect of the lateral apex. There was a stable configuration of the menisci without development of meniscal tear and there continued to be a stable low grade MCL sprain.

The petitioner returned to Dr. Jablonsky on June 28, 2010. He noted no major changes in the June 23, 2010 MRI of the left knee as compared to the prior study performed December 18, 2009, but noted evidence of continued tricompartmental chondromalacia. Dr. Jablonsky discussed the possibility of an arthroscopic evaluation and debridement with lateral release. He noted that due to the significant amount of degenerative changes in the patellofemoral joint and changes within the medial compartment, that a total knee arthroplasty might be necessary in the future.

The deposition of Dr. Bresch was taken July 14, 2010. Dr. Bresch testified that as a result of the petitioner's fall at home in October 2007, the petitioner suffered post-traumatic adhesive capsulitis and impingment syndrome. Shoulder surgery was performed at which time the doctor found chronic changes/tears. Dr. Bresch opined that a cervical problem could be causing ongoing shoulder pain and referred the petitioner to Dr. Spencer. The petitioner underwent a second surgery for chronic bicipital tendonitis. The petitioner was last seen by Dr. Bresch on January 15, 2009. She had adhesive changes and PT was recommended. Dr. Bresch testified that her condition was causally related to the fall at home on October 28, 2007. Mechanically, the shoulder was stable and he was unable to identify the source of her ongoing pain.

On September 30, 2010, Dr. Cole issued an addendum opinion. He noted that petitioner had been doing well prior to the re-injury at physical therapy, however, when he saw her, she had a profound amount of stiffness. He recommended she undergo an injection and indicated that if this did not afford even temporary relief, her prognosis with arthroscopic surgery would be poor. Given the moderate amount of arthritis, Dr. Cole recommended aggressive weight loss and Synvisc injections. If there was no improvement, then a last ditch effort at arthroscopic evaluation could be appropriate to allow an opportunity to assess articular surfaces for possible arthroplasty.

On January 12, 2011, Dr. Jablonsky performed a left knee arthroscopy with partial medial meniscectomy, patellofemoral chondroplasty, medial and lateral femoral chondroplasty and lateral release. The petitioner began physical therapy at McHenry County Orthopedics Physical

Therapy on January 27, 2011. By February 23, 2011, Dr. Jablonsky noted that her range of motion was zero to 120 degrees. By March 23, 2011, the petitioner reported that she was approximately 70% improved with physical therapy.

On May 4, 2011, the petitioner was still complaining of significant pain in the lateral patellofemoral joint and parapatellar region. Her IT band symptoms had also been worsening in spite of physical therapy. Dr. Jablonsky reviewed the intraoperative pictures, and noted that with the amount of degenerative changes within the knee, he had questions regarding a successful outcome. Dr. Jablonsky wrote: "If she continues to have breakdown of her tissues and continues to have complaints of pain, a total knee arthroplasty would be the only recommended treatment option, as a possibility in the future." (PX14)

On June 2, 2011, the petitioner reported that she remained only about 50% improved since surgery. On July 11, 2011, Dr. Jablonsky provided her with samples of Voltaren gel to reduce the distal and iliotibial band discomfort.

At the request of the respondent, and pursuant to Section 12 of the Act, Dr. Joseph D'Silva examined the petitioner on June 8, 2011.

The petitioner's husband, Paul Kilber, accompanied her to the examination by Dr. D'Silva. He observed that Dr. D'Silva spent very little time with his wife and, in fact, never physically examined Cynthia Kilber's left knee.

Dr. D'Silva opined that the petitioner sustained an isolated injury to the medial meniscus that was appropriately arthroscopically repaired. Dr. D'Silva further opined that the lateral meniscectomy that was performed during the first surgery was not related as it was not symptomatic at the time. Dr. D'Silva also stated that the petitioner had recovered from the March 1, 2005 injury, and 1-1/2 years later, complained of new onset of left knee pain. Dr. D'Silva also opined that none of the described activities would stress the meniscus and that the findings noted during the last arthroscopy, including the advanced patellofemoral joint symptoms and lateral compartment arthritis, were unrelated to the injury in 2005 and said findings did not correlate with the mechanisms of injury described by the patient. Lastly, Dr. D'Silva opined that all treatment to the left knee after 2006 was unrelated to the work accident.

On September 20, 2011, the petitioner returned to Dr. Jablonsky for a new injury that resulted from a motor vehicle accident. She told Dr. Jablonsky that the injury occurred when her seat belt was stuck in the door, and she opened the car door and fell out, landing on the left side of her body. She had complaints involving her elbow with abrasion in the olecranon region. She also had complaints of neck discomfort with tingling into the middle and ring fingers of the left hand. A CT of her neck showed generalized degenerative changes at C4-C5 and C5-C6 with no obvious fracture. X-rays of the elbow were also negative for fracture. APN lateral views of the right knee showed evidence of generalized degenerative changes. She was placed in a long arm posterior mold. She complained of tingling into the middle and ring fingers in the left hand, which was showing some mild improvement. The right knee had generalized stiffness. She was diagnosed with a left elbow contusion, a right knee degenerative joint disease with evidence of contusion and numbness and tingling involving the left ring and middle fingers.

The petitioner returned to Dr. Jablonsky for reevaluation on September 27, 2011. Her left elbow contusion and right knee were improved. Dr. Jablonsky noted evidence of distal iliotibial band irritation. The numbness and tingling in the left ring and middle fingers had resolved and was felt to be related to a contusion of the medial nerve. The petitioner also complained of an exacerbation of symptoms in the left knee degenerative joint disease and right-sided low back pain. The petitioner declined physical therapy at that time.

On April 25, 2012, Dr. D'Silva testified that the work accident of March 1, 2005 resulted in a medial meniscus tear that resolved within 16 to 18 months. The surgery performed in June 2005 resolved the meniscal condition that was the result of the March 1, 2005 accident. The second surgery, including the re-tear of the medial meniscus, was not in any way related to the work accident or the prior surgery. Additionally, the chondromalacia found in the petitioner's knee was not aggravated by the work accident. The doctor further testified that the medial meniscus tear that was the result of the work accident would not lead to later episodes of instability, as the problem had been corrected by the surgery in June 2005. Therefore, any episodes of instability, such as the second accident/fall on October 28, 2007, would be unrelated

to the work accident. The activity of riding a bike while in physical therapy would also not cause or contribute to the development of a medial meniscus tear.

On May 21, 2012, Dr. Jablonsky performed a right total knee replacement.

The petitioner was admitted to the hospital by Dr. Glosson at Centegra Health System on September 3, 2012 with severe intractable back pain radiating down the right leg with tingling, numbness and weakness. The MRI revealed post-surgical right hemilaminectomy at L3-L4 and L4-L5. At L3-L4, there was a posterior disc bulge with a right paracentral disc extrusion or a disc recurrence filling the right lateral recess causing marked narrowing with impression upon the right L4 nerve root. At L5-S1, there was also a left lateral disc bulge which was encroaching on the left neural foramen with resultant severe left foraminal narrowing which had progressed since the prior evaluation. Based on the nerve compression seen on the MRI, surgery was prescribed.

The petitioner underwent surgery on September 6, 2012, which consisted of exploration of the prior laminectomy at L3-L4-L5 on the right as well as a new laminectomy at L3-L4 on the right with medial facetectomy and foraminotomy. Neurolysis was performed and Dr. Panchal removed a large extruded herniated disc at L3-L4 on the right with decompression of L2 and L3 nerve roots also on the right side.

Post-operatively, the petitioner was noted to be doing well by September 14, 2012 when she returned to see Dr. Panchal. The doctor noted she was doing extremely well and the radicular pain in the legs was completely gone. He directed her to perform a home exercise program and she was to return in one month. On October 15, 2012, the petitioner reported that she was pleased with the results of the surgery.

A Section 12 examination was performed in January 2013 by Dr. Jesse Butler and his deposition was completed on May 3, 2013. Dr. Butler opined that the petitioner's current low back condition and recent surgery performed on September 6, 2012, were unrelated to the March 1, 2005 work accident and that instead, the disc herniation occurred, by petitioner's report, in a fall in July of 2012.

Dr. Butler further testified that the petitioner reported to him that in July 2012, her left knee buckled and she fell, causing severe pain in her low back. Dr. Butler was of the opinion that based on the history provided to him by the petitioner, the extruded herniated disc was caused by this fall.

A third lumbar surgery was performed on April 16, 2013 by Dr. Slavin. The procedure included an L3-L4 discectomy for a recurrent herniated disc. The doctor noted that the disc removed was extremely large and was in the same location as the September 2012 surgery.

CONCLUSIONS OF LAW:

With respect to the issues of whether the petitioner sustained accidental injuries arising out of and in the course of her employment and whether she gave timely notice to the respondent, the arbitrator makes the following findings of fact and conclusions of law:

The parties stipulated to the issue of accident with regard case # 06 WC 54936.

On that date, the petitioner sustained injuries to, *inter alia*, her left knee for which she underwent a left medial meniscectomy on June 3, 2005. After the work accident and initial surgery, the petitioner returned to work at full duty in October 2005 and worked until September 21, 2006.

In November 2006, while undergoing physical therapy for her low back, which the petitioner also injured in the March 1, 2005 accident, she sustained a re-injury to the left knee when riding a bicycle. Dr. Cole notes that about the same time, the petitioner also hurt her back while performing straight leg raises in physical therapy.

With regard to case # 08 WC 45282, the petitioner alleges that she sustained injuries to the left shoulder, left elbow and left side of the neck on October 28, 2007. The petitioner was not working at this time and instead claims that her left knee, which was previously injured in a

work-related accident on March 1, 2005, gave out and caused her to fall down some stairs at home.

The petitioner provided unrebutted testimony that within a few days of October 28, 2007, she called the other supervisor in her area, Sue Wyler, and told her about her fall down the stairs. The petitioner further unrebutted testimony that within 45 days of October 28, 2007, she told Peg Frisch and Diane Frisch, who are co-workers at work, what had happened, and believed that she phoned her manager, Bob Portschy, within 45 days. The petitioner testified that she did not initially report this as a work accident because it happened at home.

Eight months earlier, on February 23, 2007, Dr. Jablonsky saw the petitioner. The petitioner voiced complaints to the doctor of significant medial pain in her left knee. Dr. Jablonsky told her that he saw no other treatment options other than proceeding with arthroscopic evaluation, possible debridement, possible repair or drilling. Dr. Jablonsky explained the risks associated with surgery. The petitioner was willing to accept these risks and to proceed with the surgery. Dr. Jablonsky then sought authorization for such surgery from the respondent.

Subsequent to the petitioner's fall at home on October 28, 2007, she saw Dr. Jablonsky on January 31, 2008. She stated that while going down the stairs at home on October 28, 2007, she felt her left knee give way, landed on her left side and has had significant pain since this injury. The petitioner stated that the knee buckles and has feelings of instability and has been in significant pain since this injury. The petitioner also complained of pain involving the medial and lateral aspects of her elbow, posterior aspect of left humerus region, left shoulder region and left trapezial and neck regions. She also complained of numbness and tingling radiating from her neck to all of her fingers.

During Dr. Jablonsky's first deposition, on February 4, 2008, the following exchange took place on direct examination:

Q: In terms of whether you could render an opinion as to whether her initial knee injury that she sustained as a result of her injury at work from March 1, 2005, whether that would create the weakness which would cause her to fall, would it require to you do (sic) an arthroscopic procedure?

A: Well, I think it would certainly be helpful. If you did an arthroscopic procedure and noted there was no further damage to the area of the repair and it looked like it was intact and there was a different injury there that could be related to causing weakness or giving way of the knee, then I would - - I would say that they probably were not related. If it was in evidence that the previous repair either had failed or had a retear through that area, then I would - - I would say that it would be related to the initial injury. (Petitioner's Exhibit 3, pp. 40-41)

Neither the MRI of the left knee taken before nor the one taken after October 28, 2007 indicate any evidence of a re-tear or failure of the previous repair.

Nevertheless, on January 12, 2011, Dr. Jablonsky performed a left knee arthroscopic surgery that consisted of partial medial meniscectomy, patellofemoral chondroplasty, medial and lateral femoral chondroplasty and lateral release. During the course of the surgery, Dr. Jablonsky found evidence of a tear of the posterior horn of the medial meniscus.

The petitioner testified that she has experienced many episodes of left knee buckling. The Arbitrator notes that such episodes followed her October 28, 2007 fall down the stairs.

Dr. Brian Cole conducted a Section 12 examination of the petitioner on April 6, 2009. It was his opinion that although somewhere around August 2005, the petitioner was well-rehabilitated and had minimal complaints regarding the left knee, she was never complaint-free nor did she really have a course of more than a few months without being seen at some level for the knee. Dr. Cole further opined that he did not think that the aggravation to the left knee around November 2006, while the petitioner was undergoing physical therapy to the low back, was a whole new injury, but rather an aggravation of her pre-existing problem.

During Dr. Jablonsky's second deposition, on May 25, 2010, the following exchange took place on recross examination:

BY MR. STELLMACH:

Q: So it was the October 2007 incident?

A: Sorry.

Why don't you restate the question?

Q: It wasn't my question, it was actually counsel's question.

MR. GOLDEN: It was October - - October 28, 2007 fall on the stairs.

THE WITNESS: I understand the date. But what was the question regarding that?

I'm sorry.

MR. GOLDEN: That the weakness or her leg giving out, the left knee giving out, is consistent with the condition of her knee from the injury she sustain (sic) on March 1st, '05?

THE WITNESS: Yes. (PX6, p. 32)

Based on (1) the left knee injury the petitioner sustained in the work accident of March 1, 2005 (2) the November 2006 aggravation to her left knee while on the bicycle in physical therapy (3) the continued complaints of left knee pain by the petitioner, and (4) Dr. Jablonsky's opinion on this page, the arbitrator finds that the petitioner's left knee buckled due to the March 1, 2005 accident and resulted in her fall down the stairs on October 28, 2007. Accordingly, the Arbitrator finds that the petitioner sustained an accident on that date that arose out of and in the course of her employment by the respondent, and that she gave timely notice of the accident to the respondent.

<u>With respect to the issue of causation as it pertains to the right leg, the arbitrator makes the following findings of fact and conclusions of law:</u>

The petitioner had no complaints of any right knee pain or symptoms until April 2009. When the petitioner saw Dr. Jablonsky on April 14, 2009, she reported that she was walking on April 4, 2009 when she felt a sharp, pulling sensation anteriorly, posteriorly, and medially. The doctor's impression was right knee pain with an unclear etiology due to an injury on April 4,

2009. The history as listed on the MRI report also indicates: "the patient felt a snap ten days ago." She experienced right anterior and posterior knee pain. The petitioner was not working at that time and there is no concurrent history in the medical records to support that the right knee accident occurred due to the left knee buckling. Instead the records support that she was just walking when she felt pain.

In his deposition of May 25, 2010, Dr. Jablonsky provided no opinion as to whether the right knee was related to employment. Regarding the inciting event, Dr. Jablonsky testified, "She was just walking when she felt sharp onset of pain." (PX6, p. 6)

Dr. Jablonsky later testified regarding the right knee injury that he did not have any opinion as to the cause of the event. She was just walking and felt the new onset of pain. (PX6, p. 22)

Based on the lack of any history of a compensable accident in the medical records and the testimony of the petitioner's own treating physician, the arbitrator finds that the petitioner has failed to prove that her right knee condition is causally related to her employment. In conjunction with this finding, any medical bills related to treatment for the right knee are denied.

<u>With respect to the issue of causation as it pertains to the lumbar spine, the arbitrator makes the following findings of fact and conclusions of law:</u>

The Arbitrator finds that the petitioner's right SI joint and IT band conditions, as well as her lumbar spine condition, to be causally related to the work accident of March 1, 2005.

The petitioner had a pre-existing, degenerative condition of her lumbar spine. In 2002, she underwent a lumbar laminectomy and discectomy at L4-L5 on the right side at Northwest Community Hospital.

The petitioner described the accident of March 1, 2005 as one in which twisted her left knee and fell on her right side. Dr. Jablonsky's records reflect that when he first examined the petitioner on March 10, 2005, he found exquisite tenderness over the SI joint, but no significant tenderness involving the spinous processes. The doctor found evidence of some mild

paraspinous discomfort with some mild spasm in that area. Forward flexion was mildly limited. Dr. Jablonsky found no evidence of radiculopathy. The petitioner exhibited a negative straight leg raise but demonstrated a mild pulling sensation in the right side of her lower back. Dr. Jablonsky ordered X-rays of her left knee and right hip and diagnosed her with right hip and buttock contusions with evidence of a right SI joint strain.

The United Airlines Workers' Compensation Employee Work Status Form, dated 3/10/05, offers the following description of the petitioner's injury: "Left knee/Right Hip/Mid-Lower Back."

Dr. Jablonsky's records going forward continue to indicate that the petitioner complained of SI joint pain.

On May 9, 2005, Dr. Jablonsky wrote that the petitioner has right SI joint and IT band pain.

At the initial evaluation on July 6, 2005 at Excel Physical Therapy, the referring diagnosis was of a left medial meniscal repair, right hip and SI joint strain and iliotibial band pain. At a reevaluation at Excel Physical Therapy on July 14, 2005, the petitioner was noted to be tender to palpation on the iliac crest, right piriformis and right IT band and greater trochanter. The straight leg raising test was negative bilaterally. When she was seen in follow up by Dr. Jablonsky on July 29, 2005, she described significant discomfort involving the right IT band and SI joint regions. The diagnoses of Dr. Lami and Dr. Jablonsky are consistent for right iliotibial band inflammation and SI joint pain.

On July 29, 2005, the petitioner saw Dr. Jablonsky. He wrote that she still has some significant discomfort involving the right IT band and SI joint regions. Upon examination, Dr. Jablonsky found palpable tenderness through the hip and IT band regions and some continued tenderness through the area of the SI joint.

On August 25, 2005, the petitioner again saw Dr. Jablonsky. She reported to him that she was doing well until Saturday with her left knee when she reported that she was going upstairs and felt a rubber band-type pull with significant increasing pain. Moreover, she now presented

with new complaints of pain radiating to the lateral aspect of the *right* lower leg. Dr. Jablonsky ordered an MRI of the lumbar spine.

Such MRI, taken on August 29, 2005, revealed a small, right-sided L3-L4 paramedian disc herniation, post-operative and degenerative changes at L4-L5 with mild foraminal stenosis and a tiny left foraminal disc herniation at L5-S1.

Dr. Panchal causally related the petitioner's current condition of ill-being of her lumbar spine to the accident of March 1, 2005. (PX4, pp. 11-12, 23-24)

During cross-examination of Dr. Panchal, the petitioner's treating physician for her lumbar spine, the following exchange took place:

Q: Okay. And if there were a gap in time (sic) between the slip-and-fall of March 1st and then six months subsequent to her first report of lumbar radiculopathy, would that change your opinion?

A: I think if she - - if she had a fall and she had absolutely no symptoms from the fall, and there was documented evidence that there were no symptoms from back pain or leg pain due to the fall for six months, then I think one can say that the fall has played very - - very little role. (PX4, p. 29)

The arbitrator notes that since the March 1, 2005 accident, the petitioner certainly had ongoing complaints of sacroiliac pain, as well as right leg pain that Dr. Jablonsky diagnosed as a strain of her iliotibial band. The March 10, 2005 Work Status Form indicates that the petitioner had an injury to left knee, right hip and mid-lower back. Moreover, fewer than six months after March 1, 2005, after simply walking up stairs, the petitioner complained of what appeared to be new pain that radiated to the lateral aspect of her right lower leg.

As to the second surgery, when the petitioner presented to Centegra Health System on September 13, 2012, she reported that she had back surgery in the past and that now the pain became worse to the point where she had intractable back pain with an inability to ambulate.

In his deposition, Dr. Butler testified that the petitioner complained of a fall in July 2012 that she believed could have caused her lumbar condition after that date. This history, however, is not consistent with the history given to the medical providers in the emergency room and hospital room personnel in September 2012.

The arbitrator gives more weight to the emergency room records than to Dr. Butler's history and opinions.

Dr. Spencer testified that the petitioner came to him as a patient with a history of an injury at work, but he had no knowledge as to the mechanics of the injury. (PX5, p. 17) Further, the first time he saw her on August 22, 2007, her back pain was negligible. (Id. at 17)

Dr. Lami testified that the petitioner's diagnoses upon examination on September 22, 2005 were of right IT band inflammation with possible SI joint pain. (RX1, p. 9) He also felt she had a left meniscus tear. Dr. Lami agreed that these conditions were causally related to the fall of March 1, 2005. He is in agreement with the diagnoses of Dr. Jablonsky at that time. Upon examination, Dr. Lami found no evidence of radiculopathy and no indication of any injury to her L4-L5 or L3-L4 discs. (RX1, p. 11) Dr. Lami testified that an injured back cannot take up to one year to show signs of sciatica or radiculopathy. (RX1, p. 20)

In Dr. Lami's opinion the surgery performed was not related to the fall of March 1, 2005. As the surgery was done for radiculopathy, and as the patient did not develop radiculopathy as a result of the fall, and, Dr. Lami did not believe it would be related to the work accident. (RX1, p. 20) Dr. Lami was cross-examined by petitioner's counsel regarding the fact that Dr. Jablonsky felt that the petitioner's symptoms were radicular in nature on February 16, 2006. (RX1, p. 27)

Yet, in Dr. Jablonsky's August 25, 2005 chart note he wrote: "...she **now** has some complaints of pain which radiate to the lateral aspect of the right lower leg." (Emphasis added) Dr. Jablonsky ordered an MRI that showed, *inter alia*, a right-sided lumbar disc herniation.

The petitioner's attorney then questioned whether Dr. Lami's opinion would change if she exhibited radiculopathy within a three to six month period after the March 1, 2005 accident. Dr. Lami responded that he would not agree, but clarified that if she had radicular symptoms within

days or a week or so, which were consistent with compressive pathology in the lumbar spine, then he would say it was an aggravation of the pre-existing condition. (RX1, p. 28)

Dr. Butler testified that the petitioner had noted that on January 2, 2013, when she got in her car, she felt her back had snapped (RX3, p. 6.) Since then she had an increase in her back pain with radiation into the buttock and hip. He later testified that she had a herniation that developed sometime in the summer of July of 2012. (RX3, p. 10) The doctor noted that this happened seven and a half years after the work injury.

Dr. Butler testified regarding the mention in the records of June of 2005 that she had some discomfort in her right IT band and SI joint. He testified this was, "really somewhat of a nonspecific finding as it relates to the lumbar spine." (RX3, p. 12) The doctor reviewed the lumbar MRI performed in August of 2005, which showed moderate degeneration at the L3-L4 level without stenosis, and opined that this did not relate to the surgery in 2012. He testified that the degenerative changes on the MRI at L3-L4 were not unusual and that "the fact that she had degeneration did not predict what would happen seven years later with the disc herniation she developed on the right side." (RX3, p. 13)

Dr. Jablonsky testified that at the time of her March 1, 2005 accident that there was no evidence of radiculopathy or other nerve damage from the lumbar spine at that time. (PX3, p. 14-15) The doctor was specifically asked whether he had an opinion as to whether the fall of March 1, 2005 aggravated the prior condition in her lumbar area. He stated, "Well, difficult for me (sic) to pinpoint the exact from the fall (sic) because of the fact that these were new symptoms that presented themselves a fairly lengthy period of time after the initial fall. So I can't necessarily say that it was related specifically to the fall." When asked whether he could say her condition was aggravated by the fall, he replied, "Again, by the fall itself, I would have a hard time stating that." (PX3, p. 27)

On April 16, 2013, the petitioner underwent a L3-L4 discectomy for a recurrent herniated disc at that level. Dr. Konstantin Slavin performed the surgery. Dr. Slavin did not offer a causation opinion.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. International Harvester v. Indus. Comm'n, 93 Ill. 2d 59, 63-64 (1982)

With regard to the petitioner's lumber spine, the arbitrator finds the opinions of Dr. Kanu Panchal, one of the petitioner's treating neurosurgeons, to be the most credible.

Based on the opinions of Dr. Panchal, the medical records and the chain of events, the arbitrator finds that the petitioner's current condition of ill-being of her lumbar spine is causally related to the accident of March 1, 2005.

With respect to the issue of causation as it pertains to the left shoulder, the arbitrator makes the following findings of fact and conclusions of law:

With respect to the issue of causation for the left shoulder, the arbitrator has found that on October 28, 2007, the petitioner sustained an accident that arose out of and in the course of her employment by the respondent. The petitioner provided unrebutted testimony that she called her co-workers and manager and told them what had happened.

The petitioner saw Dr. Jablonsky on January 31, 2008 with complaints of left shoulder, neck and arm pain following an October 28, 2007 fall down some stairs at home when her left knee gave way.

The petitioner testified that Dr. Jablonsky then referred her to Dr. Spencer, who gave her a couple of shots in her neck and left shoulder. (Tr., PX5, pp. 11-12) Since the pain did not subside following the shots, the petitioner further testified, Dr. Spencer referred her to Dr. Bresch. Dr. Spencer testified that he sent the petitioner to a shoulder specialist Subsequently, Dr. Bresch performed two surgeries on her left shoulder. Dr. Bresch then referred the petitioner to Dr. Yu, a pain specialist.

Dr. Bresch testified that he diagnosed the petitioner with post-traumatic impingement and adhesive capsulitis.

During the direct examination of Dr. Bresch, the following exchange took place:

Q: And doctor, do you have an opinion based upon a reasonable degree of medical and surgical certainty whether the fall that she took at home that she related to you and, in fact, if the fall was October 28th, '07, when she fell at home on her left side, her elbow, pushing it up into the shoulder, do you have an opinion as to whether that was a cause of the left shoulder for which you treated her?

A: More likely than not it was. (PX7, pp. 17-18)

Based on the foregoing, the arbitrator finds that the petitioner's current condition of ill-being of her left shoulder is causally related to the accident on October 28, 2007.

With respect to the issue of causation as it pertains to the left leg, the arbitrator makes the following findings of fact and conclusions of law:

With respect to the left knee, the Arbitrator finds that the petitioner's initial condition of ill-being with respect to the left knee, including the first surgery, was causally related to the work accident. The petitioner's testimony was consistent with the records as to a March 1, 2005 slip-and-fall that occurred at work, after which she underwent appropriate conservative treatment and ultimately underwent a left medial and lateral meniscectomy on June 3, 2005.

On February 23, 2007, Dr. Jablonsky saw the petitioner. The petitioner voiced complaints to the doctor of significant medial pain in her left knee. Dr. Jablonsky told her that he saw no other treatment options other than proceeding with arthroscopic evaluation, possible debridement, possible repair or drilling. Dr. Jablonsky explained the risks associated with surgery. The petitioner was willing to accept these risks and to proceed with the surgery. Dr. Jablonsky then sought authorization for such surgery from the respondent.

The petitioner did not undergo this second left knee surgery until January 12, 2011.

After the first surgery but before the second surgery, the records reflect numerous instances where the petitioner expressed new or increased pain complaints or symptoms as the result of various incidents. In August 2005, she was walking down stairs when she felt a rubber band pull in her left knee. In November 2006, she was riding a bicycle in physical therapy for her low back when she felt increased left knee pain. On October 28, 2007 and January 28, 2008, the petitioner's left gave way. On February 19, 2010, while walking up stairs, the petitioner experienced new pain complaints in a new area of her left knee.

Dr. Jablonsky's second deposition was taken on May 25, 2010. During direct examination, the following exchange took place:

Q: Do you have an opinion based on a reasonable degree of medical and surgical certainty, as to whether the incident of slipping and falling on ice of March 1, 2005 was the cause of the left knee pain for which you were treating her up through 2/24/2010?

A: Yes.

Q: And it is that it is connected?

Y: Yes, it is. (PX6, pp. 14-15)

On April 6, 2009, Dr. Cole wrote the following:

"Cynthia described to me today that she was doing 'great' prior to the re-injury event while at physical therapy. I would state that she did incur an aggravation/exacerbation of the previous injury with that movement. Regardless whether (sic) it was a straight leg raise or bicycle maneuver, the mechanism was one that typically would not cause a new meniscus tear, in and of itself, but is one that might or could incite new pain or aggravate a previous pain. It is my opinion that her condition of ill being as of that incident in 2006 is more related to that incident and not her previous injury of March of 2005." (PX8)

Then, after reviewing additional records, Dr. Cole authored a report dated September 30, 2010, in which he concluded as follows:

"Because I felt her condition, as of the point of my exam on 4/06/2009, was a continuation/aggravation of her original injury, I am led to suggest that her current state of ill-being is, on a more likely than not basis, related to that aggravation, and therefore related to the original injury date in question." (PX8)

Dr. D'Silva opined that the petitioner sustained an isolated injury to the medial meniscus in the accident of March 1, 2005. She recovered from that injury and, a year and a half later, complained of a new onset of left knee pain. He opined that the findings during the second arthroscopy performed in January 2011 were unrelated to the injury in 2005 as they did not correlate with "the new mechanism of injury as described by the patient." It was his opinion that treatment of the left knee after 2006 was unrelated to the 2005 injury. Dr. D'Silva explained that the medial meniscus tear that was the result of the work accident would not lead to later episodes of instability, as the problem had been corrected by the surgery in June 2005. He also opined that riding a bike while in physical therapy would not cause or contribute to the development of a medial meniscus tear. Any episodes of instability, therefore, were unrelated to the work accident. (RX2)

Dr. D'Silva testified that in the second surgery four and a half years later, there was evidence of new injuries, plus chondromalacia of the patellofemoral joint, which were uninvolved in the initial injury, and lateral compartment disease, which was also uninvolved in the original injury. (RX2, p. 41)

Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury. Teska v. Indus. Comm'n, 266 Ill. App. 3d 740, 742, 640 N.E.2d 1, 203 Ill. Dec. 574 (1994)

The Arbitrator finds the opinions of Dr. Jablonsky, the petitioner's treating surgeon for her left knee, to be most credible. Therefore, the arbitrator finds the petitioner's current condition of ill-being of her left leg to be causally related to the accident of March 1, 2005.

With respect to the issue of TTD benefits, the arbitrator makes the following findings of fact and conclusions of law:

In Arbitrator's Exhibit #1 (AX 1), the respondent claims that the petitioner was temporarily totally disabled for the periods June 3, 2005 through August 7, 2005, August 29, 2005 through October 10, 2005 and September 21, 2006 through May 3, 2007. The respondent claims that they paid $288,163.10 in TTD benefits and seeks a credit for such amount.

The petitioner's attorney, in AX 1, failed to take the opportunity to actually identify the periods of temporary total disability that he claims for his client, but merely wrote: "*See proofs.*"

The respondent relied on the opinions of Dr. Babak Lami. In a Section 12 examination report dated May 23, 2007, Dr. Lami opined that the petitioner had reached maximum medical improvement ("MMI") and could return to "this office-type job." The petitioner told Dr. Lami that she cannot sit for more than 15 minutes. Dr. Lami explained that given the fact that the petitioner's lumbar radiculopathy was diagnosed almost a year after the fall, he cannot relate the need for the lumbar decompression to eliminate the petitioner's radiculopathy to her fall of March 1, 2005. Moreover, Dr. Lami opined that he cannot causally relate the need for a second left knee arthroscopy to her March 1, 2005 fall. The petitioner's re-injury to her knee occurred while she was rehabbing for her back surgery, which, in Dr. Lami's opinion, was not causally related to her March 1, 2005 fall. Dr. Lami found that the petitioner has subjective disabilities and pain that are out of proportion to the objective findings. (RX1, Dep. Ex. 3)

Yet, the arbitrator has found that the petitioner's current condition of her lumbar spine, and left leg are causally related to the accident of March 1, 2005, and that the petitioner's current condition of ill-being of her left shoulder is causally related to the accident of October 28, 2007.

As a left total knee replacement and a lumbar fusion have been recommended, the arbitrator finds that the petitioner has not yet reached MMI.

On May 3, 2007, Dr. Panchal took the petitioner off work until July 2007. (PX15)

On July 23, 2007, Dr. Panchal wrote that the petitioner is to stay off work for one month. Dr. Panchal referred the petitioner to Dr. David Spencer. (PX15)

On August 22, 2007, Dr. Spencer saw the petitioner and prescribed Neurontin on a trial basis. (PX11)

On September 13, 2007, Dr. Spencer found that the Neurontin did not significantly help the petitioner's leg pain. Dr. Spencer wrote that based on the chronicity of the petitioner's back pain and the development of radiographic evidence at L3-4, he recommends an ALIF surgery at L3-4 and L4-5. (PX11)

On January 17, 2008, Dr. Spencer prescribed four weeks of work hardening for the petitioner's low back. (PX11)

On February 19, 2008, the petitioner reported taking Norco for her low back pain. (PX11)

From February 21, 2008 through June 17, 2008, the petitioner underwent physical therapy for adhesive capsulitis. (PX11)

On April 16, 2008, in a United Airlines Workers' Compensation Employee Work Status Report, Dr. Spencer ordered the petitioner to be off work/no work.

On May 19, 2008, the petitioner reported difficulty with sleeping, driving, dressing, showering, washing her face/hair and reaching above shoulder height with any activity. (PX11)

On August 12, 2009, in a United Airlines Workers' Compensation Employee Work Status Report, Dr. Jablonsky wrote: "No Work Due to left knee Surgery." (PX14)

On September 24, 2009, Dr. Jablonsky wrote: "No return to work at this time." (PX14)

On February 24, 2010 and March 2, 2010, Dr. Jablonsky kept the petitioner off work. (PX14)

On January 19, 2011, Dr. Jablonsky recommended "no work at this point in time." (PX14)

On March 9, 2011, in a United Airlines Workers' Compensation Employee Work Status Report, Dr. Jablonsky ordered "no work" for the petitioner. (PX14)

On April 4, 2011, the petitioner was given light-duty restrictions. (PX14)

On May 4, 2011, Dr. Jablonsky wrote: "She has difficulty standing or sitting for longer than a half an hour or walking for more than 15 minutes. Therefore, I would recommend that her

restrictions essentially incorporate those limitations." Dr. Jablonsky reiterated these restrictions on June 20, 2011 and June 30, 2011. (PX14)

On July 11, 2011, Dr. Jablonsky gave the petitioner restrictions that included "max sit 50 minutes at a time with max walk/stand 15 mins." (PX14)

On April 16, 2013, neurosurgeon Konstantin Slavin, M.D., performed an L3-L4 discectomy on the petitioner for a recurrent herniated disc at that level. In a report dated May 8, 2013, Dr. Slavin wrote: "I do however feel that it will take her much longer to recover from the operation and the pain she has now is going to get better over the next few weeks or months." (PX16)

Since May 3, 2007, treating surgeons Kanu Panchal, M.D., Warren S. Jablonsky, M.D. and Konstantin Slavin have not released the petitioner to return to full-duty work. (PX11, PX14, PX15, PX16)

Therefore, the arbitrator finds that the petitioner was temporarily totally disabled for the periods June 3, 2005 through August 7, 2005, August 29, 2005 through October 10, 2005 and September 21, 2006 through September 23, 2013.

The respondent is entitled to a credit of $288,163.10 for previously paid TTD benefits.

With respect to the issue of medical benefits, the arbitrator makes the following findings of fact and conclusions of law:

Based on the causation analysis set forth above, the arbitrator awards medical bills for the reasonable, necessary and related care and treatment following the March 1, 2005 accident to the petitioner's left knee (including two surgeries), right hip and lumbar spine (including three surgeries), as well as the medical bills for the reasonable, necessary and related care and treatment following the October 28, 2007 accident to the petitioner's left shoulder (including two surgeries), neck and left elbow, pursuant to Section 8(a), and subject to Section 8.2 of the Act, where applicable.

The respondent is entitled to a credit for medical bills previously paid.

The respondent is entitled to an 8(j) credit in the amount of $54,605.35.

With respect to the issue of prospective medical, the arbitrator makes the following findings of fact and conclusions of law:

The petitioner is seeking an award of prospective medical in the form of a left total knee replacement.

Dr. Jablonsky has recommended such surgery.

As the arbitrator has found Dr. Jablonsky to be most credible with regard to the petitioner's left knee and as he has relied on Dr. Jablonsky's causation opinions, the arbitrator finds such treatment to be reasonable and necessary.

Therefore, the arbitrator orders the respondent to authorize and pay for the left total knee arthroplasty, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The parties agreed to defer to a later hearing the issue of prospective medical for the petitioner's lumbar spine.

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

KATRINA ALLEN,

Petitioner,

15IWCC0375

vs.

NO: 09 WC 51695

UNIVERSITY OF ILLINOIS AT CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision, and finds that Petitioner sustained accidental injuries arising out of and in the course of her employment, but that Petitioner failed to prove her current condition of ill-being is causally related to her December 07, 2009 work-related injury based upon her significant lack of credibility, her prior treating medical records which fail to corroborate her testimony as to prior medical condition and treatment, and her treating records immediately following her work-related injury, which reflect a contusion to the right upper extremity and the right hip.

The Commission first addresses the Arbitrator's finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment with Respondent. In Mores-Harvey v. Industrial Commission, 345 Ill.App.3d 1034(2004), the Court noted that when an injury to an employee takes place in an area which is the usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. The Court further noted that special hazards or risks encountered as a result of using a usual access route satisfy the "arising out of" requirement of the Act. The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred.

compensation. Illinois Bell Telephone v. Industrial Commission, 131 Ill.2d 478 (1989). Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing her duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, (1989). The Commission finds that Petitioner's December 07, 2009 slip and fall on the way into work in the lobby of the building maintained and controlled by Respondent, was as result of a wet and slippery floor, and arose out of and in the course of her employment with Respondent.

However, with regard to the issue of causal connection, the Commission finds Petitioner failed to prove her current condition of ill-being with respect to her bilateral knees and low back is causally connected to her December 07, 2009 work-related injury. Although Petitioner alleges an injury to her bilateral knees and low back as a result of a slip and fall on December 07, 2009, her claim is not corroborated by the medical evidence in the record. In our view, the preponderance of the evidence establishes that Petitioner's bilateral knee and low back condition, was caused by her pre-existing knee osteoarthritis, chronic low back pain, and degenerative lumbar spondylosis. In light of our decision with regard to causal connection, we find all other issues are moot.

The December 07, 2009 Chicago Fire Department Incident Report, and the medical records from Petitioner's emergency room visit to the University of Illinois Medical Center on that same date reflect Petitioner complained of a slip and fall, with complaints of right sided arm, right sided chest pain and right sided hip pain. The Fire Department Incident report notes Petitioner specifically denied neck and back pain, and fails to mention any complaint of knee pain. The Emergency Room records reflect complaints restricted to Petitioner's right shoulder/chest and right buttock. Petitioner's history was noted: able to ambulate without difficulty; no shortness of breath; able to raise both arms without difficulty; no neck or back pain. Petitioner's examination revealed: neck and back within normal limits, non-tender and normal range of motion; extremities within normal limits, normal range of motion, no swelling or tenderness. Petitioner was diagnosed with a contusion to the right buttock and right upper extremity, acetaminophen and ibuprofen, and advised to follow up with her primary care physician in five to seven days. A review of the Emergency Room records fails to reveal any history of an injury or complaints with regard to Petitioner's knees or low back. (PX2).

Petitioner returned to the emergency room two days later, on December 09, 2009, with a complaint of chest pain radiating to her right arm for two days, and suspicion her VP shunt for hydrocephaly may have dislodged. Petitioner's extremity exam was within normal limits without edema, and her neurological exam was without gross focal deficits. Petitioner's VP shunt was found to be in stable position, and a myocardial infarction was ruled out, after Petitioner underwent a treadmill stress echocardiogram, exercising in excess of seven minutes, which was found to within normal limits. Petitioner was discharged with diagnosis of musculoskeletal chest pain, hypertension, hyperlipidemia, morbid obesity, and a past medical history of seizure disorder. The December 09, 2009 emergency room records fail to note any history of a knee injury or a complaint with regard to Petitioner's knees, or any diagnosis relative to Petitioner's low back. (PX2).

The Commission finds Petitioner's testimony unpersuasive as she was less than candid and often contradictory and unclear. At the time of Petitioner's initial office visit with her treating physician, Dr. Chmell, the doctor noted that both Petitioner and her husband were present for her initial office visit, that Petitioner reported she fell on a slippery floor, and that Petitioner's "husband states that the floor had just been mopped and the area was not acknowledged in terms of to be cautious while walking. They also relate that it was wet outside and near the entryway." On cross examination, Petitioner testified she was unsure if Dr. Chemll took a history from her on that date, denied that her husband was present for that office visit, and could not recall providing a history about the area having just being mopped. (RX1, T79-81).

On direct examination Petitioner testified that prior to December 07, 2009 she had "no problems" with her knees, and that she was in good physical health prior to that date. Petitioner specifically denied any medical treatment to her legs prior to December 07, 2009, and any prior problems with her back or knees. (T13-14). The Commission notes Petitioner's testimony as to the lack of prior knee or back problems and treatment is significantly contradicted by the history recorded by Dr. Bryan Neal at the time of Petitioner's January 02, 2013 Section 12 examination, and by Petitioner's own subsequent admission to same on cross-examination.

On January 02, 2013, Petitioner underwent a Section 12 examination with Dr. Neal, at which time he recorded a history of pain and arthritis in Petitioner's right knee for two and a half years prior to her fall in December of 2009. At the time of the examination, Petitioner further reported that she was diagnosed with right knee arthritis by Dr. Figuero, that the x-rays of both knees prior to her December 2009 fall indicated she had arthritis, and that she had pain in both her knees prior to December 2009 fall. Petitioner initially reported that she underwent bilateral knee injections both before and after her December 2009 fall, changed her opinion and stated her injections were after her fall, and then changed her opinion again and reported she could not remember whether the injections were before or after her fall in December 2009. (RX1). On cross examination, Petitioner initially denied that she advised Dr. Neal that she had pain in her right knee and in her low back prior to her December 07, 2009 fall, that she advised Dr. Neal that she had a history of arthritis in her right knee for two and a half years before her fall, or that Dr. Figueroa had previously diagnosed it. However, on further cross examination, Petitioner admitted that Dr. Figueroa had in fact diagnosed her with knee arthritis prior to 2009, and that she had some pain and some issues in her right knee from time to time (T68-72).

Although Petitioner denied that she had any back pain prior to 2009, that she advised Dr. Neal she had low back pain for 20 years, or that she had two or three CAT scans of her low back prior to December 07, 2009, Dr. Neal recorded a history of pain in Petitioner's low back for a period of "probably 20 years," all prior to December 07, 2009. (T71-72, RX1) Dr. Neal further recorded a history that Petitioner underwent two or three CT/MRI scans in her lifetime, the first of which was done for her low back approximatly 10 years prior at the University of Illinois Medical Center, and that her low back pain treatment prior to December 2009 was rendered by Dr. Alan Olthoff at the University of Illinois Medical Center. (RX1).

The Commission also finds Petitioner's denial that on January 14, 2013 she provided Dr. Chmell with a history of re-injury to her right knee at home when she slipped stepping out of her bathtub, and that her doctor recommended an MRI due to her re-injury, disconcerting. Dr.

Chmell's office notes from that office visit document a right knee injury at home as a result of slipping while exiting her bathtub, as well as a November 23, 2013 slip and fall with injury to her right wrist, right knee, and low back when shopping on Black Friday. (RX2, T68-69).

Having carefully reviewed Petitioner's testimony, along with Petitioner's medical records, we find Petitioner lacking in credibility, and her claim of accidental injury to her low back and knees lacking in corroboration. As such, we find Petitioner failed to prove her current condition of ill-being with respect to her low back and bilateral knees is causally connected to her December 07, 2009 work-related injury.

We also find Dr. Neal's opinions most persuasive with respect to our finding of no causal connection. Dr. Neal opined that Petitioner's chronic low back pain and degenerative lumbar spondylosis were not caused by any fall of December 07, 2009, given the many year history of pre-existing symptoms, to which petitioner admitted. With regard to Petitioner's right knee, Dr. Neal opined that her knee condition had, at the most, a temporary aggravation of her pre-existing knee symptoms from her December 07, 2009 fall, which was resolved as of August 23, 2010, as evidenced by Petitioner's admission as to pre-existing osteoarthritis and symptoms, May 17, 2010 x-rays showing tricompartmental degenerative arthritis, the lack of right knee complaints in the Emergency room records from December 07, 2009, improvement in symptoms through June 21, 2010, and the break in treatment from August 23, 2010 through May 23, 2011. Dr. Neal opined that Petitioner's current right knee condition was unrelated to her December 07, 2009 fall, but was attributable to her tricompartmental disease and arthritis which were pre-existing. Dr. Neal further opined that based on the pre-existing right knee disease, prior to December 07, 2009, the expected progression of such, the expected aggravation and acceleration of her right knee arthritis secondary to her morbid obesity, the September 06, 2011 operative findings are the expected findings from her preexisting right knee pathology and the expected progression over time. Dr. Neal opined Petitioner's September 06, 2012 surgery was secondary to her pre-existing right knee condition. Dr. Neal further opined that Petitioner's left knee condition was secondary to osteoarthritis and not related, aggravated by or accelerated by the December 07, 2009 event, based upon the history Petitioner gave of pre-existing osteoarthritis, and the initial treating records which were void of any mention of left knee injury or symptoms. (RX1).

In our view, Dr. Neal's opinion is consistent with the initial treating medical records, which are void of any mention of injuries to her knees or her low back, and Petitioner's own admission as to her pre-existing right knee osteoarthritis diagnosis and pre-existing chronic low back pain.

Based upon the foregoing the Commission finds Petitioner was not credible and failed to prove that her current condition of ill-being is causally connected to her December 08, 2009 work-related injury. Furthermore, the Commission finds Petitioner failed to prove entitlement to temporary total disability benefits or a permanent partial disability award with regard to her right arm and right hip contusion sustained on December 08, 2009.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 22, 2013, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted, and Petitioner's claim for compensation is denied.

15IWCC0375

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

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

The Respondent is exempt from bonding requirement for removal of this cause to the Circuit Court based upon Section 19(f)(2). The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 1 2015
KWL/kmt
O-09/09/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0375

ALLEN, KATRINA D
Employee/Petitioner

Case# **09WC051695**

UNIVERSITY OF ILLINOIS
Employer/Respondent

On 8/22/2013, 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 0.07% 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:

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

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

0075 POWER & CRONIN LTD
RORY M McCANN
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

0902 UNIVERSITY OF IL/CLAIMS MGMT
CHUCK HUTCHISON
1737 W POLK ST M/C 940 STE B
CHICAGO, IL 60612

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

AUG 22 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0375

Katrina D. Allen
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # **09** WC **51695**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **July 2, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 7, 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 accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**31,616.00**; the average weekly wage was $**608.00**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **4** dependent children.

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

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

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

Respondent is entitled to a credit pursuant to §8(j) of the Act and pursuant to the stipulation of the parties.

ORDER

Petitioner has failed to prove, by a preponderance of the evidence that an accident occurred which arose out of and in the course of her employment with Respondent, therefore no benefits are awarded, pursuant to the Act.

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

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

L. Thompson-Smith

Signature of Arbitrator

August 22, 2013

AUG 22 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATRINA ALLEN	)	
	)	
Petitioner,	)	15IWCC0375
	)	
v.	)	**No. 09 WC 51695**
	)	
UNIVERSITY OF ILLINOIS,	)	
	)	
Respondent.	)	

FINDINGS OF FACT

This matter proceeded to trial before Arbitrator Thompson-Smith in Chicago on July 2, 2013. Issues in dispute include 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability ("TTD"); and 5) nature and extent.

Katrina Allen (hereafter "Petitioner") works for the University of Illinois-Chicago in the Outpatient Care Center building located at 1801 West Taylor Street. She testified that there are thirty (30) to forty (40) healthcare clinics in that building and she works in the Center for Women's Health, which is located on the fourth floor.

Petitioner testified on direct examination that prior to December 7, 2009 she had no prior treatment or problems with her knees, was in good physical health; and had no prior problems with her back. She acknowledged a prior medical history including implantation of a shunt at the base of her skull due to hydrocephalus.

Petitioner testified that on the morning of December 7, 2009, she was driven to work by her husband; and it had been snowing throughout the Chicago area.

There are two access points to the building: one from the second floor garage, which requires a key card for admittance. The other entrance is ground level in the front of the building, with a roundabout driveway, for drop-offs. Petitioner testified that of the estimated 1,000 employees, 25% of them used that entrance while the others use the garage entrance. On the day in question, she was dropped off at the front of the building.

Upon cross-examination, Petitioner acknowledged that the front entrance is

completely open to the general public. In addition to fellow university employees, patients, friends, family members of patients and vendors use this entrance. Petitioner told Respondent's attorney that he could walk into the building without being stopped or questioned. Petitioner could have used the garage entrance if she commuted by vehicle, but chose instead to car-pool with her husband on December 7, 2009.

At approximately 8:45 a.m., on December 7, 2009, Petitioner was dropped off and entered the front of the OCC building. She testified that she believes that the floors in the main lobby area are ceramic tile. She further testified that there were no rough surfaces on the floor. During her testimony, she introduced pictures of the floor. Petitioner indicated that although these pictures show rugs, there were no rugs present on the day of the accident. She also testified to encountering no structural or material defects with the tile. She testified on direct examination that the floor was wet and that snow from peoples' boots had not been removed. She was wearing heels that day and did not testify that she was carrying anything work-related. *See,* PX1, A-D

.

There is one bank of elevators for people to traverse floors in this building. Petitioner testified that she slipped on her way to the elevators and landed on her back and right side. Petitioner was helped by a security guard and a co-worker identified as Ms. Rivera. She was placed in a chair in the lobby; her supervisor arrived to take her report of injury and then she was sent to University of Illinois Medical Center ("UIC").

A review of the UIC records indicates that Petitioner complained of right-sided arm, chest and hip/buttock pain. This is consistent in the records from the Chicago Fire Department paramedics as well as the UIC triage notes. No mention is made of knee pain. Petitioner was diagnosed with a contusion of the hip, buttock and upper extremity. Dr. Chamberlain notes that she had "no neck/back pain." Petitioner also informed her doctors that her VP shunt felt different but she had no headache or visual change. She indicated that she had felt this before after falls but has never had to have her shunt readjusted. *See,* PX2.

Petitioner underwent a neurosurgical consult on December 9, 2009. A brain CT scan was ordered given the recent fall and her history of epilepsy, neuro-sacoiddosis and VP shunt placement. The CT was negative for shunt malfunction. She also complained of chest pain and a December 10, 2009 discharge order indicates a diagnosis of musculoskeletal chest pain,

hypertension, seizure disorder, hyperlipidemia and morbid obesity.

It is undisputed that Petitioner was off work from December 7, 2009 through December 16, 2009. She returned to work on December 17, 2009 and then saw Dr. Figueroa, her primary care physician on December 21, 2009. This is the first date that she referenced a problem with her knees and noted that she was "sore all over." She was tender without effusion and Dr. Figueroa recommended physical therapy for her lower and upper back pain and her knee pain.

Petitioner continued with physical therapy, making progress as noted by her therapist as her knees began feeling better on February 8, 2010; her knees being fine on February 10, 2010; and her having no complaints of knee pain over the weekend on February 15, 2010. However, when she returned to Family Medicine on February 23, 2010, her pain was about the same. Another prescription for physical therapy was prescribed. She went five times in March and once in April 2010.

Petitioner then saw an orthopedist, Dr. Samuel Chmell on May 17, 2010. Her chief complaint was low back and bilateral knee pain. Dr. Chmell's notes indicate that she reported falling on a slippery floor and further indicate that "her husband states that the floor had just been mopped and the area was not acknowledged in terms of to be cautious while walking." Petitioner also told Dr. Chmell that she was married and could walk down the aisle without issue, one month before the accident. She said that after the accident she had much difficulty in terms of walking any distance. Dr. Chmell's physical examination was notable for Petitioner being non-tender to palpation about the spinous process. X-rays of the spine showed minimal arthritic change and both knees showed minimal effusion. X-rays showed tri-compartmental disease with joint spacing, narrowing and osteophytes. Petitioner was given a prescription for physical therapy ("PT") and Tramadol; and encouraged to lose weight.

During cross-examination, Petitioner denied that her husband was at this appointment or that she discussed mopping of the floor with Dr. Chmell. After questioning, she indicated she saw a mop at the time of accident but was not sure if the floor had been mopped before she fell.

Petitioner attended a few PT visits, showing improvement; and attended her last PT session on June 21, 2010. She then returned to Dr. Chmell on August 23, 2010, complaining of knee pain and was diagnosed as having "bilateral knee pain, secondary to arthritis." She was provided information about injections.

Petitioner's treatment notes then ceases until December 20, 2010, when she returned to Family Medicine reporting daily pain, on a scale of one to ten at 2 to 8, which improved with glucosamine. She also saw the doctor for unrelated treatment. For the knee, the doctor suggested weight loss, consideration of steroidal injections and Ibuprofen.

She returned to Family Medicine on February 24, 2011 and her right knee was injected on March 16, 2011. Petitioner began experiencing swelling and pain in her right knee on April 29, 2011 and went to the emergency room ("ER") at UIC.

On May 2, 2011, Petitioner saw Dr. Chmell who recommended an arthroscopic procedure to address her right knee arthritis pain. Petitioner did not immediately pursue the surgery as she went on a prearranged, family cruise; and continued to work in a full duty capacity.

On September 6, 2011, Petitioner underwent a right knee arthroscopy with partial medial meniscectomy, including extensive debridement and patella chondroplasty. Procedure notes indicate significant Grade IV chondromalacia of the tibia in the medial compartment. In follow-up notes, one week later, the doctor indicated that the petitioner had no usage of medication and some improvement.

On October 10, 2011, Petitioner reported doing well without significant complaints and she was released to return to work, in a full duty capacity, without restrictions. She reported mild stiffness and intermittent right knee pain; and the intermittently use of Tylenol for pain. Dr. Chmell noted significant improvement post-operatively.

On March 19, 2012, Dr. Chmell authored a three-paragraph narrative report at the behest of Petitioner's attorney. He stated that he did find that she had arthritis however; she also had a tear of the medial meniscus that required a partial meniscectomy and that this was likely resulting from the alleged injury. *See,* PX6.

Petitioner did not pursue further orthopedic treatment until she fell at a shopping mall on November 23, 2012 (Black Friday) in Orland Park, Illinois. Petitioner re-injured her right knee and went to the Emergency Room at Palos Community Hospital. She reported additional injuries to her right wrist and low back. She followed-up with Dr. Chmell on November 26, 2012. She was placed in a knee immobilizer, referred for a MRI of her right knee, and X-rays of her back. *See,* RX2.

Petitioner missed work from the shopping mall fall. As of December 3, 2012, she thought she was able to resume work. Her lumbar x-ray was notable for a possible pars fracture and L4-5 spondylolisthesis. She was provided a prescription for PT and told to return in a month.

Petitioner saw Dr. Chmell again on January 14, 2013. This is the last chronological record. This document provides a recent history of two falls: the fall in the mall and a bathtub slip and fall at home. Petitioner denied the bathtub fall during cross-examination. Petitioner's right knee was stiffer on this date and Dr. Chmell noted it was affecting her ability to ambulate. Dr. Chmell repeated that she needed a MRI of the right knee. Petitioner indicated that she was not interested in surgical interventions but would pursue physical therapy.

At the conclusion of her direct-examination, Petitioner testified that she still has pain in her back and knees. She reported that she experiences stiffness when standing for long periods or transitioning from sitting to standing. She reiterated that she had never had back pain before December 7, 2009. She testified that she "never had a problem" with knee pain before December 2009.

On January 2, 2013, Petitioner saw Dr. Bryan Neal, at the request of Respondent, for purposes of an independent medical examination ("IME") to wit he authored a 19-page report. The petitioner was asked if she was injured at work, to which she responded "yes and no." She clarified that statement by saying that she had things going on prior to December 7, 2009; and told Dr. Neal that she had right knee osteoarthritis two & one-half (2.5) years before the subject fall. She reported that Dr. Figueroa diagnosed her with arthritis and she could not remember if she had had injections prior to the subject fall. She further reported that she has had low back pain for probably twenty (20) years. *See,* RX 1, pgs. 9-10.

After a full physical examination, Dr. Neal diagnosed Petitioner as having chronic low back pain, bilateral knee pain secondary to osteoarthritis; and morbid obesity. Dr. Neal opined that the fall of December 7, 2009 exacerbated/aggravated her low back pain and this exacerbation would have resolved by August 23, 2010. He notes there is an absence of low back treatment records after June 2010.

Turning to the bilateral knees, Dr. Neal opined that, if one were to give Petitioner the benefit of the doubt, despite pre-existing arthritis and emergency room records, which show no knee pain, Petitioner may have had a temporary

aggravation of knee symptoms as a result of the fall on December 7, 2009 through August 23, 2010. He noted that a break in treatment occurred subsequent to this date and that she ultimately resumed treatment and was referred for surgery in May 2011. Dr. Neal noted that Petitioner had a pre-existing right knee disease with an expectation of progression, given the aggravation and acceleration of her disease caused by her morbid obesity. *See,* RX1, p. 17.

CONCLUSIONS OF LAW

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

The purpose of the Illinois Workers' Compensation Act is to protect employees from risks and hazards which are peculiar to the nature of work she is employed to do. *Orsini v. Industrial Commission*, 117 Ill.2d. 38, 509 N.E.2d 1005 (1987). A finding alone that a worker was in the course of his employment at the time of accident is insufficient standing, alone, to make an injury compensable. *Id.* at 44.

Compensation for neutral risks depends upon whether the claimant was exposed to a risk of injury greater than that to which the general public is exposed. Id. This is commonly referred to as an "increased risk." It is not enough that the employment placed the petitioner in a particular place at a particular time, the so-called "positional risk" theory, as the Illinois Supreme Court has expressly rejected this. *Brady v. Louis Ruffolo & Sons Const. Co.*, 143 Ill.2d 542, 578 N.E.2d 921 (1991). If an injury results from a hazard to which the employee would have been equally exposed apart from the employment, then it does not "arise out of" it. *Id.*

This case is analogous to *Wal-Mart Stores, Inc. v. Industrial Commission*, 326 Ill.App.3d 438, 761 N.E.2d 768 (4th Dist. 2001). In *Wal-Mart*, the claimant slipped on ice in a parking lot. He was successful at arbitration, the Commission and the Circuit Court. However, the Appellate Court reversed the decision. The claimant raised precedent supporting compensability in parking lot ice slips (i.e. *Hiram Walker & Sons, Inc.* v. Industrial Commission, 41 Ill.2d 429, 430-31 (1968)). The Appellate Court pointed out that in these cases, there was no evidence that the parking lot was available for regular use by the general public. However, with *Wal-Mart,* both employees and patrons had equal access to the entire lot. Therefore, the Court held there was no increased risk.

The Commission has also expounded on a similar fact pattern in *Bays v. Birmingham Steel Corp.*, 01 IIC 0374. In *Bays,* the claimant testified that, just prior to his arrival at work, he slipped and fell as a result of a natural accumulation of ice and snow that had occurred in a parking lot owned and maintained by his employer. The Commission found that:

> Persons traveling, driving, parking or walking anywhere in the area of severe weather conditions, be they employees of companies or the general public, are subject to the risks of slipping and falling due to natural snow

> and ice accumulation. Unless there is some evidence to show that the employment presented a risk or increased risk, i.e. an employer's parking lot was somehow defective, such as in the case of potholes, parking bumpers, etc., then such conditions are not "risks" of the employment and injuries sustained from such greater weather conditions should not be held compensable. Moreover, the Commission observes that general weather conditions, such as rain, ice, snow, etc. are not under an employer's control, unless the employer somehow contributes to the risk, such as improper or defective snow and/or ice removal. *Bays v. Birmingham Steel Corp.*

Like *Bays,* Petitioner slipped in an area maintained and controlled by her employer. Furthermore, like *Bays*, the risk of slipping and falling was related to inclement weather. In addition, like *Bays,* there was no testimony of a defect in the property contributing to the fall, such as irregularities in the floor. Finally, the fall occurred in a location that was completely unrestricted to the general public and for which the public could be found traversing.

The Arbitrator notes that Petitioner is arguing that snow at the entrance of her building is a defect and since Respondent maintains control of the building, that this defect is attributable to it and thus she has proved an increased risk. However, as noted above, snow is not a defect. It is a natural occurring weather phenomenon, that everyone in the Chicago area faced on December 7, 2009. Further, Petitioner does not deny that she worked in an area of frequent, general public usage and therefore, as in *Wal-Mart,* she cannot meet an increased risk burden.

In addition, the Arbitrator finds that some of Petitioner's testimony is not supported by her medical records. On direct examination, she used clear and definitive language to maintain that she never had trouble with her knees or low back prior to the subject accident. On cross-examination, she was asked to address conflicting information in her medical records. She later acknowledged that she had pre-existing arthritis, even though this issue was not in dispute between her medical providers; and according to his notes, she freely reported a history of pre-existing back and knee arthritis to Dr. Neal.

Under oath, Petitioner completely denied telling Dr. Neal the specific detail of having a twenty-year history of back pain. Therefore, she alleges the history taken by Dr. Neal is inaccurate and infers that this medical doctor misinterpreted details of her past medical history. The Arbitrator finds this highly unlikely.

Further, Petitioner's testimony conflicted with facts found in Dr. Chmell's, records. She could not explain why her husband was referenced in Dr. Chmell's records, if he was not there to discuss the mop issue; 2) she was unable to clarify whether she slipped on a floor wet from snow or a floor recently mopped; and 3) she denied the bathtub fall referenced in her doctor's records.

The Arbitrator finds that Petitioner has failed to sustain her burden of proving, by a preponderance of the evidence, that an accident arose out of and in the course of her employment by Respondent, when she slipped and fell on December 7, 2009.

If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is said to arise out of the employment. However, if the injury results from a hazard to which the employee would have been equally exposed to, apart from the employment, it is not compensable. *Caterpillar Tractor Company v. Ind. Com.*, 129 Ill 2d. 52, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989).

The Arbitrator further notes that Petitioner did not encounter an increased risk greater than that faced by the general public. Therefore, compensation is denied; and all other issues, including: causal connection, TTD, medical bills; and the nature and extent of the injury are moot and will not be addressed.

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

HENRY BRICE,

Petitioner,

15IWCC0376

vs.

NO: 10 WC 43063

CITY OF CHICAGO,

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, TTD, PPD, maintenance, credit, penalties and fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator only to the extent that it finds maintenance benefits are merited. Maintenance benefits were denied in said Decision with it noting Petitioner failed to provide evidence of any job search after having been released to return to work with restrictions. Petitioner testified, without contradiction, to not receiving an offer of employment within his restrictions from Respondent. At best, Respondent considered Petitioner for a traffic enforcement technician, but Petitioner was required to first pass an initial test and then undergo an interview to be further considered for the position. This hiring procedure is not the same as a job offer. Petitioner did, in fact, pass the initial testing but elected to retire with the effective retirement date of August 31, 2013, rather than continuing onto the subsequent interview for the traffic enforcement technician position. The Commission finds Petitioner's entitlement to maintenance to have ended upon his retirement.

Notwithstanding its position with respect to maintenance, the Commission agrees the finding within the Decision of the Arbitrator that Petitioner failed to establish entitlement to

permanent total disability benefits. Entitlement to such benefits can be proven through a variety ways, including the demonstration of a credible but unsuccessful job search. Petitioner failed to satisfy this condition.

The Commission arrives at the conclusion that Petitioner failed to conduct a credible job search, noting inconsistencies in his testimony and by comparing his testimony with his proffered evidence. Petitioner testified that he found job leads through want ads and classified ads. He then testified to being told by the potential employers, after purportedly responding to those ads, that they weren't hiring. When confronted with this apparent contradictory testimony, Petitioner answered that he only knew that he wasn't being hired. Petitioner also testified that submitting applications for employment was part of his job search routine. The job search log he had entered into evidence indicates not a single application was tendered to a potential employer. Also found notable about Petitioner's job search log is 1) it failed to identify, by name, any individual Petitioner would have spoken with in pursuit of employment and 2) the lack of urgency with which the job search was conducted. The job search log was begun in 2012, more than a year after Petitioner was found to be at MMI, with no evidence that Petitioner sought work previously. The job search log also indicates that Petitioner, outside of a few occasions, consistently made contact regarding only two or three jobs a day but not every day. No testimony was offered of those contacts being the only job leads he identified on those particular days and would have explained why so few contacts had been made per day. Lastly, the job search log reflects Petitioner sought employment only as a driver despite his self-professed limitations as to how long he can sit or drive. The Commission questions the veracity of Petitioner's job search log. Assuming *arguendo* that Petitioner's job search log is a true record of his efforts, it is also evidence of his refusal to look for any work other than which he was found medically unfit to perform.

The Commission affirms and adopts all other aspects of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $808.72 per week for a period of 75-3/7 weeks, commencing on February 3, 2009, through February 3, 2009, through July 15, 2010, 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 $808.72 per week for a period of 162-4/7 weeks, commencing on July 16, 2010, through August 31, 2013, that being the period Petitioner was entitled to maintenance benefits under §8(a) 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 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of the person as a whole as a result of the January 7, 2009, injury to Petitioner's low back.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 6.45 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 3% loss of use of the left leg as result of the January

15IWCC0376

7, 2009, injury to Petitioner's left knee.

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: MAY 2 1 2015
KWL/mav
O: 03/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0376

BRICE, HENRY
Employee/Petitioner

Case# **10WC043063**

CITY OF CHICAGO
Employer/Respondent

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:

0391 THE HEALY LAW FIRM
DAVID HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0113 CITY OF CHICAGO LAW DEPT
NANCY J SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0376

Henry Brice
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **10** WC **43063**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Svetlana Kelmanson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 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 _____

FINDINGS

On **1/7/2009**, 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 **$63,080.16**; the average weekly wage was **$1,213.08**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$61,567.85** for TTD and **$132,050.37** for maintenance benefits, for a total credit of **$193,618.22**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$808.72**/week for **75 3/7** weeks, commencing **February 3, 2009**, through **July 15, 2010**, as provided in Section 8(b) of the Act, subject to a credit for the temporary benefits paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72**/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.

Respondent shall pay Petitioner further permanent partial disability benefits of **$664.72**/week for **6.45** weeks, because the injuries sustained caused the **3%** loss of use of the **left leg**, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

3/17/2014
Date

MAR 18 2014

15IWCC0376

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified that he worked for Respondent as a motor truck driver from 1983 through January 7, 2009. Petitioner stated he was able to perform his regular job duties despite having undergone back surgery in 2002, and had no restrictions relating to his back. He also denied taking any pain medication because of his preexisting low back condition. The morning of January 7, 2009, Petitioner slipped and fell on icy and snowy ground while unloading equipment from the work truck. Petitioner explained that his feet went out from under him and he fell backward, hurting his back and left knee. Regarding the left knee, Petitioner stated he struck the lateral side on a metal object on the ground.

Initially, Petitioner treated for his injuries at MercyWorks, Respondent's company clinic. The medical records from MercyWorks show that on January 8, 2009, Petitioner sought treatment for injuries to his low back, right shoulder and left knee after falling in the work yard. His main complaints related to his low back. X-rays showed degenerative disease of the lumbar spine and left knee. Dr. Sheth diagnosed multiple contusions and released Petitioner to return to work on light duty. On January 13, 2009, Petitioner reported the right shoulder and left knee felt much better. Dr. Sheth referred Petitioner to Dr. Goldberg, who had performed the surgery in 2002. On January 23, 2009, Petitioner followed up with Dr. Sheth, complaining of back ache. Dr. Sheth prescribed physical therapy.

The medical records from Dr. Goldberg show that Petitioner had previously undergone laminectomies at L4 and L5. On February 2, 2009, Petitioner complained of low back pain with right-sided paresthesia after falling at work. Dr. Goldberg opined the work accident aggravated preexisting degenerative disc disease with spondylolisthesis, ordered an MRI, prescribed physical therapy, and took Petitioner off work. On February 13, 2009, Dr. Goldberg noted that the MRI showed degenerative disc disease at L3-L4, L4-L5 and L5-S1, with spondylolisthesis at L4-L5. Petitioner underwent physical therapy at MercyWorks from February 9, 2009, through April 1, 2009, when it was put on hold due to lack of progress. On May 1, 2009, Petitioner followed up with Dr. Goldberg, continuing to complain of low back pain with right-sided radicular type symptoms. Dr. Goldberg recommended epidural steroid injections. On June 26, 2009, Petitioner followed up with Dr. Goldberg, reporting he intended to see his cardiologist before proceeding with the injections.

Petitioner returned to Dr. Goldberg on March 29, 2010, reporting some improvement after three epidural steroid injections and continuing to complain of low back pain with right-sided radicular type symptoms. Dr. Goldberg ordered a repeat MRI and prescribed additional physical therapy. Petitioner underwent the second course of physical therapy from April 8, 2010, through May 14, 2010, reporting no appreciable improvement. On May 7, 2010, Petitioner followed up with Dr. Goldberg, continuing to complain of persistent symptoms. On physical examination, Petitioner had a limited, painful range of motion in the lumbar spine. Straight leg raise test was negative, however. Dr. Goldberg reviewed the repeat MRI, which showed no appreciable interval changes. He recommended a functional capacity evaluation after Petitioner declined surgery. The functional capacity evaluation, performed June 29, 2010, placed Petitioner's abilities at the light physical demand level, whereas his job duties were at the medium physical demand level. On July 16, 2010, Dr. Goldberg declared Petitioner at maximum

medical improvement and imposed permanent restrictions of "[o]ccasional bending, twisting, lifting, stooping, kneeling, stair climbing, crouching. He should occasionally lift a maximum of 12 pounds floor to waist and 14 pounds overhead."

On September 22, 2010, Dr. Lami, a spine surgeon, examined Petitioner at Respondent's request. Petitioner complained of low back pain, which he rated a 7/10, with some paresthesia in the right leg. Dr. Lami opined Petitioner's symptoms were "mostly due to his degenerative spine condition." Dr. Lami agreed with Dr. Goldberg that Petitioner had reached maximum medical improvement and recommended restrictions of no lifting over 20 pounds and no repetitive bending, twisting or crawling. On April 3, 2013, Dr. Lami reexamined Petitioner. Petitioner denied undergoing any further treatment since the previous examination and complained of low back pain, which he rated a 6-9/10, with paresthesia in both legs. Dr. Lami stated that his opinions remained "unchanged;" specifically, that Petitioner's condition of ill-being and need for restrictions were "not related to the injury of January 7, 2009."

Petitioner testified that he had not worked since February 2, 2009. He continues to suffer from low back pain. Regarding his left knee, Petitioner testified it was swollen for approximately a month after the accident. Since he last saw Dr. Goldberg, Petitioner developed pain and tingling down the left leg. He also has pain in the left knee, without swelling. The pain is greater with activity. Petitioner takes extra strength Tylenol three to four times a day or Aleve once a day. He also takes Vicodin as needed, once or twice a month. Petitioner stated his cardiologist prescribed Vicodin after he complained of back pain. Petitioner further testified the back pain limits his activities of daily living, and he can hardly sleep if he does not take pain medication. Petitioner repeatedly stated he feels limited in his activities because of the medications he is taking. He also feels limited as to how long he could sit. Upon further questioning, Petitioner explained that he can sit for an hour before needing to stretch or move around because of the tingling and numbness in the left leg. According to Petitioner, Dr. Goldberg's restrictions include limited sitting.

Petitioner further testified that he is currently 66 years old and holds a CDL license. At some point after Dr. Goldberg imposed permanent restrictions, he looked for work as a truck driver. Petitioner explained that he applied for work in person with different trucking firms, acknowledging that the jobs were not within his restrictions. Petitioner had tendered his job search logs to Respondent. In August of 2013, Petitioner retired from Respondent's employ. Petitioner testified he felt financial pressure to retire because his temporary total disability checks were less than his pre-accident pay and Respondent wanted him to pay more for his group health insurance plan. However, Petitioner admitted that after retiring, he became covered by the group health insurance through his wife's employer. Upon further questioning, Petitioner testified that he retired after realizing he would not be able to find a job within his restrictions. On cross-examination, Petitioner admitted he planned to retire in 2014 anyway. Respondent introduced into evidence Petitioner's resignation/retirement request, dated August 19, 2013 and effective September 1, 2013.

Petitioner further testified that he had met with Natalie Maurin, a vocational counselor hired by Respondent. However, Respondent never offered him any job search advice, job training or a job within his restrictions. At the request of his attorney, Petitioner met with James

Boyd, also a vocational counselor. According to Petitioner, Mr. Boyd stated there was no viable job market for him.

On cross-examination, Petitioner testified he received minimal treatment and did not undergo physical therapy for his left knee injury. Regarding his low back condition, Petitioner testified he had not seen Dr. Goldberg since the visit on July 16, 2010. However, he planned to see Dr. Goldberg in the future because his back bothered him a great deal. Petitioner confirmed he did not want surgery and hoped Dr. Goldberg would offer a new type of conservative treatment. Petitioner had not consulted any doctors, other than Dr. Goldberg and the staff at MercyWorks, regarding his injuries.

Petitioner further testified on cross-examination that he never checked light duty postings with Respondent or applied for a light duty job with Respondent after Respondent did not take him back as a motor truck driver. At one point, Respondent contacted him about working as a traffic enforcement technician. However, Petitioner did not feel the job was consistent with his sitting restriction. He took a test for the traffic enforcement technician job and passed it, and Respondent invited him to interview for the job. Petitioner did not go to the interview. Instead, he stopped looking for work and retired from Respondent's employ.

Petitioner further admitted he limited his job search to driving jobs only. Petitioner testified that he responded to help wanted ads, word of mouth and looked through the Yellow Pages, contacting 10 to 15 employers a week in person. He asked a prospective employer if it was hiring and completed a job application. Petitioner acknowledged his job search logs did not document the name of the person to whom he spoke or indicate he completed an application. Furthermore, the job search logs indicated none of the employers were hiring. Petitioner explained the reason he marked the employers were not hiring was because he was "forthcoming about [his] limitations" and understood the employers were not going to hire him with his restrictions and limitations. Upon further questioning, Petitioner testified that he spoke with "personnel" or "clerks" at the company "offices." However, he acknowledged some of the addresses listed in the job search logs were residential locations, explaining those were "contractors." Petitioner further testified he had "sporadic" interviews with trucking companies, maybe three interviews total. However, the job search logs did not document any interviews. Petitioner admitted that he never followed up on the job applications he completed. Respondent introduced into evidence the job search logs, spanning the time period from February 13, 2012, through July 19, 2013. Almost all entries in the logs state that: Petitioner contacted the "office" or "clerk" via telephone or in person for a driver position; was told the employer was not hiring; and did not submit an application or a resume.

Regarding his vocational evaluation by Mr. Boyd, Petitioner admitted that Mr. Boyd thought he could work in a number of non-driving jobs. However, Petitioner was not interested in applying for those jobs because they did not pay well.

Lastly, Petitioner testified that he does not leave the house much, especially in winter. He usually leaves the house two or three times a week. He does not do household chores. He does not own a computer and does not really know how to use one.

Petitioner introduced into evidence Mr. Boyd's vocational evaluation report, dated September 24, 2012. Mr. Boyd opined Petitioner had few transferrable skills and was not employable in a competitive labor market "[o]ther than selective unskilled, entry-level jobs within the service occupations (retail clerk, security guard, bus driver, telemarketer) that would pay $8.00-10.00 per hour." Mr. Boyd qualified that with keyboarding and basic computer training, Petitioner might qualify for skilled clerical jobs paying $10.27 to $13.86 an hour at the entry level. However, Mr. Boyd was concerned that Petitioner's "advanced age" would "negatively impact his consideration by prospective employers." In his evidence deposition, taken December 13, 2013, Mr. Boyd explained: "[T]here's the differentiation in vocational rehabilitation between employability and placability [*sic*]. From a skill standpoint, there may be some employment potential ***. But in terms of being placeable, it's my experience that [Petitioner's] age would be a definite handicap." Mr. Boyd therefore opined there was no viable labor market for Petitioner, irrespective of whether he underwent vocational training.

Respondent introduced into evidence Ms. Maurin's vocational evaluation report, dated May 17, 2013. Amongst other things, Petitioner told Ms. Maurin that he rarely drives "because of his medication" and he does have a computer at home, which he uses to check e-mail and perform basic Internet search. Ms. Maurin recommended an introduction to computers class and unarmed security guard training, and opined that Petitioner was "a candidate for positions such as automotive parts counter, porter, and unarmed security guard." In her evidence deposition, taken December 18, 2013, Ms. Maurin testified that Petitioner was potentially employable, despite his age, if he received appropriate vocational services. Ms. Maurin clarified that by "porter" she meant parking valet.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Based on the chain of events, the Arbitrator finds the work accident aggravated Petitioner's preexisting degenerative disc disease with spondylolisthesis to the point where the symptoms prevented him from returning to his regular duties as a motor truck driver for Respondent. See International Harvester v. Industrial Comm'n, 93 Ill. 2d 59, 63-64 (1982) ("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"). The Arbitrator notes Dr. Lami's original causal connection opinion was equivocal, indicating Petitioner's symptoms were in part causally connected to the work accident. In his subsequent report, Dr. Lami stated that his opinions remained "unchanged;" specifically, that Petitioner's condition of ill-being and need for restrictions were "not related to the injury of January 7, 2009." The two reports are inconsistent, with no basis provided for the opinion of no causal connection. Accordingly, the Arbitrator gives little weight to Dr. Lami's reports.

Regarding the left knee condition, the Arbitrator finds the work accident caused a knee contusion resulting in minimal permanent disability.

In support of the Arbitrator's decision regarding (K), what temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner claims temporary total disability benefits from February 3, 2009, through July 15, 2010, and maintenance benefits from July 16, 2010, through the date of the arbitration hearing on February 13, 2014.

The Arbitrator finds Petitioner proved he was temporarily totally disabled from February 3, 2009, through July 15, 2010. However, the Arbitrator awards no maintenance benefits. The Arbitrator notes that Petitioner introduced no documentary evidence of job search from July 16, 2010, through February 12, 2012, and it is unclear from the record whether he looked for work during that time period. Regardless, Petitioner's job search was not *bona fide*. The record shows Petitioner deliberately "applied" for jobs that were not within his restrictions, all the while advising prospective employers about his restrictions. The Arbitrator also questions how many prospective employers Petitioner actually contacted, given the nearly identical job search log entries. The Arbitrator finds it telling that Petitioner never checked light duty postings with Respondent or applied for a light duty job with Respondent. Moreover, when Respondent attempted to place him into the position of traffic enforcement technician, Petitioner did not go to the interview after passing the initial test, choosing instead to retire.

In support of the Arbitrator's decision regarding (L), what is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner claims he is permanently totally disabled. It is well established:

> "An injured employee can establish his entitlement to PTD benefits under the Act in one of three ways, namely: by a preponderance of medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of age, training, education, experience, and condition, there are no available jobs for a person in his circumstance. Federal Marine Terminals, Inc. v. Illinois Workers' Compensation Comm'n, 371 Ill. App. 3d 1117, 1129 (2007). In Ceco Corp. v. Industrial Comm'n, 95 Ill. 2d 278, 286-87 (1983), the supreme court held that: 'an employee is totally and permanently disabled when he "is unable to make some contribution to the work force sufficient to justify the payment of wages." [Citations]. The claimant need not, however, be reduced to total physical incapacity before a total permanent disability award maybe granted. [Citations]. Rather, a person is totally disabled when he is incapable of performing services except those for which there is no reasonable stable market. [Citation]. Conversely, an employee is not entitled to total and permanent disability compensation if he is qualified for and capable of obtaining gainful employment without serious risk to his health or life. [Citation]. In determining a claimant's employment potential, his age, training, education, and experience should be taken into account. A.M. T. C. of Illinois, Inc. v. Industrial Com. (1979), 77 Ill. 2d 482, 489; E.R. Moore Co. v. Industrial Com. (1978), 71 Ill. 2d 353, 362.' "

15IWCC0376

Professional Transportation, Inc. v. Workers' Compensation Comm'n, 2012 IL App (3d) 100783WC ¶ 15-16.

In the instant case, the preponderance of medical evidence does not support a finding of permanent total disability. Further, the evidence shows Petitioner did not conduct his job search in good faith. "In the absence of medical evidence to support a claim of total disability or his having conducted a diligent but unsuccessful job search, the claimant, who is not obviously unemployable, had the burden of proving by a preponderance of the evidence that he is so handicapped that he will not be employed regularly in any well-known branch of the labor market. Valley Mould & Iron Co. v. Industrial Comm'n, 84 Ill. 2d 538, 546-47 (1981); Westin Hotel v. Industrial Comm'n, 372 Ill. App. 3d 527, 544 (2007)." Professional Transportation, 2012 IL App (3d) 100783WC ¶ 18. Like the claimant in Professional Transportation, Petitioner failed to make such a showing. Respondent's vocational rehabilitation expert, Ms. Maurin, opined that Petitioner is employable as an automotive parts counter, parking valet or unarmed security guard. Petitioner's vocational expert, Mr. Boyd, opined that, but for his age, Petitioner would be employable as a clerk, security guard, bus driver or telemarketer. However, Petitioner testified he is not interested in those jobs because they do not pay well. It is clear from the record that Petitioner chose to retire and leave the workforce. He is not entitled to permanent total disability benefits.

The Arbitrator finds Petitioner is entitled to permanent partial disability benefits. However, with regard to the paresthesia in his left leg, Petitioner failed to prove it is causally connected to the work accident. With regard to the symptoms in the low back and right leg, the Arbitrator finds Petitioner exaggerated the extent of his disability. Having carefully considered the entire record, the Arbitrator finds the injuries to the low back caused permanent disability to the extent of 15 percent of the person as a whole and the injuries to the left knee caused loss of use of the left leg to the extent of 3 percent thereof.

In support of the Arbitrator's decision regarding (N), credit or reimbursement for the payments made by Respondent, the Arbitrator finds as follows:

The parties stipulated Respondent paid $61,567.85 in temporary total disability benefits and $132,050.37 in maintenance benefits. Correspondingly, Respondent is entitled to a credit. However, Respondent also seeks reimbursement from Petitioner for overpayment of maintenance benefits.

The Arbitrator has no statutory authority to order Petitioner to reimburse Respondent for overpayment of benefits. However, Respondent may petition the circuit court for appropriate relief. See Illinois Graphics Co. v. Nickum, 159 Ill. 2d 469 (1994); Karastamatis v. Industrial Comm'n, 306 Ill. App. 3d 206, 215 (1999).

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

CYNTHIA KILBER,

Petitioner,

15IWCC0377

vs.

NO: 06 WC 054936

UNITED AIRLINES, INC.,

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 accident, medical expenses, notice and TTD and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 no reason to disturb the Decision of the Arbitrator with respect to the findings concerning Petitioner's right hip and lumbar spine, including the medical expenses for the same, and similarly leaves untouched the awarded TTD benefits. The Commission takes issue only with the finding expressed in the Decision of the Arbitrator as it pertains to the causal connection between Petitioner's March 1, 2005, accident and her current condition of ill-being.

Petitioner, while in Respondent's parking lot on March 1, 2005, slipped on a patch of ice, twisted her left knee, fell to ground and landed on her right hip and back. She was subsequently diagnosed by Dr. Jablonsky as having a meniscal tear in her left knee and then underwent left knee arthroscopy with a medial meniscal repair and a partial lateral meniscectomy on June 3, 2005. The surgery was performed by Dr. Jablonsky. Petitioner returned to full duty work effective August 8, 2005.

Dr. Jablonsky released Petitioner to return to full duty work on August 7, 2005, and Petitioner followed up with Dr. Jablonsky thrice more in 2005 and twice in 2006 and 2007, respectively, and, on

each visit complained of continued medial pain in her left knee. The Commission notes between August 29, 2005, and October 10, 2005, and then again between September 21, 2006, and September 23, 2013, Petitioner was placed on off-work status as result of treatment, first, to her lumbar spine and, subsequently, her left knee.

Petitioner presented to Dr. Jablonsky on January 31, 2008, with histories of twice falling since she was last seen by him. The first of the two falls occurred on October 28, 2007, and the second occurred on January 28, 2008, with both the result of her left knee buckling. In a separate action, Petitioner filed a workers' compensation claim for injuries to her left knee, left elbow, left shoulder and neck sustained as a result of the October 28, 2007, fall on the premise of that fall being causally connected to her March 1, 2005 fall.

The October 28, 2007, accident is found to be of little significance to Petitioner's March 1, 2005, claim as this accident does not appear to constitute an intervening accident with respect to her left knee. First, Dr. Jablonsky's record of the accident indicates Petitioner's left knee was not injured in the accident. Second, and most importantly, the accident did not change the trajectory of the treatment Dr. Jablonsky recommended. Eight months prior to the October 28, 2007, accident, on February 23, 2007, Dr. Jablonsky had recommended an arthroscopic evaluation of Petitioner's left knee, including a possible debridement or repair. Dr. Jablonsky recommended the same procedure when Petitioner was seen on July 2, 2009, despite Petitioner experiencing two falling episodes between February 23, 2007, and July 2, 2009, on October 28, 2007, and January 28, 2008, respectively. The relative insignificance of those falls with respect to her left knee is revealed in Dr. Jablonsky's January 31, 2008, treatment note where he mentions those falls only in passing. It is found, therefore that Petitioner's October 28, 2007, accident did not change the condition of Petitioner's left knee to such an extent as to break the chain of causation between Petitioner's March 1, 2005, accident and the continuing ill-condition of her left knee.

The Commission does find that the causal connection of ill-being stemming from Petitioner's original accident of March 1, 2005, and her current condition of ill-being, including the need for the prescribed left total knee arthroplasty, to have been severed by Petitioner's experiencing, as described by Dr. Jablonsky, a "significant crack" in her left knee while walking up the stairs at her home on February 19, 2010. The resultant pain was noted on February 24, 2010, to be in the patellofemoral region and the lateral aspect of her left knee with Dr. Jablonsky noting further that "[p]rior to [this incident] there was no significant change in her condition . . . ." It does not go unnoticed, as noted above, that Dr. Jablonsky, on May 25, 2010, testified only to the March 1, 2005, accident as being the cause of Petitioner's left knee pain for which he was treating Petitioner through February 24, 2010. Notwithstanding Dr. Jablonsky then volunteering that he was unsure that to be true, as again noted above, the Commission finds implied in Dr. Jablonsky's initial answer was that the pain he was treating subsequent to February 24, 2010, had its origins as the result of some other event. In the absence of any evidence to the contrary, the Commission finds the "significant crack" in Petitioner's left knee on February 19, 2010, to be that event. The Commission, therefore, finds the causal connection between Petitioner's March 1, 2005, accident and her condition of ill-being to have been severed on February 19, 2010.

Subsequent to the February 19, 2010, incident, on January 12, 2011, additional surgery was performed upon Petitioner's left knee. The surgery was a left knee arthroscopy and included a partial medial menisectomy, a lateral release and chondroplasty. During the procedure, a tear was found in the menisus. Given Petitioner's history of falls in October 2007 and January 2008 and of the "crack" in her left knee, there can be no certainty as to the origin of the tear. It is certain that, the MRI that followed the October 2007 fall produced no evidence of any tear. As Petitioner has been off work since September 21, 2006, had falls in 2007 and 2008 that where unrelated to her March 1, 2005, accident and experienced the "crack" in her left knee in 2010, the Commission cannot find any evidence to conclude that the meniscus

15IWCC0377

tear was causally connected to Petitioner's compensable March 1, 2005, accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 676.18 per week for a period of 381-2/7 weeks, from June 3, 2005, through August 7, 2005; from August 29, 2005, through October 10, 2005; and September 21, 2006, through September 23, 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 for all medical expenses under §8(a) of the Act for treatment of Petitioner's right hip and lumbar spine and only through February 19, 2010, for treatment of Petitioner's left knee.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not liable for the prospective left total knee arthroplasty as recommended by Dr. Joblonsky.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $288,163.10 for prior TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $54,605.35 for medical expenses previously paid as provided in Section 8(j) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAY 2 1 2015
KWL/mav
O: 5/24/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0377

KILBER, CYNTHIA
Employee/Petitioner

Case# **06WC054936**

08WC045282

UNITED AIRLINES INC
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:

2226 GOLDEN LAW OFFICE
LOREN GOLDEN
2400 BIG TIMBER RD SUITE 201A
ELGIN, IL 60123

0560 WIEDNER & McAULIFFE LTD
KAREN COON
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0377

Cynthia Kilber
Employee/Petitioner

v.

United Airlines, Inc.
Employer/Respondent

Case # **06 WC 54936**

Consolidated cases: **08 WC 45282**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **September 23, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 1, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$52,742.28**; the average weekly wage was **$1,014.28.**

On the date of accident, Petitioner was **42** 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 **$288,163.10** for TTD benefits paid, in the combined claims of **08 WC 45282** and **06 WC 54936**.

Respondent is entitled to a credit of **$54,605.35** under Section 8(j) of the Act for the combined claims of **08 WC 45282** and **06 WC 54936**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$676.18**/week for **381-2/7** weeks, commencing **6/3/05 – 8/7/05; 8/29/05 – 10/10/05**; and **9/21/06 – 9/23/13**, as provided in Section 8(b) of the Act.

Respondent is entitled to a credit of **$288,163.10** for prior TTD benefits paid.

Respondent shall be given a credit of **$54,605.35** for medical benefits that have been paid, as provided in Section 8(j) of the Act.

The Arbitrator awards medical bills for the reasonable, necessary and related care and treatment following the **March 1, 2005** accident to Petitioner's left knee (including two surgeries), right hip and lumbar spine (including three surgeries), as well as the medical bills for the reasonable, necessary and related care and treatment following the **October 28, 2007** accident to Petitioner's left shoulder (including two surgeries), left elbow and neck, pursuant to Section 8(a), and subject to Section 8.2 of the Act, where applicable.

The Arbitrator orders Respondent to authorize and pay for the left total knee arthroplasty, as recommended by Dr. Jablonsky, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

15IWCC0377

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

4/2/14
Date

ICArbDec19(b)

APR 3 - 2014

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Kilber,

Petitioner,

vs.

United Airlines, Inc.,

Respondent.

15IWCC0377

Case No. 06 WC 54936; 08 WC 45282

FINDINGS OF FACT:

The petitioner testified that she has worked for the respondent, United Airlines, Inc., as a supervisor of interline domestic accounting for approximately 20 years. She described her position as being primarily a desk job at which she sits before a computer. However, the petitioner stated that occasionally, she would walk around to help those working under her.

The petitioner testified that on March 1, 2005, she was exiting her vehicle in the employee parking lot when she slipped and fell on black ice. She twisted her left knee and fell on her right back and hip area.

Following the accident of March 1, 2005, the petitioner was initially evaluated by Dr. Warren Jablonsky on March 10, 2005, for complaints of right hip and left knee pain. X-rays of the left knee showed lateral compartment degenerative changes. X-rays of the right hip showed evidence of a varus hip with no other bony abnormalities. She was diagnosed with a right hip and buttock contusion with evidence of a right sacroiliac joint strain, and a left knee probable medial collateral ligament sprain with a possible medial meniscus tear. An MRI of the left knee was prescribed and the petitioner was authorized to return to work at full duty.

On March 10, 2005, petitioner underwent an MRI of the left knee, which showed a low grade injury of the medial collateral ligament with increased signal intensity in the medial meniscus which did not fit MRI criteria for a tear. There was mild chondromalacia patella with a small patellofemoral joint fusion. Dr. Jablonsky suggested she might need an arthroscopy and administered an intraarticular steroid injection. Physical therapy for right SI joint and low back pain was prescribed.

On June 3, 2005, the petitioner underwent a left knee arthroscopy with medial meniscal repair and partial lateral meniscectomy performed by Dr. Jablonsky. She returned to Dr. Jablonsky on June 6, 2005 and noted no significant complaints of pain or discomfort. By June 30, 2005, she was to work up to weight bearing as tolerated. Postoperatively, she underwent physical therapy at Excel Physical Therapy beginning on July 6, 2005.

On August 22, 2005, while at physical therapy, the petitioner reported that while ascending stairs on August 20, 2005, she felt a sharp pain in the medial left knee, accompanied by throbbing pain in the area since that time. Hip pain had also reportedly kept her awake since 2:45 a.m.

On August 25, 2005, she reported to Dr. Jablonsky that she had been doing well until Saturday, when she was going up stairs and felt a rubber band-type pull with significant increasing pain. As she now had new complaints of pain radiating to the right lower leg, an MRI of the lumbar spine was prescribed.

The MRI of the lumbar spine performed on August 29, 2005 showed a small right paramedian disc herniation at L3-L4, postoperative and degenerative changes at L4-L5 with mild foraminal stenosis and a tiny left foraminal disc herniation at L5-S1. Based on the MRI results on September 1, 2005, Dr. Jablonsky recommended an epidural steroid injection.

A Section 12 examination was performed on September 22, 2005 by Dr. Babak Lami of Illinois Spine Institute at the request of the respondent. The petitioner reported post-surgery improvement of 90% in her left knee symptoms. She reported pain in her lower back and on the lateral aspect of the right leg over the greater trochanteric area. The symptoms were not radicular at that time. The petitioner was diagnosed with low back pain with a component of

right iliotibial band inflammation and possible SI joint pain and a left knee meniscal tear. Dr. Lami recommended physical therapy for her low back and right hip and injections if physical therapy was not beneficial.

Following an evaluation at the Pain Center of McHenry County with Dr. Nasaruddin on October 13, 2005, the petitioner continued with conservative care consisting of injections and physical therapy with no improvement. The petitioner returned to work on October 11, 2005 until September 21, 2006 at full duty, as was stipulated to by the parties. (AX1)

The petitioner saw Dr. Jablonsky again on November 3, 2005, reporting that her back pain had continued after the epidural steroid injection. Dr. Jablonsky agreed with the Dr. Nasaruddin's recommendation to perform a sacroiliac joint injection.

The petitioner returned to Dr. Jablonsky on February 16, 2006 describing pain of a radicular nature in the lower extremity, as well as ongoing complaints of right SI joint pain and sudden discomfort in the left medial femoral condyle region. Dr. Jablonsky provided her with the names of possible spine specialists, including Dr. Panchal, and noted she might need a lumbar discectomy.

The petitioner began treatment with Dr. Panchal, affiliated with Centegra, who recommended a myelogram and post-myelogram CT which was performed on May 19, 2006 by Dr. Nassaruddin. The exam showed advanced disc disease at L4-L5, endplate degenerative changes, stenosis at L3-L4, neuroforaminal stenosis at L3-L4 on the left, and at L4-L5.

On September 21, 2006, petitioner underwent a laminectomy at L3-L5, medial facetectomy and foraminotomy, neurolysis, and decompression of the L4-L5 nerve root.

The petitioner saw Dr. Jablonsky again on November 28, 2006, with complaints of left knee pain and swelling which began November 8, 2006 during rehabilitation for her back while on a bicycle. She reported no history of twisting or any injury. The records reflect that she had been able to ride a bicycle throughout the summer without complaints of pain or discomfort. The MRI of the left knee performed January 11, 2007 showed no evidence of a re-tear. It did show mild to moderate osteoarthritis most pronounced within the patellofemoral joint space. Dr. Jablonsky suggested possible diagnostic arthroscopy with debridement or repair as needed.

The petitioner underwent a second myelogram and post-myelogram CT of the lumbar spine on March 2, 2007. The results suggested severe degenerative disc disease at L4-5, marginal osteophytes, broad-based bulge of L3-4 and evidence of previous surgeries.

The petitioner returned to Dr. Lami for a second Section 12 examination on May 23, 2007. Dr. Lami found her condition with respect to the lumbar spine was unrelated to the work injury of March 1, 2005, as the radiculopathy did not begin until 6 months after this fall. He also noted that the petitioner's subjective disabilities and pain were out of proportion to the objective findings and he opined she would be a poor surgical candidate. Dr. Lami further opined that the petitioner was at maximum medical improvement following injuries sustained from the accident on March 1, 2005. He stated that further treatment would not be related to her work injury and recommended she return to her office job at full duty.

The petitioner sought a second opinion from Dr. Spencer on September 13, 2007. He initially opined that her back pain was not mechanical and provided her with an injection. At a follow-up appointment, she demonstrated signs of mechanical back pain and he recommended a laminectomy.

On September 13, 2007, Dr. Lami issued an addendum report. He opined that the lower extremity symptoms were not due to radiculopathy but were rather due to inflammation of the iliotibial band. He further opined that her leg symptoms and the low back surgery were therefore unrelated to the March 1, 2005 work injury.

The petitioner testified that on October 28, 2007, she fell down the stairs in her home and injured her left shoulder, left elbow and left side of her neck.

Following the October 28, 2007 occurrence at home, the petitioner saw Dr. Jablonsky on January 31, 2008. The petitioner told Dr. Jablonsky that the injury occurred as she was going down the stairs at home, her left knee gave way and she fell. Following this fall, the petitioner complained primarily of left elbow, neck, shoulder and arm pain.

The petitioner next followed up with Dr. Jablonsky on February 7, 2008, at which time they discussed the results of the February 1, 2008 MRI of the left upper extremity.

The MRI showed evidence of a C4-C5 left-sided disc herniation, as well as bilateral foraminal narrowing at C5-C6 with left paramedian protrusion at C6-C7. The petitioner advised Dr. Jablonsky that she would follow up with her spine specialist, Dr. Spencer, at Lutheran General Hospital.

Dr. Jablonsky was first deposed on February 4, 2008. He testified that the petitioner had no lumbar complaints or radiculopathy when he first saw her in March 2005. He opined that it was possible that the second injury of October 28, 2007, aggravated the petitioner's pre-existing condition. He testified that the March 1, 2005 accident aggravated the right hip area. It was his opinion that the petitioner's current knee problems, at the time of the deposition, were most likely related to the March 1, 2005 accident rather than to any biking activities in which the petitioner engaged. Furthermore, Dr. Jablonsky could not correlate the new instance of right leg radiculopathy or lumbar condition to the accident of March 1, 2005.

The deposition of Dr. Panchal was taken on April 28, 2008. At the time of his deposition, he had not seen the petitioner since July 23, 2007. Dr. Panchal testified that the MRI indicated the petitioner had undergone a prior, right-sided L4-L5 laminectomy. He opined that the fall of March 1, 2005 contributed to the petitioner's symptoms and aggravated her degenerative condition. Dr. Panchal noted that the petitioner had continued complaints after surgery and the myelogram on March 2, 2007 showed a bulging disc at L3-L4 with scarring. Dr. Panchal further opined that the March 1, 2005 fall was connected to the herniated disc, radiculopathy and surgery. On cross-examination, however, he testified that if the petitioner had absolutely no symptoms of back pain or leg pain for six months after the accident, he would find that the March 1, 2005 fall played a very little role with regard to the petitioner's condition at that time. While Dr. Panchal testified the petitioner could not work as a flight attendant, this was not her job and no opinion was offered as to whether she could work in an office setting.

On May 29, 2008, Dr. Lami testified that he had diagnosed petitioner with low back pain with a component of a right IT band inflammation and possible SI joint pain, in addition to a left knee meniscus tear. Dr. Lami deemed that these conditions were casually related to the fall of March 1, 2005.

At the time of his examination, Dr. Lami found no indication of any injury to the petitioner's L4-5 and L3-4 disks. Dr. Lami explained the difference between iliotibial band pain and diskogenic pain and testified that the petitioner had no symptoms or complaints of sciatica or radiculopathy at the time of the September 22, 2005 examination. As the petitioner developed radicular pain at least one year after falling, he was unable to relate the need for the lumbar surgery that the petitioner underwent in September to the petitioner's fall on March 1, 2005, as an injured back would not take up to one year to show signs of sciatica or radiculopathy.

The petitioner was seen by Dr. James Bresch on June 16, 2008. The petitioner filled out an intake form in which she identified October 28, 2007 as the date of injury and told him that she had a three-month history of left shoulder pain. She reported that she initially had numbness and tingling in her left hand and was evaluated by a spine surgeon, who obtained an MRI that did not demonstrate any findings consistent with her symptomatology. It was suggested by her physical therapist that she seek an orthopedic evaluation. X-rays showed good joint space within the glenohumeral joint with some slight degenerative joint disease in the AC joint with no overall source of her symptomatology. Dr. Bresch's assessment was adhesive capsulitis. He administered a corticosteroid injection in the subacromial space. The petitioner was instructed to continue with physical therapy for range of motion and strengthening activities and to return in six to eight weeks.

The petitioner saw Dr. Bresch again on June 30, 2008 and stated that the injection did not provide any relief. Dr. Bresch noted that Dr. Spencer strongly believed her complaints were not coming from her neck. Dr. Bresch prescribed an arthroscopic subacromial decompression and release of adhesions. Left shoulder surgery was performed by Dr. Bresch on September 5, 2008. The post-operative diagnoses were left shoulder impingement syndrome, profound rotator cuff tendinopathy and detached glenoid labrum.

Due to continued post-operative complaints, a second MRI of the left shoulder was performed on October 23, 2008. The study showed post-surgical changes involving the glenoid. There was a focal full thickness tear of the supraspinatus tendon without retraction of the myotendinous junction. Also seen were degenerative changes at the AC joint causing

impingement and long head of the biceps tendinitis. The petitioner underwent a second left shoulder surgery performed by Dr. Bresch on December 12, 2008 consisting of a left shoulder arthroscopy with open bicipital tenodesis for a diagnosis of chronic bicipital tendinitis.

Dr. Spencer testified in this matter on October 16, 2008. He evaluated the petitioner on what he believed to be a referral from Dr. Panchal. He initially felt the petitioner's leg pain was independent of movement of the lumbar spine. Dr. Spencer opined that as the petitioner's pain was not mechanical, a fusion would not help. He prescribed Neurontin that reduced the leg pain, leaving her back pain as the primary problem.

At the petitioner's next evaluation by Dr. Spencer, he noted that her pain was now mechanical and a revision laminectomy was prescribed.

The petitioner followed up with Dr. Spencer on February 19, 2008 and reported an accident where she fell on her elbow. With regard to causation, Dr. Spencer testified that the petitioner had early retrolisthesis, which was related to a degenerative condition and that the March 1, 2005 fall on ice contributed to her back pain. He testified that he could not say if she was still a surgical candidate as he had not seen the petitioner since September 13, 2007.

On April 6, 2009, a Section 12 examination of the left knee was performed by Dr. Brian Cole. Dr. Cole recommended an MRI and injection. Dr. Cole causally related the petitioner's condition to an aggravation sustained in November 2006 while the petitioner was in physical therapy for her low back and was riding a bike. Dr. Cole opined the petitioner's present complaints were a result of an aggravation of her pain symptomatology and not as a result of a new injury or tear.

The petitioner was seen on April 14, 2009 by Dr. Jablonsky for a new right knee injury. She reported that she was walking on April 4, 2009 when she felt a sharp pulling sensation in her right knee. X-rays of the right knee showed some mild medial compartment narrowing and proximal tibial changes of the previous bone graft site. The impression was that of right knee pain of unclear etiology due to an injury on April 4, 2009.

The petitioner underwent an MRI of the right knee without contrast on April 16, 2009. She was found to have mild chondromalacia to the lateral facet of the patella and medial joint

compartments with increased signal intensity in the posterior horn of the medial meniscus, an acute mid-grade injury of the collateral ligaments, iliotibial band syndrome, large patellofemoral joint effusion and fluid in the subcutaneous fat anterior to the patella and patellar tendon.

The petitioner was seen on April 21, 2009 to review the MRI findings with Dr. Jablonsky. The MRI showed some medial meniscal degeneration, iliotibial band syndrome and prepatellar tendon fluid. The petitioner reported that she had lateral pain along the distal IT band, lateral joint line and medial pain and Dr. Jablonsky gave her an injection at this visit.

The petitioner was seen by Dr. Jablonsky on May 5, 2009, and reported that the injection she received on April 21, 2009 provided some relief, but she still had substantial pain. The petitioner noted she was going to hold off on any surgery at the present time.

On July 2, 2009, the petitioner saw Dr. Jablonsky for left knee complaints. He had not seen her for complaints to the left knee since February 23, 2007. He noted that dating all the way back to the February 23, 2007 visit, arthroscopic debridement to the left knee, secondary to the work injury of March 1, 2005, had been discussed and future treatment options had been contemplated since that time. Dr. Jablonsky proceeded to inject the petitioner's left knee at the time of this visit.

The petitioner followed up with Dr. Jablonsky for re-evaluation of left knee pain on July 16, 2009. He noted that the left knee condition stemmed from a left knee injury on March 1, 2005. As the petitioner reported that the left knee injection she had received at the time of the July 2, 2009 visit provided little relief, Dr. Jablonsky prescribed an MRI.

On August 10, 2009, the petitioner underwent a right knee arthroscopy with partial medial and lateral meniscectomies, patellofemoral chondroplasty and medial femoral chondroplasty. Post-operatively physical therapy was instituted.

On November 5, 2009, the petitioner was given an injection to the left knee. On November 19, 2009, she reported that the injection did not provide adequate relief. Dr. Jablonsky proceeded to recommend an MRI scan of the left knee.

On December 18, 2009, the petitioner underwent an MRI of the left knee that showed tricompartmental chondromalacia, with worsening in the patellofemoral joint compared to the prior study of March 10, 2005.

The petitioner returned to Dr. Jablonsky on January 8, 2010 to review the MRI. The petitioner felt that she would like to proceed with an arthroscopic evaluation and debridement.

The petitioner returned on February 24, 2010, stating that on February 19, 2010, while walking up the stairs at home, she felt a significant crack in the left knee. She reported an onset of pain primarily in the patellofemoral region and lateral aspect of the joint. Dr. Jablonsky found she had an exacerbation of her symptoms in her left knee with somewhat different complaints of pain after the incident of February 19, 2010. The doctor recommended a repeat MRI scan to ensure there was no other evidence of increased injury or damage.

The petitioner was seen on March 18, 2010 for right knee follow up after the arthroscopy performed on August 10, 2009. On examination, she had pain radiating from the lateral aspect of her right hip all along the course of the iliotibial band and lateral aspect of her right knee.

A second deposition of Dr. Jablonsky was taken on May 25, 2010. Dr. Jablonsky testified that the petitioner's left knee complaints through February 24, 2010 were causally related to the March 1, 2005 work accident.

With respect to the right knee, Dr. Jablonsky offered no opinion as to whether the right knee surgery was related to a work accident or to the left knee condition. He also testified that it was possible that the left knee condition was a result of the November 2006 incident in therapy rather than the March 1, 2005 accident. Upon further questioning, he conceded that it was possible that the right knee may be having an adverse effect on the left knee. He was also unaware that the petitioner was treating for her left elbow, shoulder and neck.

On June 23, 2010, the petitioner underwent an MRI of the left knee that showed tricompartmental chondromalacia most severe at the patellofemoral joint, with full thickness chondral defect of the lateral apex. There was a stable configuration of the menisci without development of meniscal tear and there continued to be a stable low grade MCL sprain.

The petitioner returned to Dr. Jablonsky on June 28, 2010. He noted no major changes in the June 23, 2010 MRI of the left knee as compared to the prior study performed December 18, 2009, but noted evidence of continued tricompartmental chondromalacia. Dr. Jablonsky discussed the possibility of an arthroscopic evaluation and debridement with lateral release. He noted that due to the significant amount of degenerative changes in the patellofemoral joint and changes within the medial compartment, that a total knee arthroplasty might be necessary in the future.

The deposition of Dr. Bresch was taken July 14, 2010. Dr. Bresch testified that as a result of the petitioner's fall at home in October 2007, the petitioner suffered post-traumatic adhesive capsulitis and impingment syndrome. Shoulder surgery was performed at which time the doctor found chronic changes/tears. Dr. Bresch opined that a cervical problem could be causing ongoing shoulder pain and referred the petitioner to Dr. Spencer. The petitioner underwent a second surgery for chronic bicipital tendonitis. The petitioner was last seen by Dr. Bresch on January 15, 2009. She had adhesive changes and PT was recommended. Dr. Bresch testified that her condition was causally related to the fall at home on October 28, 2007. Mechanically, the shoulder was stable and he was unable to identify the source of her ongoing pain.

On September 30, 2010, Dr. Cole issued an addendum opinion. He noted that petitioner had been doing well prior to the re-injury at physical therapy, however, when he saw her, she had a profound amount of stiffness. He recommended she undergo an injection and indicated that if this did not afford even temporary relief, her prognosis with arthroscopic surgery would be poor. Given the moderate amount of arthritis, Dr. Cole recommended aggressive weight loss and Synvisc injections. If there was no improvement, then a last ditch effort at arthroscopic evaluation could be appropriate to allow an opportunity to assess articular surfaces for possible arthroplasty.

On January 12, 2011, Dr. Jablonsky performed a left knee arthroscopy with partial medial meniscectomy, patellofemoral chondroplasty, medial and lateral femoral chondroplasty and lateral release. The petitioner began physical therapy at McHenry County Orthopedics Physical

Therapy on January 27, 2011. By February 23, 2011, Dr. Jablonsky noted that her range of motion was zero to 120 degrees. By March 23, 2011, the petitioner reported that she was approximately 70% improved with physical therapy.

On May 4, 2011, the petitioner was still complaining of significant pain in the lateral patellofemoral joint and parapatellar region. Her IT band symptoms had also been worsening in spite of physical therapy. Dr. Jablonsky reviewed the intraoperative pictures, and noted that with the amount of degenerative changes within the knee, he had questions regarding a successful outcome. Dr. Jablonsky wrote: "If she continues to have breakdown of her tissues and continues to have complaints of pain, a total knee arthroplasty would be the only recommended treatment option, as a possibility in the future." (PX14)

On June 2, 2011, the petitioner reported that she remained only about 50% improved since surgery. On July 11, 2011, Dr. Jablonsky provided her with samples of Voltaren gel to reduce the distal and iliotibial band discomfort.

At the request of the respondent, and pursuant to Section 12 of the Act, Dr. Joseph D'Silva examined the petitioner on June 8, 2011.

The petitioner's husband, Paul Kilber, accompanied her to the examination by Dr. D'Silva. He observed that Dr. D'Silva spent very little time with his wife and, in fact, never physically examined Cynthia Kilber's left knee.

Dr. D'Silva opined that the petitioner sustained an isolated injury to the medial meniscus that was appropriately arthroscopically repaired. Dr. D'Silva further opined that the lateral meniscectomy that was performed during the first surgery was not related as it was not symptomatic at the time. Dr. D'Silva also stated that the petitioner had recovered from the March 1, 2005 injury, and 1-1/2 years later, complained of new onset of left knee pain. Dr. D'Silva also opined that none of the described activities would stress the meniscus and that the findings noted during the last arthroscopy, including the advanced patellofemoral joint symptoms and lateral compartment arthritis, were unrelated to the injury in 2005 and said findings did not correlate with the mechanisms of injury described by the patient. Lastly, Dr. D'Silva opined that all treatment to the left knee after 2006 was unrelated to the work accident.

On September 20, 2011, the petitioner returned to Dr. Jablonsky for a new injury that resulted from a motor vehicle accident. She told Dr. Jablonsky that the injury occurred when her seat belt was stuck in the door, and she opened the car door and fell out, landing on the left side of her body. She had complaints involving her elbow with abrasion in the olecranon region. She also had complaints of neck discomfort with tingling into the middle and ring fingers of the left hand. A CT of her neck showed generalized degenerative changes at C4-C5 and C5-C6 with no obvious fracture. X-rays of the elbow were also negative for fracture. APN lateral views of the right knee showed evidence of generalized degenerative changes. She was placed in a long arm posterior mold. She complained of tingling into the middle and ring fingers in the left hand, which was showing some mild improvement. The right knee had generalized stiffness. She was diagnosed with a left elbow contusion, a right knee degenerative joint disease with evidence of contusion and numbness and tingling involving the left ring and middle fingers.

The petitioner returned to Dr. Jablonsky for reevaluation on September 27, 2011. Her left elbow contusion and right knee were improved. Dr. Jablonsky noted evidence of distal iliotibial band irritation. The numbness and tingling in the left ring and middle fingers had resolved and was felt to be related to a contusion of the medial nerve. The petitioner also complained of an exacerbation of symptoms in the left knee degenerative joint disease and right-sided low back pain. The petitioner declined physical therapy at that time.

On April 25, 2012, Dr. D'Silva testified that the work accident of March 1, 2005 resulted in a medial meniscus tear that resolved within 16 to 18 months. The surgery performed in June 2005 resolved the meniscal condition that was the result of the March 1, 2005 accident. The second surgery, including the re-tear of the medial meniscus, was not in any way related to the work accident or the prior surgery. Additionally, the chondromalacia found in the petitioner's knee was not aggravated by the work accident. The doctor further testified that the medial meniscus tear that was the result of the work accident would not lead to later episodes of instability, as the problem had been corrected by the surgery in June 2005. Therefore, any episodes of instability, such as the second accident/fall on October 28, 2007, would be unrelated

to the work accident. The activity of riding a bike while in physical therapy would also not cause or contribute to the development of a medial meniscus tear.

On May 21, 2012, Dr. Jablonsky performed a right total knee replacement.

The petitioner was admitted to the hospital by Dr. Glosson at Centegra Health System on September 3, 2012 with severe intractable back pain radiating down the right leg with tingling, numbness and weakness. The MRI revealed post-surgical right hemilaminectomy at L3-L4 and L4-L5. At L3-L4, there was a posterior disc bulge with a right paracentral disc extrusion or a disc recurrence filling the right lateral recess causing marked narrowing with impression upon the right L4 nerve root. At L5-S1, there was also a left lateral disc bulge which was encroaching on the left neural foramen with resultant severe left foraminal narrowing which had progressed since the prior evaluation. Based on the nerve compression seen on the MRI, surgery was prescribed.

The petitioner underwent surgery on September 6, 2012, which consisted of exploration of the prior laminectomy at L3-L4-L5 on the right as well as a new laminectomy at L3-L4 on the right with medial facetectomy and foraminotomy. Neurolysis was performed and Dr. Panchal removed a large extruded herniated disc at L3-L4 on the right with decompression of L2 and L3 nerve roots also on the right side.

Post-operatively, the petitioner was noted to be doing well by September 14, 2012 when she returned to see Dr. Panchal. The doctor noted she was doing extremely well and the radicular pain in the legs was completely gone. He directed her to perform a home exercise program and she was to return in one month. On October 15, 2012, the petitioner reported that she was pleased with the results of the surgery.

A Section 12 examination was performed in January 2013 by Dr. Jesse Butler and his deposition was completed on May 3, 2013. Dr. Butler opined that the petitioner's current low back condition and recent surgery performed on September 6, 2012, were unrelated to the March 1, 2005 work accident and that instead, the disc herniation occurred, by petitioner's report, in a fall in July of 2012.

Dr. Butler further testified that the petitioner reported to him that in July 2012, her left knee buckled and she fell, causing severe pain in her low back. Dr. Butler was of the opinion that based on the history provided to him by the petitioner, the extruded herniated disc was caused by this fall.

A third lumbar surgery was performed on April 16, 2013 by Dr. Slavin. The procedure included an L3-L4 discectomy for a recurrent herniated disc. The doctor noted that the disc removed was extremely large and was in the same location as the September 2012 surgery.

CONCLUSIONS OF LAW:

With respect to the issues of whether the petitioner sustained accidental injuries arising out of and in the course of her employment and whether she gave timely notice to the respondent, the arbitrator makes the following findings of fact and conclusions of law:

The parties stipulated to the issue of accident with regard case # 06 WC 54936.

On that date, the petitioner sustained injuries to, *inter alia*, her left knee for which she underwent a left medial meniscectomy on June 3, 2005. After the work accident and initial surgery, the petitioner returned to work at full duty in October 2005 and worked until September 21, 2006.

In November 2006, while undergoing physical therapy for her low back, which the petitioner also injured in the March 1, 2005 accident, she sustained a re-injury to the left knee when riding a bicycle. Dr. Cole notes that about the same time, the petitioner also hurt her back while performing straight leg raises in physical therapy.

With regard to case # 08 WC 45282, the petitioner alleges that she sustained injuries to the left shoulder, left elbow and left side of the neck on October 28, 2007. The petitioner was not working at this time and instead claims that her left knee, which was previously injured in a

work-related accident on March 1, 2005, gave out and caused her to fall down some stairs at home.

The petitioner provided unrebutted testimony that within a few days of October 28, 2007, she called the other supervisor in her area, Sue Wyler, and told her about her fall down the stairs. The petitioner further unrebutted testimony that within 45 days of October 28, 2007, she told Peg Frisch and Diane Frisch, who are co-workers at work, what had happened, and believed that she phoned her manager, Bob Portschy, within 45 days. The petitioner testified that she did not initially report this as a work accident because it happened at home.

Eight months earlier, on February 23, 2007, Dr. Jablonsky saw the petitioner. The petitioner voiced complaints to the doctor of significant medial pain in her left knee. Dr. Jablonsky told her that he saw no other treatment options other than proceeding with arthroscopic evaluation, possible debridement, possible repair or drilling. Dr. Jablonsky explained the risks associated with surgery. The petitioner was willing to accept these risks and to proceed with the surgery. Dr. Jablonsky then sought authorization for such surgery from the respondent.

Subsequent to the petitioner's fall at home on October 28, 2007, she saw Dr. Jablonsky on January 31, 2008. She stated that while going down the stairs at home on October 28, 2007, she felt her left knee give way, landed on her left side and has had significant pain since this injury. The petitioner stated that the knee buckles and has feelings of instability and has been in significant pain since this injury. The petitioner also complained of pain involving the medial and lateral aspects of her elbow, posterior aspect of left humerus region, left shoulder region and left trapezial and neck regions. She also complained of numbness and tingling radiating from her neck to all of her fingers.

During Dr. Jablonsky's first deposition, on February 4, 2008, the following exchange took place on direct examination:

Q: In terms of whether you could render an opinion as to whether her initial knee injury that she sustained as a result of her injury at work from March 1, 2005, whether that would create the weakness which would cause her to fall, would it require to you do (sic) an arthroscopic procedure?

A: Well, I think it would certainly be helpful. If you did an arthroscopic procedure and noted there was no further damage to the area of the repair and it looked like it was intact and there was a different injury there that could be related to causing weakness or giving way of the knee, then I would - - I would say that they probably were not related. If it was in evidence that the previous repair either had failed or had a retear through that area, then I would - - I would say that it would be related to the initial injury. (Petitioner's Exhibit 3, pp. 40-41)

Neither the MRI of the left knee taken before nor the one taken after October 28, 2007 indicate any evidence of a re-tear or failure of the previous repair.

Nevertheless, on January 12, 2011, Dr. Jablonsky performed a left knee arthroscopic surgery that consisted of partial medial meniscectomy, patellofemoral chondroplasty, medial and lateral femoral chondroplasty and lateral release. During the course of the surgery, Dr. Jablonsky found evidence of a tear of the posterior horn of the medial meniscus.

The petitioner testified that she has experienced many episodes of left knee buckling. The Arbitrator notes that such episodes followed her October 28, 2007 fall down the stairs.

Dr. Brian Cole conducted a Section 12 examination of the petitioner on April 6, 2009. It was his opinion that although somewhere around August 2005, the petitioner was well-rehabilitated and had minimal complaints regarding the left knee, she was never complaint-free nor did she really have a course of more than a few months without being seen at some level for the knee. Dr. Cole further opined that he did not think that the aggravation to the left knee around November 2006, while the petitioner was undergoing physical therapy to the low back, was a whole new injury, but rather an aggravation of her pre-existing problem.

During Dr. Jablonsky's second deposition, on May 25, 2010, the following exchange took place on recross examination:

BY MR. STELLMACH:

Q: So it was the October 2007 incident?

A: Sorry.

Why don't you restate the question?

Q: It wasn't my question, it was actually counsel's question.

MR. GOLDEN: It was October - - October 28, 2007 fall on the stairs.

THE WITNESS: I understand the date. But what was the question regarding that?

I'm sorry.

MR. GOLDEN: That the weakness or her leg giving out, the left knee giving out, is consistent with the condition of her knee from the injury she sustain (sic) on March 1st, '05?

THE WITNESS: Yes. (PX6, p. 32)

Based on (1) the left knee injury the petitioner sustained in the work accident of March 1, 2005 (2) the November 2006 aggravation to her left knee while on the bicycle in physical therapy (3) the continued complaints of left knee pain by the petitioner, and (4) Dr. Jablonsky's opinion on this page, the arbitrator finds that the petitioner's left knee buckled due to the March 1, 2005 accident and resulted in her fall down the stairs on October 28, 2007. Accordingly, the Arbitrator finds that the petitioner sustained an accident on that date that arose out of and in the course of her employment by the respondent, and that she gave timely notice of the accident to the respondent.

<u>With respect to the issue of causation as it pertains to the right leg, the arbitrator makes the following findings of fact and conclusions of law:</u>

The petitioner had no complaints of any right knee pain or symptoms until April 2009. When the petitioner saw Dr. Jablonsky on April 14, 2009, she reported that she was walking on April 4, 2009 when she felt a sharp, pulling sensation anteriorly, posteriorly, and medially. The doctor's impression was right knee pain with an unclear etiology due to an injury on April 4,

2009. The history as listed on the MRI report also indicates: "the patient felt a snap ten days ago." She experienced right anterior and posterior knee pain. The petitioner was not working at that time and there is no concurrent history in the medical records to support that the right knee accident occurred due to the left knee buckling. Instead the records support that she was just walking when she felt pain.

In his deposition of May 25, 2010, Dr. Jablonsky provided no opinion as to whether the right knee was related to employment. Regarding the inciting event, Dr. Jablonsky testified, "She was just walking when she felt sharp onset of pain." (PX6, p. 6)

Dr. Jablonsky later testified regarding the right knee injury that he did not have any opinion as to the cause of the event. She was just walking and felt the new onset of pain. (PX6, p. 22)

Based on the lack of any history of a compensable accident in the medical records and the testimony of the petitioner's own treating physician, the arbitrator finds that the petitioner has failed to prove that her right knee condition is causally related to her employment. In conjunction with this finding, any medical bills related to treatment for the right knee are denied.

<u>With respect to the issue of causation as it pertains to the lumbar spine, the arbitrator makes the following findings of fact and conclusions of law:</u>

The Arbitrator finds that the petitioner's right SI joint and IT band conditions, as well as her lumbar spine condition, to be causally related to the work accident of March 1, 2005.

The petitioner had a pre-existing, degenerative condition of her lumbar spine. In 2002, she underwent a lumbar laminectomy and discectomy at L4-L5 on the right side at Northwest Community Hospital.

The petitioner described the accident of March 1, 2005 as one in which twisted her left knee and fell on her right side. Dr. Jablonsky's records reflect that when he first examined the petitioner on March 10, 2005, he found exquisite tenderness over the SI joint, but no significant tenderness involving the spinous processes. The doctor found evidence of some mild

paraspinous discomfort with some mild spasm in that area. Forward flexion was mildly limited. Dr. Jablonsky found no evidence of radiculopathy. The petitioner exhibited a negative straight leg raise but demonstrated a mild pulling sensation in the right side of her lower back. Dr. Jablonsky ordered X-rays of her left knee and right hip and diagnosed her with right hip and buttock contusions with evidence of a right SI joint strain.

The United Airlines Workers' Compensation Employee Work Status Form, dated 3/10/05, offers the following description of the petitioner's injury: "Left knee/Right Hip/Mid-Lower Back."

Dr. Jablonsky's records going forward continue to indicate that the petitioner complained of SI joint pain.

On May 9, 2005, Dr. Jablonsky wrote that the petitioner has right SI joint and IT band pain.

At the initial evaluation on July 6, 2005 at Excel Physical Therapy, the referring diagnosis was of a left medial meniscal repair, right hip and SI joint strain and iliotibial band pain. At a reevaluation at Excel Physical Therapy on July 14, 2005, the petitioner was noted to be tender to palpation on the iliac crest, right piriformis and right IT band and greater trochanter. The straight leg raising test was negative bilaterally. When she was seen in follow up by Dr. Jablonsky on July 29, 2005, she described significant discomfort involving the right IT band and SI joint regions. The diagnoses of Dr. Lami and Dr. Jablonsky are consistent for right iliotibial band inflammation and SI joint pain.

On July 29, 2005, the petitioner saw Dr. Jablonsky. He wrote that she still has some significant discomfort involving the right IT band and SI joint regions. Upon examination, Dr. Jablonsky found palpable tenderness through the hip and IT band regions and some continued tenderness through the area of the SI joint.

On August 25, 2005, the petitioner again saw Dr. Jablonsky. She reported to him that she was doing well until Saturday with her left knee when she reported that she was going upstairs and felt a rubber band-type pull with significant increasing pain. Moreover, she now presented

with new complaints of pain radiating to the lateral aspect of the *right* lower leg. Dr. Jablonsky ordered an MRI of the lumbar spine.

Such MRI, taken on August 29, 2005, revealed a small, right-sided L3-L4 paramedian disc herniation, post-operative and degenerative changes at L4-L5 with mild foraminal stenosis and a tiny left foraminal disc herniation at L5-S1.

Dr. Panchal causally related the petitioner's current condition of ill-being of her lumbar spine to the accident of March 1, 2005. (PX4, pp. 11-12, 23-24)

During cross-examination of Dr. Panchal, the petitioner's treating physician for her lumbar spine, the following exchange took place:

Q: Okay. And if there were a gap in time (sic) between the slip-and-fall of March 1st and then six months subsequent to her first report of lumbar radiculopathy, would that change your opinion?

A: I think if she - - if she had a fall and she had absolutely no symptoms from the fall, and there was documented evidence that there were no symptoms from back pain or leg pain due to the fall for six months, then I think one can say that the fall has played very - - very little role. (PX4, p. 29)

The arbitrator notes that since the March 1, 2005 accident, the petitioner certainly had ongoing complaints of sacroiliac pain, as well as right leg pain that Dr. Jablonsky diagnosed as a strain of her iliotibial band. The March 10, 2005 Work Status Form indicates that the petitioner had an injury to left knee, right hip and mid-lower back. Moreover, fewer than six months after March 1, 2005, after simply walking up stairs, the petitioner complained of what appeared to be new pain that radiated to the lateral aspect of her right lower leg.

As to the second surgery, when the petitioner presented to Centegra Health System on September 13, 2012, she reported that she had back surgery in the past and that now the pain became worse to the point where she had intractable back pain with an inability to ambulate.

In his deposition, Dr. Butler testified that the petitioner complained of a fall in July 2012 that she believed could have caused her lumbar condition after that date. This history, however, is not consistent with the history given to the medical providers in the emergency room and hospital room personnel in September 2012.

The arbitrator gives more weight to the emergency room records than to Dr. Butler's history and opinions.

Dr. Spencer testified that the petitioner came to him as a patient with a history of an injury at work, but he had no knowledge as to the mechanics of the injury. (PX5, p. 17) Further, the first time he saw her on August 22, 2007, her back pain was negligible. (Id. at 17)

Dr. Lami testified that the petitioner's diagnoses upon examination on September 22, 2005 were of right IT band inflammation with possible SI joint pain. (RX1, p. 9) He also felt she had a left meniscus tear. Dr. Lami agreed that these conditions were causally related to the fall of March 1, 2005. He is in agreement with the diagnoses of Dr. Jablonsky at that time. Upon examination, Dr. Lami found no evidence of radiculopathy and no indication of any injury to her L4-L5 or L3-L4 discs. (RX1, p. 11) Dr. Lami testified that an injured back cannot take up to one year to show signs of sciatica or radiculopathy. (RX1, p. 20)

In Dr. Lami's opinion the surgery performed was not related to the fall of March 1, 2005. As the surgery was done for radiculopathy, and as the patient did not develop radiculopathy as a result of the fall, and, Dr. Lami did not believe it would be related to the work accident. (RX1, p. 20) Dr. Lami was cross-examined by petitioner's counsel regarding the fact that Dr. Jablonsky felt that the petitioner's symptoms were radicular in nature on February 16, 2006. (RX1, p. 27)

Yet, in Dr. Jablonsky's August 25, 2005 chart note he wrote: "...she **now** has some complaints of pain which radiate to the lateral aspect of the right lower leg." (Emphasis added) Dr. Jablonsky ordered an MRI that showed, *inter alia*, a right-sided lumbar disc herniation.

The petitioner's attorney then questioned whether Dr. Lami's opinion would change if she exhibited radiculopathy within a three to six month period after the March 1, 2005 accident. Dr. Lami responded that he would not agree, but clarified that if she had radicular symptoms within

days or a week or so, which were consistent with compressive pathology in the lumbar spine, then he would say it was an aggravation of the pre-existing condition. (RX1, p. 28)

Dr. Butler testified that the petitioner had noted that on January 2, 2013, when she got in her car, she felt her back had snapped (RX3, p. 6.) Since then she had an increase in her back pain with radiation into the buttock and hip. He later testified that she had a herniation that developed sometime in the summer of July of 2012. (RX3, p. 10) The doctor noted that this happened seven and a half years after the work injury.

Dr. Butler testified regarding the mention in the records of June of 2005 that she had some discomfort in her right IT band and SI joint. He testified this was, "really somewhat of a nonspecific finding as it relates to the lumbar spine." (RX3, p. 12) The doctor reviewed the lumbar MRI performed in August of 2005, which showed moderate degeneration at the L3-L4 level without stenosis, and opined that this did not relate to the surgery in 2012. He testified that the degenerative changes on the MRI at L3-L4 were not unusual and that "the fact that she had degeneration did not predict what would happen seven years later with the disc herniation she developed on the right side." (RX3, p. 13)

Dr. Jablonsky testified that at the time of her March 1, 2005 accident that there was no evidence of radiculopathy or other nerve damage from the lumbar spine at that time. (PX3, p. 14-15) The doctor was specifically asked whether he had an opinion as to whether the fall of March 1, 2005 aggravated the prior condition in her lumbar area. He stated, "Well, difficult for me (sic) to pinpoint the exact from the fall (sic) because of the fact that these were new symptoms that presented themselves a fairly lengthy period of time after the initial fall. So I can't necessarily say that it was related specifically to the fall." When asked whether he could say her condition was aggravated by the fall, he replied, "Again, by the fall itself, I would have a hard time stating that." (PX3, p. 27)

On April 16, 2013, the petitioner underwent a L3-L4 discectomy for a recurrent herniated disc at that level. Dr. Konstantin Slavin performed the surgery. Dr. Slavin did not offer a causation opinion.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. International Harvester v. Indus. Comm'n, 93 Ill. 2d 59, 63-64 (1982)

With regard to the petitioner's lumber spine, the arbitrator finds the opinions of Dr. Kanu Panchal, one of the petitioner's treating neurosurgeons, to be the most credible.

Based on the opinions of Dr. Panchal, the medical records and the chain of events, the arbitrator finds that the petitioner's current condition of ill-being of her lumbar spine is causally related to the accident of March 1, 2005.

With respect to the issue of causation as it pertains to the left shoulder, the arbitrator makes the following findings of fact and conclusions of law:

With respect to the issue of causation for the left shoulder, the arbitrator has found that on October 28, 2007, the petitioner sustained an accident that arose out of and in the course of her employment by the respondent. The petitioner provided unrebutted testimony that she called her co-workers and manager and told them what had happened.

The petitioner saw Dr. Jablonsky on January 31, 2008 with complaints of left shoulder, neck and arm pain following an October 28, 2007 fall down some stairs at home when her left knee gave way.

The petitioner testified that Dr. Jablonsky then referred her to Dr. Spencer, who gave her a couple of shots in her neck and left shoulder. (Tr., PX5, pp. 11-12) Since the pain did not subside following the shots, the petitioner further testified, Dr. Spencer referred her to Dr. Bresch. Dr. Spencer testified that he sent the petitioner to a shoulder specialist Subsequently, Dr. Bresch performed two surgeries on her left shoulder. Dr. Bresch then referred the petitioner to Dr. Yu, a pain specialist.

Dr. Bresch testified that he diagnosed the petitioner with post-traumatic impingement and adhesive capsulitis.

During the direct examination of Dr. Bresch, the following exchange took place:

Q: And doctor, do you have an opinion based upon a reasonable degree of medical and surgical certainty whether the fall that she took at home that she related to you and, in fact, if the fall was October 28th, '07, when she fell at home on her left side, her elbow, pushing it up into the shoulder, do you have an opinion as to whether that was a cause of the left shoulder for which you treated her?

A: More likely than not it was. (PX7, pp. 17-18)

Based on the foregoing, the arbitrator finds that the petitioner's current condition of ill-being of her left shoulder is causally related to the accident on October 28, 2007.

With respect to the issue of causation as it pertains to the left leg, the arbitrator makes the following findings of fact and conclusions of law:

With respect to the left knee, the Arbitrator finds that the petitioner's initial condition of ill-being with respect to the left knee, including the first surgery, was causally related to the work accident. The petitioner's testimony was consistent with the records as to a March 1, 2005 slip-and-fall that occurred at work, after which she underwent appropriate conservative treatment and ultimately underwent a left medial and lateral meniscectomy on June 3, 2005.

On February 23, 2007, Dr. Jablonsky saw the petitioner. The petitioner voiced complaints to the doctor of significant medial pain in her left knee. Dr. Jablonsky told her that he saw no other treatment options other than proceeding with arthroscopic evaluation, possible debridement, possible repair or drilling. Dr. Jablonsky explained the risks associated with surgery. The petitioner was willing to accept these risks and to proceed with the surgery. Dr. Jablonsky then sought authorization for such surgery from the respondent.

The petitioner did not undergo this second left knee surgery until January 12, 2011.

After the first surgery but before the second surgery, the records reflect numerous instances where the petitioner expressed new or increased pain complaints or symptoms as the result of various incidents. In August 2005, she was walking down stairs when she felt a rubber band pull in her left knee. In November 2006, she was riding a bicycle in physical therapy for her low back when she felt increased left knee pain. On October 28, 2007 and January 28, 2008, the petitioner's left gave way. On February 19, 2010, while walking up stairs, the petitioner experienced new pain complaints in a new area of her left knee.

Dr. Jablonsky's second deposition was taken on May 25, 2010. During direct examination, the following exchange took place:

Q: Do you have an opinion based on a reasonable degree of medical and surgical certainty, as to whether the incident of slipping and falling on ice of March 1, 2005 was the cause of the left knee pain for which you were treating her up through 2/24/2010?

A: Yes.

Q: And it is that it is connected?

Y: Yes, it is. (PX6, pp. 14-15)

On April 6, 2009, Dr. Cole wrote the following:

"Cynthia described to me today that she was doing 'great' prior to the re-injury event while at physical therapy. I would state that she did incur an aggravation/exacerbation of the previous injury with that movement. Regardless whether (sic) it was a straight leg raise or bicycle maneuver, the mechanism was one that typically would not cause a new meniscus tear, in and of itself, but is one that might or could incite new pain or aggravate a previous pain. It is my opinion that her condition of ill being as of that incident in 2006 is more related to that incident and not her previous injury of March of 2005." (PX8)

Then, after reviewing additional records, Dr. Cole authored a report dated September 30, 2010, in which he concluded as follows:

"Because I felt her condition, as of the point of my exam on 4/06/2009, was a continuation/aggravation of her original injury, I am led to suggest that her current state of ill-being is, on a more likely than not basis, related to that aggravation, and therefore related to the original injury date in question." (PX8)

Dr. D'Silva opined that the petitioner sustained an isolated injury to the medial meniscus in the accident of March 1, 2005. She recovered from that injury and, a year and a half later, complained of a new onset of left knee pain. He opined that the findings during the second arthroscopy performed in January 2011 were unrelated to the injury in 2005 as they did not correlate with "the new mechanism of injury as described by the patient." It was his opinion that treatment of the left knee after 2006 was unrelated to the 2005 injury. Dr. D'Silva explained that the medial meniscus tear that was the result of the work accident would not lead to later episodes of instability, as the problem had been corrected by the surgery in June 2005. He also opined that riding a bike while in physical therapy would not cause or contribute to the development of a medial meniscus tear. Any episodes of instability, therefore, were unrelated to the work accident. (RX2)

Dr. D'Silva testified that in the second surgery four and a half years later, there was evidence of new injuries, plus chondromalacia of the patellofemoral joint, which were uninvolved in the initial injury, and lateral compartment disease, which was also uninvolved in the original injury. (RX2, p. 41)

Every natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable unless caused by an independent intervening accident that breaks the chain of causation between a work-related injury and an ensuing disability or injury. Teska v. Indus. Comm'n, 266 Ill. App. 3d 740, 742, 640 N.E.2d 1, 203 Ill. Dec. 574 (1994)

The Arbitrator finds the opinions of Dr. Jablonsky, the petitioner's treating surgeon for her left knee, to be most credible. Therefore, the arbitrator finds the petitioner's current condition of ill-being of her left leg to be causally related to the accident of March 1, 2005.

With respect to the issue of TTD benefits, the arbitrator makes the following findings of fact and conclusions of law:

In Arbitrator's Exhibit #1 (AX 1), the respondent claims that the petitioner was temporarily totally disabled for the periods June 3, 2005 through August 7, 2005, August 29, 2005 through October 10, 2005 and September 21, 2006 through May 3, 2007. The respondent claims that they paid $288,163.10 in TTD benefits and seeks a credit for such amount.

The petitioner's attorney, in AX 1, failed to take the opportunity to actually identify the periods of temporary total disability that he claims for his client, but merely wrote: "*See proofs.*"

The respondent relied on the opinions of Dr. Babak Lami. In a Section 12 examination report dated May 23, 2007, Dr. Lami opined that the petitioner had reached maximum medical improvement ("MMI") and could return to "this office-type job." The petitioner told Dr. Lami that she cannot sit for more than 15 minutes. Dr. Lami explained that given the fact that the petitioner's lumbar radiculopathy was diagnosed almost a year after the fall, he cannot relate the need for the lumbar decompression to eliminate the petitioner's radiculopathy to her fall of March 1, 2005. Moreover, Dr. Lami opined that he cannot causally relate the need for a second left knee arthroscopy to her March 1, 2005 fall. The petitioner's re-injury to her knee occurred while she was rehabbing for her back surgery, which, in Dr. Lami's opinion, was not causally related to her March 1, 2005 fall. Dr. Lami found that the petitioner has subjective disabilities and pain that are out of proportion to the objective findings. (RX1, Dep. Ex. 3)

Yet, the arbitrator has found that the petitioner's current condition of her lumbar spine, and left leg are causally related to the accident of March 1, 2005, and that the petitioner's current condition of ill-being of her left shoulder is causally related to the accident of October 28, 2007.

As a left total knee replacement and a lumbar fusion have been recommended, the arbitrator finds that the petitioner has not yet reached MMI.

On May 3, 2007, Dr. Panchal took the petitioner off work until July 2007. (PX15)

On July 23, 2007, Dr. Panchal wrote that the petitioner is to stay off work for one month. Dr. Panchal referred the petitioner to Dr. David Spencer. (PX15)

On August 22, 2007, Dr. Spencer saw the petitioner and prescribed Neurontin on a trial basis. (PX11)

On September 13, 2007, Dr. Spencer found that the Neurontin did not significantly help the petitioner's leg pain. Dr. Spencer wrote that based on the chronicity of the petitioner's back pain and the development of radiographic evidence at L3-4, he recommends an ALIF surgery at L3-4 and L4-5. (PX11)

On January 17, 2008, Dr. Spencer prescribed four weeks of work hardening for the petitioner's low back. (PX11)

On February 19, 2008, the petitioner reported taking Norco for her low back pain. (PX11)

From February 21, 2008 through June 17, 2008, the petitioner underwent physical therapy for adhesive capsulitis. (PX11)

On April 16, 2008, in a United Airlines Workers' Compensation Employee Work Status Report, Dr. Spencer ordered the petitioner to be off work/no work.

On May 19, 2008, the petitioner reported difficulty with sleeping, driving, dressing, showering, washing her face/hair and reaching above shoulder height with any activity. (PX11)

On August 12, 2009, in a United Airlines Workers' Compensation Employee Work Status Report, Dr. Jablonsky wrote: "No Work Due to left knee Surgery." (PX14)

On September 24, 2009, Dr. Jablonsky wrote: "No return to work at this time." (PX14)

On February 24, 2010 and March 2, 2010, Dr. Jablonsky kept the petitioner off work. (PX14)

On January 19, 2011, Dr. Jablonsky recommended "no work at this point in time." (PX14)

On March 9, 2011, in a United Airlines Workers' Compensation Employee Work Status Report, Dr. Jablonsky ordered "no work" for the petitioner. (PX14)

On April 4, 2011, the petitioner was given light-duty restrictions. (PX14)

On May 4, 2011, Dr. Jablonsky wrote: "She has difficulty standing or sitting for longer than a half an hour or walking for more than 15 minutes. Therefore, I would recommend that her

restrictions essentially incorporate those limitations." Dr. Jablonsky reiterated these restrictions on June 20, 2011 and June 30, 2011. (PX14)

On July 11, 2011, Dr. Jablonsky gave the petitioner restrictions that included "max sit 50 minutes at a time with max walk/stand 15 mins." (PX14)

On April 16, 2013, neurosurgeon Konstantin Slavin, M.D., performed an L3-L4 discectomy on the petitioner for a recurrent herniated disc at that level. In a report dated May 8, 2013, Dr. Slavin wrote: "I do however feel that it will take her much longer to recover from the operation and the pain she has now is going to get better over the next few weeks or months." (PX16)

Since May 3, 2007, treating surgeons Kanu Panchal, M.D., Warren S. Jablonsky, M.D. and Konstantin Slavin have not released the petitioner to return to full-duty work. (PX11, PX14, PX15, PX16)

Therefore, the arbitrator finds that the petitioner was temporarily totally disabled for the periods June 3, 2005 through August 7, 2005, August 29, 2005 through October 10, 2005 and September 21, 2006 through September 23, 2013.

The respondent is entitled to a credit of $288,163.10 for previously paid TTD benefits.

With respect to the issue of medical benefits, the arbitrator makes the following findings of fact and conclusions of law:

Based on the causation analysis set forth above, the arbitrator awards medical bills for the reasonable, necessary and related care and treatment following the March 1, 2005 accident to the petitioner's left knee (including two surgeries), right hip and lumbar spine (including three surgeries), as well as the medical bills for the reasonable, necessary and related care and treatment following the October 28, 2007 accident to the petitioner's left shoulder (including two surgeries), neck and left elbow, pursuant to Section 8(a), and subject to Section 8.2 of the Act, where applicable.

The respondent is entitled to a credit for medical bills previously paid.

The respondent is entitled to an 8(j) credit in the amount of $54,605.35.

With respect to the issue of prospective medical, the arbitrator makes the following findings of fact and conclusions of law:

The petitioner is seeking an award of prospective medical in the form of a left total knee replacement.

Dr. Jablonsky has recommended such surgery.

As the arbitrator has found Dr. Jablonsky to be most credible with regard to the petitioner's left knee and as he has relied on Dr. Jablonsky's causation opinions, the arbitrator finds such treatment to be reasonable and necessary.

Therefore, the arbitrator orders the respondent to authorize and pay for the left total knee arthroplasty, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The parties agreed to defer to a later hearing the issue of prospective medical for the petitioner's lumbar spine.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kiezel Malgorzata,
Petitioner,
vs.

15IWCC0378
NO: 11 WC 928

Gepco 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 medical expenses, causal connection, necessity, reasonable prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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

DATED: MAY 21 2015
KWL/vf
O-3/24/15
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

Respectfully I dissent from the majority. I find that Petitioner's left elbow condition is causally connected to the work accident and award the outstanding medical expenses for treatment Petitioner received for that issue.

It is undisputed that Petitioner suffered bilateral carpal tunnel syndrome as a result of her repetitive work duties and the resulting condition of ill being was causally connected to the work injury. Dr. Karnezis performed left carpal tunnel release surgery for Petitioner on June 17, 2010. Immediately following the procedure, Petitioner began experiencing pain to the left elbow and left arm, as well as numbness to the fourth and fifth digits on her left hand. Petitioner testified her left elbow and arm symptoms began immediately after the June 17, 2010 surgical procedure.

Petitioner had right carpal tunnel release surgery on September 9, 2010. She returned to work and her right carpal tunnel release was successful. Unfortunately, Petitioner continued to experience symptoms in her left arm – specifically pain in the elbow and numbness and tingling in the fourth and fifth fingers of the left hand. Petitioner continued to follow up with Dr. Karnezis throughout 2011. She last saw Dr. Karnezis on March 7, 2011, when he diagnosed recurrent compression of the ulnar nerve based on Petitioner's continued symptoms and positive EMG testing.

Petitioner saw Dr. Atluri for a second opinion on August 16, 2012. On physical exam, Petitioner exhibited a left positive Tinel's sign and left positive digital compression testing at the Guyon's canal. Dr. Atluri stated the Tinel's test and digital compression test indicated irritability or inflammation involving a nerve. He also reviewed the operative reports of Dr. Karnezis. Dr. Atluri testified Petitioner had two symptomatic lesions in the left arm – one at the wrist and one at the elbow. The active diagnoses were left distal ulnar neuropathy, right thumb arthritis and possible left cubital tunnel. Dr. Atluri testified that review of the pre-operative and post-operative EMG testing indicated that the left ulnar neuropathy had developed post-operatively, suggesting a new abnormality. The 2010 pre-operative EMG was negative for problems of the ulnar nerve at the left wrist, while the 2012 EMG was positive for left wrist ulnar neuropathy. Dr. Atluri testified that the only reasonable explanation for this was a complication or effect of the causally related, necessary June 2010 left wrist surgery.

There is no evidence in the record of a traumatic injury occurring to Petitioner's left wrist after the 2010 EMG but before the 2012 EMG.

Dr. Atluri also testified that while the current left ulnar nerve problem at Guyon's canal was unrelated to Petitioner's work activities, "[i]t appears that it really developed following her surgery. So I think it's a complication of her carpal tunnel release. So I think it's a direct sequela or directly caused by her treatment for her work-related carpal tunnel syndrome." Dr. Atluri acknowledged this issue was a possible risk or occurrence with a carpal tunnel release as "[a]natomically, both structure are very close together."

Case law is clear that an additional injury caused by treatment for the original injury does not break the chain of causal connection making an injury compensable under the Act. See *Burnette v. Alpha Backing Co.*, 11 IWCC 1266 at 4 (2011). In this case, Petitioner began experiencing increased numbness in her left fourth and fifth fingers and Guyon's canal syndrome immediately following her causally connected left-sided carpal tunnel release surgery. Dr. Atluri testified the ulnar nerve problem was directly caused by the treatment for work-related capral tunnel. Therefore, I find that Petitioner's left ulnar nerve issues are causally connected to her non-disputed work related injury as the left ulnar nerve issues directly resulted from treatment for the work injury.

Based on the finding that Petitioner's left ulnar neuropathy at the wrist is casually related to the work accident, the outstanding medical expenses should be awarded as well. Those medical expenses are related to Dr. Karnezis' treatment prior to Dr. Atluri and then physical therapy with Hand Surgery Associates that have not been paid by group insurance.

Thomas J. Tyrrell

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

15IWCC0378

KIEZEL, MALGORZATA
Employee/Petitioner

Case# **11WC000928**

GEPCO INTERNATIONAL
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2553 LAW OFFICES OFJAMES P McHARGUE
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CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
JOSEPH D'AMATO/MATTHEW GORSKI
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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)

15IWCC0378

Malgorzata Kiezel
Employee/Petitioner

v.

Gepco International
Employer/Respondent

Case # **11** WC **928**

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 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0378

FINDINGS

On the date of accident, **April 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**19,864.00**; the average weekly wage was $**382.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit for $**8,476.88** in TTD and $**122,254.47** in medical benefits paid to date, as well as further credit of $**7,764.04** paid by group medical insurance pursuant to Section 8(j) of the Act.

ORDER

For reasons set forth in the attached decision, the requested medical expenses and prospective medical services 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 29, 2014
Date

SEP 2 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MALGORZATA KIEZEL,	)	
	)	
Petitioner,	)	15IWCC0378
	)	
vs.	)	**No. 11 WC 00928**
	)	
GEPCO INTERNATIONAL,	)	
	)	
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, a left-hand-dominant woman, fifty years old on the asserted date of loss in April 2009, began working for Gepco International, a/k/a General Cable, in February 2008. She usually worked first shift, Monday through Friday, eight hours per day. Her job duties included receiving and finishing fiber optic and copper cables, which consisted of connecting and polishing cables, assembling the connectors, and preparing them for testing. She also worked with TV boxes that ordered the cables, inserting them into the boxes. She testified she would use tools such as strippers, pliers, and a lathe, and noted there was a machine that stripped the cables automatically as well. She testified she was still employed at the respondent as of the trial date. The petitioner asserts repetitive trauma as her theory of injury; accident and notice were not disputed at trial.

The petitioner testified that she began experiencing bilateral wrist pain as well as numbness and tingling at night in approximately March 2009. The petitioner apparently saw a family physician first; those records are not present, but she was referred to Dr. Iwona Sobczak, a neurologist, for evaluation. Dr. Sobczak saw the claimant on February 1, 2010, noting a history of hypothyroidism and symptoms in both hands, left worse than right, which had begun several months prior and then worsened since. Dr. Sobczak noted somewhat elevated blood pressure and Tinel's sign bilaterally. Dr. Sobczak prescribed medication, splints, physical therapy and an EMG test. The EMG took place the next day, on February 2, 2010. It indicated moderate bilateral carpal tunnel syndrome, worse on the left, with no evidence for ulnar neuropathy or cervical radiculopathy. PX1.

On February 9, 2010, the claimant presented at Advanced Physical Therapy for an intake evaluation. They noted a history of three shoulder surgeries from 2004 through 2006 and present complaints in all five fingers bilaterally over the prior two months. She

underwent care there until March 2, 2010. See PX2; the prior shoulder surgeries are also further referenced in PX6.

On March 1, 2010, Dr. Sobczak received a letter from Dr. Lastowiecki, an endocrinologist who was treating the petitioner for chronic hypothyroidism; he noted that the claimant had an increased dosage of medication at approximately the same timeframe as the increase in symptoms related by the claimant to Dr. Sobczak. Dr Lastowiecki further noted symptoms suggestive of early menopause and had other nonspecific complaints including intermittent myalgias. See PX1.

On March 8, 2010, Dr. Sobczak noted no relief from night splints and referred the claimant to Dr. Karnezis for carpal tunnel injections and possible surgery. PX1.

The claimant saw Dr. Tom Karnezis on March 17, 2010. He noted a history of bilateral hand numbness over the last eighteen months which had gradually progressed. He noted a three-year history of medication usage for her thyroid. Following physical examination and review of the EMG results, he assessed bilateral carpal tunnel syndrome and provided bilateral wrist injections at that time. He prescribed medications and opined that her condition was due to fine manipulation at work and that she would in all likelihood eventually require surgery. See PX3.

On May 21, 2010, the petitioner presented to Dr. Karnezis. She noted four weeks relief from the injections but symptoms had recurred since. At this time he assessed her with bilateral cubital tunnel syndrome as well as carpal tunnel syndrome. He recommended surgery on both wrists and both elbows, with the left side first; while he reiterated his causal opinion as to her work activities, he did not comment on the negative EMG analysis of the elbows nor explain the change in diagnosis. See PX3.

On June 17, 2010, the claimant underwent left carpal and cubital tunnel release surgery as well as debridement of the medial epicondyle. A median nerve neuroma was observed during the procedure and neuroplasty was performed; no complications were noted during the procedure. See PX3, PX6. The petitioner began postoperative therapy on June 23, 2010. See PX7.

On June 30, the claimant advised Dr. Karnezis that she had increasing pain to the left elbow. Clinical examination noted full function and no evidence of infection. He provided support pads and instructed her to follow up, with no use of the left arm at that point. On July 19, 2010, the claimant complained of pain at the left wrist incision site; sutures were removed without incident at that point. It appears she was also treating for the right ankle, as notes of an ankle wound are present; the Arbitrator notes it is unclear if this is an error or if those records were not provided as unrelated to the case. PX3. On July 28, 2010, it was noted that the petitioner's left carpal and cubital tunnel symptoms were "resolving nicely" and the epicondylar pain had vanished. The wound was redressed and the right side was scheduled; it was noted that a small ganglion cyst was present at the right wrist and would likely be excised at that time as well. PX3.

On September 9, 2010, Dr. Karnezis performed right wrist carpal tunnel release and excision of the ganglion cyst, coupled with right elbow cubital tunnel surgery. The petitioner also was noted to have trigger finger in her bilateral ring fingers; the right ring finger had an A1 pulley release at this time and her left ring finger was injected. See PX3, PX6. On September 13, her symptoms were noted to be improved and she was referred for therapy, which she underwent. See PX3, PX7.

On September 29, 2010, she presented to Dr. Karnezis in follow-up. She was neurologically intact and her symptoms were improved. She was maintained in therapy with instructions to concentrate on strengthening. PX3. On October 27, 2010, she presented with redness and irritation to the incision site. Range of motion was full. She was instructed to continue a strengthening program and given cream for dermatitis. PX3.

On November 10, the petitioner presented to Dr. Karnezis with a small abscess in the stitch area. Debridement of this was performed that day. See PX3, PX6. The petitioner followed up for treatment for that area and was noted to have no evidence of any persistent infection on November 30, 2010. PX3. She was maintained in therapy thereafter and released to light duty. PX3.

On January 10, 2011, the petitioner presented with complaints of pain while doing fine manipulation. She was maintained in therapy. PX3, PX7. On January 31, Dr. Karnezis noted she "has done remarkably well" and assessed full duty work as of February 7, 2011. He told her to follow up in three to four weeks. PX3. The petitioner did return to work for the respondent thereafter.

On February 28, 2011, the claimant reported having been working full duty for the last month. She noted some locking in the left ring finger, which was assessed as tenosynovitis and was injected at that time. She was also noted to have some right thumb symptoms and told to return for an injection, but was otherwise maintained on full duty. The right thumb was injected on March 4, 2011, and she was later provided thumb spica splints. See PX3.

Another right thumb injection, this time to the CMC joint, was provided on May 18, 2011 by Dr. Karnezis. On July 15, 2011, he recommended ongoing therapy and splinting. On August 24, 2011, she complained of bilateral thumb tenderness and recurrent complaints in the left ring trigger finger. Dr. Karnezis recommended six additional therapy visits and maintained full duty work. PX3, PX7.

On October 19, 2011, the petitioner presented to Dr. Karnezis with ongoing hand complaints. He assessed her with ganglionic cyst formations in both ring fingers, which he opined were due to her work activities. He recommended ongoing medication use and noted she may require excision of the cysts. PX3.

On February 1, 2012, the petitioner returned to Dr. Karnezis. He noted the right elbow and wrist were doing "remarkably well" and the left ring trigger finger was "completely absent with excellent results." The ganglion cysts were "currently stable and

not bothersome." The left carpal tunnel surgery was "healed without incident" and the left cubital tunnel was healed fully and nonproblematic but she still reported complaints of numbness to the fourth and fifth digit. He recommended a repeat EMG and an ultrasound evaluation of the left cubital tunnel. See PX3.

On February 7, 2012, the petitioner underwent the EMG. It showed neuropathy at both wrists, suggestive of either persistent or recurrent carpal tunnel syndrome, as well as left elbow ulnar neuropathy. PX4. On February 24, 2012, Dr. Karnezis noted the EMG results. She apparently complained of recurrent pain to the wrists as well. He maintained his recommendation for the elbow ultrasound and provided wrist splints. PX3.

On March 7, 2012, Dr. Karnezis reviewed ultrasound results which he characterized as showing a left elbow neuroma impinging on the left ulnar nerve as well as ossification in that area. He recommended neuroplasty at that area and a left Guyon's canal release. Curiously, he specifically advised that he would recommend no use of the right arm post-surgically as well as no use of the left arm, though she did not make any complaints of right arm or hand issues at this point. See PX3. The petitioner did not treat further with Dr. Karnezis after that appointment.

On May 17, 2012, the petitioner saw Dr. John Fernandez at her employer's request pursuant to Section 12 of the Act. See generally RX1. After examining her and reviewing the medical records to date, Dr. Fernandez diagnosed symptomatic basilar joint arthritis at the right thumb, left elbow hetertopic ossification, left ring and small finger numbness and tingling status post cubital tunnel and carpal tunnel release and a probable neuroma at the left elbow. Dr. Fernandez opined the neuroma and ossification at the left elbow were likely post-surgical in nature but was unconvinced this was the source of discomfort. He opined that a revision left elbow decompression was appropriate but that she was at MMI regarding the right elbow, both wrists and the right ring finger. Regarding causation, he noted multiple idiopathic risk factors and opined that based on the job description she provided him, there would not be a causal connection to the cubital tunnel syndrome because there were no risk factors such as direct pressure, repetitive extension and flexion, or prolonged hyperflexion posture. He also opined that the thumb arthritis was not related to her work activities. However, he believed there was a relationship between the carpal tunnel syndrome and her work activities. RX1.

The respondent subsequently provided Dr. Fernandez with a job video analysis and written job description. On July 23, 2012, Dr. Fernandez produced an addendum to his earlier report, noting that the activities depicted on the video and related in the written descriptions would be a causal factor in the claimant's carpal tunnel condition, but not to her cubital tunnel condition. See RX1.

The petitioner elected to seek a second opinion and began treating with Dr. Prasant Atluri on August 16, 2012. Following his examination, Dr. Atluri assessed a left ulnar nerve lesion and status post bilateral carpal and cubital tunnel surgery, as well as right thumb arthritis. He noted he lacked the preoperative EMG and medical records. He opined she may require ulnar nerve surgery. See PX4. On August 23, 2012, Dr. Atluri

saw the petitioner in follow-up and reviewed the preoperative EMG study. He opined the carpal tunnel releases had resolved her carpal tunnel symptoms. He recommended no further treatment to the right arm and symptomatic care for the right thumb. Relative to the left arm, he recommended monitoring it for now and possible further EMG testing or revision surgery to the left elbow or wrist. PX4.

On October 4, 2012, Dr. Atluri saw the claimant, who continued to describe bilateral hand pain. However, following discussion of surgery and the relative likelihood of improvement, the claimant was uncertain as to whether she wanted to proceed with surgery. Dr. Atluri told her to follow up after she decided. On November 1, 2012, the petitioner reported worsening symptoms in her left hand. Following a discussion of treatment alternatives, Dr. Atluri recommended surgical decompression at the Guyon's canal at the left wrist and neuroplasty at the left elbow. See PX4.

On April 25, 2013, Dr. Atluri saw the claimant. She reported left hand weakness, a new finding. She reported that the workers' compensation carrier had denied the ulnar surgery and she wanted to proceed under private insurance. PX4. However, on May 30, 2013, Dr. Atluri noted that a request for surgical approval remained pending; a similar reference is present on August 22, 2013. See PX4.

On September 12, 2013, at the request of the petitioner's attorney, Dr. Atluri reviewed Dr. Fernandez' reports and medical records from Dr. Karnezis and authored an opinion report. Dr. Atluri noted similar medical diagnoses to Dr. Fernandez. Dr. Atluri opined that the petitioner's job duties did contribute to the carpal tunnel diagnosis as well as the trigger finger condition. He opined that the right thumb arthritis was chronic and degnerative but could have been aggravated by her work duties. Regarding the cubital tunnel syndrome, Dr. Atluri noted no forceful pushing, pulling, or persistent hyperflexion which would typically be associated with the development of that condition. He opined that the symptoms did not appear directly attributable to the work activities. However, he noted the ulnar symptoms may represent a complication of the original elbow surgery and opined the neuropathy at the left wrist "may represent a complication of her left carpal tunnel surgery." PX4, PX9. He recommended symptomatic treatment for the carpal tunnel symptoms, conservative care for the thumb arthritis with potential surgery if symptoms did not recede, and recommended additional EMG testing of the left ulnar nerve prior to consideration of surgical intervention, noting it was unclear if surgery would practically improve her condition. He opined, regarding her prior treatment, that while the carpal tunnel releases were reasonable and necessary, he was "unable to determine at this time whether the other interventions were reasonable and appropriate." See PX4, PX9. Dr. Atluri testified in deposition on November 13, 2013; his findings will be discussed in more detail below. See generally PX9.

On December 10, 2013, Dr. Atluri recommended a short course of physical therapy and symptom control but reiterated his surgical recommendation. PX4. The petitioner underwent physical therapy for about a month thereafter. PX5.

On February 4, 2014, Dr. Fernandez saw the petitioner again for a repeat Section 12 examination. Following discussion with and repeat physical examination of the claimant, Dr. Fernandez noted persistent left hand numbness with a possible residual ulnar neuropathy of the elbow or wrist as well as right thumb basilar joint degeneration. He noted the beginnings of Dupuytren's fibromatosis without contracture. He opined that the new medical records and examination did not change his earlier diagnosis or conclusions. He opined she could consider a revision to the left elbow ulnar release, but she should have an EMG test prior to any intervention to distinguish entrapment at the wrist from elbow pathology. He opined there was no causal connection between the claimant's work and the ulnar pathology and basilar joint degeneration. RX1.

DR. ATLURI'S DEPOSITION TESTIMONY

Dr. Atluri testified that the anomalies in the EMG of February 2012 relative to the carpal tunnel were most likely residual since the symptoms had improved significantly following the surgery, and therefore were not clinically significant. See PX9 p.17-18. He opined the Guyon's canal findings at the wrist were a new abnormality. He opined that the abnormalities at the left elbow identified on that EMG were "trickier" in determining whether it was an ongoing issue with the elbow or merely residual findings that had not resolved. PX9 p.19. He opined that the claimant's overall diagnoses were of left distal ulnar neuropathy, bilateral carpal and cubital tunnel syndrome, and right thumb arthritis; of those, the right thumb arthritis, the left ulnar neuropathy, and possibly the left cubital tunnel were active. See PX9 p.22. Relative to causation, Dr. Atluri testified to his opinion that the carpal tunnel syndrome was related to work activities, as were the trigger fingers, and that while the right thumb arthritis was a chronic degenerative process, her work activities could have aggravated it, depending on whether the symptoms arose at work or during convalescence. See PX9 pp.33-35, 40. He opined that the cubital tunnel syndrome was not related to work. See PX9 p.36. He further opined that the ulnar tunnel syndrome at the wrist was not related to work, but opined it was a complication arising from the carpal tunnel surgery. See PX9 pp.36-37. At the time of his deposition he recommended further treatment for the left ulnar nerve, but not for the carpal tunnel syndrome. PX9 pp.25-26. His recommendation was for her to have further electrodiagnostic studies to determine whether surgery should be targeted at both the elbow and wrist or only one. See PX9 pp.27, 31. However, he opined she should have left wrist decompression. PX9 pp.40-42. He further noted that the left elbow surgery, should she have it, would be strictly related to the cubital tunnel surgery only. PX9 p.43.

On cross-examination, Dr. Atluri acknowledged that the right thumb arthritis apparently began troubling the claimant in 2010 or thereafter, and that therefore the arthritis was not likely related to her 2009 work activities:

Q: But is it your opinion that her right thumb symptoms can then be relatable to her job duties in 2009?
A: No.
Q: It's your opinion that they are not?
A: Correct.

See PX9 pp.46-47. Dr. Atluri later went on to note, regarding the right thumb, that "I just don't know enough information about what she was doing at the time when those symptoms actually developed to know within a reasonable degree of certainty whether or not it's related to her job activities." See PX9 p.57. Dr. Atluri testified that he could not state with certainty whether the cubital tunnel release procedures were reasonable and necessary, and could not determine from the documentation what the specific indication was for the cubital tunnel release surgery. See PX9 pp.48-49. Dr. Atluri acknowledged that ulnar neuropathy at the Guyon's canal can be idiopathic and relatable to such things as cyst formation or thyroid conditions; he noted the claimant's risk factors included age and gender, but did not specifically mention her hypothyroidism. PX9 pp.53-54.

Dr. Atluri was asked about the specific surgical procedure which Dr. Karnezis performed that Dr. Atluri believed caused the current left wrist condition, and noted:

> A: I do not [know exactly what that procedure was]. You know, his operative report is a little bit difficult to decipher. He does talk about a Guyon's canal release ...but then when you actually look at the operative note details, I can't exactly figure out what he means, you know, what was actually released, what was actually done.

See PX9 pp.54-55. Dr. Atluri went on to note that had the ring and small finger immediately had a change in their symptoms at once following the surgery, that would make it more likely that it was a surgical complication, but if that was not the case it would be less likely. PX9 pp.55-56.

OPINION AND ORDER REGARDING DISPUTED ISSUES

As stipulated, the petitioner is due 33 & 2/7 weeks of temporary total disability benefits, a total of $8,476.87. The parties acknowledged that respondent has previously tendered the claimant $8,476.88, thus extinguishing TTD liability to date.

Causal Connection to Employment

In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. See, e.g., *Peoria County Bellwood*, 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 opinion is mandatory to establish 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).

In this case, there is a general consensus among the opining physicians that the claimant's carpal tunnel syndrome and the resultant surgery was causally related to the claimant's work, and as such, causation has been established relative to that condition. For similar reasons, causal connection to the bilateral ring trigger finger condition, as well as the surgery and injection for same, has similarly been established.

In Dr. Karnezis' appointment of May 21, 2010, he diagnosed a condition of cubital tunnel syndrome and opined it was related to the claimant's employment. However, this conclusion stands at odds with a contemporaneous negative EMG study and his causal assessment is disputed by both the claimant's second choice of physician as well as the respondent's evaluating physician, who saw the claimant on more than one occasion and also had the opportunity to view the claimant's job description in detail. Dr. Karnezis' opinion is given little weight, and the Arbitrator finds no causal relationship between the claimant's work and any cubital tunnel condition has been credibly demonstrated; similarly, no relationship between her work and the resultant elbow surgeries has been proven.

Regarding the right thumb basilar arthritis, Dr. Fernandez concludes that there was no causal connection between her work and the arthritic condition. Dr. Atluri agrees that the thumb arthritis was chronic and degenerative in nature, but believed it was possible that her work conditions had aggravated the symptoms in the thumb. Examining Dr. Atluri's deposition testimony in detail, he acknowledges he lacked solid information as to what activities she was doing when the thumb symptoms arose, which was information to which Dr. Fernandez had far greater access to when he rendered his analysis. Moreover, a review of Dr. Fernandez's opinion report shows it to be thorough and well-informed, and he is deemed credible. The causal opinion rendered by Dr. Atluri is too tenuous to establish a causal link between the petitioner's employment and the right thumb, as the right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977). As such, causal connection to the thumb arthritis is denied.

Lastly, Dr. Atluri has assessed her with ulnar nerve pathology at the left wrist, which he notes is distinct from the carpal tunnel syndrome, but believes was due to the left wrist surgery performed by Dr. Karnezis. Dr. Atluri admits that he cannot discern with certainty the exact surgery done or how it was the it became complicated, but bases his conclusion in large part on the claimant's assertion of an immediate change in her medical condition following the surgery – to wit, immediate numbness in her left small and middle fingers post-surgically, a new finding. PX9 p.54-56.

However, the medical records prior to the surgery belie this history. Dr. Karnezis, when he assessed her as having cubital tunnel in the first place on May 21, 2010, clearly noted she "has numbness to all five digits" bilaterally and has "numbness and pain to both fourth and fifth digits with the left greater than the right." PX3. Moreover, this is not an isolated reference. The physical therapist she saw in February 2010 clearly noted symptoms in all five fingers of each hand. See PX2 p.13. And Dr. Fernandez noted a history of symptoms in "all the digits" when he interviewed her originally. RX1. Given that the basis for his opinion of a post-surgical complication has been thus undermined, and further given Dr. Fernandez' credible opinion to the contrary, the Arbitrator finds no causal connection has been proven by a preponderance of the credible evidence between the left carpal tunnel surgery and the asserted ulnar condition at the left wrist.

Medical Services (Past and Prospective)

The Arbitrator has reviewed the asserted outstanding medical bills submitted by the petitioner, as well as the respondent's list of medical payments made. See PX3, PX4, RX2. Substantial expenses incurred for treatment have been paid to date; the Arbitrator's assessment of the unpaid balances submitted indicates these are for treatment related to conditions which have been deemed unrelated to her employment, and as such are denied. Regarding the 8(j) credit incurred to date, the respondent is entitled to same against any related medical costs, but shall hold the claimant harmless against recoupment efforts for same.

The future medical treatment requested is potentially threefold: 1) An electrodiagnostic study (EMG/NCV); 2) Left wrist surgery to address the ulnar nerve at that area; and 3) Left elbow surgery to revise the ulnar release. Medically speaking, both Dr. Atluri and Dr. Fernandez recommend the electrodiagnostic study and are hesitant to consider surgery without it, though Dr. Atluri is willing to proceed with the left wrist surgery at this time. The Arbitrator will address each of these individually.

Regarding the EMG study, Dr. Fernandez opines that the EMG study is not causally related to the petitioner's work activities. RX2. As it does not appear that the EMG is targeted at the carpal tunnel or trigger finger conditions, and given Dr. Fernandez' credible opinion, the prospective EMG is denied.

The left wrist surgery is denied for reasons set forth in the above section on causal connection to her employment.

Both Dr. Atluri and Dr. Fernandez acknowledge that the left elbow surgery, if it were to be pursued at all, would only be related to the cubital tunnel syndrome and the surgery she underwent for it, and therefore not related to her work. It is therefore denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SUZANNE SIEDSCHLAG,

Petitioner,

15IWCC0379

vs.

NO: 12 WC 40911
13 WC 28340

WAL-MART,

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

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 Petitioner alleged a work accident of October 29, 2010 (13 WC 28340) and October 14, 2012 (12 WC 40911). The cases were consolidated at trial and a single decision was issued. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. The Commission finds that Suzanne Siedschlag sustained a C6-C7 herniation that arose out of and in the course of her

employment on October 14, 2012. The Commission awards prospective medical treatment consisting of an anterior cervical fusion at C6-C7 to Petitioner as she demonstrated that her current condition is causally related to her work accident. The Commission affirms and adopts the Arbitrator's finding that Petitioner sustained a thoracic strain as a result of her October 29, 2010 work-related accident.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Ms. Siedschlag testified that she has been employed by Wal-Mart for 6 years as an overnight stocker. Petitioner is 5'5" tall. T.45. She was required to move products off pallets and stack them onto the shelves. T.11. Petitioner was required to reach above her head to move products off the pallet (down stacking). T.14. Petitioner testified that the pallets were between 5 and 8 feet tall and contained between 200 and 300 cases. T.12. Sharon LaBrec, Back Room Associate, testified that the pallets were between 6.5 feet and 7 feet tall. Mr. James D'Angelo, Shift Manager, testified that the pallets were approximately 7 feet tall. Both Mr. D'Angelo and Ms. LaBrec testified that the tallest shelf was about 6 feet tall. T.66.

2. Petitioner testified that she spent 50 percent of the time placing items over head. T.14. She never worked alone and often used a ladder at work, but still had to reach overhead. T.57. Ms. LaBrec stated that down stacking occurred between 50 and 75 percent of the time. T.68. Mr. D'Angelo stated that the heaviest piece of product Petitioner would have had to move was between 30 and 40 pounds. T.76.

3. On October 29, 2010, Petitioner was lifting sugar when she felt an excruciating pain in her left shoulder. T.20. She went home and took Tylenol. She could not move her left shoulder the next day and presented to Palos Community Hospital. Petitioner was diagnosed with a thoracic strain and given limited duty restrictions consisting of no overhead reaching, no climbing, no lifting over 10 pounds, and no pushing or pulling over 20 pounds. She received 2 weeks of physical therapy. Petitioner was released back to full-duty work on November 17, 2010. PX.2.

4. Petitioner testified that she worked two years without any left shoulder symptoms. On October 14, 2012, Petitioner reported to James, her manager, that she had pain, numbness and tingling in her left arm down to her index finger and thumb, and could not sleep. T.27. Petitioner testified that she could not recall if she tried to work that day. T.29.

5. Mr. D'Angelo stated that Petitioner reported that she was in pain because of her previous injury. T.78. He had no reason to believe Ms. Siedschlag was exaggerating

her pain. T.79. He testified that Petitioner indicated her pain on October 14, 2012 could have happened that night because it was similar to her prior pain. T.82.

6. Petitioner presented to Concentra on October 17, 2012 with complaints of arm pain that had been present since October 14, 2012. Petitioner reported that, due to her repetitive lifting of freight cases ranging in weight from 1 to 50 pounds and stocking them above her shoulder level, she developed pain at the back of her neck and left shoulder. Petitioner reported that her pain had been worse the previous 3 days and she was having difficulty sleeping. Her pain was stabbing and radiating down to her left hands and fingers. Her symptoms were exacerbated by raising her arm overhead or reaching above the shoulder. She had subjective numbness in the tip of her fingers. Examination of the cervical spine revealed tenderness of the left cervical muscles. She had full range of motion with pain. She had trapezius tenderness and swelling in the left shoulder. X-rays of the cervical spine and left shoulder were negative. The assessment was shoulder strain, trapezius/rhomboid. Petitioner was given restrictions of no lifting over 20 pounds, no pushing or pulling over 40 pounds, and no reaching above the shoulder. PX.2.

7. Petitioner was seen at Concentra on October 30, 2012. Her complaints were unchanged. She was diagnosed with cervical radiculopathy and cervical strain. PX.2.

8. Ms. Siedschlag underwent a cervical MRI on November 1, 2012. The MRI revealed a large extruded disc at C6-C7 posterolaterally on the left without compression of the spinal cord. It was causing narrowing of the left lateral recess and left neural foramina. PX.5.

9. Petitioner presented to Dr. Sean Salehi of Occspecialists on November 16, 2012 for an initial consultation. Petitioner reported a work injury of October 14, 2012. She could not recall any specific injury, but noted for the month prior having some left-sided shoulder pain with pain and numbness going down the entire left arm. She had some left-sided neck pain. Her pain was 8 out of 10. Dr. Salehi noted the MRI of November 1, 2012 revealed a large extruded disk on the left at C6-C7. He diagnosed Petitioner with a herniated disk at C6-C7. PX.2.

10. Petitioner was seen by Dr. Salehi on March 1, 2013. Petitioner reported that she had continued left upper extremity spasms as well as numbness and tingling with certain movements of the head. She had two epidural injections as well as physical therapy, which had greatly reduced her pain. Her symptoms, however, remained. She was currently working light duty. She was diagnosed with a herniated disc at C6-C7. Dr. Salehi discussed two options: work hardening followed by an FCE vs. a C6-C7 anterior cervical discectomy and fusion. PX.2.

11. Petitioner began treating with Dr. Abdul Amine on March 21, 2013. During the initial visit, Petitioner reported that she had been having symptoms consistent with cervical radiculopathy since October 2012. She did not recall any specific incident but stated her symptoms were work-related as she performed heavy lifting and unloading. Dr. Amine recommended an EMG to determine if carpal tunnel was contributing to her condition or if it was a cervical issue. PX.5.

12. Petitioner testified that she reviewed Dr. Amine's record indicating she had cervical radiculopathy since October 2007. As was her right, Petitioner stated that she informed Dr. Amine that the date was incorrect. T.52. The date was changed to reflect October 2012.

13. Petitioner underwent an EMG on March 28, 2013 that was consistent with chronic left C7 radiculopathy. PX.5.

14. Petitioner underwent a Section 12 examination with Dr. Robert Beatty on August 1, 2013. Dr. Beatty stated that Petitioner had pre-existing degenerative disc disease at multiple levels. Her symptoms were the same as they were two years ago. She was unable to pinpoint any distinct episode causing her symptoms. She currently had no pain. He suspected Petitioner had a disc protrusion, which was very small at that time. He noted there was no definitive incident present, and repetitive injury to the neck, in general, is not related to a disc herniation. In the vast majority of cases, there is a single episode only. She had no objective findings. There was no evidence of ongoing nerve root compression in the sense that she only had some numbness and no pain. She had significant degenerative disc disease in the neck with Modic changes on a study that was done two weeks after the date of the reported injury. In the absence of any specific incident producing a disc herniation, he was unable correlate the small soft part of the disc osteophyte complex on the left with any work accident. Given she had significant degenerative changes, an anterior cervical fusion at C6-C7 was reasonable. RX.3.

15. Dr. Salehi authored a report on January 27, 2014 opining that Petitioner's work duties, including repetitive lifting and stocking of freight cases, was a contributing factor to her diagnosis of a herniated cervical disc and the need for surgery. Her 2010 injury increased her chances of an aggravation. PX.3.

16. On March 18, 2014, Dr. Amine stated that Petitioner was a good surgical candidate. PX.5.

17. Dr. Salehi was deposed on March 11, 2014. He testified that the numbness Petitioner was experiencing over the left thumb and index finger in November 2010 was consistent with cervical radiculopathy impingement upon the nerves roots at C5-C6

or C6-C7. He noted Petitioner had a second accident and reported that she had to lift objects weighing up to 40 pounds. Petitioner reported that she did constant moving, bending, twisting and reaching. He was of the opinion she had a herniated disc in 2010 that was not properly diagnosed. The lifting was the cause of her symptoms. PX.4. pg.11. While she reported being 100 percent recovered after the 2010 incident, her 2010 injury would have made her more susceptible to future injury.

18. Dr. Salehi noted that Petitioner did not report any specific injury in October 2012, but had a month history of left sided shoulder pain with pain and numbness going down the entire left arm. This was consistent with radiculopathy, a pinched nerve as a result of a herniated disk, or foraminal stenosis. He stated that the constant overhead lifting of heavy objects would put her at risk for her symptoms. PX.4. pg.14. Her stabbing pain was consistent with a C6-C7 herniation.

19. Dr. Salehi opined that Petitioner's work duties were a competent cause to re-aggravate a previously herniated disc at C6-C7. PX.4. pg.21. She was a surgical candidate as she failed conservative treatment. PX.4. pg.22.

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.

The Commission finds that Petitioner sustained a work-related accident on October 29, 2010 that resolved by November 17, 2010. The medical records establish that Petitioner was

experiencing a tingling sensation into her left index finger following the October 2010 accident. The Commission is persuaded by Dr. Salehi's opinion that this was an indication for cervical radiculopathy impingement at either C5-C6 or C6-C7 and that Petitioner likely had a herniated disc as a result of the 2010 accident.

Petitioner credibly testified that she worked between November 2010 and October 14, 2012 without any left shoulder symptoms only to have her pain eventually returned to the point that it interfered with her ability to work. While Petitioner could not recall a specific aggravating event, the medical records support that her work duties caused an aggravation of her condition on October 14, 2012.

During Petitioner's October 17, 2012 visit to Concentra, Petitioner reported that she did repetitive lifting at work and lifted heavy objects. The medical record further indicated that Petitioner's pain had been present since October 14, 2012. This is corroborated by Mr. D'Angelo's testimony that Petitioner indicated that her pain on October 14, 2012 could have occurred that night. The Commission further notes that Petitioner's testimony as to her job duties and lifting requirements was corroborated by her co-workers' testimony. The co-workers' testimony establishes that Petitioner spent a great deal of time lifting and moving boxes weighing up to 40 pounds. She was also required to lift boxes over her head. While the Petitioner testified that she used ladders often in her work, she did not testify that she used ladders all the time. The Petitioner was 5'5" tall, which is shorter than some of the shelves and pallets. The Commission finds that Petitioner's job duties required her to lift heavy objects and lift over her head despite the availability of a ladder. In this respect, the Commission adopts Dr. Salehi's opinion that Ms. Siedschlag's job duties were a competent cause of her injury.

The Commission finds that Concentra's October 17, 2012 medical record does not support the Arbitrator's assertion that Petitioner could not pinpoint a specific episode of injury. In that record, Petitioner indicated a specific date of injury and that she performed heavy lifting. The Commission further notes that the evidence does not support the finding that Petitioner was pain free during the March 1, 2013. The March 1, 2013 record indicated that, while her pain was greatly reduced, her symptoms still remained. She had left upper extremity spasms as well as numbness and tingling with certain movements of the head.

The Commission finds that the evidence establishes that Ms. Siedschlag sustained a work-related accident arising out of and in the course of her employment on October 14, 2012. The Commission, therefore, awards Petitioner prospective medical consisting of an anterior cervical fusion at C6-C7 as recommended by Dr. Salehi. Petitioner is also entitled to the medical expenses contained in Petitioner's exhibit 8 as Respondent offered no evidence to rebut the reasonableness and necessity of those bills.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 23, 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 $2,658.26 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 22 2015

Michael J. Brennan

MJB/tdm
O: 3-23-15
052

Thomas J. Tyrrell

Dissent

I respectfully dissent from the Majority's decision. I would affirm and adopt Arbitrator Carlson's decision. I give great weight to the Arbitrator's careful and particular findings pertaining to the Petitioner's second claimed accident and the persuasive findings of Dr. Beatty. I find the Arbitrator's findings persuasive. I would affirm this decision in its entirety.

Kevin W. Lamborn

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

SIEDSCHLAG, SUZANNE
Employee/Petitioner

Case# **12WC040911**

13WC028349

WAL-MART ASSOCIATES
Employer/Respondent

15IWCC0379

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

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

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

0290 KARCHMAR & STONE
ADAM KARCHMAR
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
JASON T STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0379

Suzanne Siedschlag
Employee/Petitioner

v.

Wal-Mart Associates
Employer/Respondent

Case # **12** WC **40911**

Consolidated cases: **13 WC 28340**

An *Application for Adjustment 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 **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 _____

15IWCC0379

FINDINGS

On the date of accident, **10/29/10 & 10/14/12**, 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 not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$22,800.00**; the average weekly wage was **$440.00**.

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

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

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

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

ORDER

The Arbitrator finds that petitioner sustained a compensable work accident on October 29, 2010, for which she reached maximum medical improvement on November 17, 2010.

The Arbitrator further finds that petitioner did not sustain accidental injuries arising from her work on or around October 14, 2012, and that all compensation related to the alleged October 14, 2012 incident is denied, including an anterior cervical discectomy and fusion.

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

06·23·14
Date

ICArbDec19(b)

JUN 23 2014

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

SIEDSCHLAG, SUZANNE
Employee/Petitioner

Case# **12WC040911**

13WC028349

WAL-MART ASSOCIATES
Employer/Respondent

15IWCC0379

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:

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STATEMENT OF FACTS

Ms. Suzanne Siedschlag (hereinafter referred to as "petitioner") is an oversight stocker at Wal-Mart (hereinafter referred to as "respondent"). She has worked for the respondent since June 2008. Prior to that, petitioner worked at Jewel for ten years as a cashier and front end assistant manager. Petitioner alleges to have sustained two separate work accidents while working for the respondent.

The first accident reportedly occurred on October 29, 2010. According to the petitioner, when downstacking a pallet on October 29, 2010, she experienced left shoulder and neck pain. Petitioner testified that she reported her injury to "Joe" within two to three days of the incident. Joe was reportedly the assistant manager at the time. Petitioner originally testified that she filled out some accident forms, but later testified that she could not recall whether any accident forms were filled out.

Petitioner presented to Palos Community Hospital on October 30, 2010 reporting left chest, arm and back pain. (PX # 6, ps. 3,5). Petitioner acknowledged having experienced similar pain before, but never to this severity. (p.5). Diagnosed with musculoskeletal back pain, petitioner was to follow-up with her own doctor. (p.17).

On November 1, 2010, petitioner presented to Concentra Medical Centers complaining of left shoulder pain. (PX #2, p.4). She attributed her pain to lifting stock on October 29, 2010. (p.4). Diagnosed with a thoracic strain, petitioner was referred for physical therapy. (p.5).

When petitioner returned to Concentra Medical Centers on November 3, 2010, she reported that her symptoms were improving and that she felt better. (PX #2, p.7). Petitioner was again diagnosed with a thoracic strain, and was to continue with physical therapy. (p.7,8).

Petitioner attended six sessions of physical therapy from November 3 – November 17, 2010. (PX #2, ps.9 - 25). When examined at Concentra Medical Centers on November 17, 2010, petitioner felt that her symptoms were 100% better, and denied any pain. (p.26). Petitioner was formally discharged from care and authorized to return to regular activity. (p.26).

Petitioner alleges to have sustained a second work accident on or around October 14, 2012. She reportedly notified a co-manager, James, that she was experiencing pain and tingling in the left arm.

On October 17, 2012, petitioner returned to Concentra Medical Centers. (PX #2, p.27). She reported that she had been experiencing left shoulder pain for one month. (p.27). Petitioner's pain in the neck and left shoulder region was noted to have worsened during the last three days. (p.27). Cervical and left shoulder X-rays yielded normal findings, and petitioner was diagnosed with a shoulder/trapezius/rhomboid strain. (p.28). Petitioner was to participate in physical therapy, and was prescribed ibuprofen and Skelaxin. (p.29). With respect to work, petitioner was authorized to work modified duty with no lifting greater than 20 pounds, no pushing or pulling greater than 40 pounds, and no reaching above shoulder level. (p.29).

Petitioner returned to Concentra Medical Center for a follow-up appointment on October 22, 2012. (PX #2, p.35). Diagnosed with a cervical strain and radiculopathy, petitioner was to undergo an MRI. (p.35,36).

When petitioner returned for a follow-up visit on October 30, 2012, it was noted that she was working within her restrictions. (PX #2, p.40). Although petitioner reported that her symptoms worsened while at work, the examining physician noted that her imposed restrictions were being accommodated based upon petitioner's description. (p.40).

An MRI of the cervical spine was performed on November 1, 2012. (PX # 7). The interpreting radiologist, Dr. Mohammad Rezai, found evidence of multi-level osteophytosis, disc bulgings and herniations in the cervical spine and upper dorsal spine. (p.4). Spinal and foraminal stenosis, and minimal levoscoliosis were also noted. (p.4).

Petitioner was reevaluated by Dr. Cindy Ross of Concentra Medical Centers on November 6, 2012. (PX #2, p.42). In reviewing the MRI, Dr. Ross noted significant degenerative changes throughout the cervical and upper thoracic spine. (p.42). Dr. Ross also noted a few bulging discs, with a herniation at the C5-6 level with encroachment on the left-hand side. (p. 42). Diagnosed with cervical radiculopathy, cervical strain, and degeneration of the cervical intravertebral disc, petitioner was referred to a neurosurgeon. (p.42).

On November 16, 2012, petitioner attended an initial evaluation with Dr. Sean Salehi. (PX #2, p.44,45). It was noted that petitioner had been experiencing left-sided shoulder pain with pain and numbness involving the entire left arm for the month leading up to October 14, 2012 (p.44). During the November 16 evaluation, petitioner complained of left shoulder pain, left-sided neck pain, and numbness and weakness involving the left arm. (p.44). It was noted that petitioner had injured herself in October 2010 which involved left trapezius/scapular region pain, for which she underwent some therapy, and her symptoms resolved. (p.44). Dr. Salehi diagnosed a herniated disc at the C6-7 level. (p.45). Dr. Salehi recommended that the petitioner return for a follow-up visit and bring with her the actual MRI films. (p.45).

Petitioner returned to Dr. Salehi on December 7, 2012 for a follow-up visit. (PX #2, p.46,47). Dr. Salehi reviewed the MRI films, which he noted were of poor quality. (p.46). He found evidence of a moderate left paracentral disc herniation at C6-7 extending into the neural foramen. (p.46). Diagnosed with left radicular pain secondary to a herniated disc at C6-7,

petitioner was to undergo one to two epidural steroid injections at the C6-7 level. (p.46). In the event petitioner remained symptomatic at the time of a follow-up visit in four weeks, surgical intervention in the form of a fusion or arthroplasty would be discussed. (p.46,47).

During a follow-up visit on January 18, 2013, Dr. Salehi noted that petitioner had undergone one epidural steroid injection. (PX #2, p.48). A second injection was recommended. (p.48). Petitioner was also cautioned to quit smoking. (p.48).

Petitioner was re-examined by Dr. Salehi on March 1, 2013. (PX #2, p.82). Petitioner denied any pain. (p.82). She reported left upper extremity spasms as well as numbness and tingling with certain movements of her head. (p.82). Dr. Salehi recommended 2-4 weeks of work conditioning followed by an FCE, or, a C6-7 anterior cervical discectomy and fusion. (p.82).

On March 21, 2013, petitioner was evaluated by Dr. Abdul Amine. (RX #2 & PX #5, p.5). Two versions of Dr. Amine's March 21, 2013 report were placed into evidence. In the report entered as respondent's Exhibit 1, Dr. Amine states that petitioner had been experiencing cervical radiculopathy since October 2007. (RX #1). In the report contained within petitioner's group Exhibit 5, the March 21, 2013 report reads that petitioner had been experiencing cervical radiculopathy since October 2012. (PX #5, p.5). Petitioner testified that Dr. Amine asked her when her symptoms began, and that she was truthful in her response. Dr. Amine ordered an EMG of the upper extremities. (RX #1).

The EMG performed on March 28, 2013 was consistent with chronic left C7 radiculopathy. (PX #5, p.9).

After reviewing the EMG and cervical MRI, on April 23, 2013 Dr. Amine agreed with the surgical recommendation for an anterior cervical discectomy and fusion. (PX #5, p.4).

On August 1, 2013, petitioner attended an independent medical examination with Dr. Robert Beatty. (RX #3). Petitioner reported that two years earlier she had an episode at work wherein she experienced neck and left arm pain. (p.3). Petitioner advised Dr. Beatty that her pain two years earlier was the same as the pain she experienced with the more recent episode in 2012. (p.3,4). Petitioner reported that on October 14, 2012 she experienced neck and left arm pain, with hand numbness, which has been progressing over six weeks. (p.4). Petitioner could not pinpoint any distinct episode which caused these symptoms. (p.4). Said symptoms were in the same distribution as the symptoms two years earlier. (p.4). Petitioner had no pain during the August 1, 2013 evaluation. (p.4).

Dr. Beatty diagnosed pre-existing degenerative disc disease at multiple levels. (RX #3, p.5). Dr. Beatty suspected that at the time of petitioner's symptoms two years earlier, she had a very small disc protrusion, from which she recovered. (p.5). With respect to the more recent described incident, Dr. Beatty noted that petitioner did not have pain on multiple visits and stopped taking medication. (p.5). Dr. Beatty explained that there was no definite incident, and generally, repetitive trauma to the neck is not related to a disc herniation. (p.5). There were no objective findings on physical examination. (p.5). Dr. Beatty did not find an ongoing nerve root compression, as petitioner described only numbness with no pain. (p.5). With respect to treatment, Dr. Beatty felt that an anterior cervical fusion at C6-7 was not unreasonable, but maintained that it was not necessitated by petitioner's repetitive work on or around October 14, 2012. (p.6,7).

Dr. Salehi authored a narrative report dated January 27, 2014. (PX #3). Dr. Salehi opined that petitioner's exposure to the type of work she performed, which included repetitive lifting and stocking of freight cases, was a factor in contributing to her diagnosis of cervical

herniated disc and the need for surgery. He also added that "of course, the previous injury in 2010 increased her chances of aggravation." (p.2)

Dr. Salehi was deposed by the parties on March 11, 2014. (PX #4). Dr. Salehi testified that petitioner's work activities on March 14, 2012 – specifically, constant lifting of objects weighing between 20 to 40 lbs overhead – re-aggravated a prior C6-7 disc herniation. (p.21,22). Dr. Salehi testified that petitioner had minimal to no pain during her last visit with him on March 1, 2013. (p.32). When asked whether he was still recommending surgery, Dr. Salehi responded that a surgical decision would come only after a re-evaluation. (p.32,33). Dr. Salehi testified that evidence of treatment prior to October 2010 may affect his opinion regarding causal connection. (p.33).

Petitioner testified that her job duties as an overnight stocker involved pushing shopping carts, removing freight from pallets, and stocking shelves. She estimated that 20% of her work day was spent removing freight from pallets (also referred to as downstacking), while 50% of her work day was spent stocking shelves. Petitioner worked in the dry grocery department, which required handling can goods, cereal, flour, sugar, oil, and soda. She estimated that she downstacked between four and eight pallets per work day. The heaviest item petitioner lifted was 40-lbs. Petitioner testified that she never works alone. She also testified that she always has access to a ladder, and that she uses ladders often. She estimated that her job required her to reach up to a height of eight feet.

Sharon Lebrec also testified during the May 9 proceedings. Ms. Lebrec has worked for the respondent for three years as a backroom/stock associate. Ms. Lebrec has worked in the dry goods department. She testified that the pallets which the associates downstack are six-and-a-half to seven feet in height, and the highest shelf is six feet in height.

James D'Angelo also testified during the May 9 trial. Mr. D'Angelo has worked as a shift manager for the last three years. Mr. D'Angelo testified that the pallets are five to seven feet in height, while the highest shelf is six feet in height. According to Mr. D'Angelo, three to four associates are typically downstacking at one time, and if one associate needs help, another associate is always available.

ON THE ISSUE OF ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that petitioner was involved in a compensable work accident on October 29, 2010 when downstacking a pallet and experienced left shoulder and neck pain. Petitioner reached a state of maximum medical improvement for the October 29, 2010 accident on November 17, 2010 when (1) she reported that her symptoms were 100% better, (2) she was in no pain, (3) she was formally discharged from care, and (4) she was authorized to return to regular activity.

With respect to petitioner's second claimed accident, the Arbitrator finds that petitioner did not sustain any accidental injuries arising from her work activities on or around October 14, 2012.

In so finding, the Arbitrator notes that when petitioner presented to Concentra Medical Centers on October 17, 2012 and to Dr. Salehi on November 16, 2012, she reported that she had been experiencing left shoulder symptoms for one month prior to October 14, 2012. Dr. Beatty addressed petitioner's prior symptoms during his August 1, 2013 examination. Dr. Beatty noted that petitioner was unable to pinpoint any distinct episode which had caused her symptoms. This was also the case when petitioner testified at trial. Dr. Beatty explained that disc herniations generally are not associated with repetitive trauma.

The Arbitrator finds Dr. Beatty's findings to be more persuasive than those of Dr. Salehi, as Dr. Salehi's understanding of petitioner's work activities, particularly as it relates to the amount of overhead work performed, was inaccurate. During his deposition, Dr. Salehi opined that petitioner's work activities on October 14, 2012 aggravated an existing C6-7 disc herniation. Dr. Salehi relied on the following description of petitioner's work activities: "constant lifting of objects weighing anywhere between 20 and 40 pounds overhead." The Arbitrator finds that petitioner's actual work activities did not involve the amount of overhead lifting as expressed during Dr. Salehi's deposition. Petitioner acknowledged that she always has access to a ladder, and when asked how frequently she uses a ladder while working, she replied "often."

Additionally, petitioner's testimony that her job required her to reach up to a height of eight feet was directly contradicted by her two witnesses, Sharon Lebrec and James D'Angelo. Ms. Lebrec testified that the pallets are six-and-a-half to seven feet high, and the highest shelf is six feet high. Mr. D'Angelo testified that the pallets are five to seven feet high, and agreed with Ms. Lebrec that the highest shelf is six feet high.

The Arbitrator further notes that petitioner testified that she never works alone. James D'Angelo, a shift manager, corroborated this testimony, and further testified that if one associate needs help, another associate is always available.

ON THE ISSUE OF NOTICE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that petitioner did provide notice of the October 29, 2010 incident to Joe, an assistant manager.

As the Arbitrator finds that petitioner did not sustain any accidental injuries on October 14, 2012, all remaining issues relating to the October 14, 2012 claim are moot, including notice.

ON THE ISSUE OF CAUSAL CONNECTION, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds a causal connection between the described October 29, 2010 incident and petitioner's injuries for which she sought treatment from October 30, 2010 until she reached maximum medical improvement on November 17, 2010.

The Arbitrator finds no causal connection between petitioner's current condition and her work activities on or around October 14, 2012. The Arbitrator notes that petitioner denied any pain during the August 1 examination with Dr. Beatty, as well as during her March 1, 2013 evaluation with Dr. Salehi.

The Arbitrator also notes Dr. Amine's March 21, 2013 report entered into evidence as respondent's exhibit 1, which states that petitioner had been experiencing cervical radiculopathy since October 2007. The Arbitrator finds it compelling that Dr. Amine fails to address this in his subsequent reports. Instead, it appears the initial treating record was changed without any recognition or citation to the original record, drawing the credibility of Dr. Amine and anyone else whom may have been associated with changing the original record into question.

ON THE ISSUE OF INCURRED MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

As all medical bills entered into evidence as petitioner's group exhibit #8 were incurred after October 14, 2012, respondent is not responsible for payment, as the Arbitrator finds that petitioner did not sustain any accidental injuries arising from her work activities on or around October 14, 2012.

Incidentally, the Arbitrator notes that even if respondent were found responsible for the submitted bills, respondent's liability would be limited to that which is permitted under the Medical Fee Schedule.

ON THE ISSUE OF PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator finds that petitioner did not sustain any accidental injuries related to her work activities on October 14, 2012, prospective medical including an anterior cervical discectomy and fusion, is denied.

Incidentally, the Arbitrator notes that even if petitioner were found to have sustained accidental work injuries on October 14, 2012, Dr. Salehi testified during his evidence deposition that petitioner would need to return for a re-evaluation before he could tender a definitive surgical decision.

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARA ZELEZNAK,

Petitioner,

vs.

NO: 11 WC 35330

WAL-MART,

15IWCC0380

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, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection and denies benefits related to this claim but attaches the Decision for the purpose of the statement of facts, which is attached hereto and made a part hereof, with the modifications noted below.

Although we affirm the Arbitrator's finding of accident, we find that Petitioner failed to prove that this accident permanently aggravated her left knee condition or that it was a contributing factor in her need for surgery. Petitioner relies on the causation opinion of her treating physician, Dr. Komanduri. However, the Commission finds his opinion and testimony confusing, inconsistent, unsupported by his own records, and, ultimately, unpersuasive.

Petitioner has had multiple left knee problems and surgeries since 2007 including ACL reconstruction. On September 30, 2010, she underwent a chondroplasty of the patella and medial femoral condyle and a lateral release for patellofemoral instability. She was returned to work and released on December 18, 2010. On April 27, 2011, Petitioner returned to Dr. Komanduri and reported having "multiple giving out episodes." She began physical therapy and gave a two-week history of the left knee locking, episodes of instability, and increased pain. On May 27, 2011, Dr. Komanduri performed a cortisone injection. On June 27, 2011, Dr. Komanduri wrote that Petitioner may need an MRI and possible debridement of a meniscal injury. On July 25, 2011, Dr. Komanduri scheduled her for a diagnostic arthroscopy without doing an MRI because Petitioner felt it would not be worth the expense. Therefore, it is clear that Petitioner had a pre-existing left knee condition and symptoms as evidenced by her having been scheduled for surgery even prior to her work

accident on July 27, 2011. The specific issue in this case is whether the finding during her August 4, 2011 surgery, namely the lateral femoral condyle chondrosis, is related to that accident.

We initially note that Dr. Komanduri never documented any mechanism of injury or details regarding the accident even after the surgery. The extent of his written opinion was that it was a "fresh" injury and he believed it was work-related. (Px2, 8/29/11 note). But, he testified that Petitioner had reported multiple work injuries to him over time but she didn't want him to document them because she was afraid of losing her job. (Px10 at 8, 10, 24-25). Thus, by his own admission, he was willing to leave out critical information from his records at Petitioner's request.

We find that Dr. Komanduri's testimony regarding Petitioner's accident and causal connection with her left knee lateral chondrosis is very confusing. He testified that after his July 25, 2011 recommendation for surgery, he did not see Petitioner again until the day of surgery on August 4, 2011. (Px10 at 7). However, he also testified:

> Q: Now, were you ever given a history from [Petitioner] of a work injury between your recommendation for surgery and the actual surgical date?
> A: **More than once.**
> Q: What was that history?
> A: I know she works at Wal-Mart. I know she's on her feet all day long. **I know she had some sort of episode, and I can't – I don't recall the exact detail, whether she slipped or fell and landed on the knee. I think she slipped on a wet surface is what I remember.** She repeatedly told me about this and we discussed that she should report it.

(Px10 at 8, emphasis added).

In other words, it was his understanding that Petitioner had slipped on a wet floor and this is what she had told him "more than once." This history is not consistent with Petitioner's alleged fall off a ladder on July 27, 2011. It is clear that Dr. Komanduri was not referring to the same accident that is at issue in this case. In fact, he never mentioned anything about Petitioner falling off a ladder until after her attorney asked him about it:

> Q: Let's say if [Petitioner] had fell from a four – to six-foot height off a ladder onto her knee – let's save that for a later question. I'm sorry.
> So you did the surgery [8/4/11], correct?
> A: Right. And you have to remember, **there had been multiple injuries.** It wasn't – you know, there were multiple episodes that she had come in with pain from Wal-Mart, and so this is the one that **we know that there wasn't an articular surface injury in 2010, but there's one afterwards.**

(Id., emphasis added).

Based on this statement, Petitioner's articular surface injury (i.e., lateral chondrosis) could have happened at any time after her previous surgery in 2010. Dr. Komanduri's testimony became even more confusing because, even after he was informed that Petitioner's accident involved falling off a ladder, he was apparently unaware that Petitioner was alleging that her date of injury was July 27, 2011, which was two days after he had already scheduled surgery:

Q: And, Doctor, do you have an opinion to a reasonable degree of orthopedic and surgical certainty as to whether or not the work history or the work injury that she related to you is causally related to the injuries that you found upon her surgery?

A: So the best way for me to answer that is to give – if I can review what she told me. **She was not symptomatic prior to her work injury**. She told me that her symptoms became severe after the work injury. **There is on arthroscopy an acute chondrosis that is new since 2010**. So within – **anything that would have had to have happened, it would have had to have happened in that year between 2010 and when she presented in 2011**. So all of those things together add up to a reasonable assumption if you believe Mara's telling the truth that the injury occurred at work.

As you know, I told you repeatedly I asked her to report the injury, which would have made things a lot easier.

...

A: Why wasn't it caused by the prior surgery?

Q: Yes.

A: Boy, I would really have had to do something very aggressive to damage the joint during that procedure. I have arthroscopic pictures that show it wasn't injured. **So something traumatic occurred between 2010 and the time I next saw her in 2011**. All right? I have to – the only trauma that we know about is this injury she had at work.

(Id. at 13-14, emphasis added).

The problem with Dr. Komanduri's testimony is that he admitted that whatever happened must have happened after the 2010 surgery but *before she first presented to him in 2011*, which was in April. (Px2A). This was obviously not helpful to Petitioner's claim that her condition was related to the July 27, 2011 accident so her attorney "informed" Dr. Komanduri about the timeline:

Q: Just a follow-up on that. From the July 25th visit to the surgery –

A: Uh-huh.

Q: - you were discussing possible meniscal pathology?

A: Right.

Q: And then a work-related event happens after that. So can you kind of flush out, again, the work-relatedness of what you found on arthroscopy compared to what you were suspicious of on July 25th?

...

A: Okay. I mean, ...you're asking me what she was feeling...on July 25th and then what did she feel after the injury?

Q: Upon the surgery, correct.

A: Okay. So the findings on July 25th are primarily, you know, meniscal like. All right?

Now it can be that she had the articular – and look, I'm not misrepresenting the facts. **The articular cartilage injury could have been present on July 25th, but that wasn't the primary finding**. The findings were of a meniscal pathology. All right? Does that make it clear?

Q: Yes.

...

Q: And can you explain…exactly what lateral femoral condyle chondrosis is?
A: So the – it's medial in this case, right, so…
Q: Is it medial?
A: I think so. Do you have the operative note in front of you?
Q: Yes. The Grade IV chondrosis with an articular cartilage flap of the lateral –
A: Sorry, my error. It's lateral.

(Id. at 16-17, emphasis added).

Dr. Komanduri indicated that the acute injury could have occurred anytime within the previous six months because otherwise the cartilage would have been torn off:

Q: Can you explain – you've stated there was acute chondrosis. Can you explain that?
A: Yes, because the flap of cartilage that belongs there was still attached. It was torn off but still attached. And the arthroscopic pictures document that.
What that means is it hadn't been there so long that repetitive walking or wear and tear would have ripped that off.
Q: And you also write in your report that there is no doubt in your mind this is a fresh injury. Can you explain that?
A: Because the original cartilage is still there. Again, **had it happened five years ago or six months, even six months to a year prior, it would have been ripped – the flap of cartilage would have torn off.**

(Id. at 19, emphasis added).

However, this still isn't specific enough to prove causal connection with an accident on July 27, 2011, so Petitioner's attorney continued:

Q: Pertaining to your medical treatment of [Petitioner]…regarding the July 27, 2011, work injury…was all that treatment reasonable, necessary, and customary?
A: Yes. I mean, obviously she had some treatment prior to the work injury that, you know, wasn't caused by the work injury. But the eventual care and treatment for the cartilage loss, I believe, was.
Q: And can you explain, again, your opinion…as to whether or not **the work injury from July 27, 2011, caused the acute chondrosis** of [Petitioner]?
A: Yeah, and I think **that's what I didn't understand in your earlier question**. So to clarify, as **she was coming in for knee pain, meniscal pathology, she had symptoms that were medial joint line and she goes on to be identified postoperatively with a significant lateral** femoral condylar chondrosis.
Two things: One, **her preoperative pain prior – preinjury pain was in the wrong compartment, was in the medial compartment**. All right? Her postoperative pain or postoperative injuries in the lateral compartment. **There was an intervening traumatic event, and that's what you were trying to get at, I think**, and that – that is the only integral cause for that injury. She has a negative scope from 2010 that says that compartment was uninvolved. So and obviously **if there was evidence for another intervening injury, that could confound the – you know, the claims she's making, but right now it looks like that's the only other source of pain.**

Q: And with your opinion that the patella chondrosis was possibly preexisting, why would that not be for the lateral femoral chondrosis?

A: Okay. So the patella chondrosis is different. If you look at the arthroscopic pictures, you can see the cartilage loss and all of the cartilage that's there is gone. Okay? It's been eroded away over time with repetitive movement. Okay? **Whereas this injury occurred and that flap of tissue that was torn off is still there.** It's just attached by a thin flimsy thread of cartilage. All right? **What that means is she hadn't walked on it enough to displace it.** And honestly, **within a few weeks, that would have torn off and essentially been, you know, either floating in the joint or would have eventually been eroded away.**

Again, it's really **critical to realize that the injury is fresh enough that all of the parts that were damaged are still present in the location where they were – where the injury occurred,** even though she was walking on it.

(Id. 21-23, emphasis added).

Dr. Komanduri explicitly stated that the basis for his opinion is that, prior to Petitioner's alleged July 27, 2011 work accident, her complaints were medial but on surgery her problems were found to be lateral. However, this is not consistent with his own medical records. On July 25, 2011, two days before Petitioner's alleged accident, Dr. Komanduri wrote that Petitioner "most likely has a **lateral** meniscus tear." This completely contradicts his testimony that Petitioner's symptoms prior to the July 27th accident were medial. His testimony is also contradicted by the August 4, 2011 operative report, which does not reflect *any* medial problems. Instead, he performed a chondroplasty of the patella and **lateral** femoral condyle, a partial **lateral** meniscectomy, and an arthroscopic **lateral** release. The Commission finds that the records clearly support a finding that Petitioner's complaints were lateral even prior to her alleged work injury.

Furthermore, the "Indications" section of the operative report seems to support a finding of pre-existing lateral chondrosis:

> [Patient] has chronic pain and discomfort with a **known acute chondrosis of the lateral** condyle. She has exquisite pain, swelling, and tenderness. She has difficulty with ambulation. We discussed preoperative MRI.
>
> ...
>
> [Patient] elected not to obtain an MRI. She **has intermittent locking and catching.** We **suspect a lateral meniscal tear and possible articular surface injury.** ...

(Emphasis added.)

The Commission finds that either the acute lateral chondrosis was "known" prior to surgery and he "suspected" a lateral meniscal tear and possible articular surface injury beforehand or Dr. Komanduri wrote the "Indications" section after he performed the surgery in order to justify the surgery.

We also note that the operative report mentions "intermittent locking and catching." The Arbitrator found this to be a new finding after her work injury but that is not true.
Dr. Komanduri testified:

Q: Okay. **Did you examine her prior to surgery**?

A: **I would have in the preop holding area** because we have to document the injury. I don't – **I didn't specifically document any new findings at that time.**

(Id. at 27, emphasis added).

This would support a finding that the "intermittent locking and catching" was occurring prior to his last examination on July 25th, which was prior to Petitioner's work accident.

Other records also contradict a finding that these were new symptoms. The April 28, 2011 physical therapy record reflects a two-week history of left knee locking. Also, the FMLA certification, dated July 28, 2011 and signed by Dr. Komanduri, indicates a diagnosis of "Left knee loose bodies" and symptoms of "Knee pain, knee swelling, clicking, popping, locking." Although this form was dated after Petitioner's work accident, Petitioner testified that she didn't seen Dr. Komanduri between July 25th and August 4th and that she did not call the doctor's office. Petitioner actually did pick up FMLA forms from Respondent on July 27th to get time off for her scheduled surgery and brought those to Dr. Komanduri's office the same day but she did not ask to see the doctor at that time nor did she tell the receptionist that she was having increased problems. T.32-33. Therefore, it is clear that the symptoms described by Dr. Komanduri on the FMLA form existed at the time of Petitioner's pre-accident visit on July 25th.

Another interesting piece of evidence is that, although Dr. Komanduri's September 30, 2010 operative report related to her previous surgery indicates that the lateral compartment was "pristine," an MRI on August 10, 2010 did, in fact, reveal that Grade I-II chondromalacia was present in the **lateral** compartment. (Px2A). Therefore, either Dr. Komanduri didn't notice that or he didn't think it was significant enough to mention. Regardless, there is objective evidence that Petitioner had at least the beginnings of chondromalacia in the lateral compartment as early as August 2010 per the MRI.

We also note that, although Petitioner testified that her pain was "worse" after the work accident, she never gave specifics as to whether the pain changed sides, felt different, or anything that would help support Dr. Komanduri's opinion that the lateral chondrosis was new and related to her July 27th accident.

It is also very significant that Dr. Komanduri testified that it is hard to distinguish between a significant articular cartilage injury and a meniscal tear:

> Q: And what part of the [8/4/11], postoperative diagnosis would you say is work related? And specifically before a work trauma occurred, you had already recommended an arthroscopy for a possible meniscal tear. Can you explain which postoperative diagnosis is work related and which is not?
>
> ...
>
> A: You mean, which diagnosis? Well, look, I don't know that either – I wouldn't really say one is not related. **I mean, she had pain and symptoms on the inside of her knee, which is – it's hard to distinguish a significant articular cartilage injury from a meniscal tear.** An MRI would have helped. I explained to you why we didn't get one at that moment in time.
>
> The choice as to whether one is related or one is not related, **I think they're both related. In this case, we didn't find a significant meniscal tear I don't believe.** If there was, it was a modest problem. Her main problem was her articular cartilage injury.

(Px10 at 15, emphasis added).

Therefore, he basically admitted that, without an MRI, he could have confused Petitioner's chondrosis for a meniscal tear, which is what he thought Petitioner had before he performed the surgery. (See 7/25/11 note).

One of the major problems with Dr. Komanduri's opinion is that his records contain errors and are incomplete. Most of the time he didn't document whether Petitioner's complaints were to the right or left knee, medial or lateral, etc. And, even in the rare instances when he did mention specifics, he testified that some were in error. For example, in the post-surgery note on August 29, 2011 he stated that Petitioner's **medial** chondrosis was new and a fresh injury. But, since the evidence shows that Petitioner clearly had medial femoral condyle chondrosis prior to her alleged work injury, he testified that the reference in that note should have been "**lateral.**" (Px10 at 43).

Petitioner's pre-accident records contain multiple references to her having episodes of buckling and her knee giving out. And, despite all of Dr. Komanduri's attempts at causally relating her lateral chondrosis to a July 27th work injury, on cross-exam he admitted that:

Q: Could repeated instances of a knee giving out be sufficient to cause that trauma?
A: **It's possible, but that wasn't present during those instances or at least not as of 2010.**
Q: Okay. **But you have no idea whether it was present at any time in 2011, correct?**
A: **No, but the window is much smaller obviously.**

(Px10 at 36-7, emphasis added).

Therefore, Dr. Komanduri could not state that Petitioner's lateral chondrosis was not present prior to her alleged injury.

In contrast to Dr. Komanduri's opinion, Respondent's Section 12 examiner, Dr. Suchy, testified that:

- Petitioner gave a history of falling off the ladder and landing on her buttocks, which would not cause her knee problems.
- The records do indicate previous **lateral** complaints/problems, which can be consistent with the cartilage flap found during surgery.
- Dr. Komanduri himself actually believed Petitioner had a **lateral** meniscus tear when he saw her on July 25, 2011.
- Although the articular flap seen on the August 4th surgery *can* be a sign of acute trauma, one can't tell when it happened, it could be caused by multiple incidents of Petitioner's knee giving out, and that a flap of cartilage can be there for "many, many months."

(Rx1).

Based on the above, the Commission does not find Dr. Komanduri's testimony persuasive at all regarding causation. It is more likely than not that Petitioner's lateral femoral condyle chondrosis is the same problem that she was treating for even prior to her work accident. Dr. Komanduri's July 25th record indicating that he suspects that Petitioner had a **lateral** meniscal tear contradicts his testimony that her pre-accident symptoms were medial. He admitted that he didn't document any new findings when he saw Petitioner in the pre-op holding area before surgery, which would be inconsistent with a finding that Petitioner had new "locking and catching" after the alleged injury. And, Dr. Komanduri admitted that Petitioner's chondrosis could have been present earlier in 2011. This would support Dr. Suchy's opinion that a cartilage flap could have been

caused by the multiple documented incidents of her knee giving out and could have been there for months. Therefore, we consider the opinion of Dr. Suchy more persuasive on the issue of causal connection and find that Petitioner only sustained a temporary aggravation of her pre-existing left knee condition, for which she was already scheduled for surgery. The work accident on July 27, 2011 was not a contributing factor in her need for treatment, did not permanently change the structure of her knee, and, in particular, was not a cause of her lateral femoral condyle chondrosis.

We reverse the Arbitrator's decision regarding causation and all awards for benefits are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator with respect to causal connection is reversed and all awards for benefits are vacated.

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

DATED: MAY 22 2015

Ruth W. White

Joshua D. Luskin

SE/
O: 4/1/15
49

DISSENTING OPINION

I respectfully dissent and would affirm the Arbitrator's decision in this case. Although the testimony of Dr. Komanduri is confusing at times, I believe Petitioner has proven that her July 27, 2011 accident was at least a contributing factor in the lateral femoral condyle chondrosis that was found during surgery on August 4, 2011.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZELEZNAK, MARA
Employee/Petitioner

Case# **11WC035330**

WAL-MART
Employer/Respondent

15IWCC0380

On 11/20/2013, 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 0.10% 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:

0924 BLOCK KLUKAS & MANZELLA PC
BRYAN SHELL
19 W JEFFERSON ST SUITE 100
JOLIET, IL 60432

0210 GANAN & SHAPIRO PC
JULIE M SCHUM
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0380

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

MARA ZELEZNAK
Employee/Petitioner

v.

WAL-MART
Employer/Respondent

Case # **11** WC **35330**

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 **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 **July 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 **$22,984.00**; the average weekly wage was **$442.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$79,441.73** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $126,849.05, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $79,441.73 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $294.67/week for 26 6/7 weeks, commencing August 4, 2011 through February 8, 2012, totaling $7,913.90, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $265.20/week for 43 weeks, because the injuries sustained caused the 20% loss of the left leg, as provided in Section 8(e)12 of the Act.

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

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

Signature of Arbitrator

11/19/13
Date

NOV 20 2013

15IWCC0380

FINDING OF FACTS:

Petitioner, MARA ZELEZNAK, at the time of trial she was 48 years old. Petitioner testified that her highest level of education was high school. Petitioner has worked in retail management for almost 22 years. Petitioner is not currently working.

Petitioner testified that she had been employed by Respondent, WAL-MART, starting approximately July 2008. Petitioner worked as a mod team leader/stock associate. Petitioner provided that she would float between organizing the store in each department, stocking shelves and working in the back room binning and picking.

Petitioner testified that on July 27, 2011, she arrived at work, attended the regular meeting and was then assigned to work inventory, which would involve picking in the back room. Respondent witness, Ricky Paoletti, corroborated Petitioner's testimony, stating that they had a meeting at 10:00 p.m., which lasted five to ten minutes. Petitioner stated that after the 10:00 p.m. meeting, she grabbed her "telezon" and started working in the back room picking merchandise. Petitioner climbed a four tier ladder and was grabbing a box off of the shelf. The ladder consisted of three steps and a standing ledge on the top of the ladder. Petitioner testified that as she was coming down the ladder, while carrying the box, she fell from the third step, landing on her left foot and then falling down to her butt. Petitioner testified that she jarred her left knee. Petitioner indicated the occurrence happened anywhere between 10:30 p.m. and 12:00 a.m. Petitioner testified that she did not report this incident immediately because she was afraid of filing a claim, possibly being written up and losing her job. However, Petitioner did orally report her injury upon her return to work August 1, 2011 and again in writing on August 6, 2011 where she stated the day after the fall she couldn't walk and requested modified duty. Ricky Paoletti also corroborated the fact that Petitioner filled out an incident report on August 6, 2011 and remembers that Petitioner told him that she thought everything was O.K. (Resp. Ex. 6). Upon review of Petitioner's written statement that day, she reported that at first she didn't think she was hurt, but couldn't walk the next day. (Resp. Ex. 4). Petitioner finished her shift and was not scheduled to work again until the following Monday. Petitioner stated that from July 28 through August 1, her activities were limited to sitting around the house. Petitioner stated she couldn't walk on July 28 and she tried to "baby her left knee as much as possible."

Petitioner testified that this was not the first time she had experienced left knee pain. Petitioner had been treating with Dr. Komanduri for knee pain for at least four years prior to July 27, 2011, including several surgeries to her left knee. (Pet. Ex. 2 and 2A). Most recently Petitioner began treatment on April 27, 2011, where she had multiple giving out episodes. (Pet. Ex. 2A at 566). Clinical examination revealed no pain, no instability, a stable ACL and no meniscal injury. (*Id.*). Petitioner was prescribed patellofemoral braces, but would not wear them and Dr. Komanduri prescribed physical therapy. (*Id.*) Petitioner was evaluated at physical therapy and gave a history of left knee pain, especially with activities such as bending and climbing ladders. (*Id.* at 563). Petitioner's symptoms were greatest during work activities and at the end of her work shift. (*Id.*). On May 27, 2011, Petitioner was not responding to physical therapy. Petitioner's options were to have an MRI, cortisone injection, or to undergo arthroscopic surgery. Petitioner chose to have a cortisone injection. (*Id.* at 562). Petitioner was next seen on June 27, 2011. The injection gave her temporary relief and Petitioner was to return in one month. (*Id.* at 561). Petitioner was seen on July 25, 2011, where she declined an MRI due to cost and Dr. Komanduri recommended surgery for the left knee, with a diagnosis of lateral meniscal tear. (*Id.* at 560).

Petitioner testified that prior to July 27, 2011 she was working full duty, which included climbing ladders, walking the store and stocking. After July 27, 2011, her complaints were different as she couldn't put any pressure on the left knee. When she tried to walk, she could barely stand any pressure on the left leg. Petitioner provided that she could not afford any extra doctor's visits and was already scheduled for surgery, so she did not call to schedule an appointment to see Dr. Komanduri before the surgery, August 4, 2011.

Petitioner returned to work August 1, 2011 and was assigned to work in the back room. Petitioner told her supervisor/co-manager, Will, that she did not want to work the back room and climb ladders because she fell. Petitioner provided she was told she did not have to climb ladders. Petitioner continued to work until her surgery, although in a limited capacity, not going on ladders, not bending and trying to be as careful as possible because she had sharp pains in her knee.

Dr. Komanduri performed surgery on August 4, 2011. (Pet. Ex. 2 at 233, Pet. Ex. 3 at 18). Diagnostic arthroscopy revealed a diagnosis of patellofemoral instability with lateral subluxation of patella, Grade IV chondrosis of patella over a 15 x 18 mm area, Grade IV chondrosis with an articular cartilage flap of the lateral femoral condyle over a 20 x 20 mm area of the weight bearing surface of the lateral femoral condyle, and anterior and middle third lateral meniscal tear. Dr. Komanduri took a piece of cartilage for a carticel biopsy. (Pet. Ex. 2 at 233, Pet. Ex. 3 at 18). Prior to surgery, Dr. Komanduri diagnosed lateral meniscal tear, on the surgery date Dr. Komanduri first noted an acute chondrosis of the lateral condyle. (*Id.*).

After surgery Petitioner was evaluated for physical therapy where she provided a history of the work injury where she had fallen off a ladder while at work on July 27, 2011. (Pet. Ex. 2 at 222).

Petitioner was next seen by Dr. Komanduri on August 29, 2011 where he indicated that this was a work-related injury. The doctor noted Petitioner had no evidence for the chondrosis of her lateral femoral condyle and patella, this was a fresh injury and it was an acute chondrosis. Dr. Kmoanduri provided that the articular flap was still attached to the joint surface and it was no doubt in his mind a fresh injury and work-related. Dr. Komanduri took Petitioner off work for three months. (Pet. Ex. 2 at 207).

On September 28, 2011, Petitioner had not started physical therapy due to insurance concerns and continued off work. (Pet. Ex. 2 at 202). On November 7, 2011, Dr. Komanduri was waiting on approval for a carticel transplant. (Pet. Ex. 2 at 180). Petitioner was next seen December 7, 2011, where her carticel biopsy did not grow in the cell culture. (Pet. Ex. 2 at 176). A repeat biopsy was performed December 9, 2011. (Pet. Ex. 2 at 291). There was a follow up appointment on December 14, 2011 and January 13, 2012 to discuss the culture, which eventually was ready to go and proceed with an autologous cultured chondrocyte implantation. (Pet. Ex. 2 at 156). Petitioner underwent surgery February 7, 2012. (Pet. Ex. 2 at 327).

Petitioner testified that on February 9, 2012, she fell while getting up to go to the bathroom, which made her pain worse. Dr. Komanduri later states that there was a fall postoperatively that may have caused a new injury. (Pet. Ex. 2 at 65).

Petitioner testified that she can't walk correctly, that she has a limp, walking up and down stairs is difficult and painful, she can't bend her knee much and if she gets down on the floor she has trouble getting up again. Petitioner no longer sleeps in a bed, she sleeps in a chair. Petitioner can walk two blocks before she feels the pain in her left knee.

In support of the Arbitrator's Decision regarding "C" (Accident), the Arbitrator finds as follows:

According to *Caterpillar Tractor v. Industrial Commission*, 215 Ill. App. 3d 229, 574 N.E.2d 1198, 158 Ill. Dec. 805, (4th Dist. 1991), it is clear that the pleadings and the proceedings in Workers' Compensation cases are informal and are designed to expedite and to achieve a right result.

To obtain compensation under the Act, a claimant bears the burden, by a preponderance of the evidence, that he has suffered a disabling injury, which arose out of and in the course of his/her employment. In the course of employment refers to the time, place and circumstances surrounding the injury. That is to say, for an injury to be compensable it generally must occur within the time and space boundaries of the employment. The injury must also arise out of the employment. The arising out of component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create causal connection between the employment and the accidental injury. Stated otherwise, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E. 2d 665, (2003), (citations omitted).

In this matter, Petitioner arrived at work at 10:00 p.m, attended a meeting and was assigned to help in the back room with picking. Petitioner is shown on her time sheets as arriving at 22:00, which is consistent with her testimony. (Resp. Ex. 8 at 2). Petitioner fell off a ladder sometime around 10:30 p.m. to 12:00 a.m. Ricky Paoletti, Petitioner's supervisor, testified that employees punch in at 10:00 p.m. and they have a meeting that lasts from five (5) to fifteen (15) minutes. Ricky Paoletti testified the he had no idea if Petitioner fell between 10:00 p.m. and 12:00 a.m. He however stated that he knows she didn't fall between 10:00 p.m. and 10:30 p.m. because of the meeting beginning at 10:00 p.m. Ricky Paoletti could only account for five to fifteen minutes after 10:00 p.m., when the alleged injury was either at 10:30 p.m. or later.

Respondent also offered video surveillance, which the Arbitrator has reviewed. The surveillance shows two areas, it is date and time stamped starting July 27, 2011 at 2:59:56 a.m. and ending approximately 5:00 a.m. The Arbitrator notes that this is not the time frame of the claimed injury. Petitioner testified that she fell from a ladder approximately 10:30 p.m. through midnight. The surveillance video starts at 2:59 a.m. and shows only until 5:00 a.m. on both camera angles. Furthermore, there are people present on the video, as well as throughout the video, stocking, cleaning and binning, contrary to Ricky Paoletti's testimony during direct examination and examination by the Arbitrator that there is no one shown during the video at all. Respondent did not provide evidence of surveillance starting at 10:00 p.m. Both the Appellate Court and the Commission have held that a Party's failure to call a witness or produce evidence within his control to contradict adverse testimony creates and inference that the evidence would have been unfavorable to the Respondent. *REO Movers v. the Industrial Commission*, 226 Ill. App. 3d 216 1st Dist. (1992); *Barrett v. Central Grade School*, 04 IIC 0631.

Petitioner testified that she fell from the third rung of a ladder while carrying a box anywhere between 10:30 p.m. and 12:00 a.m. (midnight). Her estimated time frame is based on a co-worker who leaves before midnight was there to check on her when he saw her on the ground. Petitioner told a co-manager, Will, about the incident the following Monday because she was limited in what she could do. Petitioner indicated that she had far more pain subsequent to the fall and asked Will if she could avoid ladders. Petitioner continued working after the fall, but limited herself to staying off ladders and not bending due to sharp pains in her left knee.

The Arbitrator finds Petitioner's testimony was credible and consistent with her work hours entered into evidence. The evidence supports a finding that there was a work accident on July 27, 2011.

In support of the Arbitrator's Decision regarding "D" (Date of Accident), the Arbitrator finds as follows:

The Arbitrator finds the date of the accident was July 27, 2011 as stated above.

In support of the Arbitrator's Decision regarding "F" (Causal Connection), the Arbitrator finds as follows:

"It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. 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." *Sisbro,* 207 Ill.2d at 204-06.

At the time of her injury, Petitioner testified that she had been actively treating with Dr. Komanduri. A board-certified orthopedic surgeon who has performed multiple surgeries on her left knee and is familiar with her treatment. Petitioner had been working full duty while undergoing treatment including physical therapy and a cortisone injection. Dr. Komanduri prescribed surgery to repair her meniscus on July 25, 2011. Petitioner testified that after her fall on July 27, 2011 her symptoms were more intensified, she could not put any weight on her left leg, she could not walk on her weekend off and when she returned to work, she requested not to climb ladders and tried to bend as little as possible. The work accident caused a definitive change in symptoms to which Petitioner required job modification. The mechanism of injury is such that a fall from a ladder could aggravate, accelerate, or exacerbate a pre-existing symptomatic condition.

Dr. Komanduri noted on August 29, 2011 that he has performed surgeries on her left knee two other times and on both prior surgeries she had no evidence for the chondrosis of her medial femoral condyle and patella. This was a fresh injury and it was an acute chondrosis. The articular flap was still attached to the joint surface and there was no doubt in his mind this was a fresh injury that was work-related. Dr. Komanduri testified that during his last operation, Petitioner had perfect cartilage in 2010. (Pet. Ex. 10 at 14). His findings on July 25, 2011, were meniscal, the articular cartilage could have been present, but that wasn't the primary finding. The findings were of a meniscal pathology. (*Id.* at 16-17) When asked how to distinguish between a fresh injury and something that could be more chronic, Dr. Komanduri stated that "if this was an arthritic condition it would be more diffuse, over all sorts of surface areas. It is usually bi-polar, meaning it involves the femur and the tibia, and commonly there are bone spurs, there's eburnation of the bone, which is almost a burned appearance to the bone. It's smooth and glassy and it looks like it's dead. None of those things were the case here." (*Id.* at 17-18). Dr. Komanduri continued "We had a large flap of cartilage that was literally still partially attached to the joint surface, but had been ripped off and was no longer stuck to the bone like it should

have been. The end result was that we had exposed bone and exposed nerves in that area. What the flap of cartilage means is it hadn't been there so long that repetitive walking or wear and tear would have ripped that off. (*Id.* at 18-19). Dr. Komanduri stated "whereas this injury occurred and that flap of tissue that was torn off is still there. It's attached by a thin flimsy thread of cartilage. What that means is she hadn't walked on it enough to displace it and honestly, within a few weeks, that would have torn off and essentially been either floating in the joint or would have eventually been eroded away. (*Id.* at 22-23). On re-direct Dr. Komanduri was asked without an MRI if articular cartilage damage could be clinically diagnosed and he testified that it is possible because it may have caused some locking or catching during the exam and that was not something Dr. Komanduri found on the July 25, 2011 physical examination of the Petitioner. (*Id.* at 46).

Respondent sent Petitioner for an examination under Section 12 of the Act with Dr. Theodore Suchy. Dr. Suchy testified that he spent 20 minutes with Petitioner, which included taking a history and physical examination. Dr. Suchy spent 15-20 minutes on the medical records, which the Arbitrator notes are voluminous in this case, and then 10-15 minutes dictating the report. Dr. Suchy's examination occurred on December 14, 2011, just after Petitioner's biopsy done on December 9, 2011. Dr. Suchy testifies that in his review of the medical records and treatment prior to July 25, 2011, he did not document in his report any complaints of locking or catching in the medical histories. Dr. Suchy did not know of any other traumatic event that occurred other than the fall at work on July 27, 2011. (Resp. Ex. 1 at 25-26). Dr. Suchy agreed with the treatment plan in his December 14, 2011 report, stating that either a carticel or osteochondral allograph would be indicated for treatment of this. (Resp. Ex. 1, Dep. Ex. 2 at 5). Dr. Suchy testified that based on the mechanism of injury, Petitioner falling directly onto her buttocks, that the cartilage flap predated any type of injury to her buttocks. (Resp. Ex. 1 at 14).

The Arbitrator adopts the findings and opinions of Dr. Komanduri who has been the treating surgeon for Petitioner for over five years. Dr. Komanduri performed the operation and is more familiar with the case than Dr. Suchy. The Arbitrator does not find Dr. Suchy's testimony pursuasive. The Arbitrator notes that Dr. Suchy did not have an understanding of the actual mechanism of injury. Petitioner testified that she fell from the ladder landing on her left foot, jarring her knee and then falling onto her buttocks. Dr. Suchy testified that he understood Petitioner fell from a ladder directly onto her buttocks, which would have no bearing on the left knee.

It is well documented that Petitioner was working full duty, which included walking through the store, stocking and climbing up and down ladders, even while treating with Dr. Komanduri for complaints of pain to her knee. After the accident occurred on July 27, 2011, Petitioner not only had greater complaints of pain, but new symptoms of catching and locking not present at her prior visits. Dr. Komanduri noted on the August 4, 2011 operative report and testified that this was not present during his July 25, 2011 examination and Dr. Suchy agreed he did not document any reports of catching or locking in his report after a review of the records.

Petitioner had complaints of pain, but after the injury, her complaints were more intensified and different than the complaints she was having on July 25, 2011.

The Arbitrator notes that Petitioner had an unrelated injury on February 9, 2012 and therefore, any subsequent medical treatment is not causally related to the July 27, 2011 work injury.

Therefore, the Arbitrator finds that there is causal connection between the condition of ill-being and the injury of July 27, 2011. The Arbitrator finds that any injury or treatment after February 9, 2012 is not causally connected.

In Support of the Arbitrator's Decision regarding "J" (Medical), the Arbitrator finds as follows:

The Arbitrator has reviewed the medical bills (Petitioner's Exhibits 11-20 which were admitted into evidence with the objection only on the basis of liability). Based upon the evidence presented, including Petitioner's testimony, the Arbitrator's review of the medical records and bills, the Arbitrator finds Petitioner's medical bills, admitted as Petitioner's exhibits 11-19 in the sum of $184,390.583, to be reasonable, necessary, and customary. However, the Arbitrator finds that the bills after February 9, 2012 are not causally connected or related to the July 27, 2011 injury. Therefore, after deducting the bills after the cut-off date, the total of the medical bills related to the July 27, 2011 injury is $126,849.05 that is reasonable, necessary, customary and related. The Parties stipulated that there is a credit under Section 8(j) in the amount of $79,441.73. After finding the injury causally connected with the July 27, 2011 accident, the Arbitrator finds Respondent shall pay reasonable and necessary medical services of $47,407.32 through February 9, 2012, as provided in Sections 8(a) and 8.2 of the Act.

In Support of the Arbitrator's Decision regarding "K" (TTD), the Arbitrator finds as follows:

Petitioner has missed time from the work related injury starting August 4, 2011 through February 8, 2012, or 26 and 6/7th weeks.

Based upon the Arbitrator's findings as it relates to Causal Connection, Respondent shall pay Petitioner temporary total disability benefits of $294.67/week for 26-6/7 weeks, commencing August 4, 2011 through February 8, 2012, totaling $7,913.90, as provided in Section 8(b) of the Act.

In Support of the Arbitrator's Decision regarding "L" (PPD), the Arbitrator finds as follows:

Petitioner suffered from a Grade IV chondrosis of the lateral femoral condyle, which was repaired with an autologous cultured chondrocyte implantation (ACCI), which required another arthroscopic procedure to obtain a culture that could be successfully implanted. Petitioner walks with a limp, experiences difficulty going up and down stairs and does not sleep in a bed at night. Petitioner credibly testified that she experiences pain in her left knee when attempting to walk more than two blocks.

The Arbitrator finds Respondent shall pay Petitioner permanent partial disability benefits of $265.20/week for 43 weeks, $11,403.60, because the injuries sustained caused the 20% loss of her left leg, as provided in Section 8(e)12 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph George,
Petitioner,
vs.

NO: 13WC 19235

U.S. Security Associates,
Respondent,

15IWCC0381

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 30, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,700.00. 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: MAY 22 2015
o052015
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GEORGE, JOSEPH
Employee/Petitioner

Case# **13WC019235**

15IWCC0381

U S SECURITY ASSOCIATES
Employer/Respondent

On 10/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0059 BAUM RUFFOLO & MARZAL LTD
ANDREW MARZAL
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

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

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

Joseph George
Employee/Petitioner

v.

U.S. Security Associates
Employer/Respondent

Case # **13** WC **19235**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Wheaton**, on **October 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 _____

15IWCC0381

FINDINGS

On **May 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 **$9,642.00**; the average weekly wage was **$370.55**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$3,849.87** for TTD, **$620.54** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,470.41**.

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

ORDER

Respondent shall pay Petitioner the outstanding reasonable and necessary medical expenses of the Bensenville Fire Protection District and the Michigan Avenue Medical Associates pursuant to Sections 8 and 8.2 of the Act. ARB EX 1. Respondent shall pay Petitioner the outstanding reasonable and necessary physical therapy bills incurred through October 9, 2013 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Petitioner is awarded permanent partial disability benefits of $222.33/week for 21.5 weeks, because the injuries sustained caused the 10% loss of use of the left leg under Section 8(e) of the Act.

Petitioner is awarded permanent partial disability benefits of $222.33/week for 12.65 weeks, because the injuries sustained caused the 5% loss of use of the right arm under 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.

Carolyn D Hurley
Signature of Arbitrator

10/30/14
Date

OCT 20 2014

FINDINGS OF FACT

The Arbitrator initially notes that the parties stipulated to all issues at trial with the exception of nature and extent and the reasonableness and necessity of certain physical therapy treatments and the charges related thereto. ARB EX 1. The parties stipulated that on 5/25/13, the 29 year old Petitioner was employed by Respondent US Securities Associates as a crime prevention officer. Petitioner's position was unarmed and his job duties included "enforcing the rules of the company."

On 5/25/13, Petitioner was working his security position at a warehouse distribution facility owned by Respondent's client Hennessy Logistics. Petitioner testified that he worked a shift from 6:30 am to 6:00 pm. On 5/25/13, between 3 and 4 pm, Petitioner sustained a work related accident when he tripped and fell forward onto a shrink wrap machine. Petitioner testified that he struck his upper body on the machine and immediately felt pain in his shoulders, right elbow and both knees. The Bensenville fire department was called and Petitioner testified that when paramedics arrived he was seated in a chair due to his knee pain. Furthermore, carbon monoxide was detected so Petitioner was placed in the ambulance wearing an oxygen mask and an IV.

Petitioner was taken to Alexian Brothers Hospital where he complained of pain in both hands from trying to break his fall, pain across his chest and both knees. The records reflect that Petitioner weighed 394 pounds. Tenderness to the left knee with a small abrasion medial to the patella and a small area of ecchymoses was noted on the left knee. PX 2. Chest, hand and left knee x-rays were taken with normal results. No acute fractures or dislocations were noted. Petitioner was discharged to home the same day.

Petitioner testified that upon his release from the ER he continued to notice pain. He stayed off work for 3 days. The parties stipulated to the issues of TTD and TPD. ARB EX 1.

At trial, Petitioner testified that he then went to Illinois Masonic Hospital due to continued knee pain. He testified his left knee wound was cleaned and he was checked for carbon monoxide. He further testified that he was given a walker. Records of this treatment were not submitted at trial but the visit is referred to in subsequent treatment records.

Petitioner next presented at Michigan Avenue Medical Associates and began treating with Dr. Albert on 5/30/13. PX 3. Dr. Albert's records reflect the ER visit and the left knee x-ray which Dr. Albert noted showed a superficial cortical fracture of the inferior patella. Petitioner complained of left knee pain as well as pain in the right arm and elbow, left arm, and chest region to Dr. Albert. PX 3. On exam of the left knee, Dr. Albert noted tenderness on palpation of the patella and peripatellar inflammation. The right arm showed bruising on the lateral aspect of the humerus with tenderness on the bone beneath the bruise. Petitioner was taken off work for a month. He was placed on prednisone and x-rays were ordered for the right arm and right elbow. He ordered an MRI of the left knee to "rule out other pathology besides the fracture of the patella that is noted on the x-rays. Petitioner was also sent to Premier Physical Therapy for 4 weeks and to an orthopedic surgeon Dr. Shafer for evaluation of the left knee. Petitioner was allowed to continue use of the walker as needed. PX 3.

On 6/5/13 Petitioner saw Dr. Shafer. Petitioner reported falling forward and striking his left knee. Dr. Shafer also noted that Petitioner struck his right elbow directly on the olecranon area "and this caused subsequent injury to his shoulder." Dr. Shafer examined Petitioner's left knee, right shoulder and right

elbow. He noted that Petitioner reported that his pain was slowly improving but that he was unable to wean from the walker. Exam of the left knee showed mild swelling with laceration over the medial and anterior knee. There was reported pain with palpation over the medial femoral condyle and medial joint line but McMurray's signs were negative. Dr. Shafer reviewed the left knee MRI taken on 6/3/13 and noted significant bone marrow edema in the medial femoral condyle and early arthritic changes. Petitioner exhibited full shoulder range of motion with mild overhead pain and weakly positive impingement signs. Mild pain but no significant weakness to resisted rotator cuff testing was noted and some pain to palpation over the olecranon tip was noted without evidence of instability in the shoulder or elbow. Dr. Shafer diagnosed right shoulder rotator cuff tendonitis, right elbow contusion and left knee severe contusion of the medial femoral condyle. Petitioner was to continued PT, return in two weeks and remain off work. PX 3.

On 6/19/13, Dr. Shafer noted that since Petitioner's last visit, his right elbow complaints had completely resolved and "his shoulder issues are minimal." Petitioner reported continued complaints of pain in the medial and anterior aspect of the knee just underlying the laceration site with occasional buckling and locking in the knee. Following exam, Dr. Shafer assessed a resolved right elbow contusion, resolving right shoulder strain and left knee severe contusion of the medical femoral condyle. In his plan Dr. Shafer noted, "the upper extremity symptoms appear to be resolving without any issues. The knee is still symptomatic. Much of the continued irritation is likely related to Petitioner's weight. However he does have a severe contusion seen on his MRI scan with significant bone marrow edema seen at the medial femoral condyle. I expect this still to improve with conservative care. We will continue with the physical therapy and the Duexis for his pain." Petitioner was to return in 4 weeks to assess his progress. Dr. Shafer released Petitioner to sedentary work if available. PX 3.

Petitioner testified that he requested sedentary work but none was available so he remained off work. Again, TTD and TPD are not at issue.

On 7/17/13, Petitioner saw Dr. Shafer who noted increased right elbow pain and steadily improving right shoulder pain. HE noted mild paint to palpation over the right olecranon tip and over the medial lateral epicondyles with loss of grip strength and pain with both wrist flexion and extension and finger flexion and extension. He further noted continued complaints of left knee pain to palpation over the medial femoral condyle. Dr. Shafer recommended an MRI of the right elbow to rule out further pathology and sedentary work was continued. The right shoulder pain was noted to be resolving and a continued left knee contusion of the medial femoral condyle was noted. PX 3.

On 7/24/13, Dr. Shafer noted the negative right elbow MRI and noted that he agreed with the report. Petitioner reported 2-3/10 elbow pain at this visit with some increased shoulder pain since the last visit. HE continued to complain of persistent knee pain at 6-7/10. PT was continued for another 4 weeks and sedentary work was continued under a diagnosis of right elbow contusion with triceps pain, right shoulder tendonitis and left knee contusion of the medial femoral condyle. At the visit of 8/21/13, Petitioner reported minimal shoulder complaints, resolving right elbow pain and continued left knee pain. Following exam, Dr. Shafer noted that all conditions were resolving and recommend continued PT for 4 more weeks. He stated that after that time Petitioner would likely be able to return to "all activities."

On 9/11/13 Dr. Shafer reexamined the knee and assessed a severe contusion of the medial femoral condyle. Dr. Shafer recommended that he continue physical therapy for 4 more weeks followed by likely

MMI. Dr. Shafer further commented that he discussed Petitioner's light duty work and advised Petitioner that he could perform such duties without further injury and that such duties would be helpful in continuing strength build up in his knee. Petitioner was to return in 4 weeks.

The record does not contain a record of visit to Dr. Shafer in October 2013. However, the physical therapy records from 10/9/13 indicate that physical therapy was discontinued on that date in that "patient was seen by Dr. Shafer today for a scheduled follow-up visit. Writer received a phone call from Dr. Shafer's office today informing me that patient was discharged from PT treatment at this time per MD orders." At trial, Petitioner testified that he advised Dr. Shafer on 10/9/13 that his left knee pain was worsening and that Dr. Shafer ordered another left knee MRI. No record of that MRI was submitted at trial. Petitioner further testified that he saw Dr. Shafer on 10/16/13 and that after reviewing the MRI Dr. Shafer advised Petitioner to continue physical therapy and to try cortisone injections. The record does not contain corroborating medical records from a 10/16/13 date of treatment. Petitioner further testified that Dr. Shafer discontinued his care on 10/16/13 advising Petitioner that he was at MMI for the left knee.

Reference to the October 2013 visits to Dr. Shafer as well as the October 2013 left knee MRI are made in the report of Dr. Lewis retained by Respondent to perform an AMA exam on 11/19/13. In his review of Petitioner's treatment records, Dr. Lewis notes that he reviewed an office progress note from Dr. Shafer dated 10/9/13 wherein Dr. Shafer placed Petitioner at MMI for his right upper extremity issues while noting continued left knee complaints and ordering another left knee MRI. That MRI was done on 10/11/13 and interpreted by Dr. Lewis as showing moderate chondromalacia patella and resolution of the contusion. Dr. Lewis reviewed an office note from Dr. Shafer dated 10/16/13 quoting Dr. Shafer as stating "I have reviewed his therapy notes and there do not appear to be any significant functional deficits. The significant bone bruise has resolved. At this time he appears at maximum medical improvement from his contusion." RX 1.

Following his exam of the Petitioner on 11/19/13, Dr. Lewis noted that he reviewed the 6/3/13 MRI of the left knee. Dr. Lewis noted "a prominent bone contusion within the medial femoral condyle and underlying trabecular-type or nondisplaced vertically oriented subchondral fracture along the medial margin of the medial femoral condyle is not excluded." He stated "I therefore give Mr. George the benefit of the doubt that he did have a fracture of the medial femoral condyle. However, based on my examination, there were no objective abnormal findings, which included a normal range of motion, no muscle atrophy, full knee stability and no limb length discrepancy. Mr. George did report subjective complaints and had a PDQ score of 84 however, as previously mentioned there was no objective evidence of orthopedic pathology at the time of my examination on physical examination." Dr. Lewis then noted the last MRI of 10/11/13 which showed a resolution of the left knee contusion.

Based on the AMA guides 6th edition, Dr. Lewis assigned a 0% impairment rating to the left knee and applied no grade modifiers based on the 0 rating. With regard to the right elbow, Dr. Lewis applied a 1% impairment rating which when modified resulted in an overall rating of 0% impairment. Finally, with regard to the right shoulder, Dr. Lewis again assigned a 1% impairment which when modified was reduced to 0% impairment. RX 1 . Dr. Lewis testified to these ratings in his deposition on 7/28/14. RX 1.

In the interim, Respondent submitted the physical therapy visits between the dates of 9/24/13 and 10/22/13 to utilization review. The UR resulted in a non-certification for those 12 physical therapy

sessions as not medically necessary based on the ODG guidelines which supported only 12 PT sessions over an 8 week period. Prior to 9/24/13, Petitioner had attended 42 PT sessions. RX 2.

Subsequent to his release at MMI by Dr. Shafer in October 2013 and subsequent to his exam by Dr. Lewis in November 2013 Petitioner continued working both for Respondent and then a subsequent employer after Respondent lost an account. Petitioner testified that he continues to work as a security officer with substantially the same job duties and for substantially the same pay.

In March 2014, 5 months after his release, Petitioner returned to Dr. Shafer complaining of left knee pain and numbness. PX 4. Petitioner reported that he started a new job with frequent standing that results in increased knee pain at the end of the day. Exam of the knee showed no evidence of swelling or deformity and full range of motion without crepitus. McMurray's tests were negative as was the anterior and posterior drawer and varus and valgus stress testing. Petitioner complained of pain to palpation over the medial femoral condyle. Dr. Shafer assessed continued pain in the left knee over the medial femoral condyle secondary to subchondral fracture of the medial femoral condyle. In concluding that Petitioner's fracture extended to his joint surface Dr. Shafer noted that by definition of injury Petitioner had injured his cartilage. The cartilage injury can cause post traumatic arthritis and will result in permanent pain as well as the need for potential future care secondary to progression and post traumatic arthritis from the intraarticular fracture. He included that such procedures could include injections and possible surgery. Petitioner refused injections at that visit and was told to return if needed. Dr. Shafer again noted that Petitioner's right elbow and shoulder conditions had resolved, no additional care was needed and that no permanency was assessed for those conditions. He was released at full duty. PX 4.

Petitioner returned for one final visit to Dr. Shafer on 8/27/14. PX 11. Once again, Dr. Shafer noted that Petitioner would likely have permanent pain from the injury. However, he stated that "there is nothing more that can be done medically for him" and that "most of his pain would improve with weight loss." Finally, he noted that cortisone injections may be beneficial from time to time. PX 11. Prospective medical treatment under Section 8 of the Act was not requested at trial. Petitioner requested a finding on the nature and extent of his injuries.

At trial, Petitioner testified that he weighed 390 pounds. He lost 4 pounds since the accident. Currently, he testified that he has right elbow and shoulder pain when he lifts his right elbow and shoulder, pain and numbness in his right arm when stretching and "excruciating left leg/knee pain on a daily basis. Petitioner testified to increased pain after standing, walking and working for extended time periods and some pain while seated. His job duties require walking anywhere from 1 to 6 hours on his shift. He testified that his knee pain has been constant since the accident. Petitioner takes over the counter pain medication. He is not under any current work restrictions and is working full duty.

CONCLUSIONS OF LAW

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

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

Based on the physical therapy records, Petitioner was authorized by his treating physician Dr. Shafer to attend physical therapy through 10/9/13. Respondent's utilization review non-certified any physical therapy visits between 9/23/13 and 10/22/13. The Arbitrator places greater weight on the treating physician's referral of Petitioner to physical therapy in the course of his conservative treatment through 10/9/13 when Dr. Shafer discontinued the physical therapy. Accordingly, the Arbitrator finds that physical therapy expenses through 10/9/13 are reasonable and necessary expenses. As such, the Arbitrator finds that Respondent shall pay the physical therapy expenses through 10/9/13 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

The Arbitrator further notes that Respondent has agreed to pay the outstanding bills from the Bensenville Fire Department and from Michigan Avenue Medical Associates found at PX 8 and PX 9. ARB EX 1. Accordingly, the Arbitrator finds that Respondent shall pay those medical expenses pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

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

The Arbitrator initially notes that Petitioner requested a specific loss under Section 8(e) of the Act at trial. No request for a finding or award under Section 8(d)(1) of the Act was made and no evidence supporting such a finding was admitted at trial. The Arbitrator further notes the date of accident as 5/25/13 making this a post-amendatory matter under the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 0% of Petitioner's right upper extremity, 0% of his left leg and 0% of the whole person as determined by Dr. Lewis, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. RX 1. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted that Petitioner did not exhibit any objective evidence of orthopedic pathology at the time of his exam. The Arbitrator assigns some weight to this factor.

With regard to subsections (ii), (iii) and (iv) of §8.1b(b), the occupation, age and future earning capacity of the employee, the Arbitrator notes that the record reveals that the 29 year old Petitioner was employed as a security officer at the time of the accident and that he returned to full duty unrestricted work in that capacity. Petitioner testified that he currently makes substantially the same income as he made at the time of the accident. Accordingly, the Arbitrator places little weight on these factors.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the opinions of Dr. Shafer. Specifically, the Shafer placed Petitioner at MMI for all conditions in October 2013. He noted at that time that Petitioner's right upper extremity and left knee contusion had resolved. This opinion was reiterated at the 2 subsequent visits with Petitioner in March and August 2014 when Dr. Shafer noted that Petitioner would likely have permanent pain from the subchondral fracture of the medial femoral condyle and its attendant effects. However, he stated that "there is nothing more that can be done medically for him" and that "most of his pain would improve with weight loss." The Arbitrator places somewhat greater weight on Petitioner's testimony regarding his daily limitations as buttressed by the opinion of Dr. Shafer than on the ratings proffered by Dr. Lewis.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the left leg and 5% of the right arm pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Israel Vega,
Petitioner,
vs.

NO: 12WC 16887

15IWCC0382

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

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $73,000.00. 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: MAY 22 2015
o051915
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VEGA, ISRAEL
Employee/Petitioner

Case# **12WC016887**

UPS
Employer/Respondent

15IWCC0382

On 8/20/2014, 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:

0598 LUSAK & COBB
JOHN E LUSAK
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
JASON H PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

15IWCC0382

☐ 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

Israel Vega
Employee/Petitioner

v.

UPS
Employer/Respondent

Case # **12** WC **16887**

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 **May 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

On **October 25, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$62,568.41**; the average weekly wage was **$1,276.91**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$56,913.48** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $$56,913.48.

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

ORDER

Temporary Total Disability

- Respondent shall pay Petitioner temporary total disability benefits of $851.27/week for 70 & 6/7 weeks, commencing October 31, 2011 through March 11, 2013, as provided in Section 8(b) of the Act.

- Respondent shall be given a credit for TTD benefits previously paid to the Petitioner in the amount of $56,913.48.

Permanent Partial Disability: Schedule injury

- Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 100 weeks, because the injuries sustained caused a 20% loss of use to the Petitioner's 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 — 8/20/14 Date

AUG 20 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Israel Vega, **Petitioner,**	)	
vs.	)	**No. 12 WC 16887**
UPS, **Respondent.**	)	15IWCC0782

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The disputed issues are the TTD benefits owed to the Petitioner; and the nature and extent of the injury. (AX 1).

On October 25, 2011, Petitioner, an automotive mechanic employed by Respondent for the last ten years, was situated on a movable skid, under a UPS truck, fixing a brake line. While under the truck he pulled on a wrench and felt a sharp pain in his low back. Petitioner reported the incident to his supervisor who told him to go to the Clearing Clinic for medical attention. Clearing Clinic diagnosed Petitioner with a lumbar strain, instructed Petitioner to take ibuprofen for pain and released him to his regular job duties. No X-ray administered during his initial visit. Petitioner returned to Clearing Clinic on October 27, 2011, and was returned to his regular job duties with UPS, again no X-rays were administered. (RX 1.).

On October 31, 2011, the Petitioner consulted with his family doctor, Dr. Pedro Lopez at the Mercy Medical Center, as Petitioner was still having issues with his back, buttocks and left leg. Dr. Lopez authorized Petitioner off work, provided him with medication and prescribed an MRI. (PX 1.).

On November 30, 2011, Petitioner was evaluated by Dr. Gary Shapiro for a Section 12 exam. Dr. Shapiro diagnosed Petitioner with left lower extremity radiculopathy with foot drop, ordered an MRI and authorized Petitioner off work.

On December 12, 2011, Petitioner underwent an MRI and thereafter came under the orthopedic care of Dr. David Shapiro.

On December 22, 2011, Dr. David Shapiro diagnosed Petitioner with a moderate-sized left-sided disc herniation at L4-5. (PX 2.).

In March of 2012, Petitioner underwent an epidural steroid injection but continued to have symptoms.

On June 26, 2012, Dr. Gary Shapiro authored a report pursuant to his Section 12 exam of Petitioner. Dr. Shapiro found that the Petitioner had mild degenerative disc disease at L4-L5 and L5-S1 with loss of disc hydration. He also found there were small left-sided disc bulges at L4-L5 and L5-S1. It was the doctor's impression that Petitioner had mild degenerative disc disease at L4-L5 and L5-S1 with small left-sided disc bulges at L4-L5 and L5-S1.

On July 24, 2012, Dr. David Shapiro reviewed the old MRI and interpreted it as showing a small disc herniation at L4-5. He kept Petitioner off of work and ordered a new MRI which was completed on August 8, 2012.

On August 8, 2012, an MRI revealed an L4-5 disc herniation which caused mass effect on the transiting left L4 nerve and trace foraminal stenosis. There was also an impression of an L5-S1 disc herniation which likely abuts the transiting left L5 nerve and mild left foraminal stenosis.

On August 10, 2012, Dr. David Shapiro interpreted the new MRI as showing that the L4-5 disc herniation appeared larger, and surgery was recommended.

On September 6, 2012, Dr. David Shapiro performed a laminotomy and microdiscectomy at L4-5 on the left. The pre and post-operative diagnoses were left-sided disc herniation at L4-5. Postoperatively, Petitioner underwent a course of therapy and last saw Dr. David Shapiro on March 7, 2013. At that time, it was noted that Petitioner had completed work hardening. He walked with a normal gait, there was no restriction noted in his range of motion, straight leg raising was negative bilaterally, and neurologic testing was normal. Petitioner was discharged from care and authorized to return to regular duty without restrictions. (PX 2).

On March 12, 2013, Petitioner was released to return to his regular work duties with UPS by Dr. Shapiro. Petitioner continues as an employee of UPS performing his regular job duties.

On May 14, 2013, Dr. Frank Phillips performed a record review and an AMA impairment rating regarding the Petitioner. Dr. Phillips never physically examined the Petitioner. Dr. Phillips found that the Petitioner had reached MMI. He also found that the medical

records substantiated that the Petitioner had a herniated disc. It should be noted that Dr. Phillips used the singular word "disc" and not the plural "discs." Dr. Phillips concluded that the Petitioner had an impairment rating of 5% of a whole person.

CONCLUSIONS OF LAW

K. Is the Petitioner entitled to additional temporary total disability benefits as a result of his work related accident and injuries?

Based upon the medical records contained in Petitioner's Exhibit No. 2, the Arbitrator finds that the Petitioner had multiple injuries to his lumbar spine. An MRI exam performed on August 8, 2012, found that the Petitioner had an L4-5 disc herniation which caused mass effect on the transiting left L4 nerve and trace foraminal stenosis. There was also an impression of an L5-S1 disc herniation which was likely abutting the transiting left L5 nerve and mild left foraminal stenosis.

The Arbitrator finds that the Petitioner is entitled to temporary total disability benefits commencing October 31, 2011 through March 11, 2013. The Arbitrator acknowledges that Clearing Clinic did return the Petitioner to his regular employment with the Respondent on two separate occasions. The Arbitrator also notes that the records of Clearing Clinic do not indicate that any X-rays was taken of the Petitioner involving his low back. The Petitioner saw his own doctor, Dr. Lopez, on October 31, 2011 and as part of the Mercy Medical Center records, there is a slip which was given to the Petitioner by Dr. Lopez taking him off work as of October 31, 2011. The parties agreed that the Petitioner was entitled to temporary total disability benefits from November 30, 2011 through March 11, 2013. The only period of time in dispute is TTD claimed by the Petitioner from October 28, 2011, through November 29, 2011.

The Arbitrator finds that the Petitioner is entitled to receive additional temporary total disability benefits from October 31, 2011, the date that the Petitioner saw Dr. Lopez at Mercy Medical Center and was taken off work, through November 29, 2011. The Arbitrator finds that the Petitioner is entitled to 70 & 6/7 weeks of temporary total disability benefits. The Respondent is given a credit for TTD paid to the Petitioner in the amount of $56,913.48.

L. What is the nature and extent of Petitioner's injury?

Pursuant to Section 8.1d 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:

Dr. Phillip's AMA report was admitted into evidence. The Arbitrator notes that on Page 9 of Dr. Phillip's report, Dr. Phillips acknowledged that the MRI on August 8, 2012 established that the Petitioner had a herniated disc at L4-L5 and at L5-S1. Notwithstanding Dr. Phillips' statement regarding two herniated discs, in his impairment rating he states that his rating is based upon his medical opinion that the Petitioner had not two herniated disc, but one herniated disc. This is based upon Dr. Phillips' statement as follows: "Impairment rating would therefore be documented herniated disc with objective findings that has undergone surgery ...". It is apparent that in formulating his impairment rating, Dr. Phillips considered the Petitioner to have only one herniated disc, not two herniated discs. There is no question that the Petitioner had surgery on one herniated disc, that disc being L4-L5; however, it is equally apparent that the Petitioner actually had two herniated discs, the second one being L5-S1. For reasons known only to the surgeon, surgery was only performed at L4-L5 level. There was no surgery to the L5-S1 disc.

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

The Arbitrator notes that the Petitioner continues to be employed as an automotive mechanic for UPS and continues to perform his regular job duties. The Petitioner testified, without rebuttal, that after he works an entire shift, he has numbness and tingling in the upper portion of his left leg. He stated that the pain starts in his low

back, goes into his buttock and he has a numbness and tingling sensation in the upper portion of his left leg.

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

At the time of injury the Petitioner was 38 years of age and is considered to be a younger individual.

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

A review of the medical records indicates that the Petitioner has had constant complaints of numbness and tingling in his left leg both prior to surgery and after the surgery. As an example, the Arbitrator would cite the notes of ATI, the physical therapy facility which treated the Petitioner. As of January 23, 2013, those records indicate that the Petitioner continued to complain of pain in his left leg during his functional capacity examination. In fact, the FCE was stopped because of the Petitioner's complaints of pain.

The records of Dr. David Shapiro also indicate that on January 17, 2013, the Petitioner visited with Dr. Shapiro and it was noted that the Petitioner complained of having low back pain and also numbness in his left thigh. On that day the Petitioner indicated the numbness had improved but the low back pain was constant. The notes of Dr. Shapiro also indicate that on December 20, 2012, the Petitioner was again complaining of left leg weakness with numbness into both legs.

Lastly, on October 25, 2012, the Arbitrator notes that Dr. Shapiro noted that the Petitioner again complained of numbness in his left leg. It is obvious to the Arbitrator that the Petitioner evidenced complaints of left leg pain both prior to surgery and after surgery and in fact complains of left leg pain and numbness up to the present date as indicated by his testimony at the time of hearing. His complaints of left leg numbness and pain are consistent with the MRI findings of herniated discs at L4-L5 and L5-S1.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1(b) of the Act, and considering the relevance and weight of all these factors, including Dr. Phillips' AMA impairment rating, the Arbitrator concludes that the Petitioner has sustained a 20% loss of use of his person as a whole. This finding is based upon the fact that the Petitioner continues to complain up to the present date of numbness and tingling in his left leg. While it is true that the Petitioner is performing his regular job duties with the Respondent, it is also apparent

that he is performing those job duties while in pain and apparently the job duties are in turn causing pain based upon the Petitioner's statement that after working eight hours on the job, he has numbness and tingling in his left leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherri Loeb,
Petitioner,

15IWCC0383

vs.

NO: 12 WC 26016

Northshore University Health System,
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(s) 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 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.

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

DATED: MAY 22 2015

O4/22/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOEB, SHERRI
Employee/Petitioner

Case# **12WC026016**

15IWCC0383

NORTHSHORE UNIVERSITY HEALTH SYSTEM
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:

1544 NILSON STOOKAL GLEASON CAPUTO LTD
MARC B STOOKAL
205 W RANDOLPH ST SUITE 400
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
TIMOTHY O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0383

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

Sherri Loeb
Employee/Petitioner

v.

Northshore University Health System
Employer/Respondent

Case # 12 WC 26016

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 22, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 15IWCC0383

On **May 23, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$78,000.00**; the average weekly wage was **$1,500.00**.

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

ORDER

The Petitioner has failed to prove by a preponderance of the evidence that her injury arose out of and in the course of her employment with the Respondent.

In light of the determination Petitioner failed to establish her fall was causally connected to an injury arising out of and in the course of her employment with Respondent, the remaining issues of Respondent's liability for Section 8 medical benefits and the nature and extent of the injury are moot, and not reached by this Arbitrator.

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 26, 2014
Date

APR 3 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherri Loeb,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 26016**
	)	
North Shore University Health System,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on May 23, 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.

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 the Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Did Petitioner give the Respondent notice of the accident within the time limits stated in the Act; (4) Is the Petitioner entitled to TTD from September 17, 2012, through October 15, 2012; (5) Were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; and (6) the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner was employed with the Respondent since November 1998. Her job title in May of 2012, was that of a research nurse. She testified that her duties included working in the research center and serving as the research coordinator for various studies for different physicians, one of which was an acute stroke study. Prior to her position as a research coordinator, she worked as a registered nurse for a surgical group and before that position as a staff nurse on a medical and surgical floor.

The Petitioner testified that in her position as a research coordinator she would work at the main building at the Evanston Hospital campus. Her normal work hours were from 7:00 a.m. until 3:30 p.m. The Petitioner testified that her duties also required her to be on 24-hour call and to have the ability to leave the premises when she was there in order to immediately go to another hospital in the North Shore University Health System if a patient suffered a stroke.

The Petitioner testified that she drove her car to work each day to the Evanston campus. She testified that she parked in the main parking lot at the main building and that this was the closest parking lot to the main building. This lot was for patients, visitors and employees.

The Petitioner testified on direct examination that the reason she parked at the main lot was because, she needed immediate access to her car in case she was called for a stroke study at another location. The Petitioner testified that she was granted special permission to park in the main lot after discussing the issue with her supervisor and the parking supervisor. The Petitioner testified further that she was provided a vehicle sticker for her car to park in that lot.

The Petitioner testified that she had an assigned parking area in the parking lot that was segregated by signs that said "Employee Parking" and that they were labeled. These spots were on the basement floor and first floor of the parking structure. The Petitioner testified that she would park in the main lot five (5) days per week.

The Petitioner described the parking lot as a very busy parking lot. The Petitioner testified that the lot was at its busiest in terms of traffic at shift changes which occurred at 7:00 a.m., 3:00 p.m. and 11:00 p.m. The Petitioner testified that the lot was busiest at these times because "Everybody wants to get out and in at the right time." She further testified that other co-workers parked in this lot and that this was the most convenient lot for her to park in because of her job duties.

The Petitioner testified that on May 23, 2012, she left her home for work at approximately 6:15 a.m. arriving at the main parking lot a little after 7:00 a.m. She testified that she parked her car on the first floor of the parking lot, got out of the car and began to walk towards the main building. She testified that she was not rushing to get to work at that time.

The Petitioner agreed with counsel that she planned on entering the main building at work via the same route that she regularly used daily from the parking lot. She also confirmed that she had to walk through that parking lot at shift changes every day she worked.

The Petitioner testified that as she was walking from her parking space in the parking lot to the main building, she heard screeching from the right, looked to the right, saw a car, immediately moved over to the left watching the car to the right because she was afraid it was going to hit her, continued walking, and then hit the curb and went flying and landed on her left arm. The Petitioner testified that at this particular location, cars were entering the parking lot through the main entrance gate as well as passing that location in order to drive up to higher floors on the parking structure.

The Petitioner testified that when she fell she noticed and felt, "the worst pain I ever experienced in my life" in her left arm. She stayed on the ground until assistance arrived. The Petitioner testified that a security officer from the employer appeared on the scene shortly after the accident. She further testified that emergency room personnel came to the scene, examined her, obtained a wheel chair and brought her into the emergency room. She testified that she notified her supervisor, Bruce Steinert, of her accident.

The Petitioner was advised to follow up with employee health services the following day and she did so seeing Dr. Jason Koh, M.D., an orthopedic surgeon. The Petitioner testified that the doctor ordered an MRI. The MRI was performed on May 25, 2012, at North Shore

University Hospital revealing an impacted fracture of the left humerus, a labral tear and a deltoid strain. (Pet. Ex. 1) Dr. Koh recommended light duty, an arm sling, pain medications and a follow-up appointment to discuss physical therapy two (2) weeks in the future. (Id.)

The Petitioner saw Dr. Koh again on June 14, 2012 and he reviewed additional x-rays taken of the Petitioner showing fracture fragments in the humerus. The doctor continued her usage of the sling and pain medication. (Pet. Ex. 2)

On June 22, 2012, the Petitioner again saw Dr. Koh who ordered gentle physical therapy to begin in one week. The Petitioner testified that at that time she noticed and felt that her pain was increasing, it was severe pain, and she had very limited range of motion.

On June 28, 2012, Dr. Koh recommended range of motion exercises of the left elbow and shoulder and took an additional set of x-rays. Dr. Koh's records indicated that she was having continued pain in her left shoulder and that her left elbow was also painful. (Pet. Ex. 2)

The Petitioner testified that she started physical therapy at North Shore University Hospital in early July of 2012, consisting of treatment to her left elbow and shoulder.

On August 14, 2012, the Petitioner again saw Dr. Koh advising him that the pain in her left shoulder was increasing. He performed a cortisone injection into her left shoulder which she stated gave her temporary and minimal relief. After the cortisone injection Dr. Koh's records indicated that the pain had increased in her left shoulder and that her range of motion and strength were both decreased. (Pet. Ex. 2)

The Petitioner again saw Dr. Koh on September 5, 2012, at that time he ordered a repeat MRI. She was complaining of significantly increased left shoulder pain. (Id.) The Petitioner testified that Dr. Koh told her she had frozen shoulder syndrome. The Petitioner testified that she noticed and felt, "I still had the severe pain, decreased range of motion, weakness, couldn't lift anything heavy with it, decreased ability to do activities of daily living, like to brush my hair, put my arm behind my back to close my bra, put my shirt on, walk my dogs."

Dr. Koh recommended a surgical procedure for her left shoulder consisting of an arthroscopic subacromial decompression, debridement, capsular release and synovectomy. (Pet. Ex. 2)

The Petitioner testified that she underwent surgery with Dr. Koh on September 17, 2012, at the North Shore University Health System hospital consisting of a left shoulder arthroscopic labral debridement, extensive synovectomy, capsular release and subacromial decompression.

The Petitioner testified that she continued to treat with Dr. Koh and that follow-up x-rays were taken on October 29, 2012 and December 3, 2012. She testified that she continued her physical therapy at North Shore University Hospital as well.

She testified that that she again saw Dr. Koh on December 4, 2012, noting that the pain had decreased since the surgery and that her range of motion was better. Dr. Koh ordered the medications Norco, Celebrex, Flexeril as needed, a continuation of her home exercise program as opposed to formal physical therapy, and scheduled a follow-up appointment.

The Petitioner testified that she saw Dr. Koh for a final visit on April 2, 2013 noting that the pain in her left upper extremity at its worse was 3-4 on a one (1) out of ten (10) scale, aching at times, decreased range of motion, increased pain and weakness in the left upper extremity. The Petitioner testified that she was in physical therapy at North Shore University Health System from July 6, 2012 through December 18, 2012.

The Petitioner testified that she is right handed. The Petitioner was asked to describe what she currently noticed and felt about her left upper extremity and she testified to a residual loss of range of motion, pain, weakness with lifting, and soreness in her left upper extremity. The Petitioner testified that she currently takes over-the-counter medications and uses ice and heat at times for relief. The Petitioner testified that she had no prior or subsequent accidents to her left arm, elbow or shoulder.

The Petitioner identified Petitioner's Exhibit #1, an itemized billing statement from North Shore University Health System and testified that she knew that those bills were not paid through the Respondent's workers' compensation carrier.

On cross examination, the Petitioner testified that patients, employees and family members could park in the parking lot and on the first floor where she had parked. She further testified that she was directed by her supervisors to park in the parking lot. She testified that alternative parking was available at Ryan Field but that was impractical due to the nature of her job and having to leave at a moment's notice because transportation to the Ryan Field parking facility would require her to take a shuttle from the main building to that parking facility in order to get her car to attend to a stroke victim and the shuttle was not always available immediately.

The Petitioner testified that at the time of her accident she was walking to the main entrance of the hospital. She testified that it was daytime, there was no hole in the ground and that there was no ice or rain at the time she was walking and fell. She testified that she was wearing flat shoes. She further testified that she had parked in that lot before May 23, 2012. Petitioner confirmed there was no employee-only entrance she could have entered the hospital through. She indicated the route she used could have been used by any member of the public who parked on the first floor as she had.

When asked if she had heard the screeching sound that she described in her direct testimony before the day of her accident the Petitioner indicated that there is always screeching in that parking lot, it is a wild parking lot.

The Respondent offered Respondent's Exhibit 1, a video of the first floor parking lot that captured the Petitioner's accident for viewing on a laptop computer. The Arbitrator, the Petitioner and both Counsel watched the video.

Petitioner's counsel noted that the video was captioned EH PUB SFT 03, dated May 23, 2012, and had a time caption of 7:11 a.m.

The Respondent began to play the video and the Petitioner identified herself in the video. The video was played showing the fall several times. The Arbitrator had an on the record discussion with the parties and it was agreed not to play the entire video in Court. The Arbitrator stated that she would watch the entire video in her deliberations.

The Arbitrator notes there is no sound in the video. Petitioner appears to be carrying a cup of coffee in her hand and at some point looks to the right as a car passes by her. The Arbitrator notes the curb does not appear to be cracked or damaged in the video and to the plain eye a yellow stripe can be seen in the video painted on the curb. Upon reaching the curb, Petitioner trips over the curb and falls onto her left shoulder. She does not get up and is aided by several people until a wheelchair is brought to bring her into the hospital.

The Respondent showed Petitioner Respondent's Exhibit 3 and asked her if the curb in the picture fairly and accurately represented the curb that she tripped over and the Petitioner was unable to say whether it was or was not because the same curbs were on all the floors in the parking lot and it could have been anyone of those curbs. The curb is painted a bright yellow and does not appear to be damaged. Petitioner confirmed the curb she tripped over was painted yellow and she could not recall any cracks. No cracks were visible in the video either.

When questioned about whether she had to jump out of the way of the car to prevent herself from being struck by the vehicle, she stated that it was a natural reaction to having heard the screech.

CONCLUSIONS OF LAW

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

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.

While the broad language of these cases might appear to imply that any accidental injury sustained on the employer's premises is compensable, that is not the law in this State. *Caterpillar Tractor Co. v. Indus. Comm'n,* 129 Ill. 2d 52, 541 N.E.2d 665, 669 (1989).

Curbs, and the risks inherent in traversing them, confront all members of the public. *Caterpillar Tractor Co. v. Indus. Comm'n,* 129 Ill. 2d 52, 541 N.E.2d 665, 669 (1989).

The phrase "in the course of" refers to the time, place, and circumstances under which the accident occurred. Orsini v. Industrial Comm'n, 117 Ill. 2d 38, 44, 509 N.E.2d 1005, 1008 (1987).

"That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment." Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 671 (2003).

For treatment of an employee's workplace injury to be compensable under workers' compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v Industrial Commission,* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

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)

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

In *Caterpillar Tractor Co. v. Indus. Comm'n,* the Supreme Court of Illinois ruled a worker was not subjected to risk greater than that of the general public when he twisted his ankle when stepping off curb while walking from the plant to the parking lot. 129 Ill. 2d 52, 541 N.E.2d 665 (1989). An injury is not compensable unless it is causally connected to the employment. *Id. at 669.* Where liability has been imposed, the injury occurred either as a direct result of a hazardous condition on the employer's premises or arose from some risk connected with, or incidental to, the employment. *Id.* The Court in *Caterpillar* ruled the Petitioner did not establish he was exposed to a risk not common to the general public and it stated curbs, and the risks inherent in traversing them, confront all members of the public. *Id.*

Likewise, in this case, the inherent risk in walking through the parking lot Petitioner fell in is a risk the public in general faces and there was no risk connected with, or incidental to, the Petitioner's employment. In fact, Petitioner testified the entrance she was using to enter the hospital was the only entrance available to both employees and public visitors. Petitioner agreed that the curb was painted yellow, had no cracks or defects, was the same curb that is on every floor of the parking garage, the general public could park on the first floor and walked through

the same area she was walking in. She also testified that the garage was always wild, she usually heard similar screeching when in the parking garage and there was no ice, snow or rain on the floor of the garage where she was walking and fell.

In *Caterpillar*, the Supreme Court recognized that in prior cases the court had held that injuries sustained on the employer's premises by an employee going to or from his actual employment by a customary or permitted way, within a reasonable time before or after work, were incurred in the course of and arose out of the employment. [Citing Peel v. Industrial Comm'n , Deal vs Industrial Comm'n etc.] They went on to state that "while the broad language of these cases might appear to imply that any accidental injury sustained on the employer's premises is compensable, that is not the law in this State." *Id at 669*. The Court went on to state that "An examination of the cases indicates this court's continued adherence to the maxim that an injury is not compensable unless it is causally connected to the employment." *Id at 669*.

Like the Petitioner in *Caterpillar*, the Petitioner's claim in this case, that she was exposed to a risk greater than the risk the public is exposed to is not supported by the evidence. The mere fact that the Petitioner's duties take her to the place of injury, and that but for her employment she would not have been there is not of itself sufficient to give rise to the right to compensation. There is no evidence that the curb presented more risk to the Petitioner than to any other member of the general public who would be traversing the same curb.

The Petitioner has failed to prove by a preponderance of the evidence that her injury arose out of and in the course of her employment with the Respondent. The injury is not compensable.

Is Petitioner's current condition of ill-being causally related to the injury? Did Petitioner give the Respondent notice of the accident within the time limits stated in the Act? What amount is due for temporary total disability? 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? What is the nature and extent of the injury?

In light of the determination Petitioner failed to establish her fall was causally connected to an injury arising out of and in the course of her employment with Respondent, the remaining issues of notice, Respondent's liability for Section 8 medical benefits, TTD and the nature and extent of the injury are moot, and not reached by this Arbitrator. Accordingly, benefits are denied.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson — March 26, 2014

Signature of Arbitrator — Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hamida Naficy,
Petitioner,

15IWCC0384

vs.

NO: 09 WC 22616

Madden Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, penalties, fees, 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 September 2, 2014, is hereby affirmed and adopted.

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

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

DATED: MAY 22 2015
O4/22/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

NAFICY, HAMIDA
Employee/Petitioner

Case# **09WC022616**

09WC022615

MADDEN MENTAL HEALTH CARE
Employer/Respondent

15IWCC0884

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2739 SMOLER LAW OFFICE PC
ROBERT J SMOLER
415 N LASALLE ST SUITE 402
CHICAGO, IL 60654

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

5031 ASSISTANT ATTORNEY GENERAL
JILL OTTE
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

SEP 2 - 2014

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

15IWCC0384

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)

Hamida Naficy
Employee/Petitioner

v.

Madden Mental Health Center
Employer/Respondent

Case # **09 WC 22616**

Consolidated cases: **09 WC 22615**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of Chicago, on **January 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 an accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to an injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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

15IWCC0384

On the date of **July 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 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 July 23, 2008 work incident.

In the year preceding the injury, Petitioner earned $**68,304.00**; the average weekly wage was $**1,313.53**.

On April 24, 2009, Petitioner was **56** years of age, ***single*** with **0** dependent children.

ORDER

Based on his findings of fact and conclusions of law with regard to the issues of accident and causation, the Arbitrator hereby denies compensation. All other issues are moot.

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

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

Signature of Arbitrator

August 27, 2014
Date

ICArbDec19(b)

SEP 2 - 2014

15IWCC0384

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

HAMIDA NAFICY, Employee/Petitioner,	)	
v.	)	09 WC 22616 09 WC 22615
MADDEN MENTAL HEALTH CENTER,	)	Chicago
Employer/Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

This action was pursued by the Petitioner under the Workers' Compensation Act (hereinafter "WCA") seeking relief from her employer, the Madden Mental Health Center (hereinafter "Madden"). On January 10, 2014, a hearing on Petitioner's Motion For an Immediate Hearing Under Section 19(b) of the Act was held before Arbitrator Brian Cronin at the Illinois Workers' Compensation Commission in Chicago, Illinois. Petitioner Hamida Naficy was represented by counsel. Madden was represented by the Illinois Attorney General's Office. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

Petitioner is a Lead Social Worker III for Madden. On July 23, 2008, when she went into Pavilion 6 she was accused by Charge Nurse Sandy Tonos of wasting nursing staff the night before for a patient transfer. Petitioner claimed that Ms. Tonos, a tall, large, well-built woman, was angry, upset and verbally abusive to her. Ms. Tonos was standing up and shaking her hand at Petitioner. No other co-workers were present at the time. According to Petitioner's testimony, when she went to leave, Tonos grabbed Petitioner's left shoulder saying she wanted to talk to

her. After Petitioner walked out the door, Petitioner was shaking and sweating. She filed an incident report. In the Details of the Incident report, Petitioner characterized "very provocative and intimidating." (Px.2) Petitioner took the rest of the day off work, as well as the next couple of days. Petitioner testified that at that time, she suffered anxiety, bad dreams, an inability to sleep, fearfulness and shakiness.

Six days after the incident, Petitioner went to see her internist, Dr. Firooz Emami. She complained to this doctor that she can't concentrate, is very anxious, has insomnia and has lost 5 pounds. Dr. Emami prescribed Paxil and Ambien. Dr. Emami diagnosed Petitioner with post-traumatic stress syndrome and insomnia. On August 4, 2008, Dr. Emami authorized Petitioner to return to work in a less stressful environment.

Petitioner testified that she took Paxil and Ambien until her symptoms went away, which she estimated to be two months post-incident.

Petitioner testified that in October 2008, Dr. Emami released Petitioner to return to work at her regular duties. Petitioner returned to work at Pavilion 5.

On April 24, 2009, a male patient (hereinafter "the Patient") who wished to be discharged met with Petitioner. The Patient weighed over 200 pounds, was tall with a large build and had a long history of violent behavior. At that time, Petitioner stood 5'3" and weighed 125 pounds. Petitioner first met with the Patient one week earlier, and saw him each day thereafter, as needed. Petitioner would meet with the Patient in her office, the day room or the staffing room. As Petitioner recalled, the Patient was involuntarily committed to Madden. On the morning of April 24, 2009, Petitioner attended the morning meeting with two psychiatrists, other social workers and nurses. The team discussed the status of the Patient. Petitioner testified that she wanted the Patient to meet with the whole team in the staffing room. However, Dr. Chin ordered Petitioner

to meet with the Patient that day in her office. The purpose of such meeting was for Petitioner to convince the Patient to sign a document whereby he would be withdrawing his request to be discharged.

Petitioner met with the Patient that day in her office. Petitioner characterized her office as "small." Such office contained her desk, her desk chair, two cabinets and two guest chairs. She testified that two people can comfortably fit in her office. There are three chairs. Petitioner testified that she had some boxes behind her door. Petitioner claimed that if someone sits in the guest chair closer to the door, that person would block access to the door.

On April 24, 2009, when the Patient approached Petitioner, he was anxious and demanding. He wanted to be discharged. The Patient was not restrained. The two of them walked together to her office. Petitioner went into her office first, the Patient then entered and closed the door. They sat in the two guest chairs with the Patient sitting closer to the door. Petitioner calmly explained the criteria for discharge and the individual "got enraged" and hovered over Petitioner. Petitioner testified that the Patient "tried to hit" her in her head with his fist, but she "lifted up her chart." He grabbed the chart, threw it on a chair and "started ripping" the pages. Petitioner then "ran for [her] life," but she does not recall if she screamed or hollered. The Patient did not block the door. Petitioner testified that she had no means to call for help, no intercom, but that she did have a phone in her office. She also testified that the Patient was "enraged in the eyes" with a "murderous rage." Petitioner further testified that when the patient stood up, she felt intense fear and felt that she could die. The Patient did not assault her.

After the incident with the individual, Petitioner was soaking wet, shaking and crying. She went to the staffing room and told Theresa Glaze what had happened. She then went to report the incident to a nurse named Joslyn in a different building. She filed an incident report.

The nurse brought two fans because Petitioner was so wet. Petitioner sat there with the nurse and under the fans for a couple of hours. Petitioner also spoke with Cheryl McGee, the Assistant Director of Social Work, and Dr. Sharp, the Acting Medical Director. They asked her many questions, but Petitioner testified that she was unable to answer such questions because she was in a state of shock. However, Petitioner was able to complete a report that day.

Petitioner then went home and called Dr. Emami. Dr. Emami's next available appointment was not until Monday, but she was instructed to take Advil. Petitioner testified that because she had Ambien left over from August 2008, she took the Ambien to help her to sleep. Over the weekend, she stayed in bed and did not leave the house. She was anxious, depressed, unable to eat, and unable to concentrate.

When Petitioner saw Dr. Emami, he prescribed Paxil, Ambien and Valium for her. She took these medications through May or June of 2009. He recommended that she stay off work. He also referred her to Dr. Syed Ali, who she had never seen before. Dr. Ali provided medication management. Dr. Ali prescribed Paxil, Xanax and Ambien CR. Dr. Ali recommended she see a therapist for counseling, so she also saw Dr. Yasmeen Khan, a psychologist, to work through her fear issues.

In Dr. Khan's July 30, 2009, Progress Report, this psychologist wrote, *inter alia*, the following:

> "She was dressed and groomed appropriately … Hamida reported symptoms of Post Traumatic Stress Disorder (PTSD) consequent to an incident at work. (please see attached, PTSD symptom check-list.) We conducted a detailed mental health assessment (see attached). It was determined that Hamida has had her second incidence of PTSD at her work place. This is related to her perceived lack of safety in the work place. We discussed treatment options for Hamida. She decided to utilize Cognitive Behavior Therapy Model to help relieve her symptoms."

Dr. Hartman later opined that this mental health assessment does not constitute objective psychological testing, but rather self-reporting.

Petitioner saw both Dr. Ali and Dr. Kahn through the summer of 2009. Petitioner last saw Dr. Kahn on June 21, 2010 and she continues to see Dr. Ali. Petitioner remains on Paxil, but the other medications were discontinued. She testified that over the years, she has been "functioning" with this medication.

Petitioner testified that prior to the incidents of July 23, 2008 and April 24, 2009, she had not treated for any psychiatric or psychological condition, she had not been an in-patient for such problems, and had never been diagnosed with PTSD or anxiety. She also never took prescriptions for any psychiatric or psychological condition.

On July 30, 2009, Petitioner returned to work with light-duty restrictions that included no patient contact. Petitioner only returned to work for a couple days, however, as there was no light-duty work available at Madden. She worked July 31, 2009 through August 3, 2009. Dr. Ali took her off of work again. On August 31, 2009, Dr. Ali released Petitioner to return to full-duty work as of September 1, 2009. On November 2, 2009, Petitioner reported to Dr. David E. Hartman, Respondent's Section 12 examiner, that she is able to complete a full workday without psychological disruption. (Rx.6, Rx.7)

Petitioner testified that after she returned to work at Madden, she performed intake duties and sometimes worked overnight. At times she worked part time because of the closure of Howe Developmental Center. Due to the closure of Tinley Park Developmental Center, she became a Social Worker II. There was a great deal of "shift bumping" between weekends and day shift. She testified that her pay was never reduced and any changes in her schedule were related to the closure of other facilities.

Petitioner testified that she has still not fully recovered. She is still on medication. She testified that she has bad dreams, and feels anxious and fearful. She testified that she is "not the same person [she] was before." Petitioner testified that she suffers from depression. She testified that she has no difficulty sleeping or fatigue. However, Petitioner testified, she notices that her energy level is not the same as it was before the July 23, 2008 and April 24, 2009 incidents. Petitioner has completed her doctoral program, but testified that due to her inability to concentrate, her anxiety and her fearfulness, she had to postpone her completion of the program. Petitioner testified that she has not experienced the type of incidents that she experienced on July 23, 2008 and April 24, 2009 before or since those dates.

Petitioner testified with regard to Dr. Hartman's behavior when she took the written tests. She testified that he answered phone calls during the testing and was upset that she had not completed the tests by 5:30 p.m. Petitioner testified that Dr. Hartman's report contained factual errors.

Psychologist David E. Hartman, Ph.D., performed a Section 12 examination of Petitioner on November 2, 2009, which is memorialized in his report. (Rx.6) Dr. Hartman was deposed on January 25, 2011. Dr. Hartman concluded that Petitioner's symptoms do not objectively fit a pattern of genuine PTSD. (Rx.6, Rx.7) Dr. Hartman noted that while Petitioner claims to have PTSD, her claim must be viewed in her context, that of a clinical social worker in a psychiatric hospital, who would be quite familiar with the DSM-IV criteria for PTSD and would have no difficulty reciting these general criteria to treaters. (Rx.6) Moreover, Dr. Hartman points out the following:

> "PTSD is an easy disorder to fake. The diagnosis is based almost entirely upon the individual's subjective report of symptoms, which are very difficult to verify independently. Furthermore, in an effort to educate the public, the diagnostic criteria have been made widely available in print and on the Internet,

allowing unscrupulous individuals to familiarize themselves with which symptoms to falsely report." Dr. Hartman cited Resnick, P. J., West, S., and Payne, J. W. (2008). Malingering of posttraumatic disorders. In R. Rogers (Ed.) *Clinical Assessment of Malingering and Deception.* New York: The Guilford Press, p. 112-113. (Rx.6)

Petitioner's self-reported symptoms cannot be seen as accurate since "even individuals naïve to the criteria of PTSD could qualify for the diagnosis of PTSD on a checklist when asked to do so 86-94% of the time." (Rx.6, Rx.7) Dr. Hartman also opined that "in order to differentiate genuine from malingered or 'pseudo' PTSD, attention must be paid to more subtle distinctions aspects of the disorder that are published in peer reviewed diagnostic research, but which cannot be easily inferred from the DSM-IV." (Rx.6, Rx.7) Petitioner was found to have an exaggerated version of the diagnosis in almost every criterion. (Rx.6, Rx.7) Further, "her description of severe psychological impairment while maintaining good family relationships and pleasurable hobbies is contradictory and uncharacteristic of genuine PTSD, where withdrawal from family and favored activities is more typical." (Rx.6, Rx.7)

Dr. Hartman also made several notations regarding Petitioner's behavior during the testing. He observed no attentional difficulties while working on test materials or being interviewed, but he noted that Petitioner worked very slowly in completing the questionnaires. She complained frequently about having to spend her day in the examination. (Rx.6, Rx.7) However, when Dr. Hartman offered her the option of a shorter day and returning on a subsequent day to complete the evaluation, she declined. (Rx.6, Rx.7) Dr. Hartman also noted that initially Petitioner did not answer several questions for various reasons, including finding the questions irrelevant, stupid, or too personal. (Rx.6, Rx.7) Dr. Hartman testified that he tried to gently encourage Petitioner to do the best that she could with answering the questions. Petitioner's time to complete several of the questionnaires was about twice as long as it would be

for a typical educated adult. (Rx.6, Rx.7) Finally, she took long breaks during the evaluation session, and as a result, used approximately five hours to complete tests and procedures that are typically performed in about two hours. (Rx.6, Rx.7) There is no evidence that Petitioner did not understand the test questions.

Additionally, Dr. Hartman opined that Petitioner's claims are further compromised by her invalid and exaggerated results on tests sensitive to emotional and psychosomatic malingering. (Rx.6, Rx.7) He found that her self-report was in the malingered range for emotional symptoms and low intelligence on the SIMS test. (Rx.6, Rx.7) He further found that her personality profile on the MMPI-2 showed malingered depression and malingered psychosomatic and post-traumatic symptoms resembling exaggerating litigants seeking secondary gains. (Rx.6, Rx.7)

Dr. Hartman opined that psychological test patterns indicate that Ms. Naficy's complaints and claims cannot be taken as fact, and that treaters who rely upon her self-report could be misled into overpathologizing and overdiagnosing her symptoms. (Rx.6, Rx.7)

Ultimately, Dr. Hartman opined that Petitioner's symptoms fit the pattern for Narcissistic Personality Disorder, as defined by DSM-IV as a combination of grandiosity, competition with and hostility toward authority and fragile self-esteem. (Rx.6, Rx.7) This diagnosis is not the result of a particular event, but rather personality symptoms that are part of her psychological makeup. (Rx.6, Rx.7) Dr. Hartman emphasized that Petitioner remains in the same workplace and is sufficiently skilled in crisis management that she teaches patients "crisis intervention skill [and] how to tolerate the stress of the moment and to deal with their emotional mind." (Rx.6, Rx.7) He opined that common sense indicates that this factor alone precludes disabling anxiety or PTSD. "Ms. Naficy teaches the very stress management skills required for coping with a stressful work environment." (Rx.6, Rx.7)

Dr. Hartman concluded his report by opining that Petitioner's current symptoms are a combination of malingered exaggeration and a personality disorder that "causes her to assert injury by authority and the superiority of her judgment over those in authority." (Rx.6, Rx.7) He goes on to state that to the extent that Petitioner has actual symptoms, these are the by-products of a personality disorder, not PTSD, and reflect narcissistic personality disturbance, not trauma. (Rx.6, Rx.7) Dr. Hartman opined that Petitioner's personality disorder was not caused or worsened by the workplace incidents as claimed. (Rx.6, Rx.7)

On cross-examination, Dr. Hartman testified that as of December 13, 2009, Respondent has paid him $7,307.50 for his services. Dr. Hartman also testified that there was a post-it note affixed to the chart that Respondent provided to him. Dr. Hartman testified that he did not know who authored the post-it note and did not know if the statement on such post-it note was true, but that he included such statement in his report. The post-it note indicated that the nurse was disciplined and suspended for a period of time. Petitioner's Counsel asked Dr. Hartman about possible factual errors in his report. Dr. Hartman testified that he vouches for the accuracy of everything he writes, to best of his ability. Dr. Hartman testified that the teacher with whom Petitioner had a problem back in 2005 or 2006 is in a position of perceived authority relative to the students. With regard to Petitioner, Dr. Hartman testified that what we are dealing with here is "someone essentially with a very thin skin who has hot-button issues related to feeling humiliated or not listened to and becomes very angry if these situations occur and will likely have episodes like this in the future."

Dr. Hartman further testified on cross-examination that Dr. Ali and Dr. Khan did not do a diagnostic evaluation of Petitioner, but talked to her and treated her. He further testified that Dr. Ali and Dr. Khan are not in the position of diagnosing a malingerer because research indicates

that self-report in the course of treatment is an extremely unreliable and inaccurate index of whether someone actually has a condition. Clinicians who rely on self-report alone without objective measures, Dr. Hartman continued, can be easily misled and they would have no way of knowing.

Toward the cross-examination, the following exchange took place:

Q: Your testimony is that it is of no significance whether or not she was trapped in her office with an inpatient (sic) crazed, violent gentleman who was much larger than her and who blew up when he found out that he was going to be not released and that they contacted his sister, which he didn't want them to do. So that - - so whether or not that happened or not makes no difference to your conclusions, opinions or diagnoses?

A: Well, you have to understand or at least I understand that Ms. Naficy is a psychiatric social worker in an inpatient unit full of patients like this. This is the stuff of which she deals with every day. It's not a uniquely shocking experience.

Now, whether she would have been unnerved by a person in that situation, I can certainly see that. Whether that would really constitute enough to provide a chronic diagnosis of post traumatic stress disorder, I don't think so, especially in light of her previous history and especially in light of her objective test results.

Q: You report yourself on Page No. 3 of your report, the second to the last quoted paragraph at the end, "In my whole 13 years there, I was never afraid of a client."

And now, your testimony is that this happened on a regular basis to her. And she was reporting to you this is a very unique experience.

A: Well, clearly, her reactions to various events in her work history show that not to be the case. In 2008 when a nurse yells at her, she says that it caused her stress and turmoil. She has a

previous diagnosis of PTSD. She has a claim against a class instructor that a teacher twisted her wrist and caused her pain.

She has other - - and the kinds of things that she gets stressed out about are typically those which involve an authority figure who she becomes angry about.

In constellation with a patient's behavior that either affects her directly or that she thinks constitutes a danger, I don't think you can say that this is really a unique pattern or a unique incident for Ms. Naficy because I think these kinds of things have been seen to recur in her history. (Rx.7, pp. 83-85)

On May 1, 2013, the parties deposed Syed Ali, M.D., Petitioner's treating psychiatrist. Dr. Ali has treated Petitioner from May 1, 2009 through February 14, 2013. With regard to the April 24, 2009 incident, Dr. Ali testified that he diagnosed Petitioner with PTSD. Dr. Ali testified that during the incident, there was no physical contact between the Patient and Petitioner, but that this was still a life-threatening situation. Dr. Ali testified that after the April 24, 2009 incident, Dr. Emami, Petitioner's primary care physician, saw Petitioner on one occasion and diagnosed her with PTSD. When asked the basis for his diagnosis of PTSD as it related to the April 24, 2009 incident, Dr. Ali replied:

> "Based upon the fact that she had been exposed to a life-threatening situation and that resulted in her being extremely emotionally upset by that. That she had nightmares. She had flashbacks. She had a significant degree of depression. She had difficulty in being able to sleep properly. She had all those symptoms. She had she (sic) wanted to avoid going back to that situation. Any triggers or stimuli that would evoke memories of her injury because she wanted to avoid that. She became also very numb now."
> (Px.9, p. 30)

With regard to the flashbacks, Dr. Ali did not know how many flashbacks Petitioner experienced. Dr. Ali further testified that there were no particular triggers for each of her

flashbacks, but that when Petitioner did have a flashback, she was "able to be oriented to where she was and everything." Although Dr. Ali testified that Petitioner was withdrawn from the world for several months after April 24, 2009, he conceded that she never reported to him that she was not interacting emotionally with her family. Dr. Ali testified that Petitioner's prognosis is good.

II. Conclusions of Law

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

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

In Pathfinder Co. v. Indus. Comm'n, 62 Ill.2d at 559, 343 N.E.2d at 915 (1976), claimant pulled a co-worker's severed hand from a machine, fainted, and subsequently developed psychological problems. She later testified, through an interpreter, that the next thing she remembered was waking up in Resurrection Hospital the next day. Her children testified that when they saw their mother shortly after her admission to the hospital, she did not recognize them. Claimant was discharged from the hospital the next day with records showing a final diagnosis of anxiety reaction. Claimant returned to work two weeks later but soon developed headaches, difficulty seeing, a fear of the machines with which she worked, nervousness and numbness in her hands and feet. Claimant quit her job approximately three months later, and one month after that, was hospitalized for twelve days. The hospital records indicate that claimant was nervous and high-strung. Claimant's expert, who specialized in neurology and psychiatry, concluded that claimant was suffering from peripheral neuritis and residual anxiety. In reversing the Circuit Court and upholding the Commission's award, the Court stated that in order to recover under the mental-mental theory, an employee who "suffers a sudden, severe emotional

shock traceable to a definite time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained." Id. at 563, 343 N.E.2d at 917

In Chicago Transit Authority v. Illinois Workers' Compensation Commission, 371 Ill. Dec. 18, 989 N.E.2d 608 (1st Dist. 2013), claimant was a bus operator who, shortly after letting several passengers off the bus at a red light, struck and killed a pedestrian. Claimant did not directly witness the accident, but observed the victim lying on the curb in almost a fetal position with his mouth silently moving. Claimant did not seek therapy/medical treatment until more than two months later. Claimant complained of flashbacks and difficulty sleeping. The treating clinical psychologist diagnosed claimant with adjustment disorder with mixed anxiety and depression. On appeal, relying on General Motors Parts Division v. Indus. Comm'n, 522 N.E.2d 1260, 119 Ill. Dec. 410 (1st Dist. 1988), the employer argued that a claimant may recover under Pathfinder only if she proves that a sudden, severe emotional shock caused her to suffer a psychic injury that was "immediately apparent." Yet, under Pathfinder, the Court stated, the emotional shock needs to be "sudden," not the ensuing psychic injury. Accordingly, the Court held that the Commission's finding that claimant established a compensable "mental-mental" injury was not against the manifest weight of the evidence.

In Ismael Diaz v. Illinois Workers' Compensation Commission, 989 N.E.2d 233, 370 Ill. Dec. 845 (2d Dist. 2013), claimant was a police officer who was involved in a standoff with an armed suspect. After claimant saw the suspect's handgun, he drew his weapon and ordered the suspect to drop the gun, but the suspect did not comply. Claimant walked closer to the suspect with his weapon drawn, but when he got within 15 feet of the suspect and took cover behind an SUV, he saw that the suspect's gun had an orange tip on it. Claimant stated that the orange tip

indicated to him that the suspect's handgun might not be a real gun, but possibly a BB gun or toy gun. Claimant stated that 10 to 15 seconds had elapsed from the time he saw the suspect with a gun until he realized that it was a BB gun or some type of toy gun. Claimant left the scene before the resolution of the standoff. Until the suspect was restrained, he was considered by almost 40 officers to be armed and dangerous.

Claimant did not immediately experience anxiety after the incident. The following day, claimant did not experience anxiety or palpitations. However, two days later "he responded to an accident with injuries." Three days later, at roll call, he experienced dizziness and blurry vision. He was nervous, sweaty and had heart palpitations. Seven weeks later, claimant underwent a fit-for-duty evaluation. The examiners found that claimant was unfit for duty at that time as he experienced significant anxiety and depression issues. They diagnosed him with post-traumatic stress symptoms and recommended treatment. Claimant subsequently received psychiatric care, counseling and medication.

The Commission denied benefits for claimant since he "is a police officer and . . . is trained in weapons handling" and "is trained to handle encounters with subjects who are considered armed and dangerous."

On appeal, the Appellate Court decision states: "The sole issue raised by the claimant in this appeal is whether, as a police officer, he was improperly held to a higher standard of proof than workers in other occupations." The Court held that the Commission misinterpreted the requirement set forth in General Motors Parts Division v. Indus. Comm'n, 522 N.E.2d 1260, 119 Ill. Dec. 410 (1st Dist. 1988) that a claimant must prove that a traumatic incident was an "uncommon event of significantly greater proportion or dimension than that to which the employee would otherwise be subjected in the normal course of business." The Court noted that

nothing in Pathfinder requires that the "sudden, severe emotional shock" that must be proven should be considered within the context of the claimant's occupation or training. On the contrary, the Pathfinder court specifically noted that the shock experienced by the claimant in that case "would be the reaction of a person of normal sensibilities." Pathfinder, 62 Ill. 2d at 562, 343 N.E.2d at 919. After the Court's analysis, the majority concluded: "Accordingly, we believe that whether a worker has suffered the type of emotional shock sufficient to warrant recovery should be determined by an objective, reasonable-person standard rather than a subjective standard that takes into account claimant's occupation and training. To the extent that the holding in General Motors would require, in a mental-mental claim, that the precipitating event be viewed in the context of the claimant's occupation and training, we reject the court's decision in that case and decline to follow it." The Appellate Court reversed the decision of the Commission and remanded for further proceedings.

The Arbitrator finds the opinions of Dr. Hartman to be more convincing than those of Dr. Ali, Dr. Khan and Dr. Emami. Dr. Hartman opined that Petitioner's symptoms fit the pattern for Narcissistic Personality Disorder, as defined by DSM-IV as a combination of grandiosity, competition with and hostility toward authority and fragile self-esteem. Dr. Hartman further opined that Petitioner's personality disorder was not caused or worsened by the workplace incidents as claimed.

Dr. Hartman noted that prior to these two incidents, Petitioner claimed that a crisis intervention class instructor twisted her wrist and caused pain in the right side of her neck, her shoulder and her wrist.

Petitioner seeks recovery under the "mental-mental" theory of accident because she did not experience a physical injury. Petitioner claims that her alleged PTSD resulted from two stressful work incidents.

Petitioner's first alleged accident of July 23, 2008 was an instance of a co-worker yelling and shaking her finger at Petitioner because she did not agree with a decision Petitioner made regarding staffing. Although Petitioner also alleges that Ms. Tonos "grabbed" her shoulder in an effort to continue talking to her, such grab clearly does not elevate the confrontation to a physical injury. Petitioner never sought treatment for the contact that Ms. Tonos made with her that day. Instead, Petitioner complained that Ms. Tonos was a large woman who was "sabotaging" her space and intimidating her. In the "Details of Incident" report, Petitioner wrote: "Instead of being appreciated for my dedication, hard work and extra efforts in going out of the way to effectively deal with the patient's family, I was being now assaulted and questioned for my time and efficient performance."

In the CMS Supervisor's Report of Injury, Judy Bailey wrote, *inter alia*, the following: "Ms. Naficy came to my office 1109 of the Administration Building complaining that she felt 'abused and harrassed (sic).' She reported that the nurse had yelled at her (Sandy Tonos) and Dr. Syiad failed to do her work leaving her to complete her duties … Dr. Syiad according to Ms. Naficy failed to complete her duty to contact VA psychiatrist to transfer patient to VA facility."

The Arbitrator finds, based on the case law, that a reasonable person would not find this incident to be a "sudden, severe emotional shock" and thus, not a compensable injury.

Petitioner's second alleged accident of April 24, 2009 involved a confrontation she had in her Madden office with the Patient. Petitioner had met with the Patient several times in the week preceding April 24, 2009. Petitioner testified that at the morning meeting that day, she

recommended that the team meet with the Patient, but that Dr. Chin ordered her to meet with him on her own. The Patient weighed over 200 pounds and had a large build. He was young, intelligent and had a long history of violent behavior. He was reported to be unpredictable. At that time, Petitioner stood 5'3" and weighed 125 pounds. The Patient was angry when he learned that he was not going to be released from the facility that day. In the incident report, Petitioner reported that he was out of control and yelling. This confrontation resulted in no physical contact and there is no evidence that the Patient verbally threatened Petitioner with bodily harm. The Patient was not holding any type of weapon. Petitioner had a telephone in her office. The Patient stood up, and according to Petitioner's testimony and her statement to Judy Bailey, raised his fist. In the Incident Report, Petitioner wrote: "... he wanted to hit my head." In Dr. Hartman's report, he quoted Petitioner: "[H]e lifted his hands and moved toward me with his hands toward my head." There is no mention in Dr. Hartman's report of the Patient attempting to strike or grab Petitioner. Petitioner testified that she then shielded herself with the chart/clipboard. The Patient then grabbed the chart/clipboard out of Petitioner's hands and proceeded to tear up the papers held on the clipboard, and shortly thereafter, threw the torn-up pieces into a toilet. The Patient did not block the door. Petitioner ran from her office. She was not physically attacked.

As evidenced by the Patient's actions, the Arbitrator draws the reasonable inference that the Patient was focused on destroying the papers and not on injuring Petitioner.

Based on the reasonable person standard, the Arbitrator finds that the April 24, 2009 incident does not rise to the level of the shocking incidents that the claimants experienced in Pathfinder, Chicago Transit Authority and Diaz above.

The Arbitrator relies on Dr. Hartman's opinions that a person in this situation with the Patient may have been unnerved by such a confrontation, but in light of Petitioner's previous history and especially in light of her objective test results, there is insufficient evidence to provide a chronic diagnosis of post-traumatic stress disorder.

The Arbitrator notes that as a consequence of *each* incident, Petitioner's treaters diagnosed her with PTSD. Following *each* incident, she was sweaty, shaky, and anxious, and claimed she had bad dreams, an inability to sleep, and fearfulness. After *each* incident, she was prescribed Paxil and Ambien.

So, Petitioner's claim is that *both* incidents were sudden, severe emotional shocks.

This Arbitrator finds that Petitioner is not credible.

Petitioner claims that more than 4-1/2 years later, she has not fully recovered from these two incidents. She testified that she is still on medication, has bad dreams, and feels anxious and fearful. Petitioner testified that suffers from depression, but has no difficulty sleeping or fatigue. She testified that she is "not the same person [she] was before."

However, Petitioner is a well-educated woman who has worked in the State's mental health facilities for many years. Dr. Hartman noted that she is a clinical social worker in a psychiatric hospital and would be quite familiar with the DSM-IV criteria for PTSD and would have no difficulty reciting these general criteria to treaters. She earned an MA in business administration from Teheran University in 1975. Furthermore, while allegedly suffering from PTSD, she completed her MSW from Aurora University. She never reported to Dr. Ali at any time that she was not interacting emotionally with her family. Petitioner testified that she has a close family. When she presented to Dr. Khan on July 30, 2009, she was groomed and dressed appropriately. Petitioner returned to full duty on September 1, 2009. Petitioner trains others in

stress management skills and how to use them to cope with a stressful work environment. The question of whether Petitioner sustained PTSD from the two incidents was not objectively evaluated prior to her examination with Dr. Hartman. Her prior diagnosis had been by self-report only. Dr. Hartman opined that the research indicates that self-report in the course of treatment is an extremely unreliable and inaccurate index of whether someone actually has a condition.

In reviewing Diaz, the Arbitrator notes that is no evidence that the claimant was diagnosed with any psychological condition other than "post-traumatic stress symptoms." The Arbitrator further notes that more than two years prior to his accident, Officer Diaz witnessed, from a distance of 10-15 yards, a suspect being shot several times by other police officers. After this shooting incident, he had some anxiety that lasted about a week, but did not seek psychiatric treatment.

Therefore, based on all of the above, this Arbitrator finds that on July 23, 2008 and April 24, 2009, Petitioner did not sustain accidents that arose out of and in the course of her employment by Respondent and further finds that any current condition of ill-being is not causally related to these two incidents. Compensation is hereby denied. All other issues are moot.

Brian T. Cronin

ARBITRATOR BRIAN CRONIN

8/29/14

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

Hamida Naficy,
Petitioner,

15IWCC0385

vs.

NO: 09 WC 22615

Madden Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, penalties, fees, 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 September 2, 2014, is hereby affirmed and adopted.

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

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

DATED: MAY 22 2015
O4/22/15
RWW/rm
046

Ruth W. White
Ruth W. White

Charles J. DeVriendt
Charles J. DeVriendt

Joshua D. Luskin
Joshua D. Luskin

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

15IWCC0385

NAFICY, HAMIDA
Employee/Petitioner

Case# **09WC022615**

09WC022616

MADDEN MENTAL HEALTH CENTER
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2739 SMOLER LAW OFFICE PC
ROBERT J SMOLER
415 N LASALLE ST SUITE 402
CHICAGO, IL 60654

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

5031 ASSISTANT ATTORNEY GENERAL
JILL OTTE
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

SEP 2 - 2014

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

15IWCC0385

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)

Hamida Naficy
Employee/Petitioner

v.

Madden Mental Health Center
Employer/Respondent

Case # **09 WC 22615**

Consolidated cases: **09 WC 22616**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Brian Cronin, Arbitrator of the Commission, in the city of Chicago, on **January 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 an accident given to Respondent?

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

G. ☐ What were Petitioner's earnings?

H. ☐ What 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

15IWCC0885

On the date of **April 24, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 April 24, 2009 work incident.

In the year preceding the injury, Petitioner earned **$69,660.00**; the average weekly wage was **$1,339.61**.

On April 24, 2009, Petitioner was **56** years of age, ***single*** with **0** dependent children.

ORDER

Based on his findings of fact and conclusions of law with regard to the issues of accident and causation, the Arbitrator hereby denies compensation. All other issues are moot.

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

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

Signature of Arbitrator

August 27, 2014
Date

ICArbDec19(b)

SEP 2 - 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

HAMIDA NAFICY, Employee/Petitioner,	)	
v.	)	09 WC 22615 09 WC 22616
MADDEN MENTAL HEALTH CENTER, Employer/Respondent.	)	Chicago

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

This action was pursued by the Petitioner under the Workers' Compensation Act (hereinafter "WCA") seeking relief from her employer, the Madden Mental Health Center (hereinafter "Madden"). On January 10, 2014, a hearing on Petitioner's Motion For an Immediate Hearing Under Section 19(b) of the Act was held before Arbitrator Brian Cronin at the Illinois Workers' Compensation Commission in Chicago, Illinois. Petitioner Hamida Naficy was represented by counsel. Madden was represented by the Illinois Attorney General's Office. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

Petitioner is a Lead Social Worker III for Madden. On July 23, 2008, when she went into Pavilion 6 she was accused by Charge Nurse Sandy Tonos of wasting nursing staff the night before for a patient transfer. Petitioner claimed that Ms. Tonos, a tall, large, well-built woman, was angry, upset and verbally abusive to her. Ms. Tonos was standing up and shaking her hand at Petitioner. No other co-workers were present at the time. According to Petitioner's testimony, when she went to leave, Tonos grabbed Petitioner's left shoulder saying she wanted to talk to

her. After Petitioner walked out the door, Petitioner was shaking and sweating. She filed an incident report. In the Details of the Incident report, Petitioner characterized "very provocative and intimidating." (Px.2) Petitioner took the rest of the day off work, as well as the next couple of days. Petitioner testified that at that time, she suffered anxiety, bad dreams, an inability to sleep, fearfulness and shakiness.

Six days after the incident, Petitioner went to see her internist, Dr. Firooz Emami. She complained to this doctor that she can't concentrate, is very anxious, has insomnia and has lost 5 pounds. Dr. Emami prescribed Paxil and Ambien. Dr. Emami diagnosed Petitioner with post-traumatic stress syndrome and insomnia. On August 4, 2008, Dr. Emami authorized Petitioner to return to work in a less stressful environment.

Petitioner testified that she took Paxil and Ambien until her symptoms went away, which she estimated to be two months post-incident.

Petitioner testified that in October 2008, Dr. Emami released Petitioner to return to work at her regular duties. Petitioner returned to work at Pavilion 5.

On April 24, 2009, a male patient (hereinafter "the Patient") who wished to be discharged met with Petitioner. The Patient weighed over 200 pounds, was tall with a large build and had a long history of violent behavior. At that time, Petitioner stood 5'3" and weighed 125 pounds. Petitioner first met with the Patient one week earlier, and saw him each day thereafter, as needed. Petitioner would meet with the Patient in her office, the day room or the staffing room. As Petitioner recalled, the Patient was involuntarily committed to Madden. On the morning of April 24, 2009, Petitioner attended the morning meeting with two psychiatrists, other social workers and nurses. The team discussed the status of the Patient. Petitioner testified that she wanted the Patient to meet with the whole team in the staffing room. However, Dr. Chin ordered Petitioner

to meet with the Patient that day in her office. The purpose of such meeting was for Petitioner to convince the Patient to sign a document whereby he would be withdrawing his request to be discharged.

Petitioner met with the Patient that day in her office. Petitioner characterized her office as "small." Such office contained her desk, her desk chair, two cabinets and two guest chairs. She testified that two people can comfortably fit in her office. There are three chairs. Petitioner testified that she had some boxes behind her door. Petitioner claimed that if someone sits in the guest chair closer to the door, that person would block access to the door.

On April 24, 2009, when the Patient approached Petitioner, he was anxious and demanding. He wanted to be discharged. The Patient was not restrained. The two of them walked together to her office. Petitioner went into her office first, the Patient then entered and closed the door. They sat in the two guest chairs with the Patient sitting closer to the door. Petitioner calmly explained the criteria for discharge and the individual "got enraged" and hovered over Petitioner. Petitioner testified that the Patient "tried to hit" her in her head with his fist, but she "lifted up her chart." He grabbed the chart, threw it on a chair and "started ripping" the pages. Petitioner then "ran for [her] life," but she does not recall if she screamed or hollered. The Patient did not block the door. Petitioner testified that she had no means to call for help, no intercom, but that she did have a phone in her office. She also testified that the Patient was "enraged in the eyes" with a "murderous rage." Petitioner further testified that when the patient stood up, she felt intense fear and felt that she could die. The Patient did not assault her.

After the incident with the individual, Petitioner was soaking wet, shaking and crying. She went to the staffing room and told Theresa Glaze what had happened. She then went to report the incident to a nurse named Joslyn in a different building. She filed an incident report.

The nurse brought two fans because Petitioner was so wet. Petitioner sat there with the nurse and under the fans for a couple of hours. Petitioner also spoke with Cheryl McGee, the Assistant Director of Social Work, and Dr. Sharp, the Acting Medical Director. They asked her many questions, but Petitioner testified that she was unable to answer such questions because she was in a state of shock. However, Petitioner was able to complete a report that day.

Petitioner then went home and called Dr. Emami. Dr. Emami's next available appointment was not until Monday, but she was instructed to take Advil. Petitioner testified that because she had Ambien left over from August 2008, she took the Ambien to help her to sleep. Over the weekend, she stayed in bed and did not leave the house. She was anxious, depressed, unable to eat, and unable to concentrate.

When Petitioner saw Dr. Emami, he prescribed Paxil, Ambien and Valium for her. She took these medications through May or June of 2009. He recommended that she stay off work. He also referred her to Dr. Syed Ali, who she had never seen before. Dr. Ali provided medication management. Dr. Ali prescribed Paxil, Xanax and Ambien CR. Dr. Ali recommended she see a therapist for counseling, so she also saw Dr. Yasmeen Khan, a psychologist, to work through her fear issues.

In Dr. Khan's July 30, 2009, Progress Report, this psychologist wrote, *inter alia*, the following:

> "She was dressed and groomed appropriately … Hamida reported symptoms of Post Traumatic Stress Disorder (PTSD) consequent to an incident at work. (please see attached, PTSD symptom check-list.) We conducted a detailed mental health assessment (see attached). It was determined that Hamida has had her second incidence of PTSD at her work place. This is related to her perceived lack of safety in the work place. We discussed treatment options for Hamida. She decided to utilize Cognitive Behavior Therapy Model to help relieve her symptoms."

Dr. Hartman later opined that this mental health assessment does not constitute objective psychological testing, but rather self-reporting.

Petitioner saw both Dr. Ali and Dr. Kahn through the summer of 2009. Petitioner last saw Dr. Kahn on June 21, 2010 and she continues to see Dr. Ali. Petitioner remains on Paxil, but the other medications were discontinued. She testified that over the years, she has been "functioning" with this medication.

Petitioner testified that prior to the incidents of July 23, 2008 and April 24, 2009, she had not treated for any psychiatric or psychological condition, she had not been an in-patient for such problems, and had never been diagnosed with PTSD or anxiety. She also never took prescriptions for any psychiatric or psychological condition.

On July 30, 2009, Petitioner returned to work with light-duty restrictions that included no patient contact. Petitioner only returned to work for a couple days, however, as there was no light-duty work available at Madden. She worked July 31, 2009 through August 3, 2009. Dr. Ali took her off of work again. On August 31, 2009, Dr. Ali released Petitioner to return to full-duty work as of September 1, 2009. On November 2, 2009, Petitioner reported to Dr. David E. Hartman, Respondent's Section 12 examiner, that she is able to complete a full workday without psychological disruption. (Rx.6, Rx.7)

Petitioner testified that after she returned to work at Madden, she performed intake duties and sometimes worked overnight. At times she worked part time because of the closure of Howe Developmental Center. Due to the closure of Tinley Park Developmental Center, she became a Social Worker II. There was a great deal of "shift bumping" between weekends and day shift. She testified that her pay was never reduced and any changes in her schedule were related to the closure of other facilities.

Petitioner testified that she has still not fully recovered. She is still on medication. She testified that she has bad dreams, and feels anxious and fearful. She testified that she is "not the same person [she] was before." Petitioner testified that she suffers from depression. She testified that she has no difficulty sleeping or fatigue. However, Petitioner testified, she notices that her energy level is not the same as it was before the July 23, 2008 and April 24, 2009 incidents. Petitioner has completed her doctoral program, but testified that due to her inability to concentrate, her anxiety and her fearfulness, she had to postpone her completion of the program. Petitioner testified that she has not experienced the type of incidents that she experienced on July 23, 2008 and April 24, 2009 before or since those dates.

Petitioner testified with regard to Dr. Hartman's behavior when she took the written tests. She testified that he answered phone calls during the testing and was upset that she had not completed the tests by 5:30 p.m. Petitioner testified that Dr. Hartman's report contained factual errors.

Psychologist David E. Hartman, Ph.D., performed a Section 12 examination of Petitioner on November 2, 2009, which is memorialized in his report. (Rx.6) Dr. Hartman was deposed on January 25, 2011. Dr. Hartman concluded that Petitioner's symptoms do not objectively fit a pattern of genuine PTSD. (Rx.6, Rx.7) Dr. Hartman noted that while Petitioner claims to have PTSD, her claim must be viewed in her context, that of a clinical social worker in a psychiatric hospital, who would be quite familiar with the DSM-IV criteria for PTSD and would have no difficulty reciting these general criteria to treaters. (Rx.6) Moreover, Dr. Hartman points out the following:

> "PTSD is an easy disorder to fake. The diagnosis is based almost entirely upon the individual's subjective report of symptoms, which are very difficult to verify independently. Furthermore, in an effort to educate the public, the diagnostic criteria have been made widely available in print and on the Internet,

allowing unscrupulous individuals to familiarize themselves with which symptoms to falsely report." Dr. Hartman cited Resnick, P. J., West, S., and Payne, J. W. (2008). Malingering of posttraumatic disorders. In R. Rogers (Ed.) *Clinical Assessment of Malingering and Deception.* New York: The Guilford Press, p. 112-113. (Rx.6)

Petitioner's self-reported symptoms cannot be seen as accurate since "even individuals naïve to the criteria of PTSD could qualify for the diagnosis of PTSD on a checklist when asked to do so 86-94% of the time." (Rx.6, Rx.7) Dr. Hartman also opined that "in order to differentiate genuine from malingered or 'pseudo' PTSD, attention must be paid to more subtle distinctions aspects of the disorder that are published in peer reviewed diagnostic research, but which cannot be easily inferred from the DSM-IV." (Rx.6, Rx.7) Petitioner was found to have an exaggerated version of the diagnosis in almost every criterion. (Rx.6, Rx.7) Further, "her description of severe psychological impairment while maintaining good family relationships and pleasurable hobbies is contradictory and uncharacteristic of genuine PTSD, where withdrawal from family and favored activities is more typical." (Rx.6, Rx.7)

Dr. Hartman also made several notations regarding Petitioner's behavior during the testing. He observed no attentional difficulties while working on test materials or being interviewed, but he noted that Petitioner worked very slowly in completing the questionnaires. She complained frequently about having to spend her day in the examination. (Rx.6, Rx.7) However, when Dr. Hartman offered her the option of a shorter day and returning on a subsequent day to complete the evaluation, she declined. (Rx.6, Rx.7) Dr. Hartman also noted that initially Petitioner did not answer several questions for various reasons, including finding the questions irrelevant, stupid, or too personal. (Rx.6, Rx.7) Dr. Hartman testified that he tried to gently encourage Petitioner to do the best that she could with answering the questions. Petitioner's time to complete several of the questionnaires was about twice as long as it would be

for a typical educated adult. (Rx.6, Rx.7) Finally, she took long breaks during the evaluation session, and as a result, used approximately five hours to complete tests and procedures that are typically performed in about two hours. (Rx.6, Rx.7) There is no evidence that Petitioner did not understand the test questions.

Additionally, Dr. Hartman opined that Petitioner's claims are further compromised by her invalid and exaggerated results on tests sensitive to emotional and psychosomatic malingering. (Rx.6, Rx.7) He found that her self-report was in the malingered range for emotional symptoms and low intelligence on the SIMS test. (Rx.6, Rx.7) He further found that her personality profile on the MMPI-2 showed malingered depression and malingered psychosomatic and post-traumatic symptoms resembling exaggerating litigants seeking secondary gains. (Rx.6, Rx.7)

Dr. Hartman opined that psychological test patterns indicate that Ms. Naficy's complaints and claims cannot be taken as fact, and that treaters who rely upon her self-report could be misled into overpathologizing and overdiagnosing her symptoms. (Rx.6, Rx.7)

Ultimately, Dr. Hartman opined that Petitioner's symptoms fit the pattern for Narcissistic Personality Disorder, as defined by DSM-IV as a combination of grandiosity, competition with and hostility toward authority and fragile self-esteem. (Rx.6, Rx.7) This diagnosis is not the result of a particular event, but rather personality symptoms that are part of her psychological makeup. (Rx.6, Rx.7) Dr. Hartman emphasized that Petitioner remains in the same workplace and is sufficiently skilled in crisis management that she teaches patients "crisis intervention skill [and] how to tolerate the stress of the moment and to deal with their emotional mind." (Rx.6, Rx.7) He opined that common sense indicates that this factor alone precludes disabling anxiety or PTSD. "Ms. Naficy teaches the very stress management skills required for coping with a stressful work environment." (Rx.6, Rx.7)

Dr. Hartman concluded his report by opining that Petitioner's current symptoms are a combination of malingered exaggeration and a personality disorder that "causes her to assert injury by authority and the superiority of her judgment over those in authority." (Rx.6, Rx.7) He goes on to state that to the extent that Petitioner has actual symptoms, these are the by-products of a personality disorder, not PTSD, and reflect narcissistic personality disturbance, not trauma. (Rx.6, Rx.7) Dr. Hartman opined that Petitioner's personality disorder was not caused or worsened by the workplace incidents as claimed. (Rx.6, Rx.7)

On cross-examination, Dr. Hartman testified that as of December 13, 2009, Respondent has paid him $7,307.50 for his services. Dr. Hartman also testified that there was a post-it note affixed to the chart that Respondent provided to him. Dr. Hartman testified that he did not know who authored the post-it note and did not know if the statement on such post-it note was true, but that he included such statement in his report. The post-it note indicated that the nurse was disciplined and suspended for a period of time. Petitioner's Counsel asked Dr. Hartman about possible factual errors in his report. Dr. Hartman testified that he vouches for the accuracy of everything he writes, to best of his ability. Dr. Hartman testified that the teacher with whom Petitioner had a problem back in 2005 or 2006 is in a position of perceived authority relative to the students. With regard to Petitioner, Dr. Hartman testified that what we are dealing with here is "someone essentially with a very thin skin who has hot-button issues related to feeling humiliated or not listened to and becomes very angry if these situations occur and will likely have episodes like this in the future."

Dr. Hartman further testified on cross-examination that Dr. Ali and Dr. Khan did not do a diagnostic evaluation of Petitioner, but talked to her and treated her. He further testified that Dr. Ali and Dr. Khan are not in the position of diagnosing a malingerer because research indicates

that self-report in the course of treatment is an extremely unreliable and inaccurate index of whether someone actually has a condition. Clinicians who rely on self-report alone without objective measures, Dr. Hartman continued, can be easily misled and they would have no way of knowing.

Toward the cross-examination, the following exchange took place:

Q: Your testimony is that it is of no significance whether or not she was trapped in her office with an inpatient (sic) crazed, violent gentleman who was much larger than her and who blew up when he found out that he was going to be not released and that they contacted his sister, which he didn't want them to do. So that - - so whether or not that happened or not makes no difference to your conclusions, opinions or diagnoses?

A: Well, you have to understand or at least I understand that Ms. Naficy is a psychiatric social worker in an inpatient unit full of patients like this. This is the stuff of which she deals with every day. It's not a uniquely shocking experience.

Now, whether she would have been unnerved by a person in that situation, I can certainly see that. Whether that would really constitute enough to provide a chronic diagnosis of post traumatic stress disorder, I don't think so, especially in light of her previous history and especially in light of her objective test results.

Q: You report yourself on Page No. 3 of your report, the second to the last quoted paragraph at the end, "In my whole 13 years there, I was never afraid of a client."

And now, your testimony is that this happened on a regular basis to her. And she was reporting to you this is a very unique experience.

A: Well, clearly, her reactions to various events in her work history show that not to be the case. In 2008 when a nurse yells at her, she says that it caused her stress and turmoil. She has a

previous diagnosis of PTSD. She has a claim against a class instructor that a teacher twisted her wrist and caused her pain.

She has other - - and the kinds of things that she gets stressed out about are typically those which involve an authority figure who she becomes angry about.

In constellation with a patient's behavior that either affects her directly or that she thinks constitutes a danger, I don't think you can say that this is really a unique pattern or a unique incident for Ms. Naficy because I think these kinds of things have been seen to recur in her history. (Rx.7, pp. 83-85)

On May 1, 2013, the parties deposed Syed Ali, M.D., Petitioner's treating psychiatrist. Dr. Ali has treated Petitioner from May 1, 2009 through February 14, 2013. With regard to the April 24, 2009 incident, Dr. Ali testified that he diagnosed Petitioner with PTSD. Dr. Ali testified that during the incident, there was no physical contact between the Patient and Petitioner, but that this was still a life-threatening situation. Dr. Ali testified that after the April 24, 2009 incident, Dr. Emami, Petitioner's primary care physician, saw Petitioner on one occasion and diagnosed her with PTSD. When asked the basis for his diagnosis of PTSD as it related to the April 24, 2009 incident, Dr. Ali replied:

> *"Based upon the fact that she had been exposed to a life-threatening situation and that resulted in her being extremely emotionally upset by that. That she had nightmares. She had flashbacks. She had a significant degree of depression. She had difficulty in being able to sleep properly. She had all those symptoms. She had she (sic) wanted to avoid going back to that situation. Any triggers or stimuli that would evoke memories of her injury because she wanted to avoid that. She became also very numb now."* (Px.9, p. 30)

With regard to the flashbacks, Dr. Ali did not know how many flashbacks Petitioner experienced. Dr. Ali further testified that there were no particular triggers for each of her

flashbacks, but that when Petitioner did have a flashback, she was "able to be oriented to where she was and everything." Although Dr. Ali testified that Petitioner was withdrawn from the world for several months after April 24, 2009, he conceded that she never reported to him that she was not interacting emotionally with her family. Dr. Ali testified that Petitioner's prognosis is good.

II. Conclusions of Law

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

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

In Pathfinder Co. v. Indus. Comm'n, 62 Ill.2d at 559, 343 N.E.2d at 915 (1976), claimant pulled a co-worker's severed hand from a machine, fainted, and subsequently developed psychological problems. She later testified, through an interpreter, that the next thing she remembered was waking up in Resurrection Hospital the next day. Her children testified that when they saw their mother shortly after her admission to the hospital, she did not recognize them. Claimant was discharged from the hospital the next day with records showing a final diagnosis of anxiety reaction. Claimant returned to work two weeks later but soon developed headaches, difficulty seeing, a fear of the machines with which she worked, nervousness and numbness in her hands and feet. Claimant quit her job approximately three months later, and one month after that, was hospitalized for twelve days. The hospital records indicate that claimant was nervous and high-strung. Claimant's expert, who specialized in neurology and psychiatry, concluded that claimant was suffering from peripheral neuritis and residual anxiety. In reversing the Circuit Court and upholding the Commission's award, the Court stated that in order to recover under the mental-mental theory, an employee who "suffers a sudden, severe emotional

shock traceable to a definite time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained." Id. at 563, 343 N.E.2d at 917

In Chicago Transit Authority v. Illinois Workers' Compensation Commission, 371 Ill. Dec. 18, 989 N.E.2d 608 (1st Dist. 2013), claimant was a bus operator who, shortly after letting several passengers off the bus at a red light, struck and killed a pedestrian. Claimant did not directly witness the accident, but observed the victim lying on the curb in almost a fetal position with his mouth silently moving. Claimant did not seek therapy/medical treatment until more than two months later. Claimant complained of flashbacks and difficulty sleeping. The treating clinical psychologist diagnosed claimant with adjustment disorder with mixed anxiety and depression. On appeal, relying on General Motors Parts Division v. Indus. Comm'n, 522 N.E.2d 1260, 119 Ill. Dec. 410 (1st Dist. 1988), the employer argued that a claimant may recover under Pathfinder only if she proves that a sudden, severe emotional shock caused her to suffer a psychic injury that was "immediately apparent." Yet, under Pathfinder, the Court stated, the emotional shock needs to be "sudden," not the ensuing psychic injury. Accordingly, the Court held that the Commission's finding that claimant established a compensable "mental-mental" injury was not against the manifest weight of the evidence.

In Ismael Diaz v. Illinois Workers' Compensation Commission, 989 N.E.2d 233, 370 Ill. Dec. 845 (2d Dist. 2013), claimant was a police officer who was involved in a standoff with an armed suspect. After claimant saw the suspect's handgun, he drew his weapon and ordered the suspect to drop the gun, but the suspect did not comply. Claimant walked closer to the suspect with his weapon drawn, but when he got within 15 feet of the suspect and took cover behind an SUV, he saw that the suspect's gun had an orange tip on it. Claimant stated that the orange tip

indicated to him that the suspect's handgun might not be a real gun, but possibly a BB gun or toy gun. Claimant stated that 10 to 15 seconds had elapsed from the time he saw the suspect with a gun until he realized that it was a BB gun or some type of toy gun. Claimant left the scene before the resolution of the standoff. Until the suspect was restrained, he was considered by almost 40 officers to be armed and dangerous.

Claimant did not immediately experience anxiety after the incident. The following day, claimant did not experience anxiety or palpitations. However, two days later "he responded to an accident with injuries." Three days later, at roll call, he experienced dizziness and blurry vision. He was nervous, sweaty and had heart palpitations. Seven weeks later, claimant underwent a fit-for-duty evaluation. The examiners found that claimant was unfit for duty at that time as he experienced significant anxiety and depression issues. They diagnosed him with post-traumatic stress symptoms and recommended treatment. Claimant subsequently received psychiatric care, counseling and medication.

The Commission denied benefits for claimant since he "is a police officer and . . . is trained in weapons handling" and "is trained to handle encounters with subjects who are considered armed and dangerous."

On appeal, the Appellate Court decision states: "The sole issue raised by the claimant in this appeal is whether, as a police officer, he was improperly held to a higher standard of proof than workers in other occupations." The Court held that the Commission misinterpreted the requirement set forth in General Motors Parts Division v. Indus. Comm'n, 522 N.E.2d 1260, 119 Ill. Dec. 410 (1st Dist. 1988) that a claimant must prove that a traumatic incident was an "uncommon event of significantly greater proportion or dimension than that to which the employee would otherwise be subjected in the normal course of business." The Court noted that

nothing in Pathfinder requires that the "sudden, severe emotional shock" that must be proven should be considered within the context of the claimant's occupation or training. On the contrary, the Pathfinder court specifically noted that the shock experienced by the claimant in that case "would be the reaction of a person of normal sensibilities." Pathfinder, 62 Ill. 2d at 562, 343 N.E.2d at 919. After the Court's analysis, the majority concluded: "Accordingly, we believe that whether a worker has suffered the type of emotional shock sufficient to warrant recovery should be determined by an objective, reasonable-person standard rather than a subjective standard that takes into account claimant's occupation and training. To the extent that the holding in General Motors would require, in a mental-mental claim, that the precipitating event be viewed in the context of the claimant's occupation and training, we reject the court's decision in that case and decline to follow it." The Appellate Court reversed the decision of the Commission and remanded for further proceedings.

The Arbitrator finds the opinions of Dr. Hartman to be more convincing than those of Dr. Ali, Dr. Khan and Dr. Emami. Dr. Hartman opined that Petitioner's symptoms fit the pattern for Narcissistic Personality Disorder, as defined by DSM-IV as a combination of grandiosity, competition with and hostility toward authority and fragile self-esteem. Dr. Hartman further opined that Petitioner's personality disorder was not caused or worsened by the workplace incidents as claimed.

Dr. Hartman noted that prior to these two incidents, Petitioner claimed that a crisis intervention class instructor twisted her wrist and caused pain in the right side of her neck, her shoulder and her wrist.

Petitioner seeks recovery under the "mental-mental" theory of accident because she did not experience a physical injury. Petitioner claims that her alleged PTSD resulted from two stressful work incidents.

Petitioner's first alleged accident of July 23, 2008 was an instance of a co-worker yelling and shaking her finger at Petitioner because she did not agree with a decision Petitioner made regarding staffing. Although Petitioner also alleges that Ms. Tonos "grabbed" her shoulder in an effort to continue talking to her, such grab clearly does not elevate the confrontation to a physical injury. Petitioner never sought treatment for the contact that Ms. Tonos made with her that day. Instead, Petitioner complained that Ms. Tonos was a large woman who was "sabotaging" her space and intimidating her. In the "Details of Incident" report, Petitioner wrote: "Instead of being appreciated for my dedication, hard work and extra efforts in going out of the way to effectively deal with the patient's family, I was being now assaulted and questioned for my time and efficient performance."

In the CMS Supervisor's Report of Injury, Judy Bailey wrote, *inter alia*, the following: "Ms. Naficy came to my office 1109 of the Administration Building complaining that she felt 'abused and harrassed (sic).' She reported that the nurse had yelled at her (Sandy Tonos) and Dr. Syiad failed to do her work leaving her to complete her duties … Dr. Syiad according to Ms. Naficy failed to complete her duty to contact VA psychiatrist to transfer patient to VA facility."

The Arbitrator finds, based on the case law, that a reasonable person would not find this incident to be a "sudden, severe emotional shock" and thus, not a compensable injury.

Petitioner's second alleged accident of April 24, 2009 involved a confrontation she had in her Madden office with the Patient. Petitioner had met with the Patient several times in the week preceding April 24, 2009. Petitioner testified that at the morning meeting that day, she

recommended that the team meet with the Patient, but that Dr. Chin ordered her to meet with him on her own. The Patient weighed over 200 pounds and had a large build. He was young, intelligent and had a long history of violent behavior. He was reported to be unpredictable. At that time, Petitioner stood 5'3" and weighed 125 pounds. The Patient was angry when he learned that he was not going to be released from the facility that day. In the incident report, Petitioner reported that he was out of control and yelling. This confrontation resulted in no physical contact and there is no evidence that the Patient verbally threatened Petitioner with bodily harm. The Patient was not holding any type of weapon. Petitioner had a telephone in her office. The Patient stood up, and according to Petitioner's testimony and her statement to Judy Bailey, raised his fist. In the Incident Report, Petitioner wrote: "... he wanted to hit my head." In Dr. Hartman's report, he quoted Petitioner: "[H]e lifted his hands and moved toward me with his hands toward my head." There is no mention in Dr. Hartman's report of the Patient attempting to strike or grab Petitioner. Petitioner testified that she then shielded herself with the chart/clipboard. The Patient then grabbed the chart/clipboard out of Petitioner's hands and proceeded to tear up the papers held on the clipboard, and shortly thereafter, threw the torn-up pieces into a toilet. The Patient did not block the door. Petitioner ran from her office. She was not physically attacked.

As evidenced by the Patient's actions, the Arbitrator draws the reasonable inference that the Patient was focused on destroying the papers and not on injuring Petitioner.

Based on the reasonable person standard, the Arbitrator finds that the April 24, 2009 incident does not rise to the level of the shocking incidents that the claimants experienced in Pathfinder, Chicago Transit Authority and Diaz above.

The Arbitrator relies on Dr. Hartman's opinions that a person in this situation with the Patient may have been unnerved by such a confrontation, but in light of Petitioner's previous history and especially in light of her objective test results, there is insufficient evidence to provide a chronic diagnosis of post-traumatic stress disorder.

The Arbitrator notes that as a consequence of *each* incident, Petitioner's treaters diagnosed her with PTSD. Following *each* incident, she was sweaty, shaky, and anxious, and claimed she had bad dreams, an inability to sleep, and fearfulness. After *each* incident, she was prescribed Paxil and Ambien.

So, Petitioner's claim is that *both* incidents were sudden, severe emotional shocks.

This Arbitrator finds that Petitioner is not credible.

Petitioner claims that more than 4-1/2 years later, she has not fully recovered from these two incidents. She testified that she is still on medication, has bad dreams, and feels anxious and fearful. Petitioner testified that suffers from depression, but has no difficulty sleeping or fatigue. She testified that she is "not the same person [she] was before."

However, Petitioner is a well-educated woman who has worked in the State's mental health facilities for many years. Dr. Hartman noted that she is a clinical social worker in a psychiatric hospital and would be quite familiar with the DSM-IV criteria for PTSD and would have no difficulty reciting these general criteria to treaters. She earned an MA in business administration from Teheran University in 1975. Furthermore, while allegedly suffering from PTSD, she completed her MSW from Aurora University. She never reported to Dr. Ali at any time that she was not interacting emotionally with her family. Petitioner testified that she has a close family. When she presented to Dr. Khan on July 30, 2009, she was groomed and dressed appropriately. Petitioner returned to full duty on September 1, 2009. Petitioner trains others in

stress management skills and how to use them to cope with a stressful work environment. The question of whether Petitioner sustained PTSD from the two incidents was not objectively evaluated prior to her examination with Dr. Hartman. Her prior diagnosis had been by self-report only. Dr. Hartman opined that the research indicates that self-report in the course of treatment is an extremely unreliable and inaccurate index of whether someone actually has a condition.

In reviewing Diaz, the Arbitrator notes that is no evidence that the claimant was diagnosed with any psychological condition other than "post-traumatic stress symptoms." The Arbitrator further notes that more than two years prior to his accident, Officer Diaz witnessed, from a distance of 10-15 yards, a suspect being shot several times by other police officers. After this shooting incident, he had some anxiety that lasted about a week, but did not seek psychiatric treatment.

Therefore, based on all of the above, this Arbitrator finds that on July 23, 2008 and April 24, 2009, Petitioner did not sustain accidents that arose out of and in the course of her employment by Respondent and further finds that any current condition of ill-being is not causally related to these two incidents. Compensation is hereby denied. All other issues are moot.

Brian T Cronin 8/27/14

ARBITRATOR BRIAN CRONIN 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

Eugene Coleman,
Petitioner,

15IWCC0386

vs.

NO: 09 WC 11197

Precision Steel Warehouse,
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(s) 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 May 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.

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

DATED: MAY 22 2015

Ruth W. White

Ruth W. White

Charles J. DeVriendt

Charles J. DeVriendt

Joshua D. Luskin

Joshua D. Luskin

O4/22/15
RWW/rm
046

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLEMAN, EUGENE
Employee/Petitioner

Case# **09WC011197**

PRECISION STEEL WAREHOUSE
Employer/Respondent

15IWCC0386

On 5/23/2014, 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:

2333 WOODRUFF JOHNSON & PALERMO
DANIEL R KLOSOWSKI
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
LINDA ROBERT
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0386

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

EUGENE COLEMAN,
Employee/Petitioner

Case # 09 WC 11197

v.

Consolidated cases:

PRECISION STEEL WAREHOUSE,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **LYNETTE THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **April 22, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0386

FINDINGS

On **2/17/2009**, 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*** sustain an accident that arose out of and in the course of employment regarding his right elbow.

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

Petitioner's current condition of ill-being regarding his right elbow, ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**30,948.84**; the average weekly wage was $**595.17**.

On the date of accident, Petitioner was **58** years of age, **married** with **0** dependent children.

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

Respondent ***has*** 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 $8,014.84 for other benefits, for a total credit of $8,014.84 .

Respondent is entitled to a credit of $46,834.03 under Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $**396.78**/week for **0** weeks, commencing **March 4, 2009** through **March 6, 2009**, as provided in Section 8(b) of the Act.
Medical benefits
Respondent has paid all reasonable and necessary medical services as provided in Section 8(a) of the Act.
Respondent is not liable for Petitioner's treatment to the neck.
Permanent Partial Disability: Schedule injury
Respondent shall pay Petitioner permanent partial disability benefits of $ **357.10** /week for **12.65** weeks, because the injuries sustained caused the **5** % loss of the **right 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.

FINDINGS OF FACT

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

Eugene Coleman, (the "Petitioner"), testified that he was an H-grove operator for Precision Steel Warehouse, (the "Respondent"). Petitioner had been employed by Respondent for eight to nine (8-9) years. He testified that on February 17, 2009 he was operating the skiver machine, which cuts steel into long, thin pieces with smooth edges.

Petitioner testified that on February 17, 2009, while he was cleaning the burr off the machine, he felt steel go through his glove. Petitioner testified that he turned his entire body to the left and in the process, hit his right elbow on the skiver machine. On cross-examination, Petitioner testified that he moved his feet to the left when he struck his right elbow on the skiver machine. Petitioner testified that a shock and pain went up the right side, from his elbow to his neck.

Petitioner stated that he sought treatment immediately at Concentra Medical Center ("Concentra"). Petitioner testified that he received treatment for his finger cut in the office of the respondent and did not receive treatment for his finger at Concentra.

When the petitioner presented to Concentra, on February 17, 2009, he stated that "While working, I hit my right elbow on a piece of the machine." He complained of moderate pain and soreness, which radiated up to the base of his neck on his right side. Petitioner did not report a twisting injury to the neck. PX6.

On February 26, 2009, Petitioner returned to Dr. Bridgeforth at Concentra and reported right hand weakness and pain in his neck. Dr. Bridgeforth diagnosed the Petitioner with degenerative arthritis of the saddle joint of the right thumb. Dr. Bridgeforth made note that this was the first time Petitioner complained of these symptoms. PX 6

On March 6, 2009, Petitioner returned to Dr. Bridgeforth complaining of severe neck pain radiating down into his thumb and right finger. Dr. Bridgeforth explained to Petitioner that turning and hitting the right elbow on a machine would not produce severe injury. Dr. Bridgeforth found the Petitioner could return to work on a regular duty basis. PX6.

Petitioner presented to Dr. Sokolowski on May 18, 2009, who noted that Petitioner had a longstanding history of cervical stenosis. Dr. Sokolowski diagnosed Petitioner with cervical degenerative disc disease, cervical myelopathy, and cervical radiculopathy. Dr. Sokolowski did not provide an opinion as to causation however; he noted that the petitioner bumped his right elbow at work. He did not document a twisting injury to the petitioner's neck. PX2.

Petitioner denied any prior MRIs to his cervical spine during his testimony. However, Petitioner's Exhibit 3 contains an MRI of the cervical spine that the Petitioner underwent on February 5, 2008. The MRI revealed disc space narrowing at C4-5, C5-6, C6-7, and C7-T1. There were osteophytes contributing to neuroforaminal narrowing at C4-5, C5-6 and C6-7, to a moderate degree bilaterally. The MRI of February 5, 2008 was compared to an earlier MRI of the cervical spine taken on February 12, 2002. PX3.

Subsequent to the accident on February 17, 2009, the Petitioner underwent an MRI of the cervical spine without contrast, on April 10, 2009. The MRI revealed severe spinal stenosis at C3-C4 secondary to 3-4 mm central posterior disc protrusion. There was no definite abnormal signal identified in the cervical spine cord to suggest myelomalacia. Petitioner's MRI also revealed moderate to severe central spinal stenosis at C4-C5, C5-6 secondary to posterior disc osteophyte complexes. There was no definite abnormal signal identified in the cervical spine cord. Petitioner also demonstrated moderate, multi-level, cervical end-plate degenerative joint disease. PX3.

At the request of Dr. Scott Yen, petitioner's primary care physician, Petitioner was referred to Dr. Engelhard at the University of Illinois, who initially examined the Petitioner on August 11, 2009. The petitioner reported to Dr. Engelhard that his neck problem has been going on since February 17, 2009, when he was injured on the job. Dr. Engelhard noted that Petitioner hit his elbow. Dr. Engelhard makes no note of a history of a twisting injury to the Petitioner's cervical spine. Petitioner complained of neck pain which radiated into the right side of his shoulder and down into his arm. Petitioner reported that he had some difficulty with strength and walking generally. Petitioner was diagnosed with diabetes, cervical stenosis and cervical myelopathy, with radiculopathy on the right side of C4-C5 and C5-C6. Dr. Engelhard stated that Petitioner had a complex problem and that surgery alone would not alleviate his symptoms. PX5.

On September 9, 2009, the Petitioner underwent cervical laminectomy from C3-4 through C6 with bilateral foraminotomies. Petitioner's pre-operative and post-operative diagnosis remained cervical stenosis with myelopathy and cervical radiculopathy with foraminal stenosis.

On September 10, 2009, Petitioner presented for inpatient physical therapy. He reported a 6-month history of neck pain, right upper extremity pain, weakness and gait instability. Petitioner continued with inpatient physical therapy through his discharge on September 13, 2009. PX5.

On November 3, 2009, the Petitioner returned to Drs. Engelhard and Kouloumberis for a follow-up after surgery and reported that he was doing extremely well with three physical therapy sessions remaining. Petitioner's ambulation continued to improve. Petitioner reported minimal pain in the right shoulder and arm. He also stated that he was weaning off pain medications. Petitioner was advised to finish physical therapy and follow-up in one month. PX5.

15IWCC0386

Petitioner returned to Dr. Engelhard on December 15, 2009 and reported residual right arm pain though he was rarely taking pain medication. Physical examination revealed no weakness or sensory loss. Petitioner's incision was well healed and his gait was markedly improved. PX5.

On January 7, 2010, Dr. Engelhard reported to Petitioner's physical therapist that the petitioner had no weight or activity restrictions. PX5.

At trial, Petitioner reported that he could not cut bread and could not sit too long and had stiffness in his neck and shoulder. Petitioner also testified that he was using a TENS unit for his pain. Petitioner's medical records also revealed that the Petitioner has unrelated back and hip pain.

During his evidence deposition, Dr. Engelhard testified that Petitioner's condition of ill-being was caused by a twisting injury to the neck. Dr. Engelhard admitted that he did not know where he obtained the history of a twisting injury to the neck and that his opinion was based upon the petitioner's alleged twisting of the neck. Petitioner, at trial, did not testify to a sudden twisting of the neck. Petitioner testified that he physically moved his entire body to the left. PX1, pgs. 25, 46.

Dr. Espinosa, the Respondent's examining physician, testified that the Petitioner did not suffer a twisting injury to the neck and that the Petitioner's neck symptoms were not causally related to the injury of February 17, 2009. Dr. Espinosa first examined the Petitioner on April 7, 2009 and Petitioner reported that he had jumped and turned suddenly, simultaneously hitting his right elbow. Petitioner testified, at trial, that he turned his entire body and struck his right elbow on the machine.

Dr. Espinosa's physical examination did not reveal any evidence of myelopathy. Dr. Espinosa initially diagnosed the petitioner with a temporary dysfunction of the radial nerve. Dr. Espinosa reviewed the Petitioner's EMG, which revealed findings consistent with patients with diabetes. Dr. Espinosa opined that Petitioner did not aggravate a pre-existing condition but that Petitioner's symptoms were related to the peripheral neuropathy, which were chronic findings. RX1 pgs. 20-21, 27.

CONCLUSIONS OF LAW

15IWCC0386

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

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

15IWCC0386

Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

The parties agree that the petitioner sustained an injury to his right elbow and a minor injury to his finger, on February 17, 2009. However, the respondent disputes the petitioner's claim for an injury to his cervical spine because of hitting his elbow on the machine. It is the Petitioner's burden to prove, by a preponderance of the evidence, that he had an accident, at work, which caused his injury. The Arbitrator finds that the Petitioner has failed to prove, by a preponderance of the evidence and mechanism of injury, that the accident caused the chronic, permanent injury to Petitioner's cervical spine, as evidenced by diagnostic tests.

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

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

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

Petitioner's testimony at trial is not consistent with the history documented by Dr. Engelhardt. Dr. Engelhardt opined that the petitioner injured his cervical spine on February 17, 2009 because the Petitioner suffered a twisting injury to his neck. However, Dr. Engelhardt testified that he did not know from where he obtained the history noted in his report. The Petitioner did not testify to a twisting injury to his neck at trial. Petitioner testified that he turned with his entire body at trial. Dr. Engelhardt's testimony is not credible because it is not supported by the evidence introduced at trial. Dr. Engelhardt's opinion is based upon a history that the Petitioner did not provide.

15IWCC0386

Dr. Bridgeforth, the physician that initially treated the Petitioner, stated that the Petitioner's injury to the elbow would not cause injury to Petitioner's neck. Dr. Espinosa agreed. Dr. Espinosa relied upon petitioner's history of cutting his left index finger causing petitioner to jump and turn suddenly at the same time hitting his right elbow. Dr. Espinosa testified that the Petitioner's description of the mechanism of injury, would not result in a twisting injury to the neck. The history petitioner provided to Dr. Espinosa is more consistent with what the Petitioner testified to at trial. In addition, Dr. Espinosa credibly testified that the petitioner provided him with a history of the accident on which he relied upon, to form his opinion.

The Arbitrator finds the opinions of Dr. Espinosa to be more persuasive than those of Dr. Engelhard. Dr. Engelhard admitted that he did not perform a Spurling's maneuver and did not recall whether he tested Petitioner's Hoffmann's sign. Nevertheless, Dr. Engelhard diagnosed the petitioner with myelopathy. Dr. Engelhard's examination of the Petitioner revealed diminished grip strength on the left side as well as the right. Dr. Engelhard, during direct examination, testified that he reviewed Petitioner's medical records in 2007. However, on cross-examination he could not recall the findings of the petitioner's MRI taken on February 5, 2008.

Dr. Sokolowski diagnosed the Petitioner with myelopathy on May 18, 2009, three months after the injury. Dr. Sokolowski did not provide an opinion as to causation and he did not record a twisting injury to the Petitioner's neck.

The Petitioner's medical records confirm that he had prior complaints of neck pain to the extent that diagnostic tests were performed. Furthermore, the petitioner was also diagnosed with diabetes, which can cause poly-neuropathy. Dr. Espinosa testified that the grip strength tests were consistent with poly-neuropathy and that Dr. Engelhard had not performed or documented any physical findings of cervical myelopathy on physical examination. Dr. Espinosa opined that the petitioner's cervical laminectomy was not reasonable or necessary because there were no findings of spinal cord compression upon physical examination.

J. Were 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 Respondent has paid for all reasonable and necessary charges for treatment rendered to the Petitioner's right elbow. The Arbitrator finds that the Petitioner had reached maximum medical improvement on March 6, 2009, when he was released by Dr. Bridgeforth for the right elbow. Petitioner's claim for treatment to the cervical spine was not related to the accident of February 17, 2009. Respondent is not liable for medical charges related to the petitioner's cervical spine.

15IWCC0386

K. What temporary benefits are in dispute?

On March 6, 2009, Dr. Bridgeforth found that the etitioner was able to return to work full duty. The Petitioner did not return to work due to his complaints of neck pain. The Arbitrator finds that the Petitioner's neck symptoms were not causally related to the work injury. Therefore, the Petitioner was only temporarily totally disabled for two days and is not entitled to any benefits.

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

The Arbitrator finds that the Petitioner sustained a strain to his right elbow when he struck it against a machine on February 17, 2009. The Petitioner did not present any ongoing symptoms to his right elbow. The Petitioner's complaints at trial were to his neck and shoulder. The Arbitrator finds that the Petitioner's condition to the neck and shoulder are unrelated. As such, the Petitioner is entitled to an award of 5% loss of use of the arm for the contusion to the Petitioner's elbow, which caused a temporary irritation of the radial nerve.

For the above stated reasons, the Arbitrator finds that the Petitioner suffered a contusion of his right elbow, which caused a temporary irritation of the radial nerve. The Arbitrator finds that the Petitioner's surgery to the cervical spine was not causally related to the accident of February 17, 2009.

15IWCC0386

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
09WC 11197
SIGNATURE PAGE

L Thompson Scott
Signature of Arbitrator

May 23, 2014
Date of Decision

MAY 23 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antonio Almanza,

Petitioner,

15IWCC0387

vs.

NO: 13 WC 24833

Big Timber Landscaping Co,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

15IWCC0387

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,500.00. 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: MAY 22 2015

O4/21/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

ALMANZA, ANTONIO
Employee/Petitioner

Case# **13WC024833**

15IWCC0387

BIG TIMBER LANDSCAPING CO
Employer/Respondent

On 9/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0247 HANNIGAN & BOTHA LTD
KEVIN S BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0766 HENNESSY & ROACH PC
QUINN BRENNAN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0387

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)

Antonio Almanza
Employee/Petitioner

v.

Big Timber Landscaping Co.
Employer/Respondent

Case # **13** WC **24833**

An *Application for Adjustment 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 22, 2014, April 30, 2014, and May 16, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 22, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$5,281.09**; the average weekly wage was **$406.24.**

On the date of accident, Petitioner was **48** years of age, ***married*** with **1** dependent child.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$286.00**/week for **42 2/7^{ths}** weeks, commencing **July 25, 2013** through **May 16, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$12,275.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for left shoulder surgery as recommended by Dr. Scott Rubinstein.

Petitioner's claims for penalties and attorneys' fees are denied, because Respondent's dispute of accident was reasonable.

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

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

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

Milton Black

Signature of Arbitrator

September 3, 2014
Date

ICArbDec19(b)

SEP 3 - 2014

STATEMENT OF FACTS

Testimony of the Petitioner, Antonio Almanza

Petitioner testified that he began working for the respondent in April 2008 as a laborer. His job included cutting the lawn, planting trees and trimming. On July 22, 2013 he arrived at work at 6:00 a.m. and went to a job in Arlington Heights called Ventura. He testified that he worked with his foreman Mr. Juan Rodriguez. He testified that on the first job at Ventura he was trimming bushes with a power trimmer approximately 5 feet in length and that he was working by himself on a wooden "A" framed ladder which fell. Petitioner described the surface that the ladder was on as being like a little bit of a hill or an incline and indicated that the surface was uneven. Petitioner testified that while trimming the top of the bushes, the ladder toppled and he fell on the ground and partially on a concrete curb injuring his left neck area, his ribs, his lower back from the mid area towards the beltline and the left arm. The bushes he was trimming were 6 to 7 feet high and he was standing at the highest point on the ladder. He testified that immediately following the incident he had a conversation with his foreman, Juan Rodriguez and told him that he had fallen off the ladder and had injured his left shoulder. Petitioner testified that after doing one more stop that Juan Rodriguez took him back to the shop. Petitioner testified that at the respondent's location he informed Tyler Kedzie that he had injured his left shoulder and that Tyler told him to go and see a doctor. Petitioner then testified that he went home and when he got home he took some pills that his wife gave him and went to sleep. Petitioner testified that on Tuesday, July 23, 2013 is when they performed the Mariano's job in Arlington Heights and also a job at Harley-Davidson. He noticed that he could no longer work with his left arm that day and he went back to the shop at about 11:00 a.m. He testified that he again went home and called the doctor for an appointment. He further testified that he had a conversation with Tyler Kedzie and that his shoulder was bothering him a lot and that Tyler told him to go to the doctor again. Petitioner then presented himself for work on Wednesday, July 24, 2013, however did not work that day. He testified that early in the morning, he had a conversation with Colin Kedzie and that Colin told him that he should go to the doctor. Petitioner testified that he saw his primary care physician at Greater Elgin Family Care Center for the first time on July 25, 2013, and following the doctor's visit he went back to respondent and handed them his doctor's note indicating that he could not work. Petitioner testified that his primary care physician prescribed an MRI of the left shoulder and cervical spine on July 29, 2013 and he did not get the diagnostics done until September 17, 2013 because of a delay in insurance.

Petitioner testified that he had nothing to do with completing the job logs and that he never filled in or punched a timecard at work. Juan Rodriguez, the foreman kept and performed all the paperwork and kept track of the work hours.

On cross examination, Petitioner denied drinking alcohol on the job on July 22, 2013. He denied ever having a conversation with his foreman regarding any consumption of alcohol on the job. On direct examination, Petitioner testified that he worked a job at Mariano's on Monday, July 22, 2013 and on cross-examination conceded that the job at Mariano's was on Tuesday, July 23, 2013. He also denied any alcohol consumption on the job on July 23. 2013. He further testified that the foreman took him back to the shop because of left shoulder pain and not because of any drinking on the job. Petitioner testified that he understood a little bit of English and that Tyler Kedzie could speak Spanish. Petitioner denied ever having been reprimanded or suspended from work or punished in any way for drinking alcohol on the job.

On rebuttal testimony Petitioner testified that the job at Mariano's was on Tuesday July 23 and not July 22, 2013, the date of accident. He testified that he picked up garbage containers and all the garbage at the job. He testified that in the past, he would find six-packs of beers and even more, including big bottles of liquor. He

testified that the foreman, Juan Rodriguez, did not tell him that he had found any beer while working at the Mariano's job. Petitioner denied that at any time during his employment with Respondent did he ever consume alcohol beverages while on the job. He further testified that he did not carry a backpack but a cooler. He testified that his conversation with Tyler Kedzie on Friday July 26 was that he picked up his paycheck and Tyler told him to go to the doctor and that Tyler told him he was going to put him under workers' comp. Petitioner testified that he went to the Respondent's place of business on both Thursday July 26, 2013 to give them a copy of the doctor's note and on Friday, July 26, 2013 to pick up his paycheck. Petitioner testified that his final paycheck was delivered to him at this home by Adam who works for Respondent.

Testimony of Petitioner's witness, Maria Alvarado

Maria Alvarado testified pursuant to an Illinois Workers' Compensation Commission subpoena sent to her as the couple had been separated. She testified that she'd been married to the petitioner for nine years and currently resides with him. She testified that she works 3:30 p.m. until midnight daily and that on July 22, 2013 her husband, the Petitioner came home early before noon which was unusual. She testified that she was surprised that the Petitioner came home early on July 22, 2013 and that he told her that he had an accident at work when he fell from a ladder and injured his left shoulder. She testified that she gave him some Tylenol and then the Petitioner went to lie down and sleep. She testified that Petitioner went to work the next day and had left before she woke up. She testified that he also arrived home early before noon which was again unusual for him. She testified that at no point during July or August 2013 did she have any illnesses, was ever seen in a hospital or had to go see a doctor.

Medical Evidence

On July 25, 2013, Petitioner presented to Greater Elgin Family Care Center for treatment and was examined by Dr. Bhowmick. The medical history indicated a 48-year-old male presented with fall on Monday, 7/22/13 with an injury. Trauma type was fall which occurred at work. Associated symptoms included bruising and tingling in the arms. The patient fell off a ladder approximately 6 ft. to the ground and landed on left side onto gravel (Px.1 p.2). On review of systems hematology was positive for bruising (Px.1 p.3) Musculoskeletal exam revealed left rib tenderness, diffuse tenderness of the left shoulder (Px.1 p.4). Assessment was contusion of shoulder region and rib sprain (Px.1 p.4). The doctor ordered x-rays of the left shoulder, collar bone and ribs and he was given ibruprofen and Tramadol as directed for pain (Px.1 p.4). He was to remain off work until 7/29/13 (Px.1 p.10).

On July 29, 2013 he followed up with Dr. Bhowmick status post fall at work on 7/22/13. He still had a lot of pain in the left shoulder, upper back and neck with numbness of entire left arm. Assessment was acute left shoulder pain with numbness of left upper extremity, also pain in neck and upper back status post fall on left side 1 week ago. X-rays were negative (See Px.4). Dr. Bhowmick then ordered an MRI of the left upper extremity and an MRI of the cervical spine (Px.1 p.6-8). Petitioner was ordered off work until next follow up appointment on 8/1/13 (Px.1 p.11).

On September 17, 2013 an MRI of the left shoulder from St. Joseph Hospital showed a full thickness perforation supraspinatus with tendinopathy and cystic changes in the infraspinatus. There were also degenerative, inflammatory changes of the AC joint (Px.3 p.5).

On September 19, 2013, he followed up with his family physician for upper, middle and lower back pain. The context was a hard fall. Dr. Bhowmick ordered an MRI of his chest, neck, and lumbar spine (Px.2 p.4-9). On September 26, 2013, he followed up with Dr. Bhowmick, to review the MRI, which showed a partial tear. The doctor referred him for an orthopedic evaluation. He was seen again on September 27, 2013, by his PCP, He presents in the clinic for a left shoulder injury at work 7/25/2013, He was unable to get MRI done because of delay with workers comp. He is a landscaper and he is to use left upper extremity constantly. He has not been

able to work since injury. His orthopedic referral was in progress (Px2 p.16). Dr. Bhowmick issued a work note to certify that Petitioner is under his care and was seen in the office on 7/25/13, 7/29/13, 9/19/13, and 9/26/13 and is unable to return to work due to an injury (Px2 p.29).

On December 12, 2013, Petitioner was examined by Dr. Guido Marra at the request of the Respondent who reviewed the medical history and history of the accident. Dr. Marr opined that based upon the mechanism of the injury and review of the MRI scan and physical examination that the Petitioner's complaints related to his left shoulder are related to the work accident, and recommended arthroscopic surgery. Dr. Marra opined that Petitioner was not yet at maximum medical improvement and would need post-op physical therapy (Px.5).

On February 5, 2013, Petitioner saw his treating physician, Dr. Scott Rubinstein who opined that Petitioner was unable to return to work, and the diagnosis was rotator strain and possible tear and a lumbar sprain. Dr. Rubinstein recommended physical therapy (Px.6 p.3). Dr. Rubinstein noted a history of being injured back in July 2013 working as a landscaper trimming trees, standing on a ladder, the ladder tipped over and he fell down on his left side. He reviewed records from his family practitioner which involve an MRI and some medication, nothing further. There was a mention of an orthopedic referral, but this was never performed. The findings were consistent with either a very significant rotator cuff tendonitis or possibly a tear seen on the MRI, but since he has had little to no treatment, he did not think that it was right to jump to surgical management so he tried conservative measures first, including an injection of cortisone into the shoulder and orders a course of physical therapy for the lower back (Px.6 p.4-5). Petitioner began a course of physical therapy at Total Rehab PC on February 14, 2014. (See Px.7).

On February 26, 2014 Petitioner followed up with Dr. Rubinstein, and pain had improved, but he still had significant deficit in shoulder function. Petitioner did have a full thickness rotator cuff tear, noted on the MRI and would continue physical therapy (Px.6 p. 6-7). He was unable to work (Px.6 p.8). Due to the lack of improvement, on March 26, 2014, Dr. Rubenstein noted Petitioner was not responding to conservative treatment and he recommended arthroscopic surgery of the left shoulder. Petitioner was to remain off of work until surgery (Px.6 p.9-11).

Testimony of Respondent's witness, Juan Rodriguez

Juan Rodriguez testified on behalf of Respondent that he had worked as a foreman for the Respondent for 13 years. Among his job duties, was to complete job sheets for each job on a daily basis. This sheet details the hours and locations worked during the work shifts. He testified that they made four stops on July 22, 2013 the first stop being Ventura and Wilke which were both commercial locations separated by a street. Mr. Rodriguez and Petitioner arrived at this stop at approximately 7:00 a.m. He testified that he was cutting grass and the petitioner was supposedly trimming. This was at the Ventura stop. Mr. Rodriguez denied that Petitioner was ever on a ladder that day. However he also testified that there were very tall bushes and they had to knock off the top part of the bushes. Mr. Rodriguez testified that Petitioner got off the ladder, that Mr. Rodriguez himself climbed up the ladder, and that Petitioner was the one who was holding the ladder. Mr. Rodriguez testified that Petitioner was on the ladder at times that day, however that he was with the Petitioner at all times when he was on the ladder.

He testified that he climbed the ladder to trim the top part of the bushes. He denied witnessing Petitioner fall from a ladder on July 22, 2013. He denied that Petitioner ever reported to him that he fell from a ladder or that he had pain in his left shoulder.

Mr. Rodriguez confirmed that the ladder they use for pruning was made of wood. He also testified that he does the spraying regularly. He testified that while he was spraying Mr. Almanza did some pruning. He further confirmed that Petitioner used a power trimmer that day to prune bushes. He testified that there is trimming by "hills" requiring the use the ladder and that two people for the ladder, one of whom holds it.

Mr. Rodriguez testified that Petitioner did do some pruning that day and that he did not have his eyes on Petitioner for two hours straight, and that there were times that Petitioner was doing pruning where he could not see Petitioner. Mr. Rodriguez, however, continued to deny that Petitioner pruned the top of the trees.

Mr. Rodriguez testified that the following stop on the July 22, 2013, was at Mariano's, a retail store. A part of their job duties were to cut the grass and to pick up the garbage which included garbage from the parking lot. Mr. Rodriguez testified that he was spraying the weeds and he found a six pack of beer which he placed in a different location because he thought that Petitioner was the one who bought it. Later, he went to go find the beer in the location where he had hid them, he could not find them. From that point, he decided to go to back to the shop and he testified he did not want to say anything to anyone so that is why they left early that day. He testified that they did not complete their eight hours. He testified that he found the six-pack of beer near the truck and underneath a bush, and that he put three beers in a bush a little further away and supposedly the petitioner had been gathering up all the garbage around there and when he went to go look for them he could not find them. When questioned if any beers were missing from the six-pack when he found the six-pack he testified that there were only five and one was missing. He denied asking Petitioner whether he had been drinking on the job that day.

On cross examination Mr. Rodriguez testified that he found the beer cans while spraying the bushes. Mr. Rodriguez testified that he did not see Petitioner remove one of the beers from the six-pack nor did he actually see him drink a beer that day.

Mr. Rodriguez testified that there were two more stops in Elmhurst later that day (he could not recall the addresses) which they did not complete and returned to the shop early at approximately 1:00 or 1:30 p.m. because it was his belief that Petitioner had found beer.

Mr. Rodriguez confirmed that they never completed their eight hours of work that day. Respondent's Exhibit No. 1 and the timesheets show two hours at Ventura, two hours at Wilke, 1 1/2 hours at Salt Creek and 2 1/2 hours at Mariano's which equals a total of eight hours. Mr. Rodriguez could not explain the discrepancy in his testimony.

Testimony of Respondent's witness, Colin Kedzie

Colin Kedzie testified on behalf of Respondent that he is the director of operations for the past two to three years and his job includes overseeing the maintenance division, basically through scheduling of the maintenance contracts, building the roots, and doing a few sales. He puts together the crews and who they go with and who the foreman is. If there are any problems or any of the employees have issues with the equipment, he will attend to those issues. He testified he had no interaction with the Petitioner on July 22, 2013 or on July 23, 2013. He testified he spoke briefly with Petitioner on July 24, 2013 and that Petitioner told him that his wife was in the hospital or something along those lines and he would not be able to work Wednesday, Thursday, or Friday. He denied that Petitioner told him that he had fallen from a ladder. He denied that Petitioner ever reported to him that he had left shoulder pain. On cross examination he testified that if he knew that one of his employees was drinking on the job that they would probably fire him.

Testimony of Respondent's witness, Tyler Kedzie

Tyler Kedzie testified on behalf of Respondent that he is the designer/construction coordinator and has worked that job for approximately two to three years. He testified that he never had any interaction with the petitioner on July 22, 2013. He testified that the only interaction he may have had with the foreman, Juan Rodriguez, was with his brother to get their weekly day-to-day maintenance performed. Tyler Kedzie testified that he had no contact with Petitioner on July 23 or July 24 either. He testified that the first time he knew about the work injury was on Friday July 26, 2013 when Petitioner arrived at the location and advised him that he had fallen on the Monday and needed to go to a doctor. He testified that he told the petitioner at that time to bring in

any paperwork from the doctors. Petitioner said he would give it to him in the next couple of days and that would verify what it is he had issues with so they could start the process of figuring out what had happened. He testified that after this conversation Petitioner was given his paycheck and he left. He then spoke to Juan Rodriguez, the foreman who had just returned as well, and they went up to the office and had a closed meeting with the foreman to verify any of the allegations which the foreman denied. He testified that instead of the Petitioner presenting a doctor's note on Thursday July 25, that Petitioner actually presented the doctor's note to him on the Friday July 26 and indicated that he did not make a copy because their copy machine was not working that day. On cross examination when he testified that once learning of Petitioner's drinking on the job that they probably would have terminated him but as of this time he had not been officially terminated.

ACCIDENT

There are inconsistencies and contradictions in the testimony of the witnesses. The Arbitrator believes Petitioner's testimony that he fell off a ladder. The Arbitrator does not believe Juan Rodriguez's denials of such a fall or his assertions of drinking beer.

Therefore. the Arbitrator finds that on July 22, 2013 an accident occurred that arose out of and in the course of Petitioner's employment by Respondent.

CAUSATION

The sequence of events, the medical records, and the medical opinion of Dr. Guido Marra are consistent and corroborative.

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

PAST MEDICAL, PROSPECTIVE MEDICAL, AND TEMPORARY TOTAL DISABILITY

These disputes are based on liability, which has been resolved in favor of Petitioner.

Therefore. the Arbitrator finds that these claimed benefits shall be awarded.

PENALTIES AND ATTORNEYS' FEES

Although the Arbitrator does not believe Petitioner's foreman, it was not unreasonable for Respondent's principals to do so.

Therefore. the Arbitrator denies Petitioner's claims for sanctions.

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

Rebecca Goethel,
Petitioner,

15IWCC0388

vs.

NO: 13 WC 17062

Friendship Village,
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(s) of medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 29, 2014, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: MAY 22 2015

O4/21/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOETHEL, REBECCA
Employee/Petitioner

Case# **13WC017062**

FRIENDSHIP VILLAGE
Employer/Respondent

15IWCC0388

On 5/29/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0571 WITTENBERG DOUGHERTY MAGLIONE LTD
DANIEL MAGLIONE
105 W MADISON ST SUITE 600
CHICAGO, IL 60602

4412 ACCIDENT FUND HOLDINGS INC
GRACE DiGERLANDO
200 W MADISON ST SUITE 3850
CHICAGO, IL 60606-3465

15IWCC0388

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

Case # 13 WC 17062

Consolidated cases: N/A

Rebecca Goethel
Employee/Petitioner

v.

Friendship Village
Employer/Respondent

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

15IWCC0388

FINDINGS

On **May 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$14,788.28**; the average weekly wage was **$284.39**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$880.00** for TTD, **$N/A** for TPD, **$N/A** for maintenance, for a total credit of **$880.00**.

Respondent is entitled to a credit of **$8,946.34** for medical benefits that have been paid.

ORDER

Because the Petitioner failed to prove a causal relationship between her current condition of ill-being and her work injury, all benefits are denied.

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

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

Signature of Arbitrator

5/27/14
Date

MAY 29 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rebecca Goethel, **Petitioner,**	)	15IWCC0388
vs.	)	**No. 13 WC 17062**
Friendship Village. **Respondent.**	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The Petitioner has been employed by the Respondent as a home service worker since October of 2012. Petitioner's duties include bathing, wheelchair escorting, preparing meals and providing companionship for residents. (T. 7)

Non- Work Related Motor Vehicle Accident of February 7, 2013

The Petitioner testified that she was involved in a non-work related, rear-end auto collision on February 7, 2013. Petitioner presented at Alexian Brothers Medical Center Emergency Room the same day where she was assessed with thoracic and lumbosacral strains. Flexeril and Motrin were prescribed. (RX 6)

On February 12, 2013, the Petitioner was evaluated by Michael Taylor, a doctor of chiropractics, at Taylor Rehabilitation and Wellness Center who noted Petitioner's complaints of neck and lower back pain with radiation to the bilateral posterior thighs. Petitioner reported she was asymptomatic prior to the accident. The Petitioner reported a "constant, stabbing, sharp, throbbing, tingling" pain in her neck and lower back. The Petitioner complained that the pain was worse in her lower back. Dr. Taylor ordered the Petitioner off of work for two weeks. Chiropractic treatment and a lumbar MRI were also ordered. (RX 6)

On February 12, 2013, the Petitioner's lumbar MRI revealed:

> *a central herniation at L5-S1, bulging at L2-3 through L4-5 with narrowing of the foramina, mild spinal stenosis, partly congenital, a fibroid uterus and an umbilical hernia. At L4-L5 there a diffuse disk bulge protruding 2 mm was evident. At L5-S1, a central disk protrusion was measured at 3.3 mm.* (RX 6)

On February 25, 2013, Dr. Taylor noted Petitioner's back pain as severe, with increased stiffness, increased pain and decreased mobility since the last visit with muscle spasms reported at a 4/4. Petitioner reported she was unsure if she could perform her job duties. (RX 6, p. 63)

On March 19, 2013, Dr. Taylor noted Petitioner has not been able to return to her normal activities of daily living and that doing simple tasks increase her neck and back pain. Petitioner

reported that that she was experiencing "constant pain, stiffness and soreness in her neck and lower back" and continues to have pain with all movement. (RX 6, p. 72)

On April 29, 2013, Dr. Taylor noted that the Petitioner felt worse since her last examination and that she was scheduled to see pain specialist Dr. Paul Marsiglia, on April 30, 2013 for further evaluation of her lumbar and cervical issues. (RX 6, pg. 94)

On May 2, 2013, Dr. Taylor noted that Petitioner felt "much worse" since her last visit. Lumbar pain was noted to be increased and range of motion decreased. (RX 6, pg. 95)

Between February 12, 2013 and May 2, 2013, the Petitioner attended 34 sessions of chiropractic treatment/therapy for her cervical and lumbar issues with Dr. Taylor. (RX 6)

The Petitioner testified that she was off work the day of the automobile accident and that she had the next few days off of work and that she returned to work the following Monday with no restrictions. (T. p.10)

The Petitioner testified that she injured her "thoracic spine, my upper back" during the motor vehicle accident. She testified that there was no damage to her vehicle following the accident.

Work Related Accident of May 3, 2013

The Petitioner testified that on May 3, 2013, she was assisting a resident pull up her depends undergarment, when the resident began to fall. The Petitioner testified that she did not want the resident to "hit the ground," so she caught her and she landed on the Petitioner's legs. She testified that the patient weighed over 200 pounds. (T. 10) The Petitioner testified that she felt low back pain and a "pop" when the resident landed on her legs. She testified that the pain radiated down her bilateral legs. She testified that she reported the incident to her supervisor and was sent to the company clinic, Alexian Brothers. (T. 11–12)

On May 4, 2013, Dr. Taylor noted Petitioner's complaints of severe lower back pain since a work accident on May 3, 2013. Dr. Taylor prescribed a lumbar spine MRI as well as chiropractic treatment and therapeutic exercises three times a week for the next four weeks. The Petitioner was released to return to work with light duty restrictions and ordered not to lift in excess of10 pounds. (RX 6)

On May 7, 2013, a lumbar MRI impression revealed:

> The *"lumbar spine is essentially unchanged since previous study from February 2013. Unchanged 3 mm central disc protrusion at L5-S1 without stenosis. Unchanged mild right foraminal stenosis at L3-4."* (RX 6)

The Petitioner testified that she returned to work on May 4, 2013 and that she continued to work until August 1, 2013. Petitioner testified that she was off of work from August 1, 2013 through November 17, 2013. She testified that she received some temporary total disability benefits on a disputed basis. (T. 15-17)

On June 11, 2013, the Petitioner underwent another lumbar MRI pursuant to Dr. Taylor's orders

at Advantage MRI. Reportedly, the MRI exhibited disc herniations at L3-4, L4-5 and L5-S1. (RX 5)

On July 16, 2013, the Petitioner was evaluated by Dr. Marsiglia who diagnosed the Petitioner with thoracic or lumbosacral neuritis or radiculitis, displacement of the thoracic or lumbar intervertebral disc without myleopathy, myalgia and myositis. Physical therapy was prescribed along with Flexeril. (PX 2)

Between July of 2013 and October 31, 2013, Dr. Marsiglia administered two lumbar epidural steroid injections to the Petitioner.

On August 15, 2013, the Petitioner underwent bilateral L4-5 and L5-S1 transforaminal epidural steroid injections, which were performed by Dr Marsiglia. On August 29, 2013, it was noted that the epidural had provided the Petitioner with 5% relief. The Petitioner was released to return to light duty work and an EMG was prescribed. (PX 2)

On August 29, 2013, the Petitioner underwent an IME with Dr. Mark Levin. Reportedly, since her epidural two weeks ago, the Petitioner had experienced an increase in pain and leg weakness. (RX 1) Dr. Levin noted Petitioner's complaints of constant low back pain at a 7/10 to a 10/10 as well as leg pain which occurred one week after her work injury and radiated down both of her legs. Her leg pain was reportedly constant, at a 10/10 with intermittent numbness. Reportedly, the Petitioner could sit and stand for 5 minutes, she limped with minimal walking and drove for 20 minutes with increasing low back pain. The Petitioner admitted to treating with Dr. Taylor prior to her work injury and to being involved in a motor accident in January of 2013, but "had no pain from that and no litigation pending from that." (RX 1)

After evaluating the Petitioner, Dr. Levin noted that Petitioner had "marked subjective complaints of pain over the lumbar spine and lower extremities out of proportion to objective findings." Dr. Levin noted that Petitioner's "Pain Disability Questionnaire" exhibited an excessive pain rating and her clinical examination revealed multiple inconsistencies between subjective and objective findings. From an orthopedic standpoint, Dr. Levin noted that there was no evidence of any new objective pathology to the Petitioner's low back that was either caused or aggravated by the alleged incident of May 3, 2013. According to Dr. Levin, there were no objective findings to prevent the Petitioner from returning to full duty work. In Dr. Levin' opinion, any need to be off of work is coming from subjective pain, which has not been substantiated with true objective orthopedic pathology from an alleged work injury in May 2013." Dr. Levin opined that Petitioner appeared to be at MMI from any alleged work occurrence of May 3, 2013. Dr. Levin noted that he found no objective pathology related to May 3, 2013, which required any physical therapy or chiropractic care and he believed that the Petitioner had undergone excessive chiropractic care for subjective complaints. (RX 1)

On November 17, 2013, the Petitioner returned to light duty work for the Respondent. Petitioner testified that her restrictions were accommodated through March 18, 2014. (T. 24-25)

On January 11, 2014, the Petitioner was seen at that the Resurrection Emergency Room due to pain in her lower back. She testified that she was having an allergic reaction to the dye that was injected. She was discharged from the emergency room on the same day. (T. 20)

The Petitioner testified that she underwent a discogram on January 31, 2014 upon the referral of Dr. Dickson, a neurosurgeon, whom she was referred to by Dr. Taylor. (T. 18–19)

On February 4, 2014, the Petitioner went to the Northshore Emergency Room because with complaints of lower back and leg pain. (T. 20-21)

The Petitioner testified that she had received a Tens Unit from Windy City Medical and that she continued to use the Tens Unit for her lower back pain. The Petitioner testified that she was evaluated by Dr. Koutsky on March 12, 2014 upon the referral of Dr. Dixon. She testified that Dr. Koutsky prescribed a muscle relaxer, Naproxen, and physical therapy. The Petitioner testified that Dr. Koutsky also recommended a lumbar fusion. (T. 22-23)

The Petitioner testified that currently, she remained under active treatment and was receiving massage therapy for her lower back and legs. She testified that she experienced constant pain in her lower back and legs. The Petitioner testified that she had a hard time standing and sitting for long periods of time. Walking, sleeping and driving had become difficult. She testified that following her automobile accident she was able to work without pain and walk without assistance. Following her work accident, the Petitioner testified that the pain within her lower back and legs became worse and she began experiencing numbness throughout her legs. The Petitioner testified that her life had changed and she required assistance for "small daily tasks." (T. 25-27)

Petitioner has been treating with Dr. Taylor consistently through at least March 25, 2014. Manual therapy was provided and continued to be prescribed two to three times per week. Dr. Taylor diagnosed the Petitioner with lumbar disc displacement at L3–S1 with myelopathy, thoracic and lumbosacral myofascitis, lumbar radiculitis/neuritis and lumbar strain/sprain. (PX 1)

On September 16, 2013, an EMG study was conducted on Petitioner that was ordered by Dr. Taylor. The EMG findings reportedly showed a radiculopathy affecting the L5-S1 nerve roots predominately on the left. Dr. Taylor opined that the objective findings of Petitioner are related to the May 3, 2013, work accident. (PX 6)

On October 24, 2013, Dr. Marsiglia noted that he had reviewed Dr. Levin's IME. Dr. Marsiglia noted that "[u]nfortunately, I do not have the MRI images of the two different scans so I cannot tell if there has been a difference. However, even if there has been no change in objective findings on MRI, that does not exclude the fact that she could have been asymptomatic prior to the injury and now symptomatic after the injury." (PX 2)

On October 31, 2013, the Petitioner underwent bilateral L5-S1 and S1 transforaminal epidural steroid injections, which were administered by Dr. Marsiglia. The Petitioner did not return to Dr. Marsiglia thereafter. (PX2)

On November 25, 2013, Dr. Levin prepared an addendum report after reviewing the Petitioner's lumbar MRI films from February 2, 2013 and May 7, 2013. Dr. Levin noted that review of the studies revealed that "there was no serial change in the MRIs of the lumbar spine between those two dates." According to Dr. Levin, the pathology noted on the May 7, 2013 MRI was present on

the study of February 12, 2013. Dr. Levin noted that his prior IME opinions remained unchanged and he found "no evidence that there has been any true objective orthopedic pathology from an alleged occurrence of May 3, 2013". Dr. Levin performed an impairment rating and noted that the Petitioner was at "0% whole person impairment." (RX 2)

On December 10, 2013, Dr. Levin prepared another addendum report after reviewing the Petitioner's third lumbar MRI dated June 11, 2013. According to Dr. Levin, review of the Petitioner's MRIs exhibited that "all three have similar findings; the herniated disc at the L5-S1 level; as well as the chronic degenerative changes with bulging at L4-5." When comparing all three lumbar MRIs side by side, Dr. Levin noted that there was "no serial change of these lumbar findings, which were present starting on February 12, 2013 and remain unchanged on May 7, 2013 and June 11, 2013." Dr. Levin noted that his findings of August 29, 2013, and November 25, 2013, remained unchanged. (RX 3)

On January 11, 2014, the Petitioner was seen at Resurrection Emergency Room due to pain in her lower back. She was discharged from the emergency room on the same day. A Medrol Dosepak was prescribed. (PX 10)

On January 31, 2014, the Petitioner underwent a discogram, which was performed by Dr. Ossama Abdellatif. According to Dr. Abdellatif, the discogram exhibited that the Petitioner's pain was concordant with L4-5 and L5-S1 levels of discogenic pain and a percutaneous disc decompression procedure was recommended. (PX 8)

On February 4, 2014, the Petitioner was seen at the Northshore Emergency Room with complaints of low back and hip pain. Reportedly, she was able to ambulate without difficulty. Her medications were noted to be Valium and Naproxen. Toradol was provided and the Petitioner was advised to rest at home for one day. An MRI was performed at that time and revealed multilevel degenerative changes, neural foraminal stenosis greatest at L3-4, a right disc protrusion at L3-4, spinal canal stenosis greatest at L5-S1 with a mild bulge and superimposed right paracentral disc protrusion. (PX 11)

On March 12, 2014, the Petitioner was evaluated by Dr. Koutsky who noted that Petitioner did not bring her MRI scan and discogram with her. After evaluating the Petitioner, Dr. Koutsky diagnosed her with lower back and bilateral lower extremity pain. According to Dr. Koutsky, the Petitioner had failed conservative management and he requested a copy of her MRI images, discogram and EMG report. Medication was prescribed and Dr. Koutsky recommended that the Petitioner should continue with therapy. (PX 13)

OPINION AND ORDER

Causal Relationship & Prospective Medical

The burden lies with the claimant to establish the elements of a right to compensation. Wal-Mart Stores, Inc. v. Industrial Comm'n, 326 Ill.App.3d 438, 443, 761 N.E.2d 768, 773, 260 Ill.Dec.585, 590 (4th Dist. 2001) (citing *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill.App.3d 1103, 1106, 204 Ill.Dec. 354, 641 N.E.2d 578, 581 (1994)). This includes the burden of proving the existence of a causal relationship between the injury and the condition of ill-being.

Beattie v. Industrial Comm'n, 276 Ill.App.3d 446, 449, 657 N.E.2d1196, 1199, 212Ill.Dec.851, 854 (1st Dist. 1995).

The Arbitrator notes that the Petitioner clearly suffered from a pre-existing lumbar condition and that her testimony was with respect to that condition was not credible. Compensation has been denied by the Commission and affirmed by the Courts in numerous instances when the claimant's credibility was suspect and the contemporaneous medical histories conflicted with and/or failed to corroborate the claimant's testimony. Elliott v. Industrial Commission, 303 Ill.App.3d 185, 707 N.E.2d 228 (1999); McRae v. Industrial Commission, 285 Ill.App.3d 448, 674 N.E.2d 512 (1996); Banks v. Industrial Commission, 134 Ill.App.3d 312, 480 N.E.2d 139; Luby v. Industrial Commission, 82 Ill.2d 353, 412 N.E.2d 439 (1980).

Although the Arbitrator notes that benefits will not automatically be denied because of a pre-existing condition, recovery is only proper if it can be shown that the condition was aggravated or accelerated by the employment. The Petitioner must prove that "a work-related accidental injury aggravated or accelerated the pre-existing [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." St. Elizabeth's Hospital v. Workers' Compensation Commission, 371 Ill.App.3d 882, 864 N.E.2d 266, 272, 309 Ill.Dec. 400 (5th Dist. 2007).

Petitioner was involved in an undisputed work incident on May 3, 2013. However, after weighing the evidence and the testimony presented, the Arbitrator concludes that said incident had no effect on the Petitioner's pre-existing medical condition and that the Petitioner's current condition of ill being is not medically, causally related to the incident that occurred on May 3, 2013.

Based upon the aforementioned, the Arbitrator denies the Petitioner's request for prospective medical treatment.

In support, the Arbitrator emphasizes Petitioner's February 12, 2013, pre-work accident lumbar MRI as compared to Petitioner's post work accident lumbar MRI of May 7, 2013 which per the radiologist, revealed that the "*lumbar spine is essentially unchanged since previous study from February 2013. Unchanged 3 mm central disc protrusion at L5-S1 without stenosis. Unchanged mild right foraminal stenosis at L3-4.*" (RX 6)

Dr. Taylor ordered a third lumbar MRI, which was conducted at a different facility on June 11, 2013. Reportedly, the June MRI exhibited disc herniations at L3-4, L4-5 and L5-S1. (RX 5 and 6) The Arbitrator notes that Dr. Levin, an orthopedic surgeon, reviewed the studies and found no serial change in any of the films. (RX 1, 2 and 3)

The Arbitrator notes that the Petitioner's testimony with respect to her pre work accident automobile collision was not credible and was contradicted by the medical evidence. On direct exam, the Petitioner testified that her *upper back* was injured:

> Q: Going back to the auto accident in February, what part of your body did you injure in that accident?

A: It was my thoracic spine, my upper back. They said it was a back strain.

Q: The upper back, not the lower back mostly?

A: Yes. (T, p. 17)

Dr. Taylor's first note after Petitioner's auto collision notes complaints of "constant, stabbing, sharp, throbbing, tingling," pain in neck *and* lower back, *worse in her lower back.* (RX 6)

On February 25, 2013, Petitioner reported her lower back pain as severe, with increased stiffness, increased pain and decreased mobility since the last visit with muscle spasms reported at a 4/4. Petitioner reported that Petitioner was "unsure if she could perform her job duties (RX 6, p. 63)

On March 19, 2013, Dr. Taylor noted Petitioner reported that she has not been able to return to her normal activities of daily living and that doing simple tasks increase her neck and back pain. Petitioner reported that that she was experiencing "constant pain, stiffness and soreness in her neck and lower back" and continues to have pain with all movement. (RX 6, p. 72)

On April 29, 2013, Dr. Taylor noted that the Petitioner felt worse since her last examination and that she was scheduled to see pain specialist Dr. Paul Marsiglia, DO on April 30, 2013, for further evaluation of her lumbar and cervical issues. (RX 6; pg. 94)

On May 2, 2013, the day before Petitioner's work accident, Dr. Taylor noted that Petitioner felt "much worse" since her last visit. Lumbar pain was noted to be increased and range of motion decreased. (RX 6; pg. 95)

Between February 12, 2013 and May 2, 2013, the Petitioner attended 34 sessions of chiropractic treatment/therapy for her cervical and lumbar issues with Dr. Taylor. (RX 6)

Although the Petitioner testified that her pre-work incident complaints were related to her thoracic spine, this is clearly contradicted by the medical evidence which evidence ongoing and progressive lumbar issues and complaints.

In accord with the radiologist's findings with respect to the February 12, 2013 and May 7, 2013 lumbar MRI's as well as Dr. Levin's findings, the Arbitrator finds that the Petitioner presented no evidence of any new objective pathology to her low back that was either caused or aggravated by the incident of May 3, 2013. Dr. Levin noted that the Petitioner was symptomatic from a motor vehicle accident prior to her alleged work accident. Additionally, Dr. Levin noted that the Petitioner's physical exam exhibited multiple inconsistencies between subjective and objective findings and her Pain Disability Questionnaire exhibited an excessive pain rating. Dr. Levin diagnosed the Petitioner with "subjective low back discomfort out-of-proportion to objective findings." According to Dr. Levin, the Petitioner's "current findings were not substantiated to have true objective orthopedic pathology from the alleged occurrence of May 3, 2013." There were no objective findings to prevent the Petitioner from returning to full duty work and Dr. Levin opined that she was at maximum medical improvement from any incident that occurred on May 3, 2013. Furthermore, Dr. Levin opined that there was no objective pathology related to the May 3, 2013 occurrence that would require physical therapy or chiropractic care. Dr. Levin

opined that the Petitioner had undergone excessive chiropractic care for subjective complaints. (RX 1, 2 and 3)

The Arbitrator finds that the Petitioner failed to prove that her accidental injury of May 3, 2013 aggravated or accelerated her pre-existing lumbar condition. Based upon the credible evidence submitted, the Arbitrator finds that the Petitioner's condition of ill-being is not causally related to any work related incident occurring on May 3, 2013. Based upon the aforementioned, the Arbitrator denies the Petitioner's request for benefits and finds that the Petitioner is not entitled to any prospective medical treatment.

Outstanding Medical & Credit Due to Respondent

As the Arbitrator finds that the Petitioner's condition of ill being is unrelated to any incident that occurred on May 3, 2013, the Arbitrator denies the Petitioner's request for payment of all outstanding medical bills and awards the respondent a credit for all sums paid.

TTD

The Petitioner claims that she is entitled to temporary total disability benefits from August 1, 2013 through November 17, 2013 and from March 19, 2014 through April 10, 2014. The respondent disputed same and claimed a temporary total disability period of August 1, 2013 through August 29, 2013 (i.e. the date of the Petitioner's IME with Dr. Levin). The Arbitrator notes that the respondent paid temporary total disability benefits in the amount of $880.00 on a good faith basis pending the outcome of the independent medical examination. Based upon the IME findings of Dr. Levin on August 29, 2013 and the Arbitrator's finding that the Petitioner's current condition of ill being is unrelated to her incident of May 3, 2013, the Arbitrator denies the Petitioner's request for the payment of any additional temporary total disability benefits.

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

Diane M. Calais,

Petitioner,

vs. NO. 13WC 21834

Sodexo, Inc.

Respondent.

15IWCC0389

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, 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 June 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 Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

15IWCC0389

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

DATED: MAY 22 2015
SJM/sj
o-4/29/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

CALAIS, DIANE M
Employee/Petitioner

Case# **13WC021834**

15IWCC0389

SODEXO INC
Employer/Respondent

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0560 WIEDNER & McAULIFFE LTD
KRISTOPHER S DUNARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, MO 60606

15IWCC0389

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)

Diane M. Calais
Employee/Petitioner

v.

Sodexo, Inc.
Employer/Respondent

Case # **13 WC 21834**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **5/14/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/16/13**, 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 **$13,156.00**; the average weekly wage was **$253.00**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit for all medical benefits paid in this claim as listed in Respondent's Exhibit 6.

Respondent and Petitioner stipulate that Respondent is entitled to a credit for all group insurance benefits and short term disability payments under Section 8(j) of the Act.

ORDER

- The Petitioner failed to prove her current conditional of ill being is causally related to the alleged work injury.
- The Respondent is not liable for medical expenses incurred after the 4/16/13 incident.
- The Respondent is not liable for any alleged TTD benefits after the 4/16/13 incident.

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

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

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

Signature of Arbitrator

6/27/14
Date

ICArbDec19(b)

JUN 30 2014

RESPONDENT'S PROPOSED FINDINGS ON DIANE CALAIS V. SODEXO, INC.;
13 WC 21834.

With regard to the above-captioned matter, the Arbitrator finds the following:

FACTS:

The Petitioner is a 60 year old female who is employed as a food worker for the Respondent. She alleges that she sustained an injury to her left knee on April 16, 2013 after placing a box of chicken onto a cart and experiencing pain. The Arbitrator notes that accident is not in dispute. Although Petitioner experienced pain in her knee on April 16, 2013, the Arbitrator finds it significant that Petitioner underwent extensive treatment on her left knee dating back to 2008. Although Petitioner failed to introduce the records relating to her prior treatment at trial, the records were introduced into evidence by Respondent as RX 4.

In the face of the records, Petitioner acknowledged that she had undergone significant treatment on her left knee prior to the April 16, 2013 incident. She also acknowledged that Dr. Anderson had previously told her on several occasions that she would need a knee replacement in the future. With respect to her symptoms immediately prior to the incident, she stated that she had been working full duty and had not been taking any medication. After being confronted with Dr. Anderson's December 7, 2012 office note on cross examination, however, Petitioner acknowledged that she was in fact receiving medication for her left knee immediately prior to the incident, call into question Petitioner's credibility. She also acknowledged that her arthritis would occasionally "flare up" prior to the incident.

Medical Records Pre-dating Accident

The Petitioner met with Dr. Sola on October 16, 2008, where she presented a chief complaint of pain in her left knee. She denied suffering any specific traumatic injury. An MRI was performed, and reportedly showed a degenerative tear of the medial meniscus. (RX4).

The Petitioner ultimately underwent a diagnostic arthroscopy with chondroplasty of medial foraminal condyle on November 14, 2008. Petitioner's postoperative diagnosis was chondral defect of the medial femoral condyle in her left knee. (RX4).

The Petitioner participated in physical therapy from November through December of 2008. (RX4).

On December 31, 2008, Dr. Sola indicated further physical therapy was necessary to allow Petitioner to regain full use of her knee. (RX4).

Petitioner did not undergo further treatment on her left knee until her evaluation with Dr. Anderson on March 29, 2012. She reported her left knee pain had increased, but could not recall any specific mechanism of injury. On examination, tenderness, grinding, and popping were present in the knee. X-rays demonstrated moderate degenerative changes. Dr. Anderson diagnosed arthritis and opined the popping and catching could be related to the arthritis, but it was also a possible re-tear of the meniscus. Petitioner was given a cortisone injection. An MRI was also to be performed. (RX4).

Petitioner underwent the recommended MRI on April 3, 2012. It reportedly showed evidence of a flap tear of the posterior horn of the medial meniscus. Further, although the ACL was not evaluated very well, a chronic high-grade injury was suspected. Significantly, osteoarthritic changes with chondromalacic changes were also present. (RX4).

On April 12, 2012, Dr. Anderson reviewed the MRI images and informed Petitioner that she likely needed a knee replacement down the road. He diagnosed a medial meniscal tear of her left knee with degenerative changes and recommended an arthroscopy/partial meniscectomy.

Petitioner returned to Dr. Anderson on May 29, 2012, where it was noted the Petitioner's pain was improving after her procedure. At the time of the appointment, the doctor noted the petitioner's sutures were out, but the Petitioner did have a fair bit of chondromalacia in her knee. (RX4).

The Petitioner returned to Dr. Anderson on August 28, 2012, where she reported pain in her left knee after falling. The doctor opined the petitioner strained her knee, which should heal uneventfully. He recommended a shot of cortisone and restricted activity. If the Petitioner's pain did not resolve, he believed another shot of cortisone would be necessary. (RX4).

On September 18, 2012, the Petitioner returned to Dr. Anderson reporting she was miserable despite the cortisone shot and physical therapy. An MRI scan indicated a tear or post-operative change. The doctor noted he was unable to tell which was more likely. The doctor offered various treatments, including cortisone, physical therapy, and hyaluronic acid. The Petitioner stated she would like to consider an arthroscopic intervention. (RX4).

On September 19, 2012, Dr. Anderson performed an arthroscopy and partial meniscectomy. The Petitioner was diagnosed with a medial meniscal tear with moderate chondromalacia. (RX4).

The Petitioner returned to Dr. Anderson on November 1, 2012 with a chief complaint of left knee pain. Dr. Anderson administered a Euflexxa injection for Petitioner's arthritis. Dr. Anderson also opined the Petitioner would be able to return to full work duty work on November 19, 2012. (RX4).

The Petitioner returned to Dr. Anderson on November 8, 2012, and he administered a second Euflexxa injection. (RX4).

Petitioner underwent a third Euflexxa injection on November 15, 2012. She reported that her knee was not 100%. Dr. Anderson released Petitioner to return on an as needed basis. However, he indicated that Euflexxa injections could be repeated again in six months and cortisone shots could be repeated if petitioner experienced "breakthrough pain." He once again stated that Petitioner was headed for knee replacement surgery. (RX4).

The Petitioner returned on December 7, 2012, after experiencing a "flare up" in her knee pain. She denied any trauma or injury. Upon examination, it was noted the Petitioner had tenderness along the medial joint line with some subpatellar crepitation through the arc of motion. She also had range of motion from about 2° to about 110°. Dr. Anderson administered a cortisone injection. He also prescribed Naprosyn and arthritis medicine to address Petitioner's continuing left knee complaints. (RX4).

Medical Records Post Accident

The Petitioner next met with Dr. Anderson on April 30, 2013 with continued complaints of left knee pain. By history, she stated she twisted her knee when she was picking up a heavy box. The Arbitrator finds it significant that Petitioner's objective findings on examination remained largely the same when compared to the 12/7/12 visit. Namely, Petitioner continued to experience tenderness along the medial joint line with mild crepitus. In addition, Petitioner's range of motion had actually improved since her December 7, 2012 visit and was noted to be from 0° to about 110°. (PX3).

Dr. Anderson ultimately opined the Petitioner had predominantly degenerative changes and diagnosed Petitioner with a degenerative knee. He recommended a shot of cortisone or

Euflexxa and indicated he was reluctant to scope the knee because of the amount of arthritis. (PX3).

An MRI was performed on May 22, 2013. It was interpreted to show a large radial tear of the medical meniscal posterior horn at the meniscal root with extrusion of the medial meniscal body from the medial joint space. Further, there was proximal patellar tendinosis with thickening and edema, but there was no evidence of a definite defect. The doctor further opined it was likely mixed Grades III–IV chondrosis of the medial femoral condylar. (PX5).

On May 30, 2013, Dr. Anderson administered a Euflexxa injection. The doctor also discussed the possibility of knee replacements in both knees, but the Petitioner wanted to wait on that procedure. (PX3).

During his June 6, 2013 visit Dr. Anderson reviewed Petitioner's May 22, 2013 MRI scan. He interpreted it to show meniscal pathology. Petitioner elected to proceed with arthroscopic surgery despite Dr. Anderson's suggestion that it may not help due to her significant arthritis. (PX3).

On June 27, 2013, Dr. Luke Choi performed an Independent Medical Examination. After taking a history from Petitioner, reviewing her medical records, and performing a physical examination, Dr. Choi diagnosed pre-existing advanced osteoarthritis with degenerative medial meniscus tear. He did not recommend any further knee arthroscopies as the results were unfavorable and unpredictable in the setting of advanced osteoarthritis. Although Dr. Choi believed Petitioner's pain was primarily due to her pre-existing complaints, he indicated that he would not render a causation opinion until reviewing Petitioner's pre and post incident MRI images. (RX1).

Petitioner underwent arthroscopic surgery on July 17, 2013 with Dr. Anderson. (PX7).

Dr. Anderson administered a cortisone injection on July 30, 2013 after Petitioner reported her complaints continued. He also prescribed physical therapy. (PX3).

On August 27, 2013, Petitioner reported that her left knee was better, but not 100%. She reported that she was doing fine overall and anticipated returning to work in a couple of weeks. Dr. Anderson administered another cortisone injection. (PX3).

Dr. Anderson administered a Euflexxa injection on September 5, 2013. (PX3).

Petitioner received another Euflexxa injection on September 12, 2013 and reported she was doing fine overall. Dr. Anderson noted he was pleased with her progress and released her to return on an as needed basis. He once again indicated that she would need a knee replacement at some point in the future. He indicated Petitioner could repeat the Euflexxa injections in 6 months, and have cortisone injections if she had breakthrough pain. The Arbitrator notes that this is the exact same recommendation Dr. Anderson made during his last pre-incident visit on December 7, 2012. (PX3).

Although Dr. Anderson did not address Petitioner's work status in his office note, he prepared a report on September 20, 2013 indicating that Petitioner could return to work as of September 30, 2013. (RX9).

The petitioner presented to Dr. Whiteside of the Missouri Bone & Joint Center on September 16, 2013 complaining of moderate to severe right knee pain and severe left knee pain. Although the notes from the visit are handwritten, it appears that Dr. Whiteside diagnosed Petitioner with severe degenerative joint disease and recommended a left total knee replacement. (PX9).

On September 26, 2013, Petitioner underwent the recommended left total knee replacement. Dr. Whiteside noted that Petitioner gave a history of having problems with her left

knee for many years with progressive worsening pain over the last six to eight months and was now severely disabled. He also noted progressive varus deformity. Although she had undergone conservative treatment, it had not provided any significant improvement. Dr. Whiteside noted that X-rays taken reportedly showed severe degenerative arthritis, medial collapse, sclerosis, lateral osteophyte formation, posterior osteophyte formation, and mild patella drift toward the lateral on the patellar view. He also noted that Petitioner had undergone left knee surgery on four occasions between 2008 and 2013 without significant improvement in her knee. He diagnosed osteoarthritis in the left knee. Significantly, he did not state that Petitioner's total knee replacement was related to her alleged work injury. (PX10).

Petitioner presented to Collinsville Physical therapy on October 22, 2013 for an initial physical therapy evaluation. It was noted that Petitioner displayed decreased range of motion, especially with knee extension, decreased strength, increased swelling, and increased difficulty with gait and stair climbing. Petitioner was to attend physical therapy three times a week for the next four weeks. (PX8).

A November 19, 2013 physical therapy note indicates that Petitioner's knee pain and function had improved considerably. She had excellent knee flexion and good quadriceps strength. It was noted that her progress had been limited by a recent illness. She was instructed to continue physical therapy two times a week for the next four weeks. A December 10, 2013 note from Collinsville Physical Therapy indicates that Petitioner's knee pain and function continued to improve considerably. Excellent knee flexion, range of motion, and good quadriceps strength was present. Petitioner was to continue therapy twice a week for the next two weeks. (PX8).

Dr. Choi prepared an addendum IME report on December 1, 2013 after reviewing four operative reports relating to petitioner's left knee, along with pre and post incident MRI images of Petitioner's left knee. Based upon his review and previous examination of Petitioner, Dr. Choi's diagnosis remained preexisting advanced left knee osteoarthritis with a degenerative medial meniscus tear. In terms of causation, Dr. Choi indicated that the work-related injury did not cause, substantially aggravate, or accelerate Petitioner's preexisting osteoarthritic condition with a degenerative meniscal tear. Instead, he believed that Petitioner's injury was more consistent with a temporary exacerbation of her preexisting left knee condition as there was no evidence of structural damage which would change the course of her pre-existing condition. (RX2).

Significantly, Dr. Choi indicated that Petitioner had no acute findings after he compared a pre-incident 9/10/12 MRI to a post-incident 5/22/13 MRI. He noted that both pre and post incident imaging revealed a large radial tear of the posterior horn of the medial meniscus which extruded from the joint space by about 3.5 mm. In terms of further treatment, Dr. Choi recommended a total knee replacement for Petitioner's advanced degenerative joint disease, but indicated that it would not be related to the work injury in question. (RX2).

The Arbitrator notes that no records subsequent to December 1, 2013 were entered into evidence. However, Petitioner testified at trial that she returned to work full duty on February 25, 2014.

Dr. Peter Anderson Deposition Testimony

Petitioner undertook Dr. Peter Anderson's deposition on January 23, 2014. (PX 11). Dr. Anderson is a Board Certified orthopedic surgeon. (PX 11, p.4). Dr. Anderson indicated that he first evaluated petitioner on April 30, 2013. At that time. Petitioner reported that she was lifting

a heavy box when she twisted her left knee. (PX 11, p.10) Although Dr. Anderson was uncertain whether Petitioner's symptoms were due to her alleged incident during his initial visit, he ultimately came to the conclusion that Petitioner suffered a medial meniscus tear. (PX 11, p.11-14) This was based on his interpretation of the May 22, 2013 MRI, which he interpreted to show a radial meniscus tear of the posterior horn. (PX 13, p.4) He believed this was a new finding when compared to Petitioner's previous MRIs. (PX 13, p.4)

Given Petitioner's symptoms, he performed an arthroscopic medial meniscectomy. (PX 11, p.16) Postoperatively, Dr. Anderson released her to return on an as needed basis during his September 12, 2013 visit. (PX 11, p.18) At that time, he indicated she could follow up in six months for a Euflexxa injection if needed, and follow up with Cortisone injections. He further noted that he recommended Petitioner hold off on the total knee replacement as long as possible. (PX 11, p.18)

For the first time, Dr. Anderson provided an opinion with respect to causation. Dr. Anderson believed that the need for Petitioner's arthroscopic surgery was related to the alleged 4/16/13 incident based on the MRI findings of a medial meniscus tear. (PX 11, p.14) Additionally, Dr. Anderson believed that the 4/16/13 incident accelerated the need for Petitioner's total knee replacement. (PX 11, p.19)

On cross examination, Dr. Anderson acknowledged that Petitioner underwent significant treatment on her left knee dating back to 2008, which included cortisone injections, Euflexxa injections, and arthroscopic surgeries to treat her degenerative condition. (PX 11, p.23-24) In addition, he acknowledged that he previously advised Petitioner that she would likely need a total knee replacement in the future during her April 2012 and December 7, 2012 visits. (PX 11, p.29) With respect to Petitioner's post-incident treatment, Dr. Anderson admitted that Petitioner

was doing well overall during his final examination on September 12, 2013, and her future treatment plan would be essentially consistent with what it was pre-incident. (PX 11, p.36-37).

Finally, after reviewing Petitioner's physical therapy discharge form dated September 19, 2013, he noted that her pain had been reduced to 2/10. In his opinion, with such low pain complaints, he would not typically perform or recommend a total knee replacement. (PX 11, p.39-40)

Dr. Luke Choi Deposition Testimony

Respondent undertook Dr. Luke Choi's deposition on March 19, 2014. Dr. Choi testified that he is a board certified orthopedic surgeon. (RX3, p.4). He had the opportunity to perform an independent medical examination of Petitioner on June 27, 2013, and also prepared an addendum IME report on December 1, 2013. (RX3, p.6,10). He also had the opportunity to review Petitioner's medical records, conduct a physical examination, and also review diagnostic imaging from before and after the alleged incident. (RX3, p.9-11). He noted that Petitioner had an extensive past medical and surgical history with respect to her left knee. (RX3, p.11). Specifically, Petitioner had undergone arthroscopic surgery in 2008, April of 2012, and September of 2012. (RX3, p.7). After reviewing the diagnostic imaging, the multiple MRIs of the left knee revealed evidence of degenerative joint disease, most pronounced along the medial compartment with near full thickness cartilage loss due to degenerative meniscal pathology. (RX3, p.12).

With respect to causation, Dr. Choi did not believe that Petitioner's work incident aggravated or accelerated her preexisting osteoarthritic condition with a degenerative meniscal tear. (RX3, p.13-14). Instead, he believed Petitioner's incident was more consistent with a temporary exacerbation, and was not consistent with something that would change the natural

course of Petitioner's condition. In support of his opinion, Dr. Choi noted that the September 10, 2012 MRI was unchanged when compared to Petitioner's post-incident May 22, 2013 MRI. Thus, there was no evidence of any acute interval change when comparing the two MRIs.

With respect to Petitioner's treatment, Dr. Choi indicated that the left knee arthroscopy performed on July 16, 2013 was unreasonable and unnecessary. (RX3, p.15). He noted that, given Petitioner's severe end-stage osteoarthritis, the arthroscopy would not alleviate any of her symptoms. (RX3, p.15). Further, even if the surgery was reasonable, Dr. Choi did not believe it would be due to Petitioner's alleged work incident, given that there were no new findings. (RX3, p.14). Such an opinion is supported by the facts in the record. Namely, that Petitioner's pain complaints did not completely resolve after the arthroscopic surgery, and she ultimately proceeded with a total knee replacement.

Dr. Choi also noted that he had the opportunity to review additional records which revealed Petitioner underwent a left total knee replacement prior to his deposition. (RX3, p.16). In his opinion, a total knee replacement was reasonable and necessary. (RX3, p.16). However, it would be related to Petitioner's preexisting severe degenerative arthritis. (RX3, p.16-17).

On cross-examination, Dr. Choi admitted that Petitioner did not appear to undergo treatment between her last visit with Dr. Anderson in December of 2012 and her alleged work incident in April of 2013. (RX3, p.27). However, Dr. Choi viewed this break in treatment as irrelevant, and once again reiterated that the MRI findings pre and post-incident showed no acute findings. (RX3, p.39). Dr. Choi also disagreed that Dr. Anderson was in a better position to render an opinion as Dr. Choi had the opportunity to review all of petitioner's prior medical records and diagnostic imaging. (RX3, p.21-24).

CONCLUSIONS OF LAW:

As to F, whether the petitioner's present condition of ill-being is causally related to the injury, the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being and need for both surgeries is related to her April 16, 2013 work incident. The Arbitrator's decision is based on 1) Petitioner's longstanding history of prior left knee complaints, 2) Dr. Anderson's questionable opinion, which is contradictory to his medical records, and 3) Dr. Choi's credible causation opinion.

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. See, e.g., *Parro v. Industrial Commission*, 260 I11.App.3d 551 (1993). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill. App. 3d 289 (1986). The courts have established that when a pre-existing condition is aggravated by employment, it may constitute a work-related accident. *Peoria Motors v. Industrial Comm'n*, 92 Ill. 2d 260 (1982); *Cook Co. v. Industrial Comm'n*, 68 Ill. 2d 24 (1977). However, the claimant bears the burden of showing that the pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Lawless v. Industrial Comm'n*, 96 Ill. 2d 260 (1983); *Lyons v. Industrial Comm'n*, 96 Ill. 2d 198 (1983). Additionally, compensation will be denied where an injured employee's health has deteriorated so that any normal daily activity is an aggravation. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193 (2003).

In this case, it is clear that Petitioner had severe degenerative findings in her left knee dating back to 2008. These findings are confirmed by several pre-incident MRIs, which show severe degenerative changes in the knee and an actual degenerative tear in the same spot. Petitioner also underwent significant pre-incident treatment on her knee in the form of three arthroscopic knee surgeries. She subsequently underwent three Euflexxa injections to treat her arthritis prior to her April 16, 2013 incident. Additionally, Dr. Anderson himself indicated in his April 12, 2012 and November 15, 2012 notes that Petitioner was headed for a total knee replacement.

With respect to Petitioner's left knee condition prior to the incident, Petitioner testified that she was not experiencing any pain in her left knee and was not taking any medication. However, on cross examination Petitioner admitted that she had been prescribed Naprosyn and arthritis medication, which she would take as needed. Petitioner also stated in Dr. Anderson's November 1, 2012 note that her knee was not 100%. (RX4). The Arbitrator finds that this inconsistent testimony raises doubts as to the exact nature of Petitioner's complaints prior to her April 16, 2013 incident, and therefore, it is difficult to discern whether Petitioner's post-incident complaints differ from her pre-incident complaints. It also raises doubts as to Petitioner's credibility.

Although Dr. Anderson testified that Petitioner's need for a total knee replacement was at least accelerated by the April 16, 2013 incident, the Arbitrator finds this inconsistent with Dr. Anderson's own treatment records. Specifically, Dr. Anderson discharged Petitioner from care on September 12, 2013, and noted that she could return to work as of September 30, 2013. His treatment plan upon discharge was the exact same as the treatment plan during Petitioner's pre-incident November 15, 2012 visit. Namely, he indicated that Euflexxa injections could be

repeated again in six months and cortisone shots could be repeated if petitioner experienced "breakthrough pain." He once again stated that Petitioner would likely need knee replacement down the road, but noted that he would like to hold off on the procedure as long as possible. Dr. Anderson also acknowledged in his deposition that he would not typically recommend a total knee replacement on someone with Petitioner's level of pain complaints at the time of her discharge from physical therapy. The logical conclusion from Dr. Anderson's records is that he did not believe Petitioner needed a total knee replacement at the time of his September 12, 2013 visit. Therefore, the Arbitrator finds Dr. Anderson's opinion that Petitioner's April 16, 2013 incident accelerated the need for a total knee replacement to be inconsistent with his medical records.

Despite his medical records, Dr. Anderson painted a different picture during his deposition. For the first time, he indicated that the need for Petitioner's total knee replacement was work related. Not surprisingly, Petitioner did not seek the total knee replacement from Dr. Anderson, but instead presented to Dr. Whiteside to have the procedure performed. Dr. Whiteside diagnosed osteoarthritis in the left knee, but never rendered an opinion that petitioner's total knee replacement was related to her alleged work injury. (PX10). As a result, Dr. Anderson, who did not actually perform the surgery, and who recommended holding off on the knee replacement as long as possible during his last visit, is the only one of Petitioner's treating physicians to render a "causation opinion."

In contrast to Dr. Anderson, the Arbitrator finds that Dr. Choi credibly testified consistently with his IME reports. Namely, Dr. Choi did not believe that the work-related injury caused, substantially aggravated, or accelerated petitioner's preexisting osteoarthritic condition with a degenerative meniscal tear. Instead, he believed that Petitioner's injury was more

consistent with a temporary exacerbation of her preexisting left knee condition as there was no evidence of structural damage which would change the course of her pre-existing condition. (RX2).

The Arbitrator also finds it significant that Dr. Choi had the opportunity to review all of Petitioner's medical records, pre and post incident MRI imaging, and conduct a physical examination. Further adding to Dr. Choi's credibility is the fact that he would not render a causation opinion during his initial IME on June 27, 2013, until he was able to review Petitioner's pre and post incident diagnostic imaging. Ultimately, after reviewing the imaging in a sequential order Dr. Choi did not find any significant acute findings. He further noted that the degenerative findings in Petitioner's knee, including the degenerative meniscal tear, were present prior to the April 16, 2013 incident.

The Arbitrator also notes that this decision is in line with prior Commission cases denying benefits in similar situations. For example, in Joseph W. Malecki v. Team Mechanical, Inc, 12 IWCC 0793, the claimant twisted his right knee at work. He had a pre-existing degenerative right knee condition and his MD's pre-accident records note that he had severe degenerative changes in the knee, that it was getting progressively worse, and that he was a potential candidate for a total knee replacement.

The total knee replacement was ultimately performed, and the history was "severe progressive degenerative arthritis", but no mention was made of a work accident. Respondent's Section 12 MD opined that claimant's condition was due to the severe degenerative arthritis of his right knee, and that the work accident was merely a temporary aggravation. At claimant 's attorney's request, petitioner's MD wrote a report in which he opined that claimant was having no problems with his right knee until he sustained an injury at work. Id.

The Commission found this to be clearly at odds with the MD's own records, as the claimant was a surgical candidate prior to the date of accident, and the accident did not cause the need for surgery or aggravate his condition to the point where he needed surgery. Therefore, the Commission held that the claimant failed to prove a causal connection between his current condition of ill-being and an injury in the workplace. Id.

Similarly, Dr. Anderson's records here contradict his deposition testimony, which was rendered at the request of Petitioner's attorney. Specifically, his records and Petitioner's testimony reveal that she was experiencing left knee pain shortly before her April 16, 2013 incident. Dr. Anderson also indicated on several occasions prior to the incident that Petitioner was headed for a total knee replacement. Additionally, Dr. Anderson's records are devoid of a causation an opinion that the need for the total knee replacement was accelerated by the work incident, and he did not render such an opinion until his deposition. Even more importantly, Petitioner had severe degenerative findings and degenerative meniscal tears on her pre-incident MRI, which were unchanged when compared to her post-incident imaging. As a result of these considerations, the Arbitrator finds the present case analogous to Malecki.

Based on Petitioner's severe pre-existing left knee condition, Dr. Choi's credible causation opinion, and Dr. Anderson's questionable causation opinion, the Arbitrator finds that Petitioner failed to prove that her current condition of ill-being is related to her employment and denies all benefits.

As to J, whether the medical services that were provided to Petitioner were reasonable and necessary, the Arbitrator concludes as follows:

Incorporating the aforementioned finding that the Petitioner failed to prove that her injuries are causally related to her job duties, petitioner is owed no medical expenses.

Even assuming that Petitioner's current condition of ill-being is related to her work incident, the Arbitrator denies expenses for the July 16, 2013 arthroscopic surgery as unreasonable and unnecessary based on Dr. Choi's testimony. Specifically, Dr. Choi testified that given petitioner's severe end-stage osteoarthritis, the arthroscopy would not alleviate any of her symptoms. The Arbitrator also notes that Dr. Anderson himself was hesitant to perform an arthroscopy, and noted in his April 30, 2013 office note that Petitioner would "wind up chasing her own tail" due to the severe degenerative condition of her knee. (PX 3).

Dr. Choi also did not believe that there were any new findings, which warranted the procedure. Although Dr. Anderson testified that he interpreted the post-incident MRI to show a new meniscal tear, and that surgery was warranted in an attempt to delay the total knee replacement, the Arbitrator does not find his opinion as persuasive as Dr. Choi's. This is based on the fact that Dr. Choi had the opportunity to review all of Petitioner's pre and post incident MRI images at once. Although he did agree after his review that a meniscal tear present on the post-incident MRI, he made clear the tear was degenerative in nature and could also be seen on the pre-incident MRIs.

Based on these considerations, the Arbitrator denies the July 16, 2013 surgery as unreasonable and unnecessary.

As to K, what amount of compensation is due for temporary total disability, the Arbitrator concludes as follows:

Incorporating the aforementioned finding that the Petitioner failed to prove that her injuries are causally related to her job duties, the Arbitrator finds the Petitioner is owed no TTD benefits.

As to N, whether Respondent is due any credit under Section 8(j) of the Act, the Arbitrator concludes as follows:

The Arbitrator finds that Respondent is entitled to a credit for any payments made under Section 8(j) of the Act by stipulation of the parties.

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bradley Ritter,

Petitioner,

vs.

No. 12 WC 19605
15IWCC0390

Imperial Woodworking Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

On June 5, 2012, Petitioner filed an application for adjustment of claim alleging he injured his left hip "while working" on May 11, 2012. Petitioner, who was 51 years old at the time of the alleged accident, testified that he worked as a union finish carpenter for 15 years. His job duties included installing cabinets, doors, crown molding and baseboards. He also did structural work inside the walls to make sure they could accommodate the loads. He often lifted items weighing 120 to 160 pounds, and sometimes heavier items, weighing up to 400 pounds, with the help from another person.

Petitioner further testified that he began working for Respondent in 2008. He worked for Respondent 834 hours between August and December of 2008, corresponding to approximately 40 hours a week. In 2009, Petitioner worked for Respondent for a little over half a year. In 2010, Petitioner worked for Respondent and another employer. In 2011, Petitioner worked only

for Respondent, clocking in 1,954 hours, corresponding to approximately 40 hours a week. Petitioner stated he worked a lot of overtime in 2011 and felt the pressure to work fast.

Petitioner further testified that midway through 2011, he developed symptoms in his left leg. He consulted his primary care physician, Dr. Nicholas Papanos, who referred him to the Illinois Bone & Joint Institute. On August 25, 2011, Petitioner saw Dr. Marc Breslow at the Illinois Bone & Joint Institute, who recommended an injection into the left hip. Petitioner decided against the injection. Petitioner explained the reason he consulted Dr. Breslow was because he had severe pain in the left hip while working. He did not have the pain when he was not working.

Petitioner further testified that he continued to work full-time through April of 2012. He found it difficult to perform his job duties. He talked to his foremen about the problem with the left leg, and the foremen assigned him lighter tasks when they could. Petitioner took over-the-counter pain medication to help alleviate the pain. In April of 2012, the left hip felt "[p]retty bad," prompting Petitioner to consult Dr. Ritesh Shah, an orthopedic surgeon at the Illinois Bone & Joint Institute. Dr. Shah performed an injection into the hip. After the injection, the hip felt "fine" when Petitioner was off work. The hip started to hurt again when Petitioner returned to work. He was able to perform his job duties, but with difficulty.

Petitioner further testified that on May 11, 2012, while on the job, he tripped over a piece of plywood and fell. Petitioner stated the plywood was not properly installed, and he did not lift his left leg high enough. Petitioner reported the fall and continued working. A few days later, the pain in the leg became severe. On June 6, 2012, Petitioner left Respondent's employ. At that point, the leg felt "[t]errible." Petitioner stated between May 11 and June of 2012, the symptoms became "much worse." On June 11, 2012, Petitioner returned to Dr. Shah, who recommended a total hip replacement surgery. In November of 2012, Dr. Shah performed the surgery. Petitioner underwent postoperative physical therapy, followed by work conditioning. On April 30, 2013, Dr. Shah released Petitioner to return to work as a finish carpenter, with restrictions. Petitioner then went to work for another employer.

The medical records in evidence show that on August 25, 2011, Petitioner saw Dr. Breslow, reporting having atraumatic left groin pain for seven months. The pain was sharp and severe, occurring every day, worse with weightbearing activities. X-rays showed osteoarthritis of the left hip joint. Dr. Breslow recommended an intraarticular steroid injection and noted that Petitioner might require a hip replacement.

On April 4, 2012, Petitioner returned to Dr. Breslow, complaining of persistent left hip pain and reporting not undergoing the injection. Dr. Breslow referred Petitioner to a hip specialist. On April 6, 2012, Petitioner saw Dr. Shah, complaining of progressively worsening pain in the left groin for one and a half years. X-rays showed "advanced secondary osteoarthritis secondary to a cam-type femoroacetabular impingement of the left hip with evidence of vascularization of his vessels in the left hip. He has advanced secondary osteoarthritis with joint

space narrowing, acetabular sclerosis, acetabular osteophytes and a large reduction in femoral head-neck offset. He has a large medial osteophyte as well as an interior osteophyte." Dr. Shah discussed conservative treatment vs. hip replacement surgery, and performed an intraarticular injection into the hip.

On June 11, 2012, Petitioner returned to Dr. Shah, reporting only one week of pain relief after the injection and that his pain returned when he returned to work. "Currently it is at the same level as it was before the injection." Petitioner also reported falling at work a few weeks earlier "with continued pain to the left hip that he had from his previous history of osteoarthritis to the left hip." "He states that the pain is now at the same level as it was when he saw me two and one-half months ago." Dr. Shah recommended a total hip replacement. On November 27, 2012, Dr. Shah performed the hip replacement surgery. In a narrative report dated January 25, 2013, Dr. Shah stated regarding causal connection: "I believe that [the patient] has advanced left hip osteoarthritis which was a preexisting condition. The inflammation and pain from the left hip osteoarthritis can be exacerbated by particular work-type activities or traumatic incidents that could occur."

Dr. Shah testified via evidence deposition on May 13, 2013. He was asked whether Petitioner's osteoarthritis was related to activity. Dr. Shah responded: "It's always difficult to tell." Dr. Shah further testified that high impact activities, including heavy lifting, can cause pain and potentially accelerate the degeneration because of the force on the joints. However, "[t]here is no direct correlation" between the lifting and the degeneration. Upon further questioning, Dr. Shah stated: "[T]here's no direct causal cause and effect sort of relationship. I think that in general a combination of predisposing risk factors combined with multiple other factors can lead to degeneration of the hip. And so not every patient that lifts a lot, not every patient that weighs a lot has a badly arthritic joint." Increased force on the joints can accelerate the degeneration in a patient with preexisting risk factors for arthritis. Dr. Shah noted that Petitioner "has radiographic findings of cam type femoroacetabular impingement which can be a preexisting structural abnormality that can lead to arthritis." The cam type defect, together with high impact activities, "can combine to cause severe osteoarthritis." Dr. Shah was then asked whether the cam type defect, together with high impact activities, resulted in the need for the treatment Petitioner received from Dr. Shah. Dr. Shah responded: "I think it can. Again, it's difficult to tell whether it was truly the case, just because there's no way to objectively correlate that once you have severe arthritis other than the fact that you know when you're in the joint doing surgery that they have severe arthritis." Upon further questioning, Dr. Shah reiterated: "I think that heavy lifting and force combined with that preexisting deformity can lead to advanced degeneration." Regarding the fall on May 11, 2012, Dr. Shah stated: "[I]n general a patient with an arthritic joint can have pain from traumatic incidents." Dr. Shah further stated: "I think if the question is whether the fall would speed up the degeneration of his joint, I think his joint was already severely arthritic. And so *** I think the issue is that the fall may cause pain, which *** can be found from the arthritis as well."

On cross-examination, Dr. Shah testified the fall did not cause the need for the hip replacement surgery. Rather, the degenerative condition caused the need for the surgery. When asked whether Petitioner's work activities caused the need for the surgery, Dr. Shah responded: "If that was the only factor, no." On redirect examination, Dr. Shah stated: "The cause for the total hip replacement is advanced bone on bone osteoarthritis." When asked whether repetitive heavy lifting can cause or exacerbate bone on bone degeneration, Dr. Shah responded: "It can in the setting of a patient with a cam type impingement," "[b]ut there's no way to know if that was the causal effect." Dr. Shah continued: "What I am trying to say is that a cam type impingement can lead to osteoarthritis. Forces on the joint can lead to osteoarthritis. Not everybody that has cam type impingement gets osteoarthritis, not everybody that has a lot of force on their joint for a variety of factors gets osteoarthritis."

Dr. Lawrence Lieber, an orthopedic surgeon and Respondent's section 12 examiner, testified via evidence deposition on July 11, 2013, that he examined Petitioner on March 4, 2013. Dr. Lieber agreed with Dr. Shah that the fall on May 11, 2012, did not cause the need for the hip replacement surgery. Dr. Lieber opined the fall "caused soft tissue contusion around the left lower extremity, hip, back area, that caused [Petitioner] to be symptomatic for a short period of time, maybe at most a week or two in association with the fall." Dr. Lieber agreed that repetitive lifting of 100 pounds can cause stress on the hip joint. According to Dr. Lieber, the stress might cause the joint to be symptomatic, but it would not cause further deterioration of the joint. Dr. Lieber continued:

> "[T]o say that lifting 100 pounds X amount of times is definitely going to increase the arthritic condition within a joint, I don't think that's fair to say. Certainly, it can make a joint more symptomatic.
>
> And so from that standpoint, obviously you don't recommend to a patient to do something that's going to cause them to hurt. But it doesn't necessarily mean that it's going to further deteriorate an already arthritic joint *** for that matter, that type of activity I don't think there is anything in the literature that indicates that *** you lift 100 pounds 50 times a day for 20 years, you are going to get arthritis or have an increased incidence of arthritis."

Lastly, Dr. Lieber noted there is no occupational health literature stating that carpenters have an increased incidence of osteoarthritis. Dr. Lieber therefore opined there is no causal relationship between Petitioner's job activities and his osteoarthritis.

At the outset of the arbitration hearing, Respondent did not dispute that Petitioner sustained a fall at work on May 11, 2012. Respondent argued the fall caused only a soft tissue injury. Petitioner advanced a repetitive trauma theory of his osteoarthritis, which Respondent disputed. The Arbitrator found the claim compensable under the theory of repetitive trauma. The Commission disagrees and finds that Petitioner failed to prove his lifting activities at work were a contributing cause of his osteoarthritis and need for hip replacement surgery.

The evidence shows that on August 25, 2011, Petitioner consulted Dr. Breslow, reporting having atraumatic left groin pain for seven months. In other words, Petitioner developed the pain around January of 2011, after two and a half years of intermittently working for Respondent. Petitioner's Exhibit 8 shows Petitioner worked for Respondent 40 hours in August of 2010 and 621 hours from September through December of 2010, corresponding to a little less than 40 hours a week on average. Petitioner's Exhibit 8 further shows Petitioner worked for Respondent in the first, but not the second, half of 2009. In 2011, Petitioner worked full-time exclusively for Respondent. Petitioner relies on the causal connection opinion of Dr. Shah. However, Dr. Shah's causal connection opinion was non-specific and equivocal. Dr. Shah repeatedly stated Petitioner had several risk factors for developing osteoarthritis and advanced degeneration, and there was no way to tell whether his job activities were a contributing cause. The Commission finds that Petitioner failed to meet his burden of proving his work activities for Respondent were a contributing cause of his osteoarthritis or that they accelerated his need for hip replacement surgery.

With respect to the fall on May 11, 2012, the Commission finds that Petitioner failed to prove any associated temporary disability, medical expenses or permanent disability. The Commission notes that on June 11, 2012, Petitioner returned to Dr. Shah after undergoing an intraarticular injection into the hip on April 6, 2012. Dr. Shah noted: "Currently [the pain] is at the same level as it was before the injection." Petitioner reported falling at work a few weeks earlier "with continued pain to the left hip that he had from his previous history of osteoarthritis to the left hip." Dr. Shah reiterated: "He states that the pain is now at the same level as it was when he saw me two and one-half months ago."

For the foregoing reasons, the Commission denies Petitioner's claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 30, 2013, is hereby reversed and Petitioner's claim is denied.

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

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

DATED: MAY 22 2015
o-05/07/2015
SM/sk
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RITTER, BRADLEY
Employee/Petitioner

Case# **12WC019605**

15IWCC0390

IMPERIAL WOODWORKING COMPANY
Employer/Respondent

On 12/30/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 THE HEALY LAW FIRM
DAVID HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0390

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

Bradley Ritter
Employee/Petitioner

v.

Imperial Woodworking Company
Employer/Respondent

Case # **12** WC **19605**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **September 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. [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] 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 11, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** given to Respondent as explained *infra*.

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

In the year preceding the injury, Petitioner earned **$83,200.00**; the average weekly wage was **$1,066.66**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **1** dependent child.

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $711.11/week for 22 & 1/7th weeks, commencing November 27, 2012 through April 30, 2013, as provided in Section 8(b) of the Act.

Medical Benefits

Respondent shall pay reasonable and necessary medical services for bills submitted into evidence that remain unpaid, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $640.00/week for 118.25 weeks, because the injuries sustained caused the 55% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

December 30, 2013
Date

JAN 3 - 2014

15IWCC0390

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Bradley Ritter
Employee/Petitioner

v.

Imperial Woodworking Company
Employer/Respondent

Case # **12** WC **19605**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are accident, notice as to any alleged repetitive trauma injury, 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 on May 11, 2012 he was 51 years old, 5'7 tall and approximately 180 pounds. He started working for Respondent in 2008 and was employed as a finish carpenter on the claimed date of accident. Petitioner was also a member of Union Local 13 for five years and was previously a union carpenter for over 15 years.

Petitioner testified that his duties were to install cabinets, hang panels, install doors, crown molding, baseboards, and perform structural work within walls to ensure they can accommodate heavy materials. Petitioner testified that he has lifted up to 400 pounds with the help of another with another person and that he had to frequently lift items weighing 120-160 pounds alone (i.e., small doors, cabinet boxes). To perform his duties, Petitioner testified that he used both hand and power tools. *See also* PX6.

Petitioner offered into evidence a work history report from his union regarding how many hours he worked for Respondent from August of 2008 through June of 2012. PX8. According to this report, Petitioner worked 834 hours between August and December of 2008, 759 hours between January and April of 2009 (he worked the remainder of the year for other companies), 661 hours between August to December of 2010 (he worked the remainder of the year for another company), 1954.50 hours in 2011, and 800.5 hours from January through June of 2012. *Id.* Petitioner testified that he worked a lot of overtime in 2011 and that time pressures caused him to work rapidly.

Petitioner testified that he started experiencing unusual symptoms in his left leg mid-way through 2011. He testified that he sought medical treatment with Dr. Papanos, his primary care physician, who then referred him to Dr. Breslow at Illinois Bone and Joint Institute.

[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. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

Medical Treatment

On August 25, 2011, Petitioner saw Dr. Breslow and reported "seven months of atraumatic onset of left groin pain." PX1 at 63-64. Petitioner described the pain as sharp and severe that occurred daily. *Id.* He also reported difficulty with weight-bearing activities, worsening with position changes, and difficulty putting on his shoes due to stiffness. *Id.* On examination, Dr. Breslow noted diminished range of motion in the left hip particularly with internal rotation compared to the contralateral side and limitation with external rotation as well as pain. *Id.* He diagnosed Petitioner with left hip osteoarthritis, recommended a corticosteroid injection which Petitioner declined at the time, and referred Petitioner to a surgeon should conservative measures fail. *Id.* Petitioner testified that he had severe pain in his hip while working at this time. Petitioner acknowledged that Dr. Breslow did not recommend surgery on this date, but testified that it was not his specialty and so he referred Petitioner to Dr. Gordon, Dr. Shah, and another hip specialist.

Petitioner testified that he continued to engage in steady, full time work after August of 2011 through April of 2012. He testified that he was able to perform all of his duties, although it was difficult. Petitioner also testified that he discussed these difficulties in August of 2011 with a foreman, Steve Becker, and that pretty much everyone knew that he was having problems with his hip. Petitioner added that he talked to Mr. Becker in or around August 25, 2011 and that he was very accommodating about the activities that aggravated Petitioner's pain including lifting, carrying, squatting down, and pulling/tugging. Petitioner testified that he took ibuprofen, Advil, and over-the-counter medications.

Petitioner acknowledged that he did not see a doctor again until April of 2012. The medical records reflect that Petitioner returned to Illinois Bone and Joint Institute and saw Dr. Shah on April 6, 2012 reporting pain to the left groin that was progressively worsening over 1 ½ years. PX1 at 54-58. He diagnosed Petitioner with advanced left hip osteoarthritis. *Id.* Dr. Shah administered an intra-articular injection and indicated that if it did not work, or only worked temporarily, he would recommend a total left hip arthroplasty. *Id.*

Petitioner testified that his hip was feeling pretty bad at this point. He also testified that he talked to someone at work in April of 2012 about the pain in his hip, but did not specify to whom he spoke. Petitioner further testified that he was able to perform his work at this time, but with difficulty. He added that Respondent was accommodating to his needs as it could, but that he still had to do his work.

On May 11, 2012, Petitioner testified that he fell on the job and tripped over a piece of plywood that was not properly installed and that he did not lift up his left leg far enough due to pain. Petitioner testified that he continued to work and reported the incident to his foreman, Mr. Frank Cardella. After a couple of days, Petitioner testified that his pain was severe and that Mr. Garrett called him a couple of days later. Petitioner testified that after this fall, his pain never went away and he took handfuls of Advil to get through his day. Petitioner testified that he left Respondent's employment on June 6, 2012 and that his leg was terrible.

The medical records reflect that Petitioner returned to Dr. Shah on June 11, 2012 reporting a return of his pain after returning to work and performance of heavy-duty activities at the same level it was before the injection and after experiencing a fall at work a few weeks earlier. PX1 at 20-22, 49-51. Dr. Shah again recommended a total hip arthroplasty. *Id.* Petitioner testified that he was unable to work at this time and that his symptoms between May 11, 2012 to June 11, 2012 got much worse.

As of July 6, 2012, Dr. Shah continued to recommend surgery. PX1 at 17-19. He also placed Petitioner on light duty work advising him to discontinue certain work activities, "which he says he can do[.]" *Id.*

On October 8, 2012, Dr. Shah noted Petitioner's prior injection with one week of relief and chronic pain affecting his daily, recreational and work activities. PX1 at 14-16, 26. Dr. Shah also reviewed Petitioner's x-rays noting that they were "as per previous with advanced left hip osteoarthritis, joint space narrowing, acetabular sclerosis, acetabular osteophytes, and reduction in head-neck offset with a very large medial osteophyte." *Id.* He continued to recommend a total hip replacement and noted that Petitioner's hip pain had been exacerbated by his work activities. *Id.*

On November 19, 2012, Petitioner reported continued left-sided hip and groin pain that was refractory to conservative treatment including physical therapy, medications, injections, activity modification and use of a cane. PX1 at 12-13, 25. Dr. Shah noted advanced osteoarthritis in the left hip with complete joint space narrowing and significant osteophytes as well as a large medial osteophyte on Petitioner's x-rays. *Id.* Dr. Shah also noted that Petitioner had been pre-operatively cleared for surgery and that it was scheduled for November 27, 2012 and to be billed through Petitioner's regular insurance since his workers' compensation claim had been denied. *Id.*

Petitioner underwent the recommended left total hip arthroplasty with Dr. Shah on November 27, 2012. PX1 at 36-40; PX3.

Petitioner testified that the workers' compensation insurance carrier denied his claim from June of 2012 through the date of his surgery. He testified that he attempted to obtain approval again, which was denied.

After surgery, Petitioner continued to see Dr. Shah who recommended physical therapy beginning December 17, 2012. PX1 at 5, 9-11, 23-24. Petitioner underwent the physical therapy at ATI near his home. PX2.

On January 25, 2013, Dr. Shah issued a narrative report at Petitioner's counsel's request in which he opined that Petitioner had a pre-existing advanced left hip osteoarthritis condition and that "[t]he inflammation and pain from the left hip osteoarthritis can be exacerbated by particular work-type activities or traumatic incidents that could occur." PX4.

Petitioner testified that after physical therapy he returned to Dr. Shah to discuss whether he could return to work. He testified that he was supposed to have a certain amount of time for physical therapy and when he talked to Dr. Shah he ordered an extra four weeks of work conditioning. The medical records reflect that Dr. Shah recommended work conditioning on February 22, 2013 and scheduled a follow up visit nine months later (one year from the date of surgery). PX1 at 5.

Section 12 Examination – Dr. Lieber

Petitioner submitted to an independent medical examination at Respondent's request on March 4, 2013. RX1 (Dep. Exh. 2). Petitioner reported having chronic left hip pain up May 11, 2012 when he tripped over loose plywood on May 11, 2012 while working for Respondent causing him to fall and land on his left side. *Id.* Petitioner complained of stiffness about the left hip and weakness in the left thigh, but no night discomfort. *Id.* Regarding his duties as a carpenter, Petitioner reported that he was required to ambulate, bend, push and pull heavy objects, climb, and lift up to 100 lbs. on a regular basis. *Id.*

Dr. Lieber issued a report dated March 5, 2013 in which he rendered opinions about Petitioner's condition after taking a history from Petitioner, examining him, and reviewing various medical records. *Id.* He noted that

Petitioner showed no evidence of any symptom magnification in association with the left hip replacement and diagnosed Petitioner as being status post left total hip replacement secondary to degenerative osteoarthritis. *Id.* Ultimately, Dr. Lieber opined that Petitioner's showed significant degenerative osteoarthritis of the left hip that was neither caused nor aggravated by the May 11, 2012 accident at work, which he indicated was a minor injury, and he released Petitioner back to full duty work, but limited him to no lifting over 50 lbs. on a regular basis and to ground level work only. *Id.*

Continued Medical Treatment

Petitioner testified that Dr. Shah released him to work on April 30, 2013 as finish carpenter. He also testified that he returned to work on or about May 1, 2013, but not for Respondent. He added that he avoided activities like climbing ladders, carrying heavy weights, or engaging in high impact activities. Petitioner further testified that at that time he experienced stiffness and restrictive movement, inability to bend over very far, needing help to put on his shoes and socks, and pain when he forced forward bending. He also noticed that he could not carry as much as he could before, he could no longer squat, and he had more difficulty pushing/pulling heavy objects. However, Petitioner testified that he was able to perform the duties of a finish carpenter although he now performs those tasks slower with an inability to lift as much as he could before and inability to move as well as he did before. Petitioner further testified that he used to ride motorcycles as a hobby as often as he wanted in 2011, but that he only did so 5-6 times all summer after he fell on May 11, 2012.

Regarding the medical bills submitted into evidence, Petitioner testified that he received bills for medical treatment for his hip from Illinois Bone and Joint, ATI, Advocate Lutheran General Hospital, and Park Ridge Anesthesiology totaling $74,878.39, and that these bills were not yet paid to his knowledge.

Deposition Testimony – Dr. Shah

Petitioner offered the deposition testimony of Dr. Shah taken on May 13, 2013. PX5. Dr. Shah testified that he did not have a very good independent recollection of Petitioner and testified primarily by referring to his chart. PX5 at 6. Dr. Shah testified about his knowledge of the general duties of a carpenter like Petitioner. PX5 at 7.

Dr. Shah testified that after an initial examination, review of diagnostic films and taking a history from Petitioner, he diagnosed Petitioner with advanced osteoarthritis of the left hip. PX5 at 7-8. He explained that arthritis is type of joint degeneration and that there are multiple factors that could cause the type seen in Petitioner's left hip. PX5 at 8-9. With regard to Petitioner's left hip in particular, he testified that the osteoarthritis "may not be related to activity and it may be." PX5 at 9. When asked whether he knew if it was or was not so related in Petitioner's case Dr. Shah responded, "[i]t's always difficult to tell." *Id.*

Dr. Shah noted Petitioner's report to him on June 11, 2012 that when he returned to work performing heavy duty activities and after a fall at work he had a return of pain. PX5 at 11-12. He did not recall, or note in his chart, the details of what exactly happened with the fall. PX5 at 13-14.

Dr. Shah testified that generally a person with an arthritic hip experiences pain and that high impact activities or morbid obesity can accelerate arthritis and that, with regard to Petitioner specifically, the heavy lifting described by Petitioner to him could cause more force on the joint which could combine [with Petitioner's pre-existing condition] to cause severe osteoarthritis. PX5 at 15-20. However, he also noted that "[a]gain, it's difficult to tell whether it was truly the case, just because there's no way to objectively correlate that once you have severe arthritis other than the fact that you know when you're in the joint doing surgery that they have severe arthritis."

PX5 at 19. With regard to Petitioner's reported fall at work, Dr. Shah testified that a patient with an arthritic joint can generally develop pain after a traumatic incident, but he later added that Petitioner's joint was already severely arthritic and so while the fall may have caused pain so to could the arthritis cause pain. PX5 at 28-29.

On cross examination, Dr. Shah testified that Petitioner's need for a total left hip replacement was not caused by any fall at work as described by Petitioner to him, but rather it was caused by the degenerative hip condition. PX5 at 33-34. He also testified that Petitioner's work activities, if that was the only factor, did not cause Petitioner's need for a total hip replacement. PX5 at 34. However, on further re-direct and cross examination questioning, Dr. Shah clarified that Petitioner has a cam type defect in his left hip which could be aggravated by the type of heavy lifting activities that he described previously. PX5 at 37-39.

Deposition Testimony – Dr. Lieber

Petitioner offered the deposition testimony of Dr. Lieber taken on July 11, 2013. RX1. Dr. Lieber also referred to his report when testifying about Petitioner. RX1 at 6. He testified consistent with the opinions that he rendered in his report that Petitioner had pre-existing degenerative osteoarthritis that was neither caused, related nor aggravated by the May 11, 2012 event. RX1 at 9. He also testified that the May 11, 2012 slip-and-fall event caused a soft tissue injury causing Petitioner to be symptomatic for a week or two at most. RX1 at 10.

On cross examination, Dr. Lieber explained that osteoarthritis is degenerative disease of the articular cartilage of the joints that can be related to multiple etiological factors including "[m]ost common is we don't know, can be genetic in nature, can be related to infection, can be related to trauma." RX1 at 11. He defined trauma as a significant event that confirmed evidence of damage to the articular cartilage like an intra-articular fracture or dislocation. RX1 at 11-12. Dr. Lieber explained that the symptoms of trauma leading to osteoarthritis included long-standing history of pain and discomfort with associated difficulty with activities in relation to a significant traumatic event. RX1 at 12. Dr. Lieber also differentiated the symptoms of osteoarthritis, regardless of cause, with the degenerative process of osteoarthritis itself; he explained that activities such as those of daily living or repetitive lifting of 100 pounds could cause stress on the hip joint, and thus symptoms, but that these activities may have no actual effect on the joint itself citing that he was unaware of any literature indicating that such activities make the disease progress although he acknowledged they could certainly increase symptoms of the disease. RX1 at 12-17.

Ultimately, Dr. Lieber maintained his opinion that Petitioner's preexisting degenerative osteoarthritis was not caused, accelerated or related to his work activities because, as they were described to him and based on his understanding of occupational health literature, the work activities did not indicate an increase in the significance of the condition or the need for a hip replacement as described by Dr. Shah. RX1 at 17-20, 30-31. He acknowledged that he did not review Petitioner's radiographic films, know how advanced Petitioner's osteoarthritis was by the time Dr. Shaw replaced the hip, know whether Petitioner had a cam type femoroacetabular defect which was congenital or developed, or how long Petitioner's left hip had been in its then-current condition at the time that Dr. Shaw replaced it. RX1 at 24-29.

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

Petitioner asserts that he sustained a compensable injury to his left hip at work through repetitive trauma as well as on May 11, 2012 in a discrete traumatic event at work. Respondent does not dispute that Petitioner sustained an accident when he fell at work on May 11, 2012, but does dispute whether he sustained a compensable injury under a repetitive trauma theory.

The facts must be closely examined in repetitive-injury cases to ensure a fair result for both the faithful employee and the employer's insurance carrier. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006) (*citing Three "D" Discount Store*, 198 Ill. App. 3d 43, 49)). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529 (1987)). The Illinois Supreme Court went on to highlight its *Peoria County* decision stating that "[t]o deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (*citing Peoria County*, 115 Ill. 2d at 529-30).

Dr. Shah, and Respondent's Section 12 examiner, Dr. Lieber, agree that Petitioner had osteoarthritis in his left hip prior to May 11, 2012. This condition did not, however, cause Petitioner to lose any time from work and it was only after the May 11, 2012 accident that his pain increased so much that it interfered with his ability to work. The dispute is whether Petitioner's frequent lifting of over 100 lbs. at work prior to that date aggravated the disease. The parties rely heavily on the deposition testimony of Petitioner's treating physician, Dr. Shah, and Respondent's Section 12 examiner, Dr. Lieber in support of their respective positions. Based on the record as a whole, the Arbitrator finds that Petitioner established that he sustained a repetitive trauma injury to the left hip as claimed.

It has long been held that an employer takes its employee as it finds him and, in cases where a claimant has a preexisting condition, he must establish a causal connection between his work-related injury and the claimed current condition of ill-being by showing that his injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-206 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982) ("recovery for an accidental injury will not be denied as long as it can be shown that the employment was also *a* causative factor.") (*emphasis* added)). In this case, the Arbitrator finds the opinions of Dr. Shah to be more persuasive than those of Dr. Lieber, but notes that both physicians hedged their opinions on the relatedness, if any, of Petitioner's job duties on any aggravation or acceleration of the pre-existing osteoarthritis. It appears from their testimony that the medical community remains divided as to whether repetitive activities have been proved to accelerate osteoarthritis. However, Dr. Shah did testify that the heavy lifting described by Petitioner to him could cause more force on the hip joint which could combine with Petitioner's pre-existing condition to cause severe osteoarthritis. In conjunction with Petitioner's credible testimony at trial—which is corroborated by the medical records and bolstered by Dr. Lieber's notation that Petitioner did not display any evidence of malingering at his

examination—about the heavy and frequent lifting that he did for years and in particular for many overtime hours as reflected in the timekeeping records produced, the Arbitrator finds that Petitioner has established that his frequent lifting of over 100 lbs. at work was a contributing factor that accelerated his pre-existing osteoarthritic hip condition as opined by Dr. Shah.

Finally, an employee claiming that he suffered a repetitive-trauma injury must still point to a date within the statutory limitations period on which both the injury and its causal link to his work became plainly apparent to a reasonable employee. *Durand*, 224 Ill. 2d at 65 (*citing Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 209 (1993)); *see also Peoria County*, 115 Ill. 2d at 531. "[B]ecause repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work." *Id.*, (*citing Oscar Mayer v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610, 531 N.E.2d 174 (1988)). In this case, Petitioner testified about left hip pain and symptoms occurring throughout 2011 and into early 2012 which was more severe while working, but that did not prevent him from performing his duties although he did so in pain until he fell on May 11, 2012 when he reported the incident to his foreman, Mr. Cardella. Petitioner also testified that after this fall his pain never went away and he took handfuls of Advil to get through his day. While Petitioner appears to have had a rapidly degenerating left hip condition, it was not until May 11, 2012 that the severity of the condition deteriorated to the extent that it affected Petitioner's ability to work after his fall. Thus, the Arbitrator finds that the manifestation date of Petitioner's accident was on May 11, 2012.

In support of the Arbitrator's decision relating to Issue (E), whether timely notice of the accident given to Respondent, the Arbitrator finds the following:

Notice of the accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing, but not later than 45 days after the accident with some very limited exceptions. 820 ILCS 305/6(c) (West 2000). Employees who claim to have suffered repetitive trauma injuries are not exempt from meeting the statutory notice requirement. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 910-911 (4th Dist. 2007) (*citing Three "D" Discount Store v. Industrial Comm'n*, 198 Ill.App.3d 43 (1989)). The purpose of the notice requirement is to enable an employer to investigate an alleged accident. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 95 (1980). A claimant's compliance with the notice requirement is established by placing the employer in possession of the known facts related to the accident within the statutory period. *Seiber*, 82 Ill. 2d at 95. "Because the legislature has mandated a liberal construction on the issue of notice [citation] if some notice has been given, although inaccurate or defective, then the employer must show that he has been unduly prejudiced." *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96 (4th Dist. 1994). A claim is barred only if no notice whatsoever has been given. *Id.*

Petitioner testified that he had talked to his foreman, Steve Becker, about having problems with his hip in 2011, but as noted in the accident analysis above, Petitioner was able to continue to work and his physical condition only deteriorated to the point where he needed active medical care or he could no longer work after he reported his fall on May 11, 2012 to his foreman, Mr. Cardella, and discussing the injury with his superintendent, Mr. Garrett, within the days thereafter. Based on the foregoing, the Arbitrator finds that Petitioner gave proper and timely notice of his injury at work and there is no evidence that Respondent was unduly prejudiced as a result of the notice given.

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, Petitioner established that he sustained a compensable injury at work. The Arbitrator further finds that Petitioner's claimed current condition of ill being is causally related to the injury sustained at work. In so finding, the Arbitrator again notes the consistency of Petitioner's testimony with the medical records submitted into evidence, Dr. Lieber's notation that Petitioner was not malingering at the time of his examination, and relies on the opinion of Dr. Shah that Petitioner's left hip condition could have been accelerated by his heavy lifting activities at work. Thus, the Arbitrator finds that Petitioner's claimed current condition of ill-being in the left hip is causally related to his injury at work.

In support of the Arbitrator's decision relating to Issue (J), whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

As causal connection has been resolved in favor of Petitioner, 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 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:

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Mechanical Devices v. Industrial Comm.*, 344 Ill. App. 3d 752, 760 (2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added).

The medical records do not reflect any order placing Petitioner off work or restricting him from performing the full duties of his position as a finish carpenter until the date of his surgery on November 27, 2012. Thereafter, Petitioner was either placed off work or on restricted duty while he participated in physical therapy and work conditioning. Petitioner testified that he was released by Dr. Shah back to work on April 30, 2013. Thus, based on the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period from November 27, 2012 through April 30, 2013.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Based on the record as a whole[2]—which reflects that Petitioner's pre-existing left hip osteoarthritis was aggravated by his job duties requiring a total hip replacement, physical therapy and work conditioning after which he was released back to full duty as a finish carpenter—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 55% loss of use of the left leg pursuant to Section 8(e) of the Act.

[2] The Arbitrator notes her consideration of Section 8.1b of the Act, which addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011, and also notes that no AMA report was admitted into evidence at trial. 820 ILCS 305/8.1b (LEXIS 2011).

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Smith,

Petitioner,

vs.

NO. 09WC 17804

15IWCC0391

Shaw/Stone & Webster Construction,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of nature and extent, vocational rehabilitation, maintenance benefits, medical restrictions, temporary disability, penalties and fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 5, 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 $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: MAY 22 2015
SJM/sj
o-5/7/15
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

15IWCC0391

SMITH, MICHAEL
Employee/Petitioner

Case# **09WC017804**

SHAW/STONE & WEBSTER CONSTRUCTION
Employer/Respondent

On 5/5/2014, 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 0.45% 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:

0274 HORWITZ HORWITZ & ASSOCIATES
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

15 IWCC0391

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MICHAEL SMITH
Employee/Petitioner

v.

SHAW/STONE & WEBSTER CONSTRUCTION
Employer/Respondent

Case # **09** WC **17804**

Consolidated cases: _____

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

DISPUTED ISSUES

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

15IWCC0391

FINDINGS

On the date of accident, **March 11, 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 **$96,050.24**; the average weekly wage was **$1,847.12**.

On the date of accident, Petitioner was **45** 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 **$245,413.85** for TTD, **$0** for TPD, **$0** for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit for any related medical expenses already paid, under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $1,231.41/week for 160-1/7 weeks, commencing April 6, 2009 through February 16, 2012; February 27, 2012 through April 8, 2012; May 12, 2012 through June 25, 2012, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,231.41/week for 42 weeks, commencing June 26, 2012 through April 16, 2013, as provided in Section 8(a) of the Act.

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

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

4/21/14
Date

Smith v. Shaw /Stone & Webster, 09 WC 17804
ICArbDec19(b)

MAY - 5 2014

FINDINGS OF FACT

The Petitioner was a journeyman pipefitter with Local 597 who sustained in injury to his cervical spine on March 11, 2009 while moving pieces of heavy wall pipe at work. He was seen at Physicians Immediate Care for complaints of neck pain, was diagnosed with bilateral cervical strain, and released to return to work. On October 29, 2009 the Petitioner underwent surgery with Dr. Edward, Mkrdichian consisting of anterior C6-7 discectomy, osteophyte removal for decompression, and an interior C6-7 fusion using allograft bone and plating. He went through work hardening in 2011. The records indicate the Petitioner performed an exercise circuit involving weighted pulleys, rows, pushups, and other weight-based exercises using 10 to 20 pounds.

On April 12, 2011, Dr. Amad, the Petitioner's treating physician, found the Petitioner at maximum medial improvement, recommended a functional capacity evaluation, and provided interim light duty restrictions of lifting 20 pounds maximum and occasionally lifting or carrying objects weighing up to 10 pounds. He underwent a functional capacity evaluation on May 6, 2011. It showed the Petitioner capable of functioning at a medium/heavy physical demand level. It noted the Petitioner's exercise and weight lifting during work hardening workouts did not progress beyond the three hour level due to increased pain and decreased functioning. He was capable of carrying 80 pounds occasionally and 51 pounds frequently. He was capable of pushing and pulling 200 pounds occasionally and 150 pounds frequently. He was found capable of sitting and standing up to eight hours, the highest option listed on the form, with frequent position changes. On May 12, 2011, Dr. Ahmad found the Petitioner at maximum medical improvement with permanent restrictions at the medium/heavy level. He did not place any restrictions on the amount of time Petitioner was able to work.

Dr. Alzoobi treated the Petitioner from December 4, 2012 through October 1, 2013 (PX 5, p. 5, 10). He felt the Petitioner could work a maximum of four hours based on his understanding of the 2011 FCE as well as the pain reporting. Dr. Alzoobi also testified he based his return to work restrictions on his understanding that the Petitioner's narcotics would jeopardize his driving skills. (PX 5, p. 9) Dr. Alzoobi further testified during cross examination that the functional capacity report's discussion of the Petitioner being unable to progress past three hours, referred to complete weight lifting exercises during work hardening. (p. 12) He admitted the report indicated the dysfunction and pain came with increased activities at overhead and shoulder height. (p. 19) He acknowledged he had no knowledge of any such activities in the position of a planner. (p. 19) He testified that upon reading the FCE report at the deposition, that the therapist actually released the Petitioner to work sitting or standing eight hours per day with frequent positions changes. (p. 21) He testified shoulder level activities were a provocative activity per the FCE. (p. 24) He testified that as long as the Petitioner's work activities did not involve overhead activity, they may not provoke his symptoms. (PX 24)

Dr. Phillips examined the Petitioner as Section 12 IME. He examined the Petitioner on five separate occasions. Dr. Phillips testified via evidence deposition on January 28, 2014. Beginning with his November 10, 2011 examination, he felt the Petitioner could work at the medium/heavy level per the FCE. (p. 8) He reviewed a job description and felt the Petitioner could return to work as a planner. (p. 9)

On June 26, 2013, Petitioner began formal vocational rehabilitation, beginning with an initial interview on that day. At that interview, the Petitioner was represented by counsel as well as a second vocational expert of his choosing, Susan Entenberg. At the time of the interview, the Petitioner reported he was independent with regard to activities of daily living, as well as driving. Kari Stafseth, the certified

rehabilitation counselor, noted that there was s shortage of planners in the nuclear filed. She noted the position of planner was a sedentary job that involved 90% sitting. It involved no overhead lifting nor lifting more than 10 pounds and no pushing or pulling. She noted the Respondent had hired pipefitters as planners in the past. Following the interview, she opined the Petitioner could utilize his previous experience and skills related to welding in the position of a planner. The specialist recommended vocational testing. She felt the Petitioner did not have necessary computer skills to perform the work of a work planner, however, those skills could be obtained at Vocamotive within an 8 to 12 week period. She opined the Petitioner was physically capable of performing the position of work planner. She noted a return to work as a work planner would involve earnings of approximately $40.00 per hour. She recommended vocational rehabilitative services to include testing of aptitude, interest, temperament, and additional training opportunities.

On February 29, 2012, the Petitioner's vocational expert, Susan A. Entenberg, issued a report following the interview. The Petitioner drove to that interview. Following an interview and review of medical records, Ms. Entenberg agreed the Petitioner was an appropriate candidate for vocational rehabilitation. Ms. Entenberg stated, "He does maintain enough residual capacity to perform other entry level lighter occupations. It would be appropriate to explore positions such as light maintenance, counter clerk, and parts delivery as examples." Further, "I would recommend a job search for Mr. Smith with supportive rehabilitative efforts."

On August 27, 2012, the Petitioner underwent vocational testing. At the time of that evaluation, the Petitioner reported he could carry up to 10 pounds frequently, but could not lift between 10 to 25 pounds routinely. The testing specialist noted the Petitioner drove to his appointment. The results of the testing indicated aptitudes compatible with a number of occupations including project manager, production coordinator, and material expeditor, amongst others. The Petitioner underwent training in various computer programs and with typing skills through April 4, 2013.

Patrick O'Connor, labor relations manager, testified on behalf of the Respondent. He testified a planner's job duties included preparing instructions for a nuclear cleanup. He testified the Respondent has a shortage of planners and it was a steady job. He testified he made job offers to the Petitioner in which Mr. O'Connor expressed a willingness to accommodate the Petitioner's restrictions. He indicated it was a sedentary job. He testified the Respondent employs approximately 25 planners full time and approximately 25 more on a part time basis. According to Mr. O'Connor, Respondent had employed former pipefitters as work planners in the past, and that former pipefitters were generally the Respondent's best work planners due to their institutional knowledge. Mr. O'Conner testified his job offer to the Petitioner was at $45.05 per hour. He explained that the position of a planner does not involve lifting more than two pounds. It involves working at a computer. 70% of the job involves sitting whereas 30% involves standing or walking. He testified the Petitioner would be free to change position as he liked. He also testified the Petitioner would be free to get coffee, take a break, use the restroom, or otherwise change positions as often as he wished.

On April 16, 2013, Mr. O'Connor sent a certified letter to the Petitioner, offering the position of mechanical work package prep preparer with a start date of May 12, 2013. The letter indicated a willingness to accommodate restrictions. On May 12, 2013, Mr. O'Connor sent the Petitioner a job offer for the same position indicating earnings of $1,802.00 per week. According to Mr. O'Connor, the Respondent would make a good faith effort to accommodate the restrictions or "any other written medical restrictions." On March 11, 2014, another job offer was sent to the Petitioner for the same position and

earnings, and explicitly offered to accommodate Dr. Alzoobi's restrictions, or "any other bonafide medical restrictions from a licensed, treating physician.

Petitioner testified regarding his previous attempt to return to work. He filled out paperwork for several hours, and then left. He never attempted the position of a planner. He came back the next day but declined to attempt to work in that position. Petitioner's Exhibit 14 was job search logs. They included searches on March 4 and 11, 2014. The Petitioner testified he did not have any search logs prior to those dates and did not testify to any other attempts to find work.

Petitioner testified that during a normal day he takes pain medication. He testified that currently, he has little mobility in the neck. He feels pain. He lies down after three hours. He takes Tramadol, Vicodin, a patch, and uses a TENS unit. He testified that his right shoulder hurts more than his left. Petitioner testified his medication makes him loopy. He testified he has difficulty driving and concentrating. He testified that working at a desk causes neck pain and the need to use medication.

CONCLUSIONS OF LAW

1. Petitioner has met his burden of proof regarding the issue of causation. The Arbitrator finds that the medical evidence supports the finding that Petitioner's current condition of ill-being is related to his undisputed accident from March 11, 2009, which ultimately resulted in Petitioner undergoing an anterior C6-7 discectomy, osteophyte removal for decompression, and an interior C6-7 fusion using allograft bone and plating .

2. Regarding the issue of medical expenses, the Arbitrator finds that the medical treatment as indicated in the medical evidence was both reasonable and necessary. Petitioner offered into evidence medical expenses from the following providers, with the outstanding unpaid balances indicated in parentheses: Chicago Lake Shore Medical ($600.00); H-Wave ($445.00); Health Benefits ($5,845.88); Illinois Anesthesia Associates ($735.00); Orthopaedic Associates of Kankakee ($8,980.00); Riverside Medical Center ($6,135.00); and Summit Pharamacy ($14,863.00). The Arbitrator awards these expenses to the Petitioner, subject to the fee schedule and in accordance with Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

3. Petitioner has failed to meet his burden of proof on the issue of whether he is entitled to temporary total disability or maintenance subsequent to April 16, 2013. In support of this finding the Arbitrator notes that as of that date, the medical evidence shows Petitioner had reached maximum medical improvement. Furthermore, Petitioner had successfully completed the vocational rehabilitation, and had been offered a job that would accommodate his medical restrictions. The Arbitrator finds persuasive the findings and opinions of Dr. Ahmad and Dr. Phillips regarding the Petitioner's ability to return to work. Although Petitioner's treating physician, Dr. Alzoobi opined that the Petitioner is limited from working in excess of 3 to 4 hours per day and is limited in his ability to drive his automobile, these opinions do not appear to be entirely supported by the medical evidence. By the Petitioner's own admission, he has been able to drive. Furthermore, the Arbitrator notes that the Respondent has made significant efforts to accommodate the Petitoner's restrictions by offering him a job as a planner. Although Petitioner did report to the Respondent to fill out the paper work to return to work as a planner, he walked away from the job without even attempting to do the work. Accordingly, Petitioner's request for ongoing TTD or maintenance is denied.

4. Petitioner's request for further vocational rehabilitation is denied based on the findings above. Again, the Arbitrator notes that the Respondent provided Petitioner with vocational retraining in accordance with both rehabilitation experts retained in this case. Petitioner underwent training through Vocamotive, sufficient to qualify him for the job of planner with the Respondent. Respondent then offered the planner job to the Petitioner with the understanding that they would attempt to accommodate any of his restrictions. Petitioner did not even attempt to do any of the work of a planner. The facts of this case clearly show that the Respondent fully complied with its obligation to provide the Petitioner with vocational rehabilitation. However, its efforts to successfully place Petitioner in a stable, well-paying job that would have accommodated Petitioner's restrictions were thwarted by Petitioner's decision to walk away without even trying the job. As such, no further vocational rehabilitation is awarded at this time.

5. Based on the issues involved in this case and the findings above, 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))
	☐ Rate Adjustment Fund (§8(g))
	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deborah Staley,
Petitioner,

vs. NO: 13 WC 06910

Allied Tube & Conduit.

15IWCC0392

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, permanent partial disability, and medical expenses and Respondent's issues of fraud and credit 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 8, 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: MAY 22 2015

Joshua D. Luskin

o-05/19/15
jdl/wj
68

Ruth W. White

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

STALEY, DEBORAH
Employee/Petitioner

Case# **13WC006910**

ALLIED TUBE & CONDUIT
Employer/Respondent

15IWCC0392

On 10/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

4866 KNELL O'CONNOR & DANIELEWICZ PC
RACHAEL SINNEN
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

FSSTATE 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

Deborah Staley
Employee/Petitioner

Case # 13 WC 6910

v.

15IWCC0392

Allied Tube & Conduit
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **June 19, 2014** and **September 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other:

FINDINGS 15IWCC0392

On **September 25, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did 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 52 weeks preceding the injury, Petitioner earned $56,035.20; the average weekly wage was **$1077.60**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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 **$2,974.64** for short term disability benefits under Section 8(j) of the Act, for a total credit of **$2,974.64**.

ORDER

The Arbitrator has found that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment. Therefore, all other issues are rendered moot.

All compensation is hereby denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

October 8, 2014
Date

OCT 8 - 2014

FINDINGS OF FACT IN SUPPORT OF ARBITRATOR'S DECISION

SUMMARY OF TRIAL TESTIMONY

Witnesses

Petitioner, Deborah Staley, testified that on September 25, 2012, she sustained a fall while leaving work as lead freight dispatcher for Respondent. (Trial Transcript "Tr" pp. 10; 26). Ms. Amy Cole testified on behalf of Respondent as she was working as a dispatcher under Petitioner's supervision on September 25, 2012 and witnessed Petitioner's fall. (Tr. pp. 93; 102; 104). Ms. Cole is no longer employed by Respondent and last worked for Respondent on March 21, 2014. (Tr. pp. 93-94). Mr. Thomas Mountford also testified on behalf of Respondent as he has been a security officer/supervisor for Respondent for six years. (Tr. p. 163). As security officer/supervisor, Mr. Mountford regularly makes rounds of the warehouse, investigates accidents and is an Illinois Certified Emergency Medical Technician. (Tr. p. 164; 168). Mr. Mountford reported to the scene after Petitioner's September 25, 2012 fall, spoke with Petitioner, tended to her injuries and investigated the area of her fall. (Tr. p. 165). Mr. James Skalon also testified on behalf of Respondent as the Environmental Health and Safety Manager for eight years and as an employee for Respondent for 34 years. (Tr. pp. 208-209). As Environmental Health and Safety Manager, Mr. Skalon is responsible for all compliance with OSHA, safety at the plant and investigation of accidents. (Tr. p. 209). In addition, Mr. Joe Catanzara testified on behalf of Respondent as he has been the

warehouse supervisor for 22 months, was working on September 25, 2012 and reported to the scene following Petitioner's fall. (Tr. p. 185). As warehouse supervisor, Mr. Catanzara handles safety issues with Mr. Skalon and investigated Petitioner's fall. (Tr. pp. 188-189). Further, Mr. Williams Leavy testified on behalf of Respondent as payroll administrator for Respondent for over 2 years from June 2010 through October 2012 and June 2014 to present. (Tr 2. pp. 6-7). As payroll administrator, Mr. Leavy processes weekly pay roll, puts time files through a payroll system and produce checks with deductions and earnings. (Tr 2. P. 7). Ms. Heather Dunn also testified on behalf of the Respondent regarding the investigation she conducted as a claim adjuster for Gallagher Basset that resulted in the denial of Petitioner's claim for workers' compensation benefits. (Tr. pp. 128 – 152).

Location of the shipping office in the warehouse

Respondent's plant is about 1.2 million square feet with 400,000 square feet for the warehouse and 800,000 square feet for the manufacturing area. (Tr. pp. 210-211). Petitioner testified that she parked in an employee designated parking lot. (Tr. p. 11). The premises were not open to the public. (Tr. p. 12). Petitioner and Ms. Cole both confirmed that their job duties required them to be in the shipping office located in the southwest corner of the warehouse. (Tr. pp. 56; 95-96; 172). To get to the shipping office from the parking lot, Petitioner would walk through the main entrance, use a security card to enter the warehouse and walk through the warehouse. (Tr. pp. 13; 96). There was no other way to get from the

parking lot to the shipping office without going through the warehouse. (Tr. p. 24).

The warehouse held steel tubing and there were forklifts for racking the pipes. (Tr. p. 17). The tubes are stacked and arranged in rows to create aisles. (Tr. p. 57; 96). There were yellow lines on the cement floor that indicated where tubes could be stacked. (Tr. pp. 59 – 61; 97-98; 233). Forklifts and foot traffic traveled between the aisles. (Tr. pp. 57-58). Petitioner had to walk between the aisles in the warehouse to get from the main entrance to the shipping office. (Tr. p. 58). With numerous aisles, there were several paths that employees including Petitioner could choose from when walking through the warehouse. (Tr. pp. 58-59; 61; 97; 187). No one for Respondent instructed employees including Petitioner on the path to take through the warehouse. (Tr. pp. 59; 97-98; 188; 232). There was no designated route or walkway for employees coming to and from the shipping office. (Tr. pp. 172; 232).

Conditions of the warehouse

The entire warehouse floor was made of a finished, nonslip concrete floor that was not slippery and not waxed. (Tr. pp. 19-20; 168; 193; 198).

Petitioner testified that the warehouse floor was dirty with oil droppings, dirt, and pieces of paper. (Tr. pp. 21-22). However, witnesses confirmed that the warehouse floor was clean and there was no debris or liquid on the floor. (Tr. p. 98). Petitioner testified that the tubing stored in the warehouse contained fluids, mainly a coating for the tubes. (Tr. pp. 17-18). Petitioner

testified that she personally observed liquids leaking from the pipes. (Tr. p. 18). This testimony was contradicted by Mr. Mountford, Mr. Catanzara, Ms. Cole and Mr. Skalon who testified that there was no fluid that came from the pipes in the warehouse. (Tr. pp. 113; 168; 205). Inspections are regularly done of the warehouse floor. (Tr. p. 224). The pipes are completely dry when taken for storage in the warehouse as manufacturing is done on the other side of the plant. (Tr. p. 224). While chemical solutions are used to coat the pipes, chemical solutions were not applied in the warehouse. (Tr. pp. 177; 183-184; 206). No liquids, chemicals or solutions were kept in the warehouse. (Tr. pp. 113; 196; 224). No solutions, water, solvents, chemicals or paint is transferred or pipelined through the warehouse. (Tr. p. 197). There were no leakages in the pipes in the ceiling for the fire system, no water hoses or other sources of water in the warehouse. (Tr. p. 169). Although threaded pipes were stored in the warehouse, drilling or threading does not occur in the warehouse. (Tr. pp. 169; 177; 183-184; 206).

The area immediately outside of the warehouse was paved. (Tr. p. 114). Gravel was located about 60 yards outside the warehouse by the property line. (Tr. pp. 225-226). Mr. Skalon testified that the gravel outside the warehouse was about 180 yards from the site of Petitioner's fall. (Tr. p. 228). Petitioner testified that semi trucks, golf carts and fork trucks traveled both inside and outside the warehouse. (Tr. pp. 21). Ms. Cole confirmed that there was gravel outside the warehouse and forklifts would pass through those areas. (Tr. pp. 124). Ms. Cole also confirmed that there were golf carts that would travel outside and inside the warehouse. (Tr. p. 124). Petitioner speculated that the dirt would come off the wheels of the

forklift trucks and golf carts. (Tr. p. 19). However, witnesses for Respondent testified that there was no gravel within the warehouse floor. (Tr. pp. 113; 225-226). Further, the forklifts were electronic and not gasoline. (Tr. pp. 170-171; 196; 199 – 200; 234-235). Although the forklifts used hydraulics, hydraulic fluid was never seen on the warehouse floor. (Tr. pp. 196; 199 – 200; 234-235). Also, forklifts were maintained and repaired regularly. (Tr. p. 200; 234-235).

The warehouse floor was cleaned regularly. (Tr. pp. 200-201). Ms. Cole testified that she saw employees clean the floor often. (Tr. pp. 98-99). Even Petitioner admitted that she witnessed employees using push brooms. (Tr. p. 64). Mr. Skalon testified that there is a tennant floor sweeper with a vacuum and brush that can pick up even gravel as well as a floor scrubber with a double squeegee and vacuum. (Tr. pp. 218-220). The sweeper and floor scrubber is regularly used on the warehouse floor. (Tr. pp. 218-220). Mr. Skalon confirmed that the floor is dry after the floor scrubber is used. (Tr. pp. 221-222).

Petitioner admitted that she did not recall seeing fluid on the warehouse floor on the date of the fall. (Tr. p. 62). Petitioner, however, testified that she recalled seeing papers on the floor right in front of the shipping office on the date of the fall. (Tr. p. 63). Ms. Cole, on the other hand, did not notice any paper or liquids on the floor on September 25, 2012. (Tr. p. 99). Furthermore, Mr. Catanzara worked in the same office area as Petitioner. (Tr. p. 187). While Petitioner worked inside the shipping office, Mr. Catanzara had a desk outside the office. (Tr. p. 195). Mr. Catanzara did

not notice any newspaper or paper debris near the shipping office on September 25, 2012. (Tr. p. 195).

September 25, 2012 fall

All witnesses present on September 25, 2012 confirmed that it was not snowing or raining on the day of Petitioner's fall. (Tr. pp. 65; 99; 170; 234).

Petitioner testified that on September 25, 2012 she was leaving the shipping office around 5:00 pm – 5:20 pm. (Tr. pp. 23; 100). Petitioner was wearing flat rubber soles and a hardhat. (Tr. pp. 24-25; 68-69; 101-102). Respondent only required Petitioner to wear a closed toe shoe for safety measures. (Tr. pp. 69; 102). Petitioner was carrying a purse, water bottle and lunch pack. (Tr. pp. 25; 68). Petitioner was leaving work for the day and was no doing anything for work. (Tr. pp. 66; 100). Petitioner confirmed that she was not going to a meeting or taking documents to another department. (Tr. pp. 66; 100). Petitioner was leaving work and walking with a co-worker, Amy Cole, who was to her right. (Tr. pp. 23; 28-29; 102; 104). Ms. Cole witnessed Petitioner's fall however she did not see Petitioner's feet at the time of the fall. (Tr. pp. 102; 104). The two were talking to one another. (Tr. p. 68). As Petitioner was turning a corner from one aisle to the next, her right foot slipped back and Petitioner fell forward. (Tr. pp. 26; 69-70; 102).

Petitioner testified that she did not notice what caused her foot to slide back and did not see any specific thing on the floor. (Tr. pp. 27; 31). Ms. Cole testified that there were no cracks on the floor where Petitioner fell. (Tr. pp.

110-111). There was no liquid on the floor where Petitioner fell. (Tr. pp. 110-111). There was no dirt, paper or other debris on the floor where Petitioner fell. (Tr. pp. 110-111). Petitioner did not trip or slip on the joint expansion between the cement. (Tr. pp. 110-111). Petitioner did not trip or slip on the yellow lines on the cement. (Tr. pp. 110-111). Even Petitioner did not recall any liquid, dirt or papers on the floor where she fell on September 25, 2012. (Tr. p. 65). She did not remember seeing any cracks on the ground. (Tr. p. 70). Petitioner confirmed that she did not trip on any pipes or materials that were stacked in the warehouse. (Tr. pp. 70; 110-111).

Petitioner rolled over and sat up. (Tr. p. 103). Petitioner's clothes were not wet following her fall. (Tr. pp. 71; 112; 167). There was no material stuck to Petitioner's clothing. (Tr. p. 113). Mr. Catanzara and Mr. Mountford came to the scene. (Tr. pp. 31; 71; 103). According to Mr. Mountford, Petitioner said her knee had fallen out / popped. (Tr. p. 165). Petitioner never told Mr. Catanzara, Mr. Mountford or Ms. Cole what she slipped on. (Tr. pp. 73; 104). Petitioner testified that she spoke with Ms. Dunn over the phone following her fall. (Tr. p. 73). Petitioner did not tell Ms. Dunn that there was liquid on the ground, debris on the floor or any cracks or holes in the floor. (Tr. pp. 74-75). Ms. Dunn testified to the conversations that she had with Petitioner and Ms. Cole. (Tr. pp. 128 – 152). Ms. Cole's testimony was consistent with the statements provided to Ms. Dunn following the September 25, 2012 fall. (Tr. pp. 128 – 152).

Mr. Mountford testified that the area where Petitioner fell was clear of any paper, debris or gravel. (Tr. p. 167). Mr. Mountford testified to cleaning up

the area where Petitioner fell of the bandages and other medical supplies he used in caring for Petitioner post fall. (Tr. p. 171). Mr. Mountford confirmed that there was no other debris or liquid on the ground where she fell. (Tr. p. 171). Mr. Catanzara also did not notice any debris or any substances on the ground where Petitioner fell. (Tr. p. 191). Ms. Cole also testified that she did not notice any paper or liquids on the floor on September 25, 2012. (Tr. pp. 99).

Photographs of the warehouse

Several photographs were taken of the warehouse floor where Petitioner fell. (Tr. p. 106; Respondent's Exhibit "Rx" 1). Ms. Cole confirmed that these photographs fairly and accurately depicted the warehouse floor as it was on September 25, 2012 including the type of material and the way in which the material was stacked in the warehouse. (Tr. pp. 106 -107). Ms. Cole confirmed that the location of the pen seen in Respondent's Exhibit 1(a) through 1(e) fairly and accurately depicted the location where Petitioner fell. (Tr. p. 108). Ms. Cole also confirmed that the location where Ms. Cole stood in Respondent's Exhibit 1(f) and 1(g) fairly and accurately depict how and where Petitioner fell on September 25, 2013. (Tr. p. 108). Respondent's Exhibit 1(i) shows an expansion joint between the cement blocks. Although the pen is located to show the evenness of the joint, it does not depict the location where Petitioner fell. (Tr. pp. 108-109). Mr. Skalon confirmed that there is no uneven concrete where Petitioner fell. (Tr. p. 215).

Due to the Arbitrators findings above, all other issues are rendered moot.

Compensation is hereby 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

Kevin Johnston,
Petitioner,

vs. NO. 14 WC 06647

East Dundee & Countryside Fire District,
Respondent.

15IWCC0393

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical expenses and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof . The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 17, 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.

15IWCC0393

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 22 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-05/19/15
jdl/wj
68

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF 19(b) DECISION OF ARBITRATOR
8(a)

JOHNSTON, KEVIN
Employee/Petitioner

Case# **14WC006647**

15IWCC0393

EAST DUNDEE & COUNTRYSIDE FIRE PROTECTION DISTRICT
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:

5154 FOOTE MIELKE CHAVEZ & O'NEILL
CRAIG S MIELKE
10 W STATE ST SUITE 200
GENEVA, IL 60134

0863 ANCEL GLINK
BRITT ISALY
140 S DEARBORN ST 6TH 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)

Kevin Johnston,
Employee/Petitioner

v.

East Dundee & Countryside Fire Protection District,
Employer/Respondent

Case # **14** WC **6647**

Consolidated cases: **none**

15IWCC0393

An *Application for Adjustment 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 **7/14/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

15IWCC0393

FINDINGS

On the date of accident, **2/5/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of his 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 **$95,138.68**; the average weekly wage was **$1,829.59**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** 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 agreed that Respondent shall be entitled to a credit for any amounts paid by its group health carrier on account of the injury, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. (Arb.Ex.#1).

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries arising out of his employment on February 5, 2014, and failed to prove that his current condition of ill-being is causally related to said alleged accident. Accordingly, his claim for compensation is hereby denied.

No benefits are awarded.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

9/11/14
Date

ICArbDec19(b)

SEP 17 2014

STATEMENT OF FACTS:

Petitioner has been employed by the Respondent as a firefighter for 22 years and currently holds the rank of lieutenant. Prior to the events of February 5, 2014, Petitioner appeared to be in general good health, was not aware that he may have suffered from heart disease or high blood pressure and did not consider himself to be obese. Prior to February 5, 2014, Petitioner had not been treated for heart disease or high blood pressure and had no lost time from his duties as a firefighter as a result of heart disease or high blood pressure. Petitioner admitted to being a smoker and had been smoking one to one and a half packs of cigarettes per day since the 1990's. He tried unsuccessfully to stop smoking and had recently started using an electronic cigarette to help in the effort. Since the events of February 5, 2014 he has stopped smoking. In February of 2014 Petitioner weighed around 265 pounds. Petitioner is six feet one inch tall. At the time of arbitration Petitioner weighed 237 pounds.

Petitioner and his fellow firefighters work shifts of 24 hours on and 48 hours off with each 24 hour shift starting and ending at 6:00 AM. Petitioner testified that during colder months in the snow, he would plug the heater of his diesel truck into a socket in to the garage in order to keep the truck's engine block warm, although he could not recalling doing so on the date of the alleged accident.

On February 5, 2014, Petitioner arrived at the fire station shortly before 6:00 AM. He did not recall the weather that morning, and that his last recollection was talking to one of the guys coming off the prior shift. He indicated that the next thing he remembers is waking up in the hospital.

The records from Sherman Hospital reflect the following histories: "The patient apparently a fireman and was shoveling the snow this morning and had a VF arrest. The patient was seen immediately then by the paramedics at the firehouse, who found him in VF arrest. He was immediately shocked and responded appropriately." (PX6, p.50); "This is a 43 year old white male patient who is a firefighter who suffered sudden cardiac arrest while he was at his job. Apparently, he was clearing snow." (PX6, p.46); "This 42 year old patient, who is a fireman was using a snow blower outside of the firehouse and suffered a cardiac arrest." (PX6, p.43). Petitioner underwent quadruple bypass surgery on February 6, 2014. (PX6, pp.58-63).

Respondent submitted into evidence the deposition transcripts of four (4) co-workers who were also on-duty on February 5, 2014 -- firefighters Tyler Burd, Ashley Rebou, Jeremy Schwab and Kanen Terry. All four witnesses agreed that they found Petitioner in the parking lot outside the apparatus room of the fire house, lying in the snow. They also consistently testified that they used resuscitation efforts, got him on a flat board, transferred him into the fire station, and continued working on him until they obtained a heart rhythm. They then loaded Petitioner into an ambulance and took him to Sherman Hospital where he slowly revived.

Firefighter Tyler Burd testified that he saw a snow blower approximately 5 to 6 feet away from the Petitioner's body but that there was no path in the snow between the snow blower and Petitioner's body. (RX2, p.16). As for the duties involved in clearing the snow from the parking lot, Mr. Burd testified that clearing the snow was done by the whole crew. (RX2, pp.21–29).

Firefighter/paramedic Ashley Rebou testified that she believed the snow blower was in front of the garage, maybe two to three feet away from Petitioner, but that she saw no path between his body and the snow blower and that it did not appear that he had done any snow blowing or the presence of any snow shovels. (RX3, p.12).

Firefighter Jeremy Schwab testified that he thought it was unusual that Petitioner had walked in around 5:59, one minute before the shift started and that Mr. Johnston had flopped on to the recliner "as if something – something was off.".(RX4, p.6-7). Mr. Schwab testified that he saw a snow blower approximately 5–10 feet away from the body but that he saw no snow blowing or snow clearing activity. (RX4, pp.14–22). Mr. Schwab testified that it was always a crew-effort to clean the snow and that it would be unusual for Petitioner to have done the snow clearing without the rest of the crew. (RX4, pp. 28-29). Mr. Schwab also testified that he knew Petitioner was a cigarette smoker, and that he saw him smoke perhaps half a pack a day. (RX4, p.29).

Firefighter/paramedic Kanen Terry testified that he saw the Petitioner's body three feet in front of and to the driver's side of where the black truck is shown in RX6, between the black truck and the garage in the photograph. He indicated that Petitioner's head was located probably a foot from the corner of the curb. (RX5, pp.10-11). Mr. Terry testified that there was no snow shovel and no snow blower nearby. (RX5, p.11). Mr. Terry also testified that he regularly smoked with Petitioner and that the latter smoke on average a pack of cigarettes per day. (RX5, pp.15-16). Mr. Terry noted that in January Petitioner pulled out an e-cigarette and was taking puffs off of it as opposed to a real cigarette. (RX5, pp.16-17) Mr. Terry indicated that Petitioner stated that he was trying to quit and that he was trying to adjust the dose of nicotine in the e-cigarette he was using, saying at one point that there was too much nicotine and was toning it back. (RX5, p.17).

Since February 5, 2014, Petitioner testified that he has not worked. Petitioner testified that prior to February 5, 2014, he had never suffered any cardiac problems that he was aware of and that he considered himself healthy.

Dr. Christopher Berry, Petitioner's cardiologist, testified that Mr. Johnston at rest, sitting and breathing, could have had the same ischemic event as he did on February 5, 2014. (PX13, p.44).

At the request of Respondent, Dr. Dan James Fintel, a cardiac surgeon and professor of cardiology at Northwestern University School of Medicine and Hospital, examined Petitioner pursuant to §12 of the Act. Dr. Fintel noted that Petitioner provided a past history of working a firefighter and having responded to 200-300 fire calls per year, and using a treadmill about once a week for 30 minutes at 3 mph. (RX1, p.11). He noted that Petitioner reported no prior experiences of chest pain, shortness of breath, rapid heartbeats or passing out. (RX1, p.12). Petitioner admitted to 20 years of smoking at least one pack per day and that he had recently begun using an e-cigarette in the hope of quitting smoking. (RX1, pp.12-13). He also noted that Petitioner was not on any cardiac medications prior to February 5, 2014. (RX1, p.13). Dr. Fintel indicated that the medical records revealed that Petitioner had suffered a cardiac arrest from myocardial infarction on February 5, 2014. (RX1, p.13-14). Tests showed severe blockages of coronary arteries and coronary artery disease that existed well prior to February 5, 2014. (RX1, pp.17-18). Dr. Fintel also noted that other records suggested evidence of a prior infarction or heart attack that may have occurred several weeks before the incident in question. (RX1, p.20).

Dr. Fintel went on to opine that "…any activity on a day in which the ambient temperature was 15 degrees in a cardiac patient (such as Petitioner) can be life threatening or life ending." (RX1, p.24). He noted that going from the heated firehouse to the outside and suddenly breathing cold air "… in a susceptible individual like Mr. Johnston who had undiagnosed severe triple vessel coronary disease, a change in the blood flow of the coronary arteries such that a further reduction in blood flow to the heart muscle would occur just by exposure to the cold without even having to posit picking up a shovel, if indeed he did any shoveling at all…" (RX1, p.24). Dr. Fintel went on to state that "… any activity in cold weather can be a life stressor and an arrhythmogenic stimulus for an individual with severe underlying coronary artery disease." (RX1, p.25). Dr. Fintel also felt that prior to the alleged accident Petitioner "… had sustained a silent heart attack to the tip of his heart which caused some degree of scarring or fibrosis and abnormal wall motion …" that Petitioner may not have been aware of. (RX1, p.27). In addition, Dr. Fintel noted that nicotine in both e-cigarettes and regular cigarettes can cause

cardiac problems in patients. (RX1, p.30). Dr. Fintel also felt that Petitioner's medical treatment was "... all a direct consequence of the severe underlying preexisting triple vessel coronary artery disease." (RX1, p.32).

On cross examination, Dr. Fintel admitted that he did not know the dosage of nicotine that Petitioner was using in his e-cigarette and admitted it was pure "speculation as to the impact, if any, of the e-cigarette on the event of February 5, 2014." (RX1, p.39). Dr. Fintel also noted that "risk factors" for coronary artery disease such as family history -- in regards to which Petitioner had a father who had suffered a heart attack in his 50's -- as well as smoking, diabetes, hypertension, high cholesterol and sedentary life style are thought to increase the likelihood that coronary disease will progress and lead to a heart attack. (RX1, pp.42-43). Dr. Fintel also noted that Petitioner's heavy smoking for 20 years was "probably the major cause chronically of developing advance atherosclerosis." (RX1, p.43). Dr. Fintel also noted that "[w]orking as a fireman is not consider to be a regular risk factor for coronary artery disease. It depends on occupational exposure and data that I don't have available to me." (RX1, p.44). When pressed further, Dr. Fintel note that "[i]t could be a risk fact based on what his occupational exposure was, but it was not definitely a risk factor." (RX1, p.45).

Dr. Fintel was questioned about the elements of the statutory presumption. Dr. Fintel admitted that Petitioner suffered from heart or vascular disease, that the ischemic attack and the cardiac arrest resulted from that heart or vascular disease and that, in turn, caused Petitioner's disability. (RX1, p.52). Dr. Fintel also agreed that if one were to assume Petitioner was engaged in snow removal, that such activity could have been the trigger for the heart attack. (RX1, pp.53-54). Dr. Fintel also agreed with the general statement that the occupation of a fireman is a risk factor for premature coronary artery disease above and beyond the other risk factors; however, Dr. Fintel noted that he was unaware of what specific activities Petitioner engaged in that would have increased his risk of atherosclerosis. (RX1, p.54).

Petitioner's treating cardiologist, Dr. Christopher Berry, testified that he treated Petitioner post operatively to manage cardiac arrhythmias and to counsel him on lifestyle modifications. (PX13, pp.9-10). Dr. Berry confirmed that Petitioner suffered from coronary artery disease, meaning plaque buildup in the arteries that supply blood to the heart muscle. (PX13, p.10). Petitioner had suffered a myocardial infarction meaning a sudden occlusion of one of the heart arteries supplying blood to the heart muscle which leads to immediate cessation of blood flow to that territory of the heart and over the following minute cause necrosis of the heart muscle. (PX13, pp.10-11). Dr. Berry opined that Petitioner suffered "demand related ischemia" in that he suffered from severe preexisting coronary diseased that was aggravated by the activity he was performing. (PX13, p.11). Dr. Berry also noted that Petitioner had multiple risk factors including obesity, family history of coronary artery disease, smoking and possible undiagnosed prediabetes or diabetes. (PX13, p.12). In addition, Dr. Berry noted that in patients with either blocked or partially blocked arteries and/or evidence of a prior heart, "... activity above and beyond what they are accustomed to or even what they may be accustomed to can cause the cells to become ischemic ... [a]nd can trigger cardiac arrhythmias." (PX13, p.17). Dr. Berry could not specify the amount of exertion that would be necessary to trigger such an event, other than to say that it would not be significant whether he was shoveling snow for 5 minutes or 50 minutes. (PX13, pp.17-18).

Dr. Berry also testified that based on his knowledge of the literature on the subject, "... there is an association of cardiac events in firemen that is above and beyond that which would be expected of age-matched controls." (PX13, pp.20-21). Further, Dr. Berry expressed his own opinion that "occupational exposure as a firefighter can be considered a risk factor for coronary artery disease." (PX13, p.21). As of the date of his deposition (May 1, 2014), Dr. Berry was of the opinion that Petitioner was unable to work as a firefighter and that it was premature to express a prognosis as to when or if Petitioner would ever be able to return to work as a firefighter. (PX13, pp.25-26). Dr. Berry further explained that as of May 1, 2014 Petitioner was cleared to commence a three month course of cardiac rehabilitation and that Petitioner would be re-evaluated thereafter. (PX13, pp.26-27).

On cross examination, Dr. Berry agreed that Petitioner suffered from preexisting critical three-vessel coronary artery disease, with 100% occlusion of the left anterior descending artery, 90% and 99% stenosis of the distal and posterolateral branch of the right coronary artery, respectively, 60% stenosis of the proximal circumflex and 50% stenosis of the mid circumflex artery and 60% and 70% in a separate diagonal artery. (PX13, pp.29-30). Dr. Berry also testified that while he felt it unlikely, it was possible that Petitioner might or could have suffered this cardiac event on the date in question just by being exposed to 15 degree Fahrenheit temperatures. (PX13, p.31). Dr. Berry explained that exposure to cold "… is a physical stressor that may promote an ischemic event" and that he "… would consider extreme temperature as a physiologic stressor which may aggravate underlying medical disease." (PX13, p.32). Dr. Berry also acknowledged that it would be speculative for him to testify as to any specific date of exposure on the part of Petitioner to smoke, fumes or other chemicals or substances. (PX13, pp.33-34).

WITH RESPECT TO ISSUES (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, AND (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

§6(f) of the Act provides in pertinent part:

"Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), or paramedic 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… However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim …"

Based on the above, it would appear that for a firefighter such as Petitioner, with over 20 years of service, a statutory presumption exists that the cardiac event he experienced on February 5, 2014 arose out of and in the course of his employment, and that a causal relationship likewise exists between said condition and the hazards of his employment. Respondent points to the above statutory language and essentially argues that in order for the presumption to apply Petitioner must first prove that the condition or impairment resulted either "directly or indirectly" from the employment, as if those two words didn't already encompass the only two possible types of conditions, and that Petitioner somehow has to show one or the other for the presumption to apply. The Arbitrator disagrees with this interpretation. Instead, the Arbitrator views the statute's reference to "direct or indirect" as simply setting forth the underlying principle and basic parameters of §6(f) – namely, that the presumption applies regardless of whether or not the claimant can initially prove that the condition was the direct result of one of the enumerated jobs. Indeed, to hold otherwise would render such a presumption entirely meaningless.

Instead, the crux of the issue is whether or not Respondent rebutted the presumption in question. Towards this end, on the question of accident, Respondent presented the deposition testimony of four fellow firefighters and/or paramedics that were on the job at the time of the incident, and who without question saved Petitioner's life – namely, Tyler Burd, Ashley Rebou, Jeremy Schwab and Kanen Terry. None of these individuals actually saw Petitioner outside prior to finding him lying facedown in the snow, so none of them could testify as to what Mr. Johnston was doing at the time he suffered the cardiac event. Petitioner himself had no recollection of what he was doing or even why he had gone outside. In fact, the only evidence we have with respect to Petitioner's

possible intentions on that date in question was the testimony of Tyler Burd who indicated that while he was preparing his rig Lieutenant Parthun, the crew chief from the previous shift, "… peeked his head in the ambulance and said that Lieutenant Johnston was going outside to shovel around his car …" (RX2, p.7). No objection was made to Mr. Burd's statement along these lines, and Lieutenant Parthun was never called to testify.

As far as whether Petitioner actually engaged in any snow removal activity prior to the incident, all four witnesses agree that it was part of their duties to clear the parking lot of snow, and that Petitioner often joined them, although most seem to indicate that this was typically done as a group. Indeed, Jeremy Schwab testified that it would have been unusual for Petitioner to be out snow blowing the parking lot without the rest of the crew. (RX4, p.28). Furthermore, none of the witnesses seem to be able to agree as to the exact location or even the presence of a snow blower or shovel in proximity to the body. However, the general consensus seems to be that there was no sign a path had been cleared in the area. Indeed, Mr. Burd testified that he never actually heard a snow blower going. (RX2, p.16). Mr. Burd did testify that it appeared some snow may have been cleared around Petitioner's vehicle, but he conceded that Petitioner may have simply parked in a spot previously occupied by a crew member from the previous shift. (RX2, pp.18-19). All in all, there is no solid evidence that Petitioner was actually removing snow at the time of the event.

The firefighters also testified to the fact that Petitioner was quite a heavy smoker. Petitioner himself readily admitted that he smoked a pack and a half or less per day, that he had smoked at the start of his shift in the past, and that he had probably smoked on the morning of the incident. And while Petitioner testified that he had been trying to quit smoking by using e-cigarettes, Kanen Terry -- who noted that he smoked with Petitioner "regularly" – testified that during the month leading up to the incident Petitioner smoked e-cigarettes and regular cigarettes "50/50 of the times that [they] were outside smoking together…" (RX5, 18). Mr. Burd likewise testified that Petitioner "… went through at least two packs a day" and that he would smoke "out by the garage." (RX2, pp.13-14). The Arbitrator notes that it appears from the testimony that Petitioner's body was found not too far from the garage, near the curb that abuts the first parking space and the narrow parkway between the curb and the side of the garage. (See photo at RX6).

Based on the above, the Arbitrator is not convinced that Petitioner was actually shoveling or removing snow at the time of the event, or even that his intention was to do so. Instead, the Arbitrator is more inclined to believe that as a 1 to 2 pack-a-day smoker he was heading outside for smoke. Even so, one could say that the act of stepping outside to smoke was an act of personal comfort, one which Respondent was well aware of and apparently acquiesced to, and which therefore brought the conduct within the course and scope of his employment. However, to be compensable, an injury must also arise out of the employment.

For a finding that an injury "arose out of" employment, the injury must have had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Swartz v. Industrial Commission*, 359 Ill.App.3d 1083, 1086, 837 N.E.2d 937, 940, 297 Ill.Dec. 486 (3rd Dist. 2005); citing *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671, 278 Ill.Dec. 70 (2003). That being said, the accidental injury need not be the sole causative factor, nor even the primary causative factor, so long as it was *a* causative factor in the resulting condition of ill-being. *Sisbro*, 797 N.E.2d at 673.

A claimant with a preexisting condition that makes him more vulnerable to injury may obtain compensation under the Act so long as employment was a causative factor. *Swartz*, 837 N.E.2d at 940. The supreme court has rejected the argument that "where a causal connection between work and injury has been established, it can be negated simply because the injury might also have occurred as a result of some 'normal daily activity.'" *Id.*, at

940-941; citing *Sisbro*, 797 N.E.2d at 676. Instead, whether an injured employee's health has deteriorated so that any normal daily activity is an overexertion or whether the work-related activity engaged in presents risks no greater than those to which the general public is exposed are factors to be considered when determining whether sufficient causal connection between employment and an injury has been established. *Id.*, at 941; citing *Sisbro*, 797 N.E.2d at 676.

The Supreme Court's conclusion in *Sisbro*, supra, is quite instructive with respect to the present case. To wit, the court noted that "[w]hen an employee with a preexisting condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and the resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. Generally, these will be factual questions to be resolved by the Commission." *Id.*, at 678.

As far as the medical evidence is concerned, both Petitioner's treating cardiac physician, Dr. Berry, and Respondent's §12 examining physician, Dr. Fintel, agreed that Petitioner had severe, preexisting coronary artery disease. In fact, Dr. Fintel believed that Petitioner most likely suffered a "silent heart attack" during the weeks leading up to the event on February 5, 2014. Both physicians agree that shoveling snow could trigger such an ischemic attack, with Dr. Fintel questioning whether Petitioner was actually shoveling at the time. In light of the Arbitrator's factual findings along these lines (see above), the Arbitrator discounts Dr. Berry's opinion to the effect that said activity was the triggering event. Furthermore, the Arbitrator discounts Dr. Berry's opinion that occupational exposure could have played a role in this case, given that there was absolutely no evidence submitted that would quantify or even generally describe the type or frequency of Petitioner's exposure in this regard. Instead, the evidence overwhelming shows that Petitioner had multiple risk factors – including the fact that he was obese, had a family history of coronary artery disease, was a long-term and heavy smoker, and was possibly diabetic or prediabetic as well as hypertensive – and that the near fatal cardiac event he subsequently suffered could have happened at anytime and anywhere. Luckily for him, it happened outside a firehouse where highly-trained paramedics were able to act quickly and save his life.

Based on the above, and the record taken as a whole, the Arbitrator finds that Respondent successfully rebutted the presumption outlined in §6(f) by showing that Petitioner's preexisting coronary artery disease alone was the cause of the cardiac event on February 5, 2014. Furthermore, the Arbitrator finds that the act of stepping outside, whether it be for a smoke or with the intention of clearing snow, did not present a risk of injury that was greater than that to which a member of the general public is regularly exposed. More to the point, Petitioner was a heart attack waiting to happen, and his employment activities neither aggravated nor accelerated his already severe and highly advanced coronary artery disease. Along these lines, the Arbitrator finds the opinion of Dr. Fintel to be more persuasive than that offered by Dr. Berry as to the role Petitioner's employment may have played in the attack. As a consequence, the Arbitrator finds that it cannot be said Petitioner suffered accidental injuries arising out of his employment on the date in question, nor that his current condition of ill-being is causally related to the alleged accident. Accordingly, Petitioner's claim for compensation is hereby denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to medical expenses. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to prospective medical care and treatment. 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:

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 failed to prove his entitlement to temporary total disability benefits. Accordingly, Petitioner's claim for same is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHY HAMILTON,

Petitioner,

vs.

NO: 12 WC 28956

SOUTHWEST AIRLINES, INC.,

15IWCC0394

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability, penalties/fees, and "Maintenance Vocational Rehabilitation," and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident and denies benefits related to this claim but attaches the Decision for the purpose of the statement of facts, which is attached hereto and made a part hereof with the modifications noted below.

The Commission agrees with the Arbitrator who found that Petitioner's testimony denying any prior back treatment after 1995 was "clearly and knowingly false. The petitioner lacks credibility and the Arbitrator does not accept her testimony as being in good faith." (Dec. 4). Petitioner testified:

Q: With respect to your back had you ever injured your back or sought treatment for your back in the past?
A: About 17 years ago when I worked at Osco.
Q: What happened?
A: I pulled a muscle.
Q: Did you get treatment for that?
A: I went to a chiropractor for a little while and that was it.
Q: What's a little while?
A: Maybe a month or so.

Q: And after that chiropractic treatment did you have any other treatment to your low back at all until this accident?
A: No.

(T.67).

The medical records clearly contradict Petitioner's testimony and indicate that she underwent cervical, thoracic, and lumbar MRIs on October 24, 2011, several months prior to her alleged work accident on May 14, 2012. The history section for that lumbar MRI indicates that Petitioner had lower back pain and radiculopathy with left hip and bilateral groin pain. The May 18, 2012 record from Community Urgent Care Center reflects (in various places):

"Onset pain this am"
"Hx 17 yrs ago 'ruptured discs'"
Recent injury = "No"
Context = "Sitting at son's award ceremony for extended period last night & subsequently felt lower back tightening & radiation to both hips"
"Went to chiropractor today w/ no relief after Morph 800mg 6 hours ago"
Where = "home"
Similar symptoms previously = "Yes"
"epidural injection 8 months ago"
Past Hx = …lumbar disc degeneration
"Epidural injection (last 8 months ago)"

This record also shows that, subsequently, "Pt called needs note for proof of visit and that symptoms started Sunday." This is inconsistent with what Petitioner reported initially; that she had the onset of pain that morning. The Commission also notes that the Sunday prior to this Urgent Care visit was May 13, 2012. Petitioner claims that she was injured at work May 14, 2012, which was a Monday. Whether Petitioner's onset of pain was the morning of her Urgent Care visit after sitting at her son's award ceremony for an extended period of time or if it was the Sunday prior, neither is consistent with Petitioner's alleged date of accident at work. In addition, this record indicates that Petitioner underwent an epidural injection eight months prior, which completely contradicts her testimony that she had received no treatment for seventeen years. Finally, the June 25, 2012 record of Dr. Rahman reflects a history that Petitioner had neck and low back pain since 1995 due to a work injury.

We find that Petitioner's willingness to give such clearly and knowingly false testimony about her previous treatment and low back condition causes her to be not credible regarding the alleged accident. We also give minimal weight to the May 19th injury report and the record of Petitioner's chiropractor, Dr. Stein. Unlike the Arbitrator, we find that Petitioner's lack of credibility outweighs the probative value of these records. Based on the above, a review of all of the evidence, and our agreement with the Arbitrator's assessment of Petitioner's credibility, we find that Petitioner has failed to prove that she actually sustained an accident while lifting luggage at work on May 14, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator with respect to accident is reversed and all orders for benefits are vacated.

15IWCC0394

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:
MAY 26 2015

Charles J. DeVriendt

Ruth W. White

Michael J. Brennan

SE/
O: 4/1/15
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

HAMILTON, KATHY
Employee/Petitioner

Case# **12WC028956**

SOUTHWEST AIRLINES INC
Employer/Respondent

15IWCC0394

On 3/11/2014, 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 0.08% 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:

0290 KARCHMAR & STONE
LARRY KARCHMAR ESQ
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOHN WHEELER
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0394

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)

Kathy Hamilton
Employee/Petitioner

v.

Southwest Airlines, Inc.
Employer/Respondent

Case # 12 WC 28956

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 **February 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 **Vocational Rehabilitation**

FINDINGS

On the date of accident, **05/14/12**, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**24,460.80**; the average weekly wage was $**470.40**.

On the date of accident, Petitioner was **42** 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 $**4,456.76** for TTD, $ **Ø** for TPD, $ **Ø** for maintenance, and $ **Ø** for other benefits, for a total credit of $.

Respondent is entitled to a credit of $ **Ø** under Section 8(j) of the Act.

ORDER

SEE ATTACHED 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

March 11, 2014
Date

ICArbDec19(b)

MAR 11 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHY HAMILTON,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 12 WC 28956
	)	
SOUTHWEST AIRLINES, INC.,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Section 19(b) of the Act. Prior to hearing, the parties noted that a fee petition was on file from the petitioner's former attorney, and the parties agreed to defer hearing on that petition to a future hearing, if needed.

STATEMENT OF FACTS

The petitioner, 42 years old at the time of the accident, began working for Southwest Airlines in April 2012. She described having had a training period both in a classroom setting and on varied job assignments (ticket counter, baggage service, gate assistant, etc). Following that initial training period, she was assigned to the ticket counter at Midway Airport. She described the job duties as using the computer system to check passengers in, tagging luggage for the flights, and using the adjacent scale to weigh each piece of luggage to determine if it was more than fifty (50) pounds.

Approximately two weeks into that assignment, on May 14, 2012, the petitioner began her work day at approximately 5:30 A.M. The petitioner testified she was performing her usual duties when at some point between 6:30 and 7 A.M. she was checking in a passenger, who placed a suitcase on the scale. The petitioner testified she recalled the suitcase weighing between 45 and 50 pounds. The claimant took hold of the luggage move it to the conveyor belt behind her; she testified she lifted it approximately four to six inches, and then felt immediate pain in her low back. The petitioner testified a co-worker, Jozette Adams, asked the claimant if she was okay, and told the petitioner to go to the break room; the petitioner went on break for about 15 minutes, then returned to her counter. The petitioner testified she was able to complete her shift but her back was tight and painful throughout the day. The petitioner testified she was not scheduled to work the next three days, and treated herself with ice and over the counter medication.

On May 18, 2012, the petitioner saw Dr. Stein, a chiropractor. His records note a history of picking up a bag at work causing low back pain which had worsened after

sitting on bleachers at her son's school. While this appears to be an initial visit, either the petitioner had treated with him before or else she brought older records, because included in these records is a report of a lumbar MRI scan dated October 13, 2011, which noted findings of disk degeneration and bulging at multiple levels, with a history of symptoms of low back radiculopathy. MRIs of the cervical and thoracic spine are present from later in October 2011 as well. See PX4. The Arbitrator notes the petitioner testified that she had suffered a low back injury in 1995 while working at Osco, which she described as a back strain requiring a brief course of conservative care, but denied any other back treatment or complaints prior to this injury.

The petitioner was referred to the Community Urgent Care Center on May 18. Those records note a history of "17 yrs ago 'ruptured discs'" and the history of sitting at her son's bleachers the night before, with onset of pain that morning which had prompted her to go to the chiropractor. It also noted a history significant for a diagnosis of lumbar disk degeneration with epidural injections, the most recent of which was eight months prior. No history of a work incident is present in these records. See PX5.

On May 19, 2012, the petitioner presented at work and completed an accident report. See PX24. At the company's direction, she presented at MacNeal Hospital that day. She reported injuring herself while rotating to pick up a heavy suitcase, and denied any prior history of back pain. She was assessed with back pain following overexertion, and she was given medication, a light duty restriction, and instructed to follow up with the employee health department. See PX3.

The petitioner presented to Concentra Medical Center on May 21, 2012. She reported injuring her back reaching for customer baggage. She reported no history of injuries or impairments to her back. She was prescribed physical therapy, which she began that day. See PX1. She also treated with Dr. Stein during this period. PX4.

She underwent therapy sessions at Concentra until May 30, 2012. At that time the petitioner reported resolution of the low back pain, and she was released to regular work and discharged from care. PX1.

On June 6, 2012, the petitioner returned to Concentra. She reported that the night before, she was waiting for the shuttle while sitting on a bench, and then stood up and felt an immediate sharp pain in the low back. This had worsened over the course of the evening. She was prescribed light duty and physical therapy. PX1. The petitioner continued to treat with therapy and chiropractic care through June 20, 2012. During this time she was kept on light duty, which her employer could not accommodate. PX1, PX4. She was thereafter recommended a medical consultation.

The petitioner then elected to treat with Dr. Mohammed Rahman on June 25, 2012, for a neurosurgical evaluation on a referral from Dr. Trevor Marcotte for a history of neck pain radiating into the arms. The petitioner reported this condition had been present since 1995. An MRI scan had demonstrated C5 to C7 spondylosis. She also presented with complaints of low back pain which had begun in 1995 and been

reaggravated in 2012 due to a work injury. No reference to any treatment in 2011 is noted. However, Dr. Rahman was able to review a lumbar MRI scan (he did not state a date of the scan) which showed severe degenerative disk disease from L4-S1. Dr. Rahman recommended L4-S1 fusion surgery, noting she would "need an updated MRI prior to surgery." See PX9.

The petitioner underwent a lumbar MRI on June 27, 2012. It was apparently not compared to the prior MRI. It was suggestive for multilevel disk degeneration and degenerative bony changes with broad-based herniation at L4-5 and L5-S1. See PX2.

Dr. Rahman thereafter performed surgery in the form of a two level lumbar fusion on July 17, 2012. See PX6, PX9. Following surgery, on July 27, 2012 Dr. Rahman penned a letter prescribing the petitioner off work until January 17, 2013, while she was engaging in postoperative rehabilitation. PX9. The petitioner underwent a period of physical therapy until January 11, 2013. PX8.

On March 8, 2013 Dr. Rahman authored a letter in which he opined that while the petitioner probably had longstanding degenerative disc disease, the May 2012 work incident had aggravated the need for the lumbar fusion surgery. He opined she had been temporarily disabled for at least 6 months following the surgery. He noted most of his patients "can easily return to work without any restrictions at the 6 month mark" but he had not seen her since September 2012, and left that practice in October 2012. He did not make any findings of current inability to work or MMI standing. PX9.

On April 2, 2013, the petitioner presented to Dr. Rahman at his new office. She reported "doing very well" but asserted flareups of pain depending on activity. X-rays showed the hardware "is in perfect alignment." No evidence of neurological impairment was noted on examination. He opined she would not be able to perform all her prior job functions, but did not prescribe specific restrictions in this report. No further treatment was prescribed at that point. PX9.

The respondent commissioned a Section 12 examination with Dr. Gunnar Andersson on April 18, 2013. He noted he did not have access to the preoperative MRI films. He was apparently not provided with any pre-injury medical records and the petitioner apparently did not discuss such with him. He opined the petitioner had a low back injury consistent with a strain. He concurred the claimant was at MMI and was unable to opine whether the fusion was related to the injury without access to the MRI films. He did not believe any further medical care was required at that time. See RX1. On August 8, 2013, he was provided with the MRI films of June 27, 2012; it does not appear that he was ever informed of the October 2011 MRI. He opined the pathology identified on the MRI was of degenerative bulging rather than herniations and took note of extensive facet arthritis. He opined there was no evidence of acute injury to the spine and believed the only issue present was of longstanding degeneration. He opined that the fusion was a medically accepted treatment course for that pathology but that no relationship to the injury was apparent. RX2.

The petitioner sought no care for her low back for some time and then presented to Dr. Salman, a pain management specialist, on October 14, 2013. He noted she had undergone cervical epidural injection on October 1, 2013. She reported the lumbar spine surgery and was given a prescription for a new MRI scan; this was performed on October 18, 2013 and was compared to the October 2011 MRI, but not to the June 2012 MRI. It revealed the expected postsurgical changes; no hardware displacement was noted. PX26. On November 12, 2013, the petitioner reported to Dr. Salman. She had undergone cervical epidural injections on October 29, 2013. He prescribed medication to the claimant. PX26. On February 3, 2014, the petitioner presented to Dr. Salman. She reported increased complaints to her lumbar spine. He noted she would be a candidate for a lumbar transforaminal injection, but did not specifically set a date for such. PX26.

The petitioner testified she is a high school graduate with some college experience, and has worked as a supervisor at Osco and has worked in several clerical and secretarial positions, with experience including medical billing and clinical research coordination. She testified that she has looked online for jobs with various websites and had submitted her resume to various companies. She asserted she would spend five to seven hours per week searching for work. However, while she presented a resume as PX25, she provided no documentary evidence of a job search, such as job logs, and did not specify which company or companies she had applied for. She testified she had applied for SSDI and an appeal from an initial denial was pending.

OPINION AND ORDER

Accident

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including accidental injury within the scope of employment. See, e.g., *Parro v. Industrial Commission*, 260 Ill.App.3d 551 (1st Dist. 1993). The petitioner's rendition of events is consistent with her usual and expected job duties. The respondent's suspicions are certainly understandable, especially as her initial presentation at the Urgent Care facility (PX5) did not include a report of a work injury.

The Arbitrator, moreover, takes particular note that at trial, the claimant specifically denied any prior back treatment or condition of ill-being after 1995. She also averred this to her own treating neurosurgeon, and to the employer's recommended medical providers, as well as the Section 12 examining physician. Her own medical records demonstrate this to be clearly and knowingly false. The petitioner lacks credibility and the Arbitrator does not accept her testimony as being in good faith.

Had the claimant's accident not been witnessed, or had she not discussed the work injury with her chiropractor on her May 18th presentation, the Arbitrator would most likely conclude that the claimant had failed to credibly prove an accident at work. However, supported by that documentation, the Arbitrator finds sufficient evidence to corroborate an accidental injury.

Causal Relationship

Dr. Rahman opined that the petitioner's workplace injury aggravated her low back degenerative disk disease, which in turn led to the fusion surgery. Dr. Andersson concluded that the injury would have caused a strain or sprain, but opined that the fusion surgery was ultimately related to nontraumatic causes.

It is quite clear, given that the petitioner had lumbar radiculopathy in 2011 and that the most recent epidural injection took place less than a year prior to the asserted accident, that a substantial degree of the petitioner's condition was indisputably degenerative in nature. Of note, the treating surgeon was apparently unaware of her ongoing 2011 treatment, as he made no reference to it in his June 25 report. The Arbitrator further notes neither the radiologist nor the treating surgeon apparently compared the 2011 and 2012 MRI films to determine whether there was in fact a change in the claimant's organic structures, which would assist in either establishing or contradicting whether an aggravation of the petitioner's condition did in fact occur. Dr. Andersson, the examining physician, was never informed by the claimant of her prior history and was never given the opportunity to compare the MRIs.

In the absence of any truly conclusive evidence, the Arbitrator notes that the right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977). Dr. Andersson is deemed credible and his assessment that the petitioner's spinal condition was degenerative and unrelated to a traumatic event is persuasive. As such, while the petitioner did have a back strain initially, the treatment following her discharge from Concentra on May 30, 2012, is not related to the asserted workplace accident.

The petitioner also apparently has a not insignificant concern relative to her neck and upper back. No causal connection regarding those conditions is apparent from the record and the Arbitrator finds those conditions, and any treatment incurred for them, to be unrelated to the accident asserted herein.

Medical Services

The fusion surgery and subsequent treatment is denied as unrelated to the injury in question. The Arbitrator awards the medical costs relating to the treatment at the Urgent Care Center, MacNeal Hospital, CepAmerica Illinois, and Concentra Medical Center, as well as Dr. Stein's treatment during May 2012, as these relate to the injury herein. See PX10-14. All other medical costs are denied as not causally related. Pursuant to petitioner's request, those bills shall be paid to the claimant via counsel, subject to the limits of Sections 8(a) and 8.2 of the Act, and the providers shall seek recompense from the claimant directly, rather than the respondent.

Even presuming causal connection, the petitioner's treatment with Dr. Salman would be denied as excessive under Section 8(a). Her first choice of treating providers was her chiropractor, Dr. Stein. Her second choice of provider was Dr. Rahman, to whom she was referred by Dr. Marcotte, who is not affiliated with the respondent's provider. Her treatment with Dr. Salman is therefore a third choice of provider and is excluded under Section 8(a) as having exceeded her physician options.

Temporary Total Disability, Maintenance and Vocational Assistance

The Arbitrator will address these issues jointly.

The claimant has established eligibility for TTD beginning May 18 and extending through May 30, inclusive, when she was released to full duty. This is a period of 13 days. Deducting the 3-day waiting period under 8(b), the respondent shall pay the petitioner TTD for 1 & 3/7 weeks. At the appropriate TTD rate of $319.00 (statutory minimum TTD rate), a total liability of $455.71 results. The respondent is given credit for $4,456.76 in disability benefits heretofore paid. The $4,001.05 in excess disability benefits shall be credited against any future finding as to permanent disability. Regarding TTD eligibility for the 43 weeks of asserted TTD benefits from June 6, 2012 extending through the asserted MMI date of April 2, 2013, the above findings as to causal relationship control this issue, and benefits are accordingly denied.

The petitioner seeks maintenance from MMI through the trial date and vocational assistance thereafter. Even if a causal relationship were found to exist between the asserted accident and the surgery, the claimant produced no job logs and no evidence of any sort of good faith counseling program. Even had her credibility not been wholly lacking, her alleged job search has clearly not been acceptable within the guidance of *Roper v. Industrial Commission*, 349 Ill.App.3d 500 (5th Dist. 2004) and *National Tea Co. v. Industrial Commission*, 97 Ill.2d 424 (1983), and therefore does not meet the requirements to establish maintenance benefits.

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 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). Here, the claimant's credibility was a matter of serious question. The respondent also secured a Section 12 examination to dispute the petitioner's causal analysis. The disputes are clearly within reasonable boundaries. Even had the petitioner demonstrated causal connection, penalties and fees would not be appropriate.

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

Janet Snyder,

Petitioner,

15IWCC0395

vs.

NO: 12 WC 15682

Great Plains Orthopedics,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses, prospective medical expenses, notice, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Respondent timely filed a Petition for Review of Arbitrator McMarthy's decision issued on June 1, 2014. The Commission subsequently issued a Return Date on Review of October 3, 2014. On December 3, 2014, the Commission issued a motion for a Rule to Show Cause on Respondent's failure to perfect its appeal by not filing an authenticated transcript. Pursuant to the notification of the Rule to Show Cause, Respondent submitted an authenticated transcript on December 11, 2014. Petitioner filed a Motion to Dismiss Respondent's Petition for Review, which was entered by Commissioner White on December 10, 2014 and continued to March 13, 2015. Petitioner then filed a Motion to Strike Respondent's Statement of Exceptions and Additions in Supporting Brief on February 24, 2015. Respondent filed a Response to Petitioner's Motion to Dismiss Respondent's Petition for Review on March 12, 2015. The aforementioned motions were heard by the Commission on March 13, 2015.

15IWCC0395

The Commission finds that the Rule to Show Cause issued on December 3, 2014 was satisfied on December 11, 2014 when Respondent submitted the authenticated transcript to perfect the Respondent's review. The Commission therefore denies Petitioner's Motion to Dismiss Respondent's Review. The Commission also denies Petitioner's Motion to Strike.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 10, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Dismiss Respondent's Petition for Review filed on December 10, 2014 is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Strike Respondent's Statement of Exceptions and Additions in Supporting Brief filed on February 24, 2015 is hereby denied.

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 $7,300.00. 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: MAY 26 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 3/26/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

15IWCC0395

SNYDER, JANET
Employee/Petitioner

Case# **12WC015682**

GREAT PLAINS ORTHOPAEDICS
Employer/Respondent

On 6/10/2014, 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:

1824 STRONG LAW OFFICES
HANIA SCHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0445 RODDY LAW LTD
FRANCIS J O'BYRNE
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

15IWCC0395

Case # 12WC 15682

Janet Snyder
Employee/Petitioner

v.

Great Plains Orthopaedics
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed out to each party. The matter was heard by the Honorable **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 **Prospective Medical**

15IWCC0395

FINDINGS

On 11-10-2009,, 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 her employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $29,522.48; the average weekly wage was $567.74.

On the date of accident, Petitioner was **38** years of age, ***single*** with **one** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of $0.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

THE ARBITRATOR FINDS THE PROPER DATE OF ACCIDENT TO BE NOVEMBER 10, 2009.

Respondent shall pay reasonable and necessary medical services of $6,908.00, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner TTD benefits for a period totaling up to two weeks in the amount of **$376.00 per week**.

Respondent shall provide and pay for the medical care and treatment prescribed by Dr. Blair Rhode.

In no instance shall this award be a bar to a subsequent hearing and determination of an additional amount of medical benefits or compensation for 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. Douglas McCarthy
Signature of Arbitrator

June 6, 2014
Date

JUN 10 2014

15IWCC0395

FINDINGS OF FACT

Janet Snyder, the Petitioner, is claiming accidental injuries as the result of repetitive trauma while working for the Respondent, Great Plains Orthopedics. The Petitioner has filed two claims which are duplicative in nature. The first claim, 10 WC 28791, was filed by the Petitioner's previous attorneys. The second claim, 12 WC 15682, was filed by her current attorneys, the Strong Law office. Strong Law has substituted in as attorneys on the first claim. At arbitration, Petitioner's attorney indicated that an attorney fee petition filed by the first firm is pending. As the two claims are duplicative, both alleging an accident of September 8, 2009, and as the Petitioner has represented to the Arbitrator that an attorney fee petition is pending, the Arbitrator will dismiss the first claim, 10 WC 28791, with the understanding that the attorney fee issue will be addressed when the remaining case is resolved.

The Petitioner began working for the respondent, an orthopedic clinic, in August 2001 as a patient registrar. Her job involved many duties related to patient registration. One of the duties involved the Petitioner retrieving paper charts for each patient, along with some preparation and modification of those charts. According to the Petitioner, the charts weighed anywhere from eight ounces, when they were unassembled, to eight pounds, when they were filled with clinical records. The Petitioner testified that the charts could be up to five inches thick. Each day she had to grab the charts from shelving about five and a half feet above ground and take them to her work station for updating. She said that she grabbed the charts from the shelves with one hand, squeezing and pulling them towards her. She further said that she pulled charts for both new and existing patients. In modifying or updating the charts, the Petitioner would have to write notes by hand or type, use a stapler and operate a hole puncher so the documents could be placed in the chart. She said that she would lift and carry between fifty and eighty five charts over the course of her normal eight hour work day. She also estimated that the clinic serviced between ten and fifty patients per day, and that she checked in between twenty eight and thirty five of those patients. She said that there was another registrar working with her, but that she handled more than her share of the patients. The check in process required her to take information, such as current insurance status, from the patient and add it to their chart. She said this took about fifteen minutes per patient. Once completed, she would take the chart and the patient to the waiting room. As part of the check in procedure, the Petitioner made computer entries. She estimated that she spent five to five and a half hours per shift keyboarding. She said that she took a thirty minute lunch each day, but worked through her scheduled breaks. She submitted into evidence a job description which she prepared for her attorney which described her job duties, and her testimony was consistent with that document. (PX 2)

Janet Smith, the chief operating officer for the Respondent, also testified concerning the Petitioner's job duties. She said that the Petitioner described her duties accurately in her testimony. She agreed that the Petitioner did regularly remove and lift

charts, which she said were in bins, and add to them using a hole punch. She said that each patient registration took between ten and fifteen minutes. She said that the Petitioner could have been keyboarding up to five hours per shift, though the keyboarding was not constant typing. She also agreed that the Petitioner did more registrar work than her partner.

Her testimony differed from that of the Petitioner concerning the number of patients seen each day and the size of the charts which she pulled and carried. She said the clinic served an average of ten patients per day, not the twenty eight estimated by the Petitioner. She prepared an exhibit taken from the business office which showed the clinic had an average of ten new patients per day in 2008 and 2009. (RX 3) On cross examination, Ms. Smith acknowledged that the exhibit did not contain information on the number of existing patient charts the Petitioner pulled and carried each day to perform her updates. She estimated the clinic had 25,000 open files or charts.

The Petitioner said that she began having symptoms of numbness and tingling of her dominant right hand for some time prior to September 8, 2009. She said the symptoms were more noticeable when she grabbed charts and used the hole punch. Further, she said that after the right hand symptoms became more bothersome, she began using her left hand more while performing her duties. The first medical treatment she obtained was with Dr. Garst, an orthopedic surgeon with the Respondent clinic. She saw him on September 8, 2009. She completed a hand history form for the doctor, explaining she had upper extremity problems from the fingers to the elbow on the right. She indicated the problems had been present for two years prior to her visit. Dr. Garst performed an examination and diagnosed a probable right carpal tunnel syndrome. He ordered nerve studies from Dr. Li, which were performed on September 29, 2009.

The Petitioner provided a similar history to Dr. Li concerning her symptoms and their onset, and his tests were interpreted as normal for any nerve entrapments of the right arm. She returned to Dr. Garst on October 6, and his notes indicate they discussed the negative studies. However, the doctor still believed the petitioner had right carpal tunnel syndrome. He elected to do a cortisone injection into the wrist. On November 10, 2009, the petitioner returned to Dr. Garst. She reported that the injection provided temporary relief. Dr. Garst again diagnosed right carpal tunnel and recommended surgery to be performed in the near future. (PX 4)

The Petitioner testified that she then had a conversation with Debbie Duckworth, the human relations director for the Respondent. Ms. Duckworth later testified that this conversation took place on or about November 12, 2009. The Petitioner said that she told Ms. Duckworth that she had been diagnosed with carpal tunnel by Dr. Garst and that she believed it was work related. She said that she was told to see Dr. Pena at the OSF occupational clinic. Ms. Duckworth's testimony basically matched that of the Petitioner. Ms. Smith also testified that around the same time, she had a conversation with Dr. Garst concerning the Petitioner. She said that the doctor told her of his diagnosis and the negative nerve studies, and asked if he could discontinue treating the Petitioner. She said that she granted the doctor's request.

Dr. Pena saw the Petitioner for the first time on November 13, 2009. It appears from his office notes that he saw her on referral from Ms. Duckworth as he e-mailed Ms. Duckworth a copy of his initial office notes. (PX 3) His note indicates that he was seeing the Petitioner as a first visit on a potential workers compensation claim. Her history was of bilateral hand numbness, the right greater than the left. She said that her right wrist and elbow pain had been present for four years and it had gotten worse over the past eight months. She told Dr. Pena that she had gone to Dr. Garst suspecting she had arthritis like her mother. However, after seeing Dr. Garst on November 10, 2009, she "...started realizing that work hurt my hands." (PX 3; 11-13-09) She gave Dr. Pena a history of her job duties that were producing her symptoms, including hand writing and typing in registration, hole punching, stapling, stamping, using her key pad on the computer, and pulling files. Dr. Pena thought the Petitioner gave a poor effort during her examination. His assessment was as follows: "Alleged bilateral hand paresthesias, right greater than left, with clinical and EMG/NCV support lacking. The alleged work duties and their intensity would have to be investigated. There is evidence in the literature that most clerical work is not involved in carpal tunnel." (Id) He suggested she be seen for an independent medical exam by Dr. Rotman. He also suggested a video be done of her work duties and their intensity if the Respondent agreed to have the IME performed. He also wanted another set of nerve studies done by a different neurologist.

The Petitioner returned without an appointment to Dr. Pena two weeks later on November 27, 2009. She told him that Ms. Duckworth questioned the need for more nerve studies. Dr. Pena's office note also indicates that the Respondent was using a new administrator to handle their workers compensation claims. She asked him for approval of the treatment prescribed by Dr. Garst. Dr. Pena refused to approve the treatment and any other further care until the new administrator approved it and/or the previously suggested IME. He said he would not see the Petitioner again until the administrator clarified those issues and released her to full duty. There is no indication that the Petitioner was ever seen again by Dr. Pena concerning her injuries.

The next relevant event was an ergonomic evaluation performed by Matt DeLost, a therapist employed by the Respondent, on December 4, 2009. The Petitioner said that the evaluation of her work station was arranged by the Respondent. The evaluation report was sent to both Dr. Garst and Janet King, who was identified at arbitration as being part of the respondent's management group. At the evaluation, the Petitioner's work station was examined in order to see whether some of her carpal and cubital tunnel symptoms could be reduced. (PX 4; Ergo eval. 12-4-09) Several changes were made to the petitioner's work station as a result of the evaluation. First, her keyboard was secured so that she could type without resting her elbow on her desk top to keep it from moving. Similarly her mouse and pad were repositioned to prevent her from resting her elbow on her desk. Next, padding was added to her hole punch handle to reduce the effect of her striking it with her palms as she worked. The therapist concluded that the changes would help her symptoms, and the Petitioner testified that she did notice some improvement after they were implemented. (Id)

The Petitioner was next seen by the aforementioned Dr. Rotman for an examination at the Respondent's request on February 8, 2010. He determined that she did not have any nerve entrapments in her right arm and further opined that nothing about her work would have caused her symptoms. (RX 1; Dep. X 2)She was next seen for treatment by her family doctor, Dr. Sidler, on February 17, 2010. All of her treatment since then has come through his referral or the referral of others in that chain. The Petitioner had six weeks of physical therapy at the Respondent's facility. She was then sent to a rheumatologist, who in turn recommended new nerve studies. Those were done by Dr. Troung on June 11, 2010, and they were interpreted as showing moderate right carpal and cubital tunnel. Rheumatology then referred her to Dr. Mahoney, an orthopedist at Midwest Orthopedics. It should be noted that the Petitioner testified that she was referred to Dr. Mahoney by Ms. Duckworth, an assertion denied by Ms. Duckworth. Dr. Mahoney ultimately performed right carpal tunnel surgery on August 4, 2010, and right cubital tunnel surgery on November 24, 2010. The Petitioner was released to return to full duty work on December 27, 2010, and she testified that she did return to work, though her job duties were somewhat different than she'd done previously.

In June 2011, the Petitioner voluntarily left her job to take one which she said was better. She did not testify as to the specifics of the new job. She had no more medical care for her upper extremities until May 14, 2012 when she went to Dr. Sidler. She told him that her left hand and forearm were symptomatic. He in turn referred her to Dr. Rhode, an orthopedic surgeon. (PX 11) Dr. Rhode examined her on May 30, 2012. Her history was that she developed left arm symptoms while performing her job with the Respondent. She said that her right upper extremity bothered her initially and that she developed her left arm problems because she was overusing it to compensate for the right. Dr. Rhode diagnosed left carpal and cubital tunnel, which he attributed to her job. He ordered nerve studies from Dr. Trudeau which revealed moderate to severe left carpal tunnel and mild left cubital tunnel. (PX 7) Ultimately on November 14, 2012, Dr. Rhode recommended surgery to both areas.(PX 15)

The Petitioner was next sent to Dr. Rotman for another examination on February 4, 2013. This time he found evidence of carpal tunnel on the left, which he characterized as mild. He said the condition was idiopathic in origin and not causally related to her job with the Respondent. (RX 1; Dep. X 3)

The Petitioner is now requesting that the Respondent pay for the treatment prescribed by Dr. Rhode, along with payment of past TTD and medical. Respondent has denied the claim in its entirety, and requests credit for medical paid by group if the claim is found to be compensable.

Drs. Rhode and Rotman testified on the issue of causation. Dr. Rhode said that the Petitioner's work over the course of her employment for the Respondent was a causative factor in the development of her injuries. He cited her gripping and grabbing of rather large charts, along with her other job duties, which he said were highly repetitive, as causative factors. (PX16 at 26, 27) He further noted that she had only two

other risk factors, obesity and gender. (Id) He went on to explain the mechanism of injury: "...I remember the patient describing how big these charts are; that she would have to kind of one hand grip with her hand. And, yes, that's a static force that has to be generated to hold all of those records so they don't fall on the floor, to move them about. " (Id at 111) Dr. Rhode noted that the right arm problems were initially predominant, but referred to Dr. Pena's November 2009 note as an indication that she was having left arm symptoms as well. (Id at 106-107) He understood that the Petitioner grabbed between thirty and eighty five charts per day.(PX 15) He said that if the Petitioner's actual exposure was drastically different than her description to him, his opinions could change. (PX 16 at 109)

Dr. Rotman testified that the work activity required no repetitive heavy gripping, no forceful gripping and no repetitive flexion or extension of the elbows. As such, he said, the work was not a causative factor. (RX 1 at 14-15) He acknowledged that her only other risk factors were obesity and gender, but indicated her problems were idiopathic. (Id at 52) Dr. Rotman also testified that he did not know how frequently the Petitioner pulled charts or used her computer on the job. (Id at 40)

Conclusions of Law

On the issue of whether the Petitioner sustained an accident arising out of her employment which is causally related to her bilateral nerve entrapments, the Arbitrator must decide if the Petitioner's work duties were a causal factor in the development of those conditions. If causation is found, then the proper date of accident and the issue of notice need to be determined.

There was really no dispute as to the Petitioner's job duties during her nine plus years on the job as a registrar. She testified in detail how she grabbed charts and what she did with them. She explained the other clerical duties which she performed on a daily basis. Her written job description matched her testimony. The Respondent also submitted a performance evaluation which contained a list of the Petitioner's job duties which was consistent with her testimony. (RX 2) Ms. Smith testified that the Petitioner's testimony was accurate insofar as her job duties were concerned. She said the Petitioner could well have used a keyboard five hours every day. She also said the Petitioner did have to pull and carry patient charts. She also said that approximately 20 % of the charts the Petitioner worked with were the heavy charts which she had described. She also said that the majority of the charts the Petitioner pulled were one inch thick. The main dispute had to do with the number of charts the Petitioner worked with on an average day. Ms. Smith's exhibit showed an average of only ten new patients a day, equating to only ten charts. However, Ms. Smith acknowledged that the exhibit did not consider the number of existing files the Petitioner might have pulled and updated during a normal shift. The Petitioner testified that she performed that task every day. Also, the exhibit says nothing about the rest of the Petitioner's job; i.e. her other

clerical duties which the Respondent's own ergonomic evaluator modified in hope that her symptoms would improve.

Dr. Rhode had a clear and accurate understanding of what the Petitioner did on her job. More importantly, he gave a clear explanation as to how those job duties could have been a causative factor in the development of her conditions. The Arbitrator finds his explanations persuasive, especially when he explained how the static force required while she gripped and pulled the charts could aggravate her condition. While there is a real question as to how many charts the Petitioner might have pulled on an average day, it is clear that that activity when added to the rest of her work activities required her to use her hands throughout the day and place pressure on her elbows, as the ergonomic report indicates. Dr. Rhode was basing his opinions on the assumption that the Petitioner handled at least thirty charts per shift. While it is clear from Ms. Smith that the clinic only served only a third of that number in new patients, it is also clear that the Petitioner pulled additional charts each day on existing patients. The history which Dr. Rhode used in formulating his opinions was clearly not drastically different than the Petitioner's actual exposures. Dr. Rotman's opinions are not persuasive. He said her job did not require heavy gripping, yet he had no idea how often she gripped during the course of a day. Also, he was recommended as an examiner by Dr. Pena, whose independence is clearly in question based upon his comments made during his initial encounter with the Petitioner.

Based upon the above evidence, the Arbitrator finds the Petitioner's conditions of ill being are causally related to her work duties performed for the Respondent.

The term repetitive trauma was established by the Supreme Court in the Peoria County Belwood case decided many years ago. It was referenced by the Court in order to set a standard for the date of accident in a case which did not involve a single trauma. As the Court later explained in its Durand decision, the standard of proof is the same as in a single trauma case. The Petitioner must simply prove that her work was a causative factor. As stated above, the Petitioner satisfied her burden of proof on that issue. The accident date used should be the date when the injury manifest itself, which is the date when both the fact of the injury and the causal relationship between the injury and the petitioner's employment would have become plainly apparent to a reasonable person. Here the Petitioner is alleging a date of September 8, 2009, the date she first sought treatment. Apparently, she learned from Dr. Garst on that day that he suspected carpal tunnel. However, she later told Dr. Pena that she went to Dr. Garst because she thought she had arthritis. It wasn't until after her nerve studies and her follow up visits with Dr. Garst, that she became aware of a firm diagnosis, and that is when she told Dr. Pena that she began to consider work as a cause. The Arbitrator believes the proper manifestation date was November 10, 2009, the date of her last visit with Dr. Garst. The evidence established that on or about that date the Petitioner knew of her injury and knew it might be related to her work. Notice was clearly provided to the Respondent soon after that visit when the Petitioner called Ms. Duckworth and was referred to Dr. Pena.

15IWCC0395

With respect to the medical expenses, bills were marked and entered into evidence as Petitioner's Exhibit 18. In reviewing this exhibit and consistent with his previous findings of causation and accident, the Arbitrator awards the following medical bills that are related to the Petitioner's condition of bilateral carpal tunnel and bilateral cubital tunnel syndrome.

MEDICAL BILL LIST – LEVEL 1

CLIENT: Janet Snyder
D/A: 09/08/09
DATE: 05/01/13

NAME OF PROVIDER	ACCOUNT NUMBER	DATE OF SERVICE	AMOUNT OF BILL
Memorial Medical Center	228569125	06/19/12	$1,660.00
Orland Park Orthopedics	SNYJAN0001	05/30/12-11/14/12	$1,214.00
Dr. Sidler	2409	05/14/12	$80.00
Dr. Edward Trudeau	297821-1	06/19/12	$3,846.00
OSF Medical Group	710522	06/25/10	$108.00
	TOTAL		**$6,908.00**

/keh

The Arbitrator orders the Respondent, Great Plains Orthopaedics, to pay the Petitioner $6,908.00, reasonable and necessary and causally related to the medical expenses. The medical bills are to be paid to Petitioner at a rate pursuant to Illinois Workers' Compensation fee schedule.

Dr. Mahoney took Petitioner off of work post-operatively after her right carpal tunnel surgery from August 4, 2010 to August 10, 2010. The Petitioner was again taken off of work post-operatively for her right cubital tunnel syndrome from November 24, 2010 to November 30, 2010.

The Arbitrator, based on the medical records of Dr. Mahoney and based on the testimony of the Petitioner, finds that the Petitioner is entitled to TTD from August 4, 2010 to August 10, 2010 and from November 24, 2010 to November 30, 2010,a period of two weeks.

The Arbitrator based on the testimony of Dr. Rhode orders the Respondent to provide and pay for the medical care and treatment he recommends.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey L. Backenger,

Petitioner,

vs.

NO: 13 WC 15229

15IWCC0396

Wal-Mart Stores, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Respondent herein and notice given to all parties, the Commission after considering the issues of causation, medical expenses, temporary total disability benefits, wage rate, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent, and based on our complete review of the record we find the following:

On the issue of Petitioner's wages, we note that the wage statement provided by Respondent (RX7) shows that Petitioner had six pay periods for work from July 1, 2011 through July 15, 2011 ($1,190.83) and from May 4, 2012 through June 29, 2012 ($2,925.08) totaling $4,115.91. The pay periods cover two week intervals. In his Response to Respondent's Statement of Exceptions, Petitioner's computations include pay from the June 17, 2011 pay

period, which is from when Petitioner was off work. The Commission notes that 52 weeks before the accident starts at July 1, 2011 and while Petitioner may claim that the June 17, 2011 pay period includes hours worked from June 18, 2011 through July 1, 2011, there is nothing in the wage statement to support such a claim. The Commission can only go by the evidence provided and cannot and will not make assumptions. The wage statement only indicates what was paid for each pay period. Based on the wage statement provided, Petitioner earned $4,115.91 over a 12 week period (6 pay periods). Therefore, taking Petitioner's earnings and dividing that by the time worked, $4,115.91÷ 12=$342.99, which would be Petitioner's average weekly wage. The Commission finds that Petitioner's average weekly wage is $342.99. As such, Petitioner's temporary total disability rate is $228.66.

Regarding Petitioner's period of temporary total disability, the Commission notes that the record shows that Petitioner was taken off work from August 17, 2012 through October 29, 2012 (PX5) and from April 19, 2013 (when Respondent stopped accommodating Petitioner's restrictions (T.36-37,41,AX1) through the date of hearing. The Arbitrator awarded temporary total disability benefits from July 1, 2012 through July 7, 2012; however, as noted by Respondent in its Statement of Exceptions, there is nothing in the record showing that Petitioner was taken off work from July 1, 2012 through July 7, 2012. As such, the award of temporary total disability benefits from July 1, 2012 through July 7, 2012 is not supported by the record. Therefore, the Commission finds that Petitioner has established entitlement to temporary total disability benefits from August 17, 2012 through October 29, 2012 and from April 19, 2013 to May 19, 2014, totaling 67-1/7 weeks.

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 $228.66 per week for a period of 67-1/7 weeks, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $339.93 for medical expenses under Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner penalties of $7,676.45 as provided in Section 19(k) of the Act, $10,000.00 as provided

15IWCC0396

in Section 19(l) of the Act, and attorney's fees of $3,070.58 as provided under Section 16 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 $32,800.00. 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.

MAY 27 2015

DATED:
MJB/ell
o-04/06/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

BACKENGER, JEFFREY L
Employee/Petitioner

Case# **13WC015229**

15IWCC0396

WAL-MART STORES INC
Employer/Respondent

On 7/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0529 GREG E TUITE & ASSOC
PO BOX 59
ROCKFORD, IL 61101

0560 WIEDNER & McAULIFFE LTD
BROOKE TORRENGA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jeffrey L. Backenger
Employee/Petitioner

v.

Wal-Mart Stores, Inc.
Employer/Respondent

Case # **13** WC **15229**

Consolidated cases: _____

15IWCC0396

An *Application for Adjustment 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 cities of **Rockford and Woodstock**, on **5/19/14 & 6/4/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 _____

15IWCC0396

FINDINGS

On the date of accident, , Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$20,939.88**; the average weekly wage was **$402.69**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3690.16** for TTD, **$0.00**for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$3690.16**.

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 $268.43/week for 63 2/7 weeks, commencing 7/1/12 through 7/7/12, 8/17/12 through 10/29/12, and 4/19/13 through 5/19/14 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 6/29/12 through 6/4/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $339.93, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner penalties of **$17,798.98 in total** , as provided in Section 16 of the Act; **$7,899.49**, as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) of the Act and attorney fees of $3577.89 as provided in Section 16 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E Mc — June 17, 2014

Signature of Arbitrator — Date

ICArbDec19(b)

JUL 7 - 2014

15IWCC0396

FINDINGS OF FACT

On June 29, 2012 Petitioner was employed as a lead assembler for Wal-Mart Stores at their Rockton, Illinois store. He had been employed there since 2007 as a lead assembler. Mr. Backenger had a variety of duties ranging from assembling items for sale to working on the floor. He is right hand dominant and testified that he did not have a history of any prior right shoulder injuries.

Mr. Backenger testified that he had previously injured his left shoulder while working for Wal-Mart. The medical records indicate that this incident occurred in September 2010 and ultimately resulted in a subacromial decompression and Mumford procedure being performed by Dr. John Orwin on July 25, 2011. He participated in an extensive physical therapy both prior to and subsequent to the left shoulder surgery. He underwent a functional capacity evaluation for the left shoulder condition on February 7 and 8, 2012. On February 14, 2012, Dr. Orwin released Mr. Backenger to return to work. Dr. Orwin also released Petitioner from his care. On June 19 and June 26, 2012, Petitioner saw Dr. Henry Juan, his physician for general medical care. The medical records contain no complaints involving either the right or left shoulder at that visit.

On June 29, 2012, Petitioner sustained an undisputed accident to his right shoulder and arm. He was working in the meat department and entered a cooler to retrieve some meat. He had climbed a ladder to pull a piece of meat off a rack. While on the ladder, his foot slipped and he fell backwards. While falling, he struck his neck and right shoulder upon a rack. He noted immediate pain in his right shoulder and reported the incident. He attempted to work the following day, but had to go home because of pain.

On July 3, 2012 Mr. Backenger sought treatment from Dr. Juan, a primary physician. Dr. Juan's records contain a history that is consistent with that given by Petitioner at trial. Dr. Juan noted Mr. Backenger to be in moderate to severe pain. Upon examination, he noted that the right shoulder had a decreased range of motion. He also noted tenderness at the AC joint, glenohumeral joint, deltoid muscle, trapezius, biceps, triceps, and latissimus dorsi muscles. An x-ray was taken and Dr. Juan subsequently imposed restrictions of no working above shoulder height, no ladders or climbing, no lifting over five pounds, and no use of the right shoulder and right upper extremity. Dr. Juan referred Petitioner to Dr. Ronald Garcia who saw him on July 5, 2012. Dr. Garcia's history is also consistent with Petitioner's testimony. Dr. Garcia noted right shoulder tenderness along with flexion limited to 90° as compared to 180° on the left. Abduction was similarly restricted. The Neer and Hawkins impingement signs were both positive on the right. Dr. Garcia recommended physical therapy and performed a steroid injection into the right shoulder joint. The employer offered Mr. Backenger light duty on July 7, 2012. In this job, he answered the phone and performed zoning with the left hand. During this time he was receiving physical therapy at Mercy Health. A July 18, 2012, note from physical therapy noted decreased

range of motion and strength, and considerable loss of use of the dominant right upper extremity. Petitioner returned to see Dr. Garcia on July 19, 2012. The doctor noted that the previous steroid injection did not help; therefore, Dr. Garcia took Petitioner off work and recommended an MRI. The MRI was performed on August 6, 2012. This showed mild to moderate osteoarthritic degenerative changes along with abnormal fluid within the joint space and the bicipital tendon and sheath. A small tear was suspected through the anterosuperior labrum. There was also mild right acromioclavicular joint arthropathy with edema within the joint. Petitioner returned to Dr. Garcia the following day. The doctor referred Mr. Backenger to Dr. Craig Lyons, an orthopedic surgeon. Dr. Garcia also imposed restrictions of no reaching above shoulder with the right arm, no lifting greater than five pounds with the right arm and no pushing/pulling greater than twenty pounds with the right arm.

Mr. Backenger was seen by Dr. Lyons on August 9, 2012. The doctor noted that the previous physical therapy and injections had not provided any significant relief. He also noted a positive Hawkins and Neers test during the examination. Dr. Lyons diagnosed "impingement and significant biceps tendonitis after fall". He recommended an arthroscopic decompression along with a distal clavicle resection and biceps tenotomy. Petitioner underwent surgery on August 17, 2012. In addition to the decompression and tenotomy, the doctor performed a partial thickness rotator cuff repair.

Petitioner began therapy approximately one month post surgery. During the initial evaluation, the therapist noted significant pain and limitation in his active and passive range of motion. On October 2, 2012, Petitioner returned to his family physician who evaluated the right shoulder. He noted pain at the 6 out of 10 level, which was aggravated with movement such as turning a steering wheel and lifting. He noted tenderness at the deltoid muscle, trapezius muscle, AC joint, and glenohumeral joint. On October 12, 2012 Mr. Backenger saw Dr. Lyons physician assistant. The PA performed a right shoulder injection and told Mr. Backenger to continue with physical therapy. Around that same time, the PA completed a return to work slip that indicated that Petitioner could only return to work with a restriction of no use of the right arm. (PX 11). On November 16, 2012, Mr. Backenger was seen by the PA, who once again noted pain at the 6 out 10 level causing difficulty sleeping. He was using a TENS unit and attending physical therapy. The PA noted that the post-operative course was being slowed by glenohumeral joint arthritis and stiffness. He recommended continued physical therapy, the TENS unit and a home exercise program. Petitioner was last seen by Dr. Lyons on December 28, 2012. He noted that Mr. Backenger's evaluation showed crepitus, pain, loss of active motion, night pain and disability secondary to his shoulder. Continuing conservative treatment was recommended.

Shortly thereafter, Mr. Backenger chose to return to Dr. John Orwin, the doctor who had surgically repaired the left shoulder. Mr. Backenger saw Dr. Orwin on February 6, 2013 in the Beloit office. An examination along with x-rays was performed. After the examination, Dr. Orwin recommended a fluoro-guided glenohumeral joint injection. In addition, he gave Mr. Backenger a slip that limited him to one-handed work. (PX 10). Mr. Backenger testified that he gave a copy of the slip to the night manager of Wal-Mart store. He was not offered any employment.

Petitioner did undergo the joint injection, which was performed by Dr. Lee at UW Madison, on February 14, 2013. Physical therapy was initiated at Beloit Health System on February 21, 2013. Shortly after this, Petitioner underwent an EMG/NCS at the University of Wisconsin Hospital in Madison. This did not show any specific nerve involvement in the right arm. Petitioner returned to Dr. Orwin on April 23, 2013. Dr. Orwin noted that the glenohumeral joint injection had given 5-6 days of relief. He noted the continuing limited range of motion of the right shoulder. His diagnosis was right shoulder glenohumeral degenerative changes exacerbated by a fall at work along with failed conservative measures. Therefore, he recommended arthroscopic debridement of the glenohumeral joint. On March 27, 2013 a "peer review report" was prepared by Dr. David Trotter at the request of Wal-Mart. Dr. Trotter did not evaluate the Petitioner but instead performed a medical record review. Around this same point in time, Petitioner received a settlement offer letter from Wal-Mart's Claims Management Services. Shortly after this, he was sent home after being told there was no work available because Wal-Mart had determined the case not to be compensable. Petitioner has had no further medical treatment since the surgery recommendation by Dr. Orwin. Petitioner also testified that there have not been any intervening injuries since the original accident on June 29, 2012. He further indicated that he does wish to proceed with the surgery recommended by Dr. Orwin.

CONCLUSIONS OF LAW

Issue F – Is Petitioner's Current Condition and Need for Surgery Causally Related to the June 29, 2012 Accident?

The Arbitrator finds that Petitioner's current condition of ill being and need for surgery to the right shoulder is causally related to the injury of June 29, 2012. The Arbitrator bases his finding upon the opinion of the treating physician, Dr. John Orwin, and the totality of the medical records. (PX 9). The Arbitrator finds Dr. Orwin to be a highly qualified shoulder surgeon at the University of Wisconsin – Madison as evidenced by his curriculum vitae. (PX 10). He was not hired to provide a forensic medical/legal opinion by either party. Instead, he has been Petitioner's treating physician since May 24, 2011, when he began treating his left shoulder condition. The fact that he was familiar with Petitioner's right shoulder condition, both before and after the work accident, places him in the best position to determine whether or not that accident caused the need for the surgery that he is proposing. In his report, Dr. Orwin states:

> "It is my opinion to a reasonable degree of medical certainty, that Mr. Backenger was having little, if any, problems with his right shoulder joint at the time of his accident on June 29, 2012. It is my opinion, however, that Mr. Backenger most likely did have glenohumeral arthritis in his shoulder, but he was completely asymptomatic. It is my opinion that the accident aggravated the arthritis in his shoulder beyond the normal progression necessitating his index [*sic*] surgery by Dr. Lyons and the subsequent treatment." (PX 10).

Later in his report, he states the following:

> "I do feel that Mr. Backenger most certainly had this arthritis in his shoulder prior to the accident, but he was asymptomatic. Therefore, the accident aggravated this arthritis

beyond the normal progression therefore making it compensable by workman's compensation. I don't believe that Dr. Lyons surgery made his overall condition any worse. Unfortunately, it just didn't make him significantly better."

These opinions are consistent with the medical records that were offered into evidence. The records from Mercy Beloit Medical Center (PX 3), Mercy Health Sports Medicine (PX 4), and Mercy Health Walworth (PX 5) all document the fact that prior to the accident of June 29, 2012, Petitioner made no complaints of any kind pertaining to his right shoulder. These include 27 physical therapy visits at the Research Park Sports Medicine Physical Therapy Center between July 26, 2011 and November 23, 2011, as well as treatment at the Beloit Memorial Hospital physical therapy department from December 14, 2011 through February 3, 2012. (PX 8). Probably the most significant document from Beloit Health is the Functional Capacity Evaluation performed on February 7, 2012 and February 8, 2012. That evaluation showed full strength in all movements of the shoulder. In addition, his range of motion was as follows: Flexion 165°; Extension 135°; Abduction 165°; External rotation 80°; and Internal rotation to T8.

Mr. Backenger made numerous complaints of pain in his left shoulder while performing the specific tasks of the Functional Capacity Evaluation. There are no complaints noted in regard to the right shoulder. During the evaluation, he was asked to ascend and descend a ladder with 25 and 35 pounds on his right shoulder. He was able to perform this task with no problem. The fact that Petitioner had a completely normal assessment both objectively and subjectively just five months prior to the June 29, 2012 accident documents the fact that any pre-existing arthritis that existed before the accident was totally asymptomatic. The Arbitrator further notes that an unrelated evaluation with Dr. Juan performed three days before the work injury contains no mention of any difficulties with the right shoulder.

In contrast, an evaluation performed a week later, and just four days after the June 29, 2012, accident shows a dramatic change in his condition. When Petitioner saw Dr. Juan on July 3, 2012, he rated his pain as 8 out of 10. His right shoulder had decreased range of motion, and there was tenderness noted in multiple muscles and joints in the front and back of the right shoulder. By July 5, 2012, Dr. Garcia noted right shoulder flexion and abduction to be 90°, an almost 50% reduction from normal. Approximately five weeks post accident, Dr. Lyons noted asymptomatic underlying arthritis. He further noted that Petitioner had full range of motion and strength prior to the fall but now had very painful range of motion with numerous objective tests. The MRI demonstrated significant fluid within the biceps consistent with an extensive biceps tendonitis as well as a downward slopping of the acromial tip and some degenerative acromioclavicular joint changes. His diagnosis was "impingement and significant biceps tendonitis after fall". A review of the medical records shows that Petitioner's impaired range of motion did not improve and that his pain level remained constant from the time of injury through the date of Dr. Orwin's recommendation for a second surgery. This evidence supports Dr. Orwin's opinion that the June 29, 2012, fall aggravated, both subjectively and objectively, the pre-existing arthritic condition.

In support of its refusal to authorize the surgery recommended by Dr. Orwin, Respondent presented four medical reports – two from Dr. David Trotter and two from Dr. Peter Hoepfner. Dr. Trotter never examined Petitioner, but instead performed a "peer review" consisting of a

review of a portion of Petitioner's medical records. Dr. Hoepfner did examine Petitioner on September 17, 2013. Neither Dr. Hoepfner nor Dr. Trotter had Petitioner's pre-injury treatment records, and in particular the records related to the prior left shoulder injury. Both doctors also stated that Mr. Backenger had only suffered a soft tissue injury as a result of his fall on June 29, 2012. Both doctors opined that they believed the need for surgery proposed by Dr. Orwin was solely related to pre-existing arthritis in the glenohumeral joint. Dr. Trotter went so far as to state that Mr. Backenger likely had previous "periods of impingement syndrome and painful arthritis of the right shoulder." The Arbitrator notes there is no evidence to support this statement and is mere conjecture. There is absolutely no evidence of any symptomatic or painful arthritis of the right shoulder before the incident in question. Dr. Trotter also states on numerous occasions that one would have expected complaints of "markedly greater severity and frequency of painful motion after the June 29, 2012 incident".

Similarly, Dr. Hoepfner states that Petitioner only described moderate anterolateral shoulder discomfort at the time and "waited several days before seeking treatment", and therefore is consistent with a shoulder strain/sprain and tendonitis. The treatment records show that Mr. Backenger went to his physician four days after the incident. At that time was complaining of an 8 out 10 pain level and had an almost a 50% loss of range of motion in the shoulder.

The Arbitrator choses to give little weight to these opinions due to the fact that the opinions do not correlate to the evidence of record. In addition, it is clear that the doctors did not review all of the medical records that have been presented to the Arbitrator. In particular, there is no indication that they reviewed the physical therapy records from 2011 and 2012. Those records contain no complaints of any right shoulder problems. Nor did they review the Functional Capacity Evaluation performed just five months prior to the accident in question. The FCE showed normal right shoulder strength, full range of motion, and the ability to climb a ladder with a thirty-five pound weight on the right shoulder. Ultimately, Drs. Trotter and Hoepfner have not directly addressed the question of an aggravation of a pre-existing condition. In particular, they have not addressed the question of why the change between an asymptomatic shoulder pre-injury and a significantly limited and painful shoulder post injury does not constitute an aggravation of a pre-existing condition. The evidence presented by Petitioner supports Dr. Orwin's opinion regarding aggravation and acceleration and therefore, the Arbitrator finds in Petitioner's favor on the issue of casual relationship.

Issue G – What were Petitioner's Earnings on the Date of Accident?

Respondent offered an earnings history report as Respondent's Exhibit 7. In reviewing the report, it appears that there were only twelve pay periods in which Petitioner had earnings during the 52 weeks before the accident. The remainder of the time, Mr. Backenger was out of work due to his prior to his left shoulder injury. The payroll records show that Mr. Backenger is normally paid every two weeks. The records reveal that during those two-week periods, he would normally work between 45-65 hours. This is consistent with his testimony that he would normally work approximately 36 hours per week. The records also reveal that he apparently worked two one-week periods of less than 36 hours. This first occurred during the week before he started missing time due to his left shoulder injury (7/15/11 pay period). The second time was

when he returned to work after being off work (5/4/12 pay period). Therefore, between July 1, 201, and June 29, 2012, there were five two-week pay periods and two one-week pay periods resulting in a total of twelve pay periods. The total earnings for those twelve pay periods (7/1/11-7/15/11 and 5/4/12-6/29/12) is $4,429.59. Dividing that gross amount by twelve renders an average weekly wage of $402.69. Based upon the Arbitrator's judgment that this method most accurately describes the average weekly wage during the year before the accident, the Arbitrator finds that Petitioner's average weekly wage as of the date of injury was $402.69.

Issue J – Has Respondent Paid All Appropriate Charges for All Reasonable and Necessary Medical Expenses?

Petitioner submitted a medical bills exhibit marked as Petitioner's Exhibit 1. The sole bill not paid by Respondent are charges owed to Beloit Health Systems for physical therapy to Petitioner's right shoulder rendered in March 2013. The bill total is $339.93. Since both the medical provider and the Petitioner reside in Wisconsin, the Act requires that out of state treatment be paid at the lesser of the Wisconsin Fee Schedule or the Illinois Fee Schedule, if Wisconsin does not have a Fee Schedule. Should Wisconsin not have a fee schedule, the bill should be paid pursuant to the Illinois Fee Schedule, as it would apply in Rockford, the designated hearing site. Since the Arbitrator has already ruled in Petitioner's favor on the issue of casual relationship, the Arbitrator finds that Respondent is liable for payment of the unpaid medical charge owed to Beloit Health System.

Issue K – Should Prospective Medical Care be Ordered?

There is no dispute that Petitioner is in need of further treatment to the right shoulder. Neither of Respondent's examining doctors stated that Dr. Orwin's proposed surgery to the right shoulder was unnecessary. Dr. Orwin discusses the need for surgery both in his office notes as well as his narrative report. Noting that conservative measures have failed to improve Mr. Backenger's range of motion and right shoulder pain, Dr. Orwin recommends that an arthroscopic debridement of the glenohumeral joint is needed. In addition, if this procedure does not give Petitioner symptomatic relief, it may be necessary to perform a joint arthroplasty in the future.

Having previously determined that Petitioner's condition of ill being is causally related to the fall at work, the Arbitrator orders Respondent to authorize and pay for treatment to the right shoulder recommended by Dr. Orwin.

Issue L – Should Respondent Pay Temporary Total Disability Benefits?

Petitioner claims three distinct periods of temporary total disability. The first is July 1, 2012 through July 7, 2012. The second is August 17, 2012 through October 29, 2012. Finally, Petitioner claims that he has been disabled from April 19, 2013 through the date of hearing. The Respondent agrees to the period of disability from August 17, 2012 through October 29, 2012, and claims credit of $3,690.16. Petitioner testified that he attempted to work the day after the accident but could not tolerate the pain. He did return to work on July 8, 2012, he then worked up until August 17, 2012, when surgery was performed by Dr. Lyons. He was released to return

to work with restrictions of no use of the right arm as of October 29, 2012. (PX 12). Respondent accommodated the restriction until April 19, 2013. In the interim, he had seen Dr. Orwin on February 6, 2013. Dr. Orwin also restricted Mr. Backenger to one-handed work with no use of the right arm. (PX 11). On April 19, 2013, Respondent made an offer to Mr. Backenger to settle his worker's compensation claim for the June 29, 2012 incident. Shortly thereafter, he was informed by the night manager that accommodated work would no longer be provided, based on their position that the claim was no longer compensable. Petitioner has not worked since that time.

There is nothing to indicate that Petitioner is no longer employed by Wal-Mart. He is under a restriction of no use of the right arm by both Dr. Lyons and Dr. Orwin. He still has significant loss of motion of that arm and is experiencing moderate to severe pain in the shoulder. Petitioner was performing accommodated work for the Respondent until he was sent home, apparently based on Dr. Trotter's opinion regarding causation. Based upon the above and the fact that the Arbitrator has previously found in favor of the Petitioner on the issue of casual relationship, the Arbitrator finds that Petitioner has been temporary totally disabled since April 19, 2013 and has continued to be so through the date of hearing.

Issue M – Should Penalties and Attorney Fees be Awarded?

The intent of Sections 16, 19(k) and 19(l) of the Worker's Compensation Act is to expedite the compensation of injured workers and penalize an employer who unreasonably or in bad faith delays or withholds compensation due to an employee. The Arbitrator notes that Respondent initially acted reasonably in its handling of Mr. Backenger's claim. They paid all of Mr. Backenger's bills except for a physical therapy bill in March 2013. Respondent stipulates that Petitioner was temporarily and totally disabled from August 17, 2012 through October 29, 2012. At that point, Respondent began accommodating Petitioner's restriction s and provided one-handed work for him to do. It was not until Respondent obtained the "peer review" report from Dr. Trotter that Respondent's conduct became unreasonable.

The test is not whether there is some conflict in a medical opinion; instead it is whether the Respondent's conduct in relying upon the medical opinion of its examiner to dispute liability is reasonable given the circumstances presented. In the present case, Respondent relied upon the opinions of a physician who reviewed only a portion of Petitioner's medical records. He never spoke with the Petitioner or examined him. It is clear that he did not have any of the pre-injury medical history when he rendered his first two opinions, nor did he obtain any x-rays or review any imaging studies. Based on the information that he reviewed, Dr. Trotter stated that Petitioner merely sustained a soft tissue injury when he fell off the ladder at work. He further stated that this soft tissue injury healed within approximately four weeks of the incident, despite the fact that Petitioner ultimately went on to surgery with Dr. Lyons. Dr. Trotter does not indicate the medical or scientific basis for his opinion other than "his experience". The Arbitrator notes that the Dr. Trotter's opinions are inconsistent with Respondent's acknowledgement that Petitioner was totally disabled from August 17, 2012 through October 29, 2012, the period of post operative recovery. The Arbitrator further notes that Dr. Trotter no longer practices in Illinois and is licensed to practice in a number of states. Petitioner obtained copies of 1099's from Dr. Trotter's 2013 tax return. These documents reveal the fact that Dr.

Trotter provides substantial medical/legal consulting for a variety of insurance companies. In light of all of the medical evidence and Petitioner's testimony, the Arbitrator finds that Dr. Trotter's opinions are entitled to little or no weight, and the employer's reliance upon those reports to dispute compensability of the claim is unreasonable.

Respondent's other expert physician, Dr. Hoepfner also failed to review all of the relevant medical records. In particular, he failed to review the physical therapy records, and the functional capacity records that showed full function of the right arm just five months prior to the work injury. The Arbitrator finds that Respondent's reliance upon this report is also unreasonable. Dr. Hoepfner also opined that Petitioner only sustained a sprain or strain of the shoulder when he fell off the ladder. The basis of this statement was his belief that Petitioner only had moderate anterolateral shoulder discomfort at the time of injury and waited several days before seeking treatment. As noted above, this is a mischaracterization of the evidence in that Petitioner complained of severe pain in the shoulder when he went to the doctor four days after the accident. Petitioner also testified that he attempted to return to work the day after the accident and had to go home because of the pain in the shoulder. Like Dr. Trotter, Dr. Hoepfner never addresses head on the fact that Mr. Backenger's arm was fully functional before the accident and became severely impaired shortly after the accident. The failure to provide a medical basis for the opinion of no aggravation in the face of evidence showing an asymptomatic and fully functional right arm prior to the accident makes Dr. Hoepfner's opinion also unreasonable.

The Arbitrator notes that the only opinion rendered by a truly independent physician in this case is that of Dr. Orwin. The Arbitrator notes that Dr. Orwin is an extremely qualified and extensively published shoulder specialist. He serves as the team physician for the University of Wisconsin football and basketball teams. His opinion that the fall aggravated and accelerated the underlying degenerative arthritis is consistent with the facts presented in this case. Respondent's refusal to accept the opinions of the treating physician and refusal to pay benefits after April 19, 2013 was unreasonable and vexatious.

Section 19(k) allows the Commission to award compensation in addition to that otherwise payable equal to 50% of the amounts payable at the time of the award. When a delay has occurred in the payment of benefits, the employer has the burden to justify the delay. Section 19(l) penalties are appropriate when there has been a delay in payment of fourteen days or more. In such cases, the Arbitrator shall allow the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Sections 8(a) and 8(b) that have been withheld, not to exceed $10,000.00. Finally, Section 16 of the Act allows that when an employer has been guilty of unreasonable or vexatious delay within the provisions of Section 19(k), the Arbitrator can assess attorney fees and costs against the employer. Based upon the evidence cited above, the Arbitrator awards 19(k) penalties of $7,899.49 based upon 50% of the outstanding TTD benefits of $15,798.98. Based upon 19(l), the Arbitrator awards $10,000.00 in penalties based upon a $30.00 a day for a total of 422 days. Finally, considering Section 16 of the Act and based upon the penalties awarded above, the Arbitrator awards attorney fees of $3,577.89 pursuant to Section 16 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

TERRY BONE,

Petitioner,

vs.

NO: 11 WC 43241

ARAMARK MANAGEMENT SERVICES,

15IWCC0397

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court. Pursuant to the Circuit Court's Order dated October 28, 2014, this matter was remanded to the Commission "for clarification of which facts/evidence support its decision to reduce the PPD award from 30% to 15% of a foot."

The Commission questions whether this case has been reversed by the Circuit Court as its only directive was that the case has been "remand[ed] to the Commission for clarification of which facts/evidence support its decision..." The jurisdiction of the circuit court to review a decision of the then Industrial Commission, (now IWCC), under the Workmen's Compensation Act is wholly statutory, and its power, in the exercise of this special statutory jurisdiction, is limited by the provisions of the statute. *Kudla v. Industrial Com.*, 336 Ill. 279. Section 19(f)(2) of the Illinois Workers' Compensation Act, 820 ILCS 305/19(f)(2), states in pertinent part:

> The court may confirm or set aside the decision of the Commission. If the decision is set aside and the facts found in the proceedings before the Commission are sufficient, the court may enter such decision as is justified by law, or may remand the cause to the Commission for further proceedings and may state the

> questions requiring further hearing, and give such other instructions as may be proper.

Beginning in 1919, our Supreme Court stated: Under the statute the circuit court had two courses open to it on review of the proceedings by certiorari: either to set aside the decision and enter such decision upon the facts as is justified and required by law, or to remand the cause to the commission for further proceedings. *Peabody Coal v. Industrial Commission*, 287 Ill. 407; 122 N.E.843; 1919 Ill. LEXIS 1184.

This was further explained by the Supreme Court in *Thompson v. Industrial Commission*, 377 Ill. 587; 387 N.E.2d 350; 1941 Ill. LEXIS 686, where the Court cited to *Peabody*. The Supreme Court in *Thompson* reiterated the power of the circuit court in a workers' compensation matter and stated: If the decision is set aside the court has two alternatives: (a) either to enter such a decree as is justified by the facts and required by law, or (b) to remand the cause to the commission for further proceedings. The court may state the questions requiring further hearing and give such other instructions as may be proper, but the only remanding order authorized by the statute is a remandment for further proceedings.

The Circuit Court can either confirm the actions of the Commission and find that its Decision is not against the manifest weight of the evidence, or it can reverse the Decision of the Commission, finding it to be against the manifest weight of the evidence.

It is not the intention of the Commission to ignore the Order of the Circuit Court, or for that matter any court. 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 Commission affirms its award of 15% loss of use of the right foot.

By Section 8.1(b) of the Act, 820 ILCS 305/8.1(b), for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a);

Dr. John Krause performed an AMA rating. He found Petitioner has a six percent combined lower extremity impairment which converts to a two percent person-as-the-whole impairment. RX.3. pg.5. Dr. Krause testified that the Petitioner has atrophy of the calf, thickening of the Achilles tendon and diminished range of motion, all of which are permanent. RX.3. pg.30. Dr. Krause found that the Petitioner has satisfactory alignment, full hind foot motion, satisfactory plantar flexion and normal sensibility. *Id.*

(ii) the occupation of the injured employee;

Mr. Bone was employed as a shuttle driver.

(iii) the age of the employee at the time of the injury;

Mr. Bone was 39 years old at the time of the injury.

(iv) the employee's future earning capacity; and

Mr. Bone currently earns fifty cents per hour more than he did prior to the accident. T.13, T.19.

(v) evidence of disability corroborated by the treating medical records.

Mr. Bone sustained a right Achilles laceration on September 23, 2011. He underwent open repair of the Achilles tendon on September 26, 2011 and was returned to work full-duty and without restriction on August 10, 2012. PX.3, PX.4. He currently performs the same work duties as he did prior to the accident. T.13, T.19. Subjectively, the Petitioner experiences some pain while pushing a cart uphill. T.17. He also experiences some tightness in the morning or if it is cold outside. *Id.* He will also develop a shooting pain up to the kneecap, while walking on uneven ground. The shooting pain causes his knee to buckle. *Id.*

The Petitioner testified that he has not sought medical treatment since August 2012 and does not take pain medication. T.20. He has not sought treatment in spite of his alleged complaints.

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.

15IWCC0397

The Commission has considered each and every factor as required under Section 8.1(b) of the Act. The Commission has assigned no greater weight to any specific factor.

A determination of the extent or permanency of a claimant's disability is a question of fact, and the Commission's decision will not be set aside unless it is against the manifest weight of the evidence. *Peabody Coal Co. v. Industrial Comm'n*, 355 Ill. App. 3d 879, 883, 823 N.E.2d 1107, 291 Ill. Dec. 521 (2005); *Roper Contracting v. Industrial Comm'n*, 349 Ill. App.3d 500, 506-07, 812 N.E.2d 65, 285 Ill. Dec. 476 (2004). The test is whether there is sufficient factual evidence in the record to support the Commission's determination, not whether this court, or any other tribunal, might reach a different result. *Benson v. Industrial Comm'n*, 91 Ill. 2d 445, 450, 440 N.E.2d 90, 64 Ill. Dec. 538 (1982); *Pietrzak v. Industrial Comm'n*, 329 Ill. App. 3d 828, 833, 769 N.E.2d 66, 263 Ill. Dec. 864 (2002). For a finding of fact to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Caterpillar, Inc. v. Industrial Comm'n*, 228 Ill. App. 3d 288, 291, 591 N.E.2d 894, 169 Ill. Dec. 390 (1992).

Based on its review of the record, the Commission affirms its award of 15% loss of use of the foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $489.92 per week for a period of 25.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the Petitioner 15% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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 $12,300.00. 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: MAY 27 2015

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB/tdm
O: 5-12-15
052

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

MYRTLE GUYNES,

Petitioner,

vs.

NO: 02 WC 48041

15IWCC0398

STATE OF ILLINOIS
DEPT OF HUMAN SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) OF THE ACT

This matter comes before the Commission pursuant to Petitioner's Section 19(h) Petition filed January 9, 2007. A hearing was held before Commissioner Michael J. Brennan on November 24, 2014. After reviewing the record in its entirety and being advised of the applicable law, the Commission hereby denies Petitioner's Petition finding that Ms. Guynes failed to prove a material increase of her condition as required under Section 19(h) of the Act.

By way of procedural history, Ms. Guynes was found to have developed bilateral carpal tunnel as a result of her repetitive job duties as a Human Services Case Manager. In its Decision dated May 18, 2005, the Arbitrator found causal connection through January 25, 2003, which was the date Dr. Thomas Wiedrich placed Petitioner at maximum medical improvement (MMI). Petitioner was awarded temporary total disability benefits (TTD) from September 3, 2002 through January 25, 2003, representing 72-6/7 weeks. Petitioner was returned to work with modified duties. Petitioner testified that her work duties were re-assigned but her work load increased and her symptoms continued. The Arbitrator awarded Petitioner 20% loss of use of the person-as-a-whole pursuant to Section 8(d)(2) as her permanent restrictions altered her ability to

15IWCC0398

perform her job duties. The Commission affirmed and adopted the Arbitrator's Decision on October 19, 2006 (06 IWCC 48041).

On January 9, 2007, Petitioner filed its 19(h)/8(a) Petition seeking additional medical expenses and TTD benefits as her condition had since destabilized. During the May 24, 2007 hearing, Petitioner's attorney stated that they were not alleging a material increase in her permanent disability at that time. In its 19(h)/8(a) Decision dated June 11, 2008, the Commission found that the May 4, 2006 MRI revealed worsening carpal tunnel on the right. Petitioner was taken off work on August 30, 2006 and then worked from May 14, 2007 through May 21, 2007, at which time she was given more restrictive restrictions and taken off work. The Commission found Petitioner's condition had destabilized and awarded additional TTD benefits from August 30, 2006 through May 13, 2007 and May 21, 2007 through May 24, 2007, representing 37-2/7 weeks pursuant to §8(b) of the Act and $114.68 in unpaid medical expenses pursuant to §8(a) of the Act.

On August 29, 2013, Petitioner filed its Motion for Hearing stating that the 19(h) Petition filed January 9, 2007 and previously the subject of a Commission Decision dated June 11, 2008, remained pending before the Commission, and Petitioner moved the subject matter for a hearing on increased permanency.

Respondent filed a Motion to Strike Petitioner's Motion on July 25, 2014. Respondent argued that no 19(h)/8(a) Petition was pending before the Commission as the 2007 Petition had been decided and was currently not pending before the Commission. Consequently, Petitioner was time barred from filing a new Petition as they failed to file a new 19(h) Petition within 30 months of the June 11, 2008 Decision. Petitioner filed its reply on August 29, 2014. Petitioner argued that the Commission's Decision was not a final Decision addressing permanency; therefore, the Commission had jurisdiction to hear the 19(h) Petition.

Commissioner Brennan denied Respondent's Motion to Strike during the November 24, 2014 Chicago Review Call finding Petitioner came before the Commission pursuant to its August 29, 2013 Motion requesting a hearing on the 19(h) Petition previously filed January 9, 2007. The matter proceeded to hearing.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The Commission finds:

1. Ms. Guynes testified she has not worked since August 2007 and is currently on State Employee Retirement System (SERS) disability. The Commission notes that Ms. Guynes has two prior workers' compensation claims, 91 WC 56477 and 94 WC 50188. Petitioner was awarded 20% loss of use of each hand for each claim.

2. Petitioner presented to Dr. Wiedrich on May 7, 2007 with continued numbness and pain at various times throughout the day. The following median nerve examinations were all negative: Thenar Atrophy, Phalen's Test, Pronator Provocation, FDS Arcade Stress, Circle Sign, Median Nerve Compression, and the Tinel's at the elbow, forearm and wrist. Her ABP strength was 5/5. Petitioner was given restrictions consisting of no lifting more than 5 pounds, 5 minute rest breaks every 20 minutes when performing repetitive work, and no repetitive activities greater than 15 minutes in a half hour. PX.1.

3. Petitioner underwent a Section 12 examination with Dr. James Elmes of Chicago Consulting Physicians at the request of the State Employee Retirement System on October 4, 2007. The record indicated Petitioner was 5'8" tall and weighed 360 pounds. Examination was negative for symptom magnification. The EMG was positive for median nerve compression and decreased median nerve conduction time bilaterally. Her pain ranged between 3 and 7 out of 10. Her prognosis was poor for the return to regular job duties as a Human Services Caseworker unless her job could be modified to fit her limitations. PX.2.

4. On August 13, 2007, Ms. Guynes was seen by Dr. Wiedrich. Petitioner reported that she had returned to work for 5 days in May 2007, but her employer could not accommodate her restrictions. Petitioner had random episodes of numbness in her fingers with no specific cause. The following median nerve exams were all negative: Thenar Atrophy, Phalen's Test, Pronator Provocation, FDS Arcade Stress, Circle Sign, Median Nerve Compression, and the Tinel's at the elbow, forearm and wrist. Her ABP strength was 5/5. The following ulnar examinations were also negative: Claw, Froment's Sign, Jeanne's Sign, Masse's Sign, First Dorsal Interosseus Atrophy and Elbow Flexion Test, Wartenberg, Hypothenar, Tinel, Pitres-Testut, Bouvier Maneuver and the Phalen's at the Guyon's canal. Dr. Wiedrich noted the nerve conduction study showed some improvement. No further treatment was necessary as she was at MMI. She was to follow-up in 3 months as required by her disability certification. Her work restrictions were continued. PX.1.

5. Petitioner presented to Dr. Wiedrich on January 14, 2008 with an increase in pain along the surgical incision. She had intermittent stiffness of her hands as well as continued occasional numbness and tingling. She felt a little worse overall. The median and ulnar nerve examination findings were unchanged from the prior examination. A possible repeat EMG was to be considered. PX.1

6. Petitioner's pain continued though her examination findings remained unchanged. On February 23, 2009, Ms. Guynes reported that she would get numbness when she used the computer for any period of time. She had tenderness in her palms and her hands would swell with activity. Dr. Wiedrich noted that additional surgery would not benefit her as she had 5 prior surgeries without improvement. On August 20, 2009, Dr. Wiedrich noted

Petitioner's sensation had slightly improved and she was overall stable. She was given restrictions of no more than 15 minutes of repetitive activity per half hour. PX.1.

7. On September 20, 2010, Dr. Wiedrich saw Petitioner for follow-up of her left trigger thumb. Petitioner continued to have waxing and waning of her numbness and tingling in her bilateral hands. The examination findings remained unchanged from prior examinations. Her carpal tunnel remained stabled and no additional treatment was warranted. She was to follow-up as needed. PX.1.

8. Ms. Guynes was seen by Dr. Wiedrich on February 23, 2012 with continued numbness, tingling and pain when using her hand for any significant amount of time. She had a positive Phalen's Test. There was a flexor retinaculum cyst over the base of her left thumb that was tender to palpation. The diagnosis was carpal tunnel syndrome. PX.1.

9. Petitioner underwent an EMG of the bilateral upper extremity on April 18, 2013. Petitioner complained of increased weakness with activities, dropping objects, and constant numbness and tingling. She had difficulty performing fine motor activities. She was off work. The EMG revealed right carpal tunnel syndrome, moderate in severity and a left ulnar neuropathy. The EMG report noted that there was no significant change seen when compared to the previous evaluation of April 2007. PX.1.

10. Joseph Belmonte performed a vocational assessment on August 21, 2013 at the request of Petitioner's attorney. Mr. Belmonte met Ms. Guynes on one occasion only. He was subsequently deposed on April 9, 2014. Mr. Belmonte opined that Petitioner had lost access to her usual and customary job and line of occupation. He found no alternative work was available to Petitioner except that which was so limited in quantity, dependability or quality that no stable labor market existed. PX.3. pg.16. There was no alternative work available for her within her restrictions and she had no transferable skills. While Ms. Guynes had a college level education and a positive long-term stable work history performing clerical and administrative duties, her advanced age and significant restrictions meant that vocational rehabilitation would not yield any return on investment. PX.3.pg.17. Mr. Belmonte opined that Petitioner qualified under the odd-lot theory of disability.

11. Respondent had Dr. Craig Phillips of Integrity perform a Section 12 examination on January 27, 2014. Petitioner weighed 224 pounds. Dr. Craig found no objective findings except for pain over the basilar joints of both thumbs, which was mild. She had a negative provocative test at the 1st CMC for synovitis or arthritis. Her examination was completely benign and there was nothing with regard to her subjective complaints and physical examination that was due to her work activities. Her symptoms had plateau and she was stable. She needed no further surgery. Her risk factors included being a postmenopausal female who was overweight. She could work without restrictions and she

sustained no specific injury on April 25, 2002. She had no permanent impairment as a result of her April 25, 2002 injury. RX.3.

12. On June 20, 2014, Amy Portz of Creative Case Management, Inc. performed a transferable skills analysis/labor market survey at the request of the Respondent. Ms. Portz found Ms. Guynes had transferrable skills, rudimentary computer skills and the capacity to learn. Her yearly salary range was between $26,000.00 and $31,200.00. There were full-time jobs available to her as she had a solid work history, transferable skills, and a college degree. While she had been released to work without restrictions and had basic computer skills, she had been out of work for 10 years. RX.4.

13. Petitioner testified that she had a heart attack in 2007 that required surgery. She had stents inserted in 2010 and 2013. Her surgeries have since brought her a lot of anxiety and depression. She would get to the point where she could not function emotionally and was unable to do anything. T.22. Her health issues have hindered her from securing employment. T.23. Ms. Guynes also has arthritis in her back, both knees and shoulder. *Id.* She testified that her husband has throat cancer and she is his caregiver. T.24. Her husband is in a nursing home as she cannot provide all his necessary care. T.44. However, she picks him up every day and then drops him back off at the nursing home. T.45. She feeds him and tends to his needs as best as she can. *Id.*

14. Petitioner testified that since the June 2008 hearing, she has had continuous periods where she cannot function due to her arthritis. T.24. She has periods of time when she cannot use or write with a pen. She has difficulty holding objects. She cannot tolerate cold temperatures and cannot use air conditioning. T.25. She has difficulty driving as she cannot grip things for a long period of time. She has a hard time holding the newspaper. Her pain wakes her up in the night and she has tingling in her hands. Her situation has not gotten better. While she can do some things, she cannot be productive. If she does anything that really aggravates her hands, she is then out of commission for 3 to 4 days if not a couple of weeks. T.26. She takes Tramadol and Tylenol. She has not had any accidents since 2007.

15. Petitioner testified on cross-examination that she has not been able to use a pen since her first diagnosis of carpal tunnel. T.40. She had sensitivity to cold temperatures prior to May 2007. She had gripping issues in 2007, but they are now worse. T.41. Her condition would wake her up in 2007, but it now does not wake her up as much. She may wake up 5 to 6 times a month. T.43. She had 10 surgeries, 3 carpal tunnel releases on the left, 2 on the right, and a trigger finger release. She would like to go back to work, but her employer did not follow the restrictions. Her condition has since worsened. T.42.

16. Petitioner testified that she has applied for the jobs contained in the labor market survey prepared by Ms. Portz. Her time frame for applying for a job varied as she was having a lot of health issues. She has not received any job offers. T.20. She has also looked for

15IWCC0398

work on her own but has not secured an offer. T.21. She has looked for positions as a receptionist, a cashier, and a shampoo girl. *Id.* It took her a year to a year and a half following her heart attack to resume looking for employment. T.30. She testified that she has never really recovered from the stents.

17. Since March 2010 to the present, Petitioner has spent a total of a month to 2 months looking for a job. T.34. She has not maintained her job search logs as well as she should have. T.37.

Pursuant to Section 19(h):

> [A]s 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... after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended.

The Commission finds that Petitioner's Section 19(h) Petition filed January 2007 was timely. During the May 2007 hearing, Petitioner's attorney stated on the record that they were not alleging a material increase at that time as her condition had not yet re-stabilized. The Respondent did not object to Petitioner's statement. The Commission finds that the issue of material increase was specifically reserved by the Petitioner and not addressed by the Commission; therefore, the issue of material increase was still pending before the Commission.

The Commission, however, finds that Ms. Guynes failed to prove a material increase in her condition.

In *Gay v. Industrial Commission*, 178 Ill. App. 3d 129, 132 (1989), the Illinois Supreme Court explained that:

> [t]he purpose of a proceeding under section 19(h) is to determine if a petitioner's disability has "recurred, increased, diminished or ended" since the time of the original decision of the Industrial Commission. (Ill. Rev. Stat. 1985, ch. 48, par. 138.19(h); *Howard v. Industrial Comm'n* (1982), 89 Ill. 2d 428, 433 N.E.2d 657). To warrant a change in benefits, the change in a petitioner's disability must be material. (*United States Steel Corp. v. Industrial Comm'n* (1985), 133 Ill. App. 3d 811, 478 N.E.2d 1108.) In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Industrial

> Commission's first decision. (*Howard*, 89 Ill. 2d 428, 433 N.E.2d 657.) Whether there has been a material change in a petitioner's disability is an issue of fact, and the Industrial Commission's determination will not be overturned unless it is contrary to the manifest weight of the evidence. *Howard*, 89 Ill. 2d 428, 433 N.E.2d 657; *United States Steel Corp.*, 133 Ill. App. 3d 811, 478 N.E.2d 1108.

The Commission finds no objective evidence supporting Petitioner's contention that her condition has materially increased. Rather, the Commission notes that all the objective testing revealed no increase in her condition between 2007 and 2013. Dr. Wiedrich noted Petitioner's condition had remained stable and she even had a slight improvement of her condition. Dr. Wiedrich's medical records are consistent with Petitioner's testimony. Her testimony establishes that all of her subjective complaints are similar to her subjective complaints from prior to the first hearing in May 2007. Furthermore, the EMG from April 18, 2013, when compared to the April 2007 EMG, revealed no significant change in her condition.

The Commission also finds that Ms. Guynes failed to prove that she is permanently and totally disabled. The evidence establishes that Petitioner has significant health issues, including a heart attack, stents, and depression, none of which are related to her bilateral carpal tunnel. She testified that she did not look for work for up to a year and a half following her heart attack. She also did not look for work following her surgeries for her stents. Additionally, Petitioner testified that her depression has affected her job search. In total she dedicated up to two months only looking for a job since March 2010. The Petitioner did not admit into evidence her job search logs. The Commission has no evidence to support that Ms. Guynes participated in a good faith job search.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §19(h) Petition is hereby denied.

DATED: MAY 27 2015

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 5/5/15
052

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Pevril,

Petitioner,

vs. NO: 09 WC 52079

15IWCC0399

John H. Stroger Jr. Hospital of Cook County,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on Remand from the Circuit Court of Illinois. The Circuit Court reversed the Commission's Decision and remanded the matter back to the Commission "for further determination consistent with this Order."

This matter was originally tried before Arbitrator Molly Mason on December 4, 2012. Arbitrator Mason issued her decision on December 27, 2012. In her decision, Arbitrator Mason made the requisite findings of fact and conclusions of law, and found that Petitioner failed to prove that he suffered a work-related injury on October 22, 2009, and denied compensation. The Arbitrator pointed out multiple instances in which Petitioner's testimony was contradicted by witness testimony as well as the medical records and found that Petitioner was not credible

Petitioner filed a Petition for Review and oral arguments were held before the Commission on December 5, 2013. On December 11, 2013, the Commission affirmed and adopted the Arbitrator's Decision.

Petitioner appealed the Commission Decision to the Circuit Court of Cook County and on September 30, 2014, the Circuit Court found that the Commission's decision was against the manifest weight of the evidence and reversed its decision. The Circuit Court specifically

disagreed with the Commission's findings regarding Petitioner's credibility. The Circuit Court explained:

> "[T]he Arbitrator's decision finding Plaintiff's testimony not credible, and that Plaintiff failed to prove a compensable work accident occurred, is against the manifest weight of the evidence. The Arbitrator did not address the remaining issues as she found them moot. The Board affirmed and adopted the Arbitrator's decision. Therefore, the Court reverses the Board's decision and remands it for further determination of the remaining issues."

We presume the Court is referring to Petitioner when speaking of "Plaintiff" and of the Commission when referencing the "Board." Based on those presumptions, the Commission hereby reverses its Decision and remands the matter back to the Arbitrator to address all outstanding issues regarding Petitioner's claim.

The Commission notes that while the Arbitrator did not address certain issues in her decision due to her finding of no accident under the Illinois Workers' Compensation Act, evidence was taken at arbitration regarding the issues of accident, causal connection, temporary total disability benefits, medical expenses, and permanent disability benefits. While the Commission finds that the record is sufficient to address any and all outstanding issues, we nonetheless hereby remand the matter back to the Arbitrator as ordered by the Circuit Court.

Therefore, the Commission hereby remands this matter to the Arbitrator, pursuant to the express orders of the Circuit Court, for further determination consistent with the Circuit Court's Order.

As a matter of law, the Commission disagrees with the Circuit Court's Order, in that the Court concludes that it retains jurisdiction "for further appeals," and cautions the parties of the consequences of their failure to follow the requirements of Section 19(f) in the future.

DATED: MAY 28 2015
MJB/ell
disc-05/12/15
52

Michael J. Brennan

Charles J. DeVriendt

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES D. STANLEY,

Petitioner,

vs. NO: 10 WC 42768

15IWCC0400

FRESH EXPRESS, INC.; CHIQUITA BRANDS CO., NORTH AMERICA; CHIQUITA FRESH NORTH AMERICA, LLC & SPECIALTY RISK SERVICES (SRS),

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 causation, medical expenses, permanency, credit, penalties and attorney fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

With regard to the issue of causation, the Arbitrator's decision indicates that he "finds that Petitioner's present condition of ill-being of his left and right legs to be causally related to the accident of September 12, 2010." (Arbitrator's Decision, p. 11).

The initial ambulance report (Px1) notes Petitioner's only complaints involved the left leg. At Gottlieb Hospital (Px1), he complained of left knee pain, denying any other pain or injury. X-rays were taken of the left leg, and a laceration to the posterior left knee area was sutured. Petitioner followed up with Dr. Khanna the next day, September 13, 2010, and the doctor indicated he had complained of bilateral thigh pain after the injury. (Px2). Bruising was noted in the medial right thigh, and Petitioner had pain with right knee range of motion. The right leg examination was otherwise normal. Bilateral leg pain and contusion were diagnosed.

Petitioner then followed up with family physician Dr. Savcic on September 14, 2010, and complained of left knee injury with significant pain. (Px3). Right knee examination at that time indicated no pain, full range of motion and no edema. The left knee had mild edema and erythema, and mildly decreased range of motion due to pain.

On September 16, 2010, Petitioner went to Mercy Hospital complaining of lower left leg swelling. (Px4). Deep vein thrombosis (DVT) testing was negative. There was an indication of right ankle swelling and the diagnosis was right leg edema. However, based on the context of the report, this appears to be a clerical error, as the Petitioner's complaints at this facility were only on the left side.

On September 20, 2010 Petitioner visited the company clinic, noting increased pain, increased left foot swelling and negative DVT testing. (Px2). A left knee MRI was performed that same day, and on September 27th the Petitioner was referred to Dr. Giannoulias by Dr. Khanna. The MRI showed soft tissue edema and bony contusions consistent with contusion, joint effusion, synovitis, a Baker's cyst and a non-displaced horizontal tear of the medial meniscus. It also showed a bipartite patella with lateral patellofemoral chondromalacia and chondral fissuring. (Px5).

Petitioner saw Dr. Giannoulias on September 28, 2010, giving a history of injury to the posterior knees due to crush, in particular to the left knee. His main complaint was swelling, pain and catching in the left knee. After examination and review of the MRI, Dr. Giannoulias diagnosed a crush injury to the legs with medial meniscal tear. Therapy was prescribed to improve swelling and range of motion, but the doctor indicated that Petitioner would likely need arthroscopic surgery to address the meniscal tear, since it had been symptomatic for him and painful with range of motion. It appears the left knee may have been injected that day as well. (Px5).

On October 1, 2010, while Dr. Khanna noted only left knee complaints, the diagnosis remained bilateral knee pain, including possible right knee meniscus tear, and a right knee MRI was prescribed. (Px2). Petitioner went to Westlake Hospital on October 5, 2010, again complaining of left leg swelling, and repeat testing again indicated no sign of DVT. The diagnosis was bilateral knee pain. (Px7). The last visit to the company clinic was October 8, 2010, at which time Petitioner complained of significant pain from the left knee to the ankle. The report notes he had an injection to the left knee with lightheadedness, that he was to follow up with Dr. Giannoulias, and that left knee surgery was pending. The only report of Dr. Giannoulias in the evidentiary record is from September 28. 2010, and while it notes surgery was likely going to be needed at some point, it does not indicate that any such surgery was specifically prescribed at that time by him. On October 18, 2010 Dr. Savcic noted bilateral knee pain, and that Petitioner had lightheadedness. On October 28, 2010 Dr. Savcic took him off work. (Px5 & Px3).

Petitioner initially saw Dr. Psaradellis on November 2, 2010, noting a bilateral leg crush injury. Petitioner stated that he had gotten worse with physical therapy, however no physical therapy records preceding November 2, 2010 were presented into evidence. Petitioner complained of bilateral knee pain, right greater than left, and left leg swelling that was activity-related, as well as numb feelings. He had good range of motion and no instability bilaterally. Dr.

Psaradellis noted a lot of hypersensitivity to both legs. While he stated that he reviewed bilateral x-rays and MRIs, no right knee/leg x-rays or MRIs from prior to 2012 were presented by either party into evidence. Dr. Psaradellis diagnosed bilateral crush injuries to the legs, and stated that he was not convinced the meniscus tear was causing Petitioner's symptoms. His main concern was the hypersensitivity. Physical therapy records of Athletico from November, 2010 through February, 2011, only reference treatment to the left knee. Petitioner's functionality was improved, but he complained of ongoing stiffness and pain. (Px6).

On January 4, 2011, Dr. Psaradellis stated that Petitioner likely sustained some venous injuries and that leg swelling could be permanent. On February 8, 2011 he noted Petitioner had returned to full time work and was doing well other than some ongoing left leg swelling, and he was returned to full duty. There was then a treatment gap between April 5, 2011 and October 18, 2011. On April 5, 2011 Petitioner indicated he had been working but said he was starting to have left knee pain, but he had full range of motion and trace effusion. He didn't want another injection because he had been lightheaded with the prior one, and he felt he could keep working. The next visit of October 18, 2011 was after an alleged October 12, 2011 second accident date, which is the subject of consolidated case number 12 WC 34588.

Respondent's Section 12 examiner, Dr. Miller, testified that he believed a tear was misdiagnosed – he agreed there was signal there on the MRI, but that it was a grade II signal, which indicated only a 10-20% possibility that it was actually a tear. In any case, he did not believe the meniscal problem, if there was one, was related. (Rx1).

With regard to the right leg, while there is some evidence that Petitioner may have had a meniscal tear in the right knee, Dr. Psaradellis stated that any such tear was "not overly impressive". The Petitioner had minimal right knee complaints following this accident, and any finding of a tear appears to the Commission to be an incidental finding, and unrelated to the accident.

Based on the above, the Commission finds that Petitioner clearly sustained a crush injury to both legs, a posterior left knee laceration, and bilateral knee strains on September 12, 2010. He also may have, as indicated by Dr. Psaradellis, sustained permanent venous damage to the legs, although there is a question based on a review of all of the medical as to whether Petitioner actually had ongoing swelling or simply had the feeling of swelling in his legs. Dr. Khanna, who is the company doctor, noted the MRI showed a meniscal tear, which was why she referred Petitioner to Giannoulias, but she doesn't specify a causal connection of the tear to the accident. Dr. Giannoulias, who saw Petitioner once, opined Petitioner's left knee symptoms were related to the meniscal tear, and that while he was trying conservative treatment, Petitioner likely would ultimately need surgery for it. Dr. Psaradellis opined on November 2, 2010 that he wasn't convinced that Petitioner's symptoms were related to the tear. Dr. Miller not only opined that a left meniscal tear was not related to the accident, it was questionable as to whether the MRI films actually depicted a meniscal tear.

As noted, the Commission finds unquestionably that the Petitioner sustained bilateral crush injuries to the legs. However, we find that the preponderance of the evidence does not support a finding that his symptoms are related to any meniscal tears he may have. We often

analyze the issue of causation in applicable cases in terms of a "chain of events" analysis. In a nutshell, this means that we can determine that a claimant had no evidence of a physical problem prior to an accident, has an accident, and subsequently has physical problems involving the impacted body part, inferring that the accident thus caused the physical problem. This is a relatively easy determination in a case where a claimant has, for example, a clearly broken limb following an accident impacting that limb. In cases like the one at bar, it can be more difficult to make such an analysis, as there may be multiple possible involved pathologies. Here, we believe the preponderance of the evidence indicates that while Petitioner may have strained both knees, we do not believe the evidence supports that his symptoms are the result of meniscal tears, and as such do not believe the evidence supports the causal relationship of any meniscal tears to the accident.

As a result, we note the following with regard to the benefits awarded to Petitioner. At arbitration, the parties did not specify an applicable period of temporary total disability (TTD), instead stipulating that all TTD had been paid. At the same time, the Arbitrator indicated Respondent was entitled to a credit of $8,260.05 for TTD paid. Because the parties stipulated that all TTD was paid, the proper award would have been to either award the agreed TTD and award the credit to Respondent, or to simply find that all TTD had been paid. We want to make it clear that Respondent is not entitled to a credit against TTD where no TTD has been awarded. Because there was no award of TTD, and no evidence that Respondent overpaid TTD, Respondent is not entitled to a TTD credit, and we vacate same. If the $8,260.05 is an overpayment of TTD over and above the period of TTD that the parties agreed to, then Respondent is entitled to the credit. Based on the evidence in the record, it is impossible for the Commission to determine which of these scenarios is correct.

With regard to medical expenses, at the second hearing date before the Arbitrator (August 16, 2013), the parties indicated they had come to agreement that Respondent would pay all reasonable and necessary charges related to the September 12, 2010 accident up until the second claimed accident of October 12, 2011. Respondent also has proven entitlement to Section 8(j) credit for any payments made via the Petitioner's group carrier, as he testified that the Respondent contributed to the coverage premiums. When determining Section 8(j) credits, the Respondent is entitled to credit for both the payments made by the group carrier as well as any discounts or write offs obtained by said group carrier.

The Commission modifies the permanency awarded by the Arbitrator. The Arbitrator awarded 15% of the left leg and 5% of the right leg. The Commission finds that, as a result of the September 12, 2010 accident, Petitioner sustained the loss of use of 10% of the left leg and 5% of the right leg. We reduce the award with regard to the left leg based on our finding that any left medial meniscus tear is not related to the accident.

The Commission affirms the Arbitrator's determination that the Petitioner is not entitled to penalties or attorney fees pursuant to Sections 19(k), 19(l) or 16.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as indicated above.

15IWCC0400

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $336.00 per week for a period of 32.25 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 leg and 5% of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses causally related to the September 12, 2010 accident which may have been incurred through October 11, 2011, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit for any medical expenses paid prior to hearing, as well as any medical expenses paid through group insurance under §8(j) of the Act, provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit pursuant to §8(j) under this order.

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 $18,200.00. 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: MAY 29 2015
TJT: pvc
o 4/7/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STANLEY, JAMES D
Employee/Petitioner

Case# **10WC042768**

12WC034588

13WC007262

FRESH EXPRESS INCORPORATED; CHIQUITA BRANDS CO, NORTH AMERICA; CHIQUITA FRESH NORTH AMERICA, LLC; & SPECIALTY RISK SERVICES (SRS)
Employer/Respondent

15IWCC0400

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:

0761 PAUL W GRAUER & ASSOC
1300 WOODFIELD RD
SUITE 205
SCHAUMBURG, IL 60173

1886 LEAHY EISENBERG & FRAENKEL LTD
JAMES P TOOMEY
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

15IWCC0400

☐ 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 D. Stanley
Employee/Petitioner

v.

Fresh Express Incorporated; Chiquita Brands Company, North America; Chiquita Fresh North America, L.L.C.; and Specialty Risk Services (SRS).
Employer/Respondent

Case # 10 WC 042768

Consolidated cases: 12 WC 34588 & 13 WC 7262

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **CHICAGO**, on **7/17/2013 and 8/16/2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other

FINDINGS

15IWCC0400

On 9/12/10, 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*** sustain an accident that arose out of and in the course of employment with Respondent.

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 $ 14,560.00 (Straight time 26 weeks); the average weekly wage was $560.00.

On the date of accident, Petitioner was 47 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 $ 8,260.05 for TTD, $ -0- for TPD, $ -0- for maintenance, and $ -0- for other benefits, for a total credit of $ 8,260.05.

The parties have stipulated that all TTD benefits have been paid.

Respondent is entitled to a credit of $ $818.26 under Section 8(j) of the Act, if applicable.

ORDER

Respondent shall be given credit of $4,000.00 for PPD benefits paid under Section 8(e)12 of the Act.

Respondent shall pay Petitioner $1,799.84 for the reasonable and necessary medical expenses incurred as provided in Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay petitioner permanent partial disability benefits of $336.00/week for 32.25 weeks, because the injuries sustained caused a 15% loss of the left leg, as provided in Section 8(e)(12) of the Act.

Respondent shall pay petitioner permanent partial disability benefits of $336.00 /week for 10.75 weeks, because the injuries sustained caused a 5% loss of the right leg, as provided in Section 8(e)(12) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

December 30, 2013
Date

ICArbDec p. 2

JAN 3 - 2014

15IWCC0400

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES STANLEY
Employee/Petitioner

v.

Case # 10 WC 42768
Consolidated w/ 12 WC 34588
13 WC 07262

FRESH EXPRESS, INC.
Employers/Respondents

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

A. **FIRST ACCIDENT – 9/12/10 (10 WC 42768)**

James Dean Stanley (hereafter "Petitioner") testified that he had been employed with Fresh Express, Inc. (hereafter "Respondent") as a forklift operator since March 15, 2010. He testified that his job duties consisted of picking and loading orders, and that Respondent dealt in the products of salad, lettuce, cabbage, and vegetables. He testified that the forklifts he operated were "like a box" with forks in the front and a mast for the forks to reach higher levels. He indicated that an operator would have to step onto the forklift, and that the step was approximately 10 inches. He testified that there is a steering knob and a hand control for forklift operation. He further testified that the operator stood, rather than sat, in operation of the forklift.

Petitioner testified that on September 12, 2010, he was picking an order. He testified that he had the forklift raised a little bit so that he did not need to bend as far down to place product. He further testified that at that time, he was standing in front of the pallet that was on the forks. He testified that another forklift driver did not see him, and backed his forklift into Petitioner, pinning Petitioner's bilateral legs between the pallet and the other driver's forklift. Petitioner testified and indicated in open court that the pallet struck the front of Petitioner's legs, three to four inches above his knees, while the other forklift struck the back of his knees. Petitioner testified that he yelled "ow" and that he felt pain in his knees. After the other driver pulled forward, Petitioner testified that he took one step away from the pallet and fell to the ground. Petitioner testified that an assistant supervisor named Americo called 911, and that Petitioner was transported via ambulance to Gottlieb Hospital.

At the time Petitioner was seen in the Emergency Room at Gottlieb Memorial Hospital, he gave a history of the afore-described accident (Tr. 1, p. 21, PX 1)

The Gottlieb Emergency Room records indicate that Petitioner stated he was at work and hit with a pallet of wood to the left knee. The Petitioner stated: "I was hit pretty hard." He complained of left knee pain, which he rated as a 6 -7/10. He denied any other injury. (PX 1)

The Petitioner underwent an x-ray to the left leg, which was consistent with a laceration in the postero-medial aspect of the distal thigh. Petitioner was also examined by Mark A. DeSilva, M.D., who diagnosed a horizontal laceration across the left popliteal fossa that was approximately 12 centimeters in length. Dr. Mark DeSilva placed 18 sutures to close the laceration. Dr. DeSilva instructed Petitioner to seek treatment with an orthopedic surgeon on the following day. (PX 1) Petitioner refused crutches, but was given a knee immobilizer. (PX 1)

On September 13, 2010, Petitioner was seen by Dr. Priti Khanna at Advanced Occupational Medicine Specialists, Respondent's company clinic. (PX 2) Petitioner described the accident of getting pinned by a pallet and another forklift, but stated that "he fell to the ground and complained over pain over both of his thighs." (PX 2) Dr. Khanna noted bruising over the medial aspect of Petitioner's right thigh superior to his right knee. She noted a negative Lachman's, with no medial or lateral joint line pain on the right knee. With regard to the left lower extremity, Dr. Khanna noted bruising over the posterior aspect of the left thigh, with a laceration over the left popliteal fossa with 18 sutures in place. (PX 2) Examination of the left knee was deferred due to the laceration. Dr. Khanna diagnosed "bilateral leg contusions", "left posterior knee laceration", "bilateral leg pains" and placed Petitioner on sitting work restrictions only. (PX 2) Petitioner returned to work light duty and sat at a table sorting paperwork while wearing a left knee immobilizer (TR. 1, p. 27)

On September 14, 2010, Petitioner presented to Dr. Mirela Savcic, his primary care physician, complaining of a left knee injury where his pain was 10/10. He also told her that Dr. Khanna had released him to light-duty work. Dr. Savcic conducted an examination, noting full range of motion, no pain, no edema, and no erythema in the right knee. (PX 3) She noted mild erythema and edema in the left knee, with a mild decrease in range of motion due to pain. She ordered Petitioner off work and to return in one month. (PX 3)

On September 16, 2010, Petitioner presented to Mercy Hospital's emergency department with an admitting diagnosis of left leg swelling. Also noted was "edema, leg and ankle swelling." Dr. Scott Heinrich noted that the left leg laceration was healing well. An ultrasound was negative for left lower extremity DVT from the left common femoral to the distal left superficial femoral veins, and Dr. Heinrich diagnosed dependent edema with lower extremity swelling. (PX 4)

Petitioner returned to Advanced Occupational Medicine Specialists ("AOMS") on September 20, 2010, complaining of increased pain since September 14, 2010 and increased swelling in the left foot since September 15, 2010. (PX 2) Dr. Khanna noted positive ecchymosis to the left posterior thigh and right popliteal fossa. It was Dr. Khanna's impression that Petitioner suffered 1. Bilateral leg crush injury; 2. Left post-knee laceration; 3. Bilateral thigh contusions; 4. Bilateral leg pain. Petitioner was restricted to seated work on only and was directed to continue to elevate his legs when possible. Dr. Khanna ordered an MRI of the left knee. (PX 2)

Petitioner underwent the MRI of the left knee on September 20, 2010, at Athletic Imaging. Jon R. Jester, M.D., interpreted the images as follows:

1. Anterolateral and posteromedial soft tissue edema, most consistent with contusions.
2. Bony contusions anterolaterally and anterior and posteromedially.
3. Non-displaced horizontal tear of the posterior horn and posterior body segment of the medial meniscus.
4. Bipartite patella with lateral patellofemoral chondromalacia and chondral fissuring.
5. Joint effusion, synovitis and medial Baker's cyst.
6. Tibial insertion of the patellar tendinosis. (PX 5)

Petitioner presented to Dr. Khanna at AOMS on September 27, 2010 for review of the MRI. Dr. Khanna noted on examination that the ecchymosis had resolved bilaterally, but Petitioner still had bilateral knee pain. (PX 2) In reviewing the MRI, she diagnosed a medial meniscus tear of the left knee. She partially removed the sutures for the laceration to the left upper extremity and referred Petitioner to Dr. Christos Giannoulias for the medial meniscus tear.

On September 28, 2010, Petitioner presented to Dr. Giannoulias, an orthopedic surgeon, at G & T Orthopedics. Dr. Giannoulias noted complaints of catching, pain and swelling. (PX 5) He noted pitting edema in the left leg, tenderness over the medial joint line of the knee, pain with circumduction and pain with McMurray's maneuver. (PX 5) Dr. Giannoulias noted that the MRI noted a medial meniscus tear on the left knee. Dr. Giannoulias recommended physical therapy to get the swelling under control and increase range of motion, as Petitioner was still recovering from acute trauma. He opined that Petitioner would ultimately need arthroscopy on the left knee because the knee was symptomatic and painful with circumduction. Dr. Giannoulias released him to sitting work only. (PX 5)

Petitioner returned to Dr. Khanna at AOMS on October 1, 2010, and the remaining sutures were removed. Dr. Hanna noted a negative Lachman's on the right knee, but did not test the left knee. She recommended an MRI of the right knee. (PX 2) The Arbitrator notes that the report of the MRI of the right knee is not in the records provided at hearing.

On October 5, 2010, Petitioner returned to Dr. Khanna complaining of worsening bilateral lower extremity swelling and pain. Dr. Khanna's Progress Note for this visit indicated that she reviewed the right knee MRI in detail but she made no comments regarding same. She released Petitioner to sitting work only, effective October 8, 2010. (PX 2) Dr. Khanna also sent Petitioner to Westlake Hospital's emergency department for an immediate left lower extremity venous doppler. (PX 2) Petitioner was discharged from Westlake in good condition with no apparent findings of deep vein thrombosis. (PX 7)

Petitioner underwent four sessions of physical therapy at AOMS, from October 6, 2010 through October 15, 2010. (PX 2) He followed up with Dr. Khanna on October 8, 2010, complaining of significant pain. He underwent a corticosteroid injection into the right knee. Dr. Khanna diagnosed a left medial meniscus tear and ACL sprain. (PX 2) A note indicated that Petitioner was lightheaded after the injection and was sent home after getting to work. (PX 2)

Petitioner presented to Dr. Savcic on October 18, 2010, complaining of bilateral knee pain and lightheadedness. (PX 3) The Arbitrator notes that the medical record, which is five pages long, is missing pages 3-4, which presumably included the examination and recommendations. (PX 3)

On November 2, 2010, Petitioner presented to Dr. Telly Psaradellis, an orthopedic surgeon at Midland Orthopedic Associates. (PX 8) Dr. Psaradellis noted complaints of bilateral knee pain, left greater than right, and lower extremity swelling that was activity related, with numbness in the left lower extremity. (PX 8) Dr. Psaradellis noted good range of motion in both knees, but indicated "a lot of hypersensitivity to touch involving both lower legs." (PX 8) He also noted mild edema in the left lower extremity compared to the right. (PX 8) Dr. Psaradellis reviewed the MRI of the right knee, which demonstrated bone contusions involving the tibial plateau and the report suggested intrasubstance edema of the ACL suggestive of a sprain. However, in Dr. Psaradellis' view, it appeared the ACL was intact. Dr. Psaradellis noted that the MRI of the left knee demonstrated a non-displaced tear involving the posterior horn of the medial meniscus as well as bony contusions involving the femur and tibia. It was his impression that Petitioner had sustained a bilateral crush injury to the lower extremities. (PX 8) Dr. Psaradellis indicated he was not convinced the meniscal tear was the cause of Petitioner's left knee symptoms, and believed the symptoms may be neurogenic in nature. He ordered Petitioner off work. He prescribed Lyrica, bilateral TED hose, and physical therapy. (PX 8)

Petitioner underwent physical therapy at Athletico from 11/8/10 to 2/4/11, a total of 31 sessions. (Tr. 1, p. 40, PX 6)

Petitioner returned to Dr. Psaradellis on November 30, 2010, noting improvement. Dr. Psaradellis noted some pitting edema on the left, and noted that the hypersensitivity was much better. (PX 8) He recommended continued physical therapy, Lyrica and continued to keep Petitioner off work. (PX 8)

Petitioner returned to Dr. Psaradellis on January 4, 2011. Dr. Psaradellis noted that Petitioner was improving but indicated that the swelling was the same and could sometimes worsen. He also noted that it was likely Petitioner had sustained some venous injuries as a result of his crush injuries and that the swelling in his legs be permanent. (PX 8) Dr. Psaradellis noted that Petitioner's complaints of dry mouth, headache, and occasional upper extremities were not an orthopedic problem, but instead he should see his PCP. (PX 8) He recommended a return to work in one week.

On February 8, 2011, Petitioner advised Dr. Psaradellis that he had returned to work eight hours a day and was doing well for the most part. (PX 8) Dr. Psaradellis saw Petitioner again on March 8, 2011 and told him to return PRN. Petitioner advised that he was tolerating work quite well, but noted stiffness and swelling in his knees, particularly the left knee. (PX 8) On April 5, 2011, Petitioner returned complaining of left knee pain. He declined a steroid injection offered by Dr. Psaradellis. (PX 8) The medical records indicate no further treatment until Mr. Stanley's allegation of a new accident on October 12, 2011.

B. SECOND ACCIDENT – 10/12/11 (12 WC 34588)

Petitioner testified that on October 12, 2011, he was employed by the Respondent. He further testified that he was picking layers of product to build a pallet. Petitioner testified his job required him to repetitively get on and off the forklift throughout the day. He stated that he works in an air-conditioned warehouse that is kept at 40 degrees Fahrenheit. Petitioner explained that the platform for the base of the forklift is approximately 10 inches off the ground. (Tr. 1, p. 43) Petitioner stated he needed to get on and off the forklift platform approximately 30-40 times per day. (Tr. 1, p. 43) This testimony by Petitioner was uncontradicted.

As he was working, Petitioner testified, he heard a "pop," which was both a sound and a feeling. He testified that the pop was on the outside of his knee. Petitioner testified that he gingerly limped to the office, which was 150 to 300 feet away, to report the incident to his supervisor, Kevin Lowe. He testified that he told Mr. Lowe that he needed to go home because his knee hurt. He testified Mr. Lowe told Petitioner that he could leave.

On the following day, October 13, 2011, Petitioner sought treatment at Mercy Hospital Emergency Room and complaining of pain in his knees (Tr. 1, p. 49) (PX 4). The emergency room records corresponding to the afore-said date indicate Petitioner complained of pain in his left knee. Petitioner gave a history of the "first" injury of September 2010 as well as the "second" one on October 12, 2011. The emergency physician recommended that Petitioner continue to use a knee immobilizer and gave him wraps to support the knee. The E.R. doctor noted:

> "The patient is a 48-year old male who presents with left knee pain. Duration lasting approximately 1 day(s). The course is constant. Type of injury - injured w. fork lift 1 year ago, left knee meniscal injury. There are risk factors including repetitive stress and trauma. 48-yo man no pmh of knee injury as above, presents with worsening knee pain after repetitive climbing in/out of forklift at work. Pt. states no new trauma, no twisting, no injury to suggest dislocation." (PX 4)

Petitioner was instructed to follow up with his orthopedic doctor. (Tr. 1, p. 50).

On the same day, Petitioner presented to Clearing Clinic, complaining of pain in his left knee. (PX 9) He told Dr. Anita Carani that it had been one day since the onset of pain, and that he presented to the emergency department for a chronic knee injury from work. (PX 9) She noted, "He does not want to give us work info." (PX 9) She documented an essentially normal left knee examination, including a negative Lachman's test with pain. She placed Petitioner on restrictions of no stair climbing and discharged him to his orthopedic surgeon. (PX 9)

The Clearing Clinic records contain a document dated October 13, 2011 entitled "note from front desk." The note, appearing to be drafted by Ashley Olsen, indicated, "[H]e told her not to [call] because no claim was started and he just wanted to use his own insurance.... Gave us his insurance to use." (PX 9)

In another note, which indicated a time of 1:15 p.m., Dr. Carani wrote: "since no case# yet to re-open old w/c injury, pt claims his lawyer recommended he come here since he can't be seen by his pcp til monday or tuesday, f/u from Mercy E.R. yesterday, pt brought no paperwork." (PX 9)

Petitioner presented to Dr. Telly Psaradellis on October 18, 2011. The doctor wrote: "last week, he was lifting something at work and had a severe, sharp pain in his left knee." (PX 8) Dr. Psaradellis examined the knee and note no effusion and full range of motion. Dr. Psaradellis released him to return to work as of the 20th, and diagnosed a simple "flare up" of his knee problem. (PX 8) Petitioner returned to work as a forklift operator, effective October 20, 2011. (Tr. 1, p. 51)

Petitioner presented to Dr. G. Klaud Miller for a Section 12 examination ordered by Respondent on February 15, 2012. (RX 1) Dr. Miller is a board-certified orthopedic surgeon. He testified that on review of the initial records from Gottlieb Memorial Hospital that Petitioner had a laceration at the distal left thigh, just above and behind the left knee. (RX 1, pp. 9-10). Dr. Miller testified that Petitioner refused to answer all of his questions outside of stating that he had pain everywhere. (RX 1, pp. 15-16). According to Dr. Miller, Petitioner stated he had been crushed between a pallet and a forklift, and that he had complaints of pain with almost every activity. (RX 1, p. 17)

Dr. Miller testified that he conducted an examination of Petitioner, who found that Petitioner had range of motion from 0 degrees to 115 degrees on the left knee and 0 degrees to 125 degrees on the right knee. (RX 1, p. 18) Dr. Miller testified that normal was 135 degrees, so Petitioner had functional limitations in range of motion. Dr. Miller testified that Petitioner made no complaints of pain during range of motion testing. (RX 1, pp. 18-19). Dr. Miller testified that Petitioner had no effusion in either knee. (RX 1, p. 19) He testified that Petitioner was diffusely cutaneously hypersensitive in a circumferential manner bilaterally in a band around the knee on both sides of the entire knees. (RX 1, pp. 19-20). He testified that there was inconsistency in that he did a 90 percent squat and went up and down a single stair 5 times without difficulty, but that he presented with a still gait. (RX 1, pp. 20-21). He testified that outside of the band of hypersensitivity, which he compared to sunburned skin, Petitioner had normal sensation in his leg. (RX 1, p. 21) Dr. Miller testified that measurement of the lower legs was normal, in that there was a centimeter difference in circumference between his dominant right side and non-dominant left side. (RX 1, pp. 22-23).

Dr. Miller testified that he diagnosed Petitioner with a non-physiologic pain syndrome which made no anatomical sense, as a person cannot have pain in a circumferential manner as Petitioner described. (RX 1, p. 23) He testified that Petitioner suffered a left knee laceration and a contusion, possibly a sprain, but that those had long resolved. (RX 1, p. 24) Dr. Miller further noted that as of February 15, 2012, Petitioner's presentation could not be related to any other accident as well. (RX 1, p. 25) Dr. Miller testified that Petitioner could have returned to work with restrictions within a week or two of the September 12, 2010 accident. (RX 1, p. 27)

On cross-examination, Dr. Miller testified that Petitioner's age predisposed him to a meniscal tear, as such a tear can be degenerative in nature. (RX 1, pp. 32-33). He further testified

that he noted no objective evidence of a tear. (RX 1, p. 34) Dr. Miller testified that since Petitioner had no swelling on examination, Petitioner therefore had no permanent venous injury. (RX 1, pp. 37-38). He did not necessarily think Dr. Psaradellis was wrong, but that the swelling on examination on January 4, 2011 may have been to a sprain. (RX 1, p. 38) After denying that he had reviewed the MRI disc, Dr. Miller clarified that he actually reviewed the two MRIs. (RX 1, p. 44) He testified that the review of the September 20, 2010 MRI of the left knee showed a grade II signal of the medial meniscus, which was not consistent with a tear, as it did not touch the articular surface. (RX 1, pp. 45-46). He reviewed the MRI of the right knee on October 1, 2010, which showed grade I signal in the medial and lateral menisci. (RX 1, p. 47) Dr. Miller explained that a grade I signal is not a tear at all, and a grade II signal correlates with a true tear between 10-20% of the time, while a grade III signal correlates with a true tear 80-90% of the time. (RX 1, p. 52)

C. THIRD ACCIDENT – 2/25/12 (13 WC 07262)

Petitioner testified that on February 25, 2012, he was operating a forklift for Respondent. Petitioner further testified that he felt pain in his knee. On direct examination, he referenced left knee pain. However, on cross-examination, Petitioner referred to having felt pain in the right knee. Petitioner testified he reported the accident and pain to his supervisor, Kevin Lowe.

On February 25, 2012, the same day on which the afore-described incident occurred, Petitioner presented to Mercy Hospital's Emergency Department complaining of right knee pain. He advised the triage nurse that while standing on a forklift, he transferred his weight wrong and had a sudden sharp pain with mild swelling. (PX 4) He denied any new falls or trauma. Dr. Sara Friedman noted a history of "turning to the side with knee giving way." She noted a negative McMurray. (PX 4) She recommended a reevaluation with Dr. Psaradellis and a possible repeat MRI. X-rays noted bipartite patella, but no acute fracture.

The E.R. doctor at Mercy Hospital noted:

> "The patient is a 48-year old male who presents with acute on chronic knee pain re-aggravated at work today. Turned to the side with knee giving way. PMH significant for previous injury/trauma s/p struck with a forklift in 2010. Duration lasting today pta. The course is constant. Location: Right anterior medial knee. The degree of pain is moderate. The degree of swelling is minimal. Degree of dysfunction: Right knee has partial weight bearing. The mitigation factor is rest." (PX 4)

On February 28, 2012, Dr. Savcic recommended an MRI of the right knee, noting Petitioner's history of having felt a "pop" in his right knee while driving a forklift. (PX 4)

On March 5, 2012, Petitioner underwent an MRI of the right knee at Mercy Hospital. Jonathan Meyer, M.D., the radiologist, interpreted the MRI as follows:

1. Fragmentation of the patella laterally, more than normally seen with a bipartite patella and suggestive of with old fracture. There is thinning of the patellofemoral cartilage and a small amount of edema in the posterior aspect of the patella.
2. Medial compartment narrowing with a tear of the medial meniscus.
3. Edema at the medial collateral ligament, likely reactive to the medial compartment/meniscal disease.
4. Small joint effusion and prepatellar soft tissue edema. (PX 4)

Petitioner presented to Dr. Psaradellis on March 6, 2012. Dr. Psaradellis noted no significant effusion in the right knee. He reviewed the MRI and noted a possible subtle medial meniscus tear that was not overly impressive, but noted significant patellofemoral and medial compartment arthrosis. (PX 8) Dr. Psaradellis noted an exacerbation of pre-existing right knee arthritis, which was occurring from time to time due to the strenuous nature of his work. (PX 8) He ordered Petitioner off work for a week.

On March 13, 2012, Petitioner returned to Dr. Psaradellis, who administered a cortisone injection into the right knee. He released Petitioner to return to work on March 20, 2012. (PX 8)

On March 12, 2013, nearly a year after his last visit relative to his knee complaints, Petitioner returned to Dr. Psaradellis complaining of right worse than left knee pain. Dr. Psaradellis noted no effusion in either knee and full range of motion in both knees. He further noted on x-ray films moderate arthritic involvement of the patellofemoral compartment bilaterally. He diagnosed patellofemoral arthritis, and indicated that there was no good surgical treatment for the condition. Dr. Psaradellis administered bilateral cortisone injections. (PX 8) Petitioner noted relief after the injection and continues to perform his same job for Respondent. (Tr. 1, pp. 55-56)

On cross-examination, Petitioner testified that the alleged accident on February 25, 2012 occurred while picking cases and twisting. He testified that the swelling in his knees comes and goes from time to time. He stated that Dr. Psaradellis told him it would be a waste of time to have surgery on his knees. He testified that he gave his off work notes to his supervisor, who on any given day could be Kevin Lowe, Pat Didio, or Tom Stewart. He testified that he stands 5 feet 7 inches and currently weighs 217 without his boots. Petitioner admitted that he received a company handbook when he began working for Respondent in March 2010. He testified that he was familiar with reporting requirements for work accidents.

Petitioner testified that he got into and out of a forklift 30 to 40 times if not more on a given day. On cross-examination, he testified that he lives in a three-floor bungalow. He testified that he does not go up any stairs, and stays on the ground floor at all times. As such, he testified that he could not advise how many stairs were from floor to floor. However, he admitted that he could go up the six stairs that led up to the entrance of his home. Petitioner denied previously injuring his knees other than the three separate claims heard together before the Arbitrator, but admitted to breaking his right foot when he fell off a ladder seven years ago.

Petitioner testified that if he sits for a while, he needs to constantly stretch his legs or get up and walk. He testified that walking two to three blocks results in discomfort in his knees. He testified that going up or down "lots" of stairs caused "lots" of pain. He also indicated that working more than forty hours causes increased pain.

Respondent presented two witnesses at trial, Milton Vicenteno and Kevin Bak.

Milton Vicenteno, Respondent's Environmental Health and Safety Manager, testified that he has been employed by the Respondent for the last seven years. (Tr. 1 p. 87) He testified that every month they have a safety training class that they expect every employee to attend. Aside from the classroom, they have safety "huddles" on the shop floor. He stated that they train their employees every year on the incident reporting policy. Employees are expected to "report" all work-related injuries and illnesses, as minor as they may be, to the "supervisor" or safety department by end of the shift (Tr. 1, p. 88). Failure to comply will result to disciplinary action up to and including termination.

Petitioner testified on direct examination, without contradiction, that he reported the second accident of October 12, 2011, to Kevin Lowe, a supervisor at Respondent, on that same day.

Milton Vicenteno, the safety manager, testified that it was never documented in Respondent's "report log" that is maintained by Respondent (Tr. 1, p. 91). In fact, Mr. Vicenteno testified that he was unaware of any 2011 incidents or "near misses."

Petitioner's testimony that he reported the second accident to Kevin Lowe, before being excused to go home and then to Mercy Hospital ER, is unrefuted and uncontradicted by any other testimony.

Respondent failed to call a witness to refute or deny Petitioner's direct testimony that he reported the accident to supervisor Kevin Lowe. Also, the Mercy Hospital ER records corroborate the reported accident. (PX 4)

Kevin Lowe, who would be a witness under the control of the Respondent, was never called as a witness. Therefore, the testimony of the Petitioner in this regard is unrebutted. Respondent offered no explanation for Kevin's absence even though the "safety manager" testified live. None of the witnesses produced by Respondent contradicted Petitioner's testimony regarding "notice".

Mr. Vicenteno acknowledged that Petitioner had contacted him regarding knee complaints. He testified that he did not recall whether or not Petitioner had ever complained to him about knee complaints stemming from the second and third accidents, respectively in 2011 and 2012 (Tr. 1, p. 92).

Mr. Vicenteno further testified that Respondent sends injured employees to its clinic "AOMS", Advanced Occupational Medicine Specialists (PX 2) (Tr. 1, p. 94).

On cross-examination, Mr. Vicenteno testified that Petitioner made complaints to him about his knees from time to time. Mr. Vicenteno admitted that he did not know whether the complaints related to the accident number one, two or three (Tr. 1, pp. 95-97). He also admitted that for some reason the complaints about Petitioner's knees did not get documented and put into the database.

Mr. Vicenteno also admitted that during a normal eight-hour shift, he did not have information as to how often Petitioner had to get on or off the forklift because it varies depending on the volume of the customer orders and the particular day. He admitted that Respondent has never calculated the average number of times that the forklift drivers get on and off the forklifts per shift (Tr. 1, pp. 97-98). He testified it would be very difficult to calculate because of the varying numbers of orders that are processed (Tr. 1, pp. 98-99).

Mr. Vicenteno visited Mr. Stanley in the hospital after the first accident because he felt that the accident warranted him to make sure that Mr. Stanley was "OK" (Tr. 1, p. 100). While in the hospital room, he described the injuries as "lacerations to the back of ... his legs." Mr. Vicenteno did not suggest that Petitioner go back to work. Mr. Vicenteno's investigation disclosed that Petitioner was picking an order when he was injured; that he was off the forklift at the time of his injury; that a co-worker driving a forklift was unaware of his presence and "actually pinned him between a forklift and a pallet that he was actually placing those finished goods cases on to the pallet." (Tr. 1, p. 101)

Respondent's second witness, Kevin Bak, is a workers' compensation claims adjuster. He has been employed with Sedgwick since September 2007 (Tr. 1, p. 105). Mr. Bak testified that he generally becomes aware of workers' compensation claims regarding Fresh Express through the risk manager, Milton Vicenteno. (Tr. 1, p. 107) Mr. Bak testified that he was only aware of one claim that has been opened for Mr. Stanley. Mr. Bak also admitted that he was given Applications for Adjustment of Claim forms for two other claims, but was not aware of what those losses were (Tr. 1, p.107). Mr. Bak stated that he forwarded those Applications to Milton Vicenteno, who had no record of any loss for either of those two claims. Mr. Bak testified that since they already had an attorney on the file, he forwarded the Application for Adjustment of Claim forms of both those claims to the attorney. The attorney could ask Petitioner's counsel whether he had any information on those so a potential investigation could be made (Tr. 1, p. 107-108).

Mr. Bak testified that he has never been contacted by Petitioner or Petitioner's attorney regarding the second or third claim. Mr. Bak also testified that he has never received any medical bills pertaining to the second or third claim.

On cross-examination Mr. Bak admitted that it is not required under the Act to be contacted by a Petitioner's attorney regarding any claims (Tr. 1, p. 110).

CONCLUSIONS OF LAW FOR CASE # 10 WC 42768

F. Is Petitioner's current condition of ill-being causally related to the injury?

Regarding the first accident on September 12, 2010, the Petitioner had his lower extremities crushed between a pallet and the rear of another driver's forklift. Immediately after this accident, the Franklin Park Fire Department arrived at Respondent's warehouse and took Petitioner to Gottlieb Hospital where he received treatment for his lower extremity injuries.

The medical records show that he received 28 stitches in his left leg for a 12 cm. laceration and was placed in a knee immobilizer. He was then directed to the company clinic, Advanced Occupational Medicine, where he received treatment for a bilateral leg crush injury, left knee laceration, bilateral thigh contusion and bilateral leg pain. Within four days, he was suspected of having a DVT (deep vein thrombosis) and was seen in the emergency room at Mercy Hospital. He complained of leg and ankle swelling, but an ultrasound was negative for definitive blood clots. Eventually his orthopedic doctor, Dr. Telly Psaradellis recommended "TED Hose" for his leg swelling.

An MRI of the left knee, which Petitioner underwent on September 20, 2010, only eight days after the accident, revealed the following pathology:

1. Anterolateral and posteromedial soft tissue edema, most consistent with contusions.
2. Bony contusions anterolaterally and anterior and posteromedially.
3. Non-displaced horizontal tear of the posterior horn and posterior body segment of the medial meniscus.
4. Bipartite patella with lateral patellofemoral chondromalacia and chondral fissuring.
5. Joint effusion, synovitis and medial Baker's cyst.
6. Tibial insertion of the patellar tendinosis. (PX 5)

With the exception of Dr. Miller, Respondent's Section 12 examining physician, Doctors Khanna, Psaradellis and Giannoulias all acknowledged Petitioner had sustained bilateral crush injuries to the lower extremities and that he had a left knee meniscal tear.

Accordingly, the Arbitrator finds the opinions of the three treating doctors coupled with the findings on the MRI of the left knee (above) to be more credible and persuasive than the sole opinion of Dr. Miller.

Based on the foregoing, the Arbitrator finds that Petitioner's present condition of ill-being of his left and right legs to be causally related to the accident of September 12, 2010.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

When closing proofs, the parties agreed that Respondent would pay Petitioner for all reasonable and necessary medical treatment related to the accident of September 12, 2010 up to the claimed October 12, 2011 accident, and Respondent requested an 8(j) credit for any such treatment paid by Petitioner's group carrier. The Arbitrator notes that several bills allegedly unpaid on PX 9 are actually paid and written off on the bills attached to PX 9. The Arbitrator therefore orders Respondent to pay the following bills, subject to the fee schedule:

Franklin Park Fire Department:	$450.00
Mercy Medical on Pulaski:	$114.00
Mercy Hospital and Medical Center:	$433.54
EMP of Chicago, Inc.:	$177.48
Pathology Consultants of Chicago:	$37.00
MacNeal Physicians Group:	$326.00
Midland Orthopedic Associates:	$92.17
Reimbursements of out-of-pocket expenses:	$169.65

Respondent is entitled to an 8(j) credit of $818.26 for payments made by its group carrier for treatment related to the September 12, 2010 date of accident, if applicable.

L. What is the nature and extent of the injury?

After review of the testimony and all exhibits submitted, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the left leg and 5% loss of use of the right leg. Petitioner sustained a bilateral crush injury to his lower extremities that resulted in a left medial meniscus tear and permanent swelling in both legs.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that penalties and fees are inapplicable in the present matter, as the testimony of Kevin Bak was persuasive in that he paid all medical bills presented to him. The Arbitrator notes that the unpaid bills, with the exception of Midland Orthopedic and EMP of Chicago, do not even list Sedgwick Claims Management Services as a responsible party. In light of Petitioner's attorney's cross-examination of Mr. Bak that he did not need to contact the adjuster, the Arbitrator finds that a claim of penalties for bills not submitted to Respondent is disingenuous. Moreover, Petitioner testified that he is currently not getting bills from any provider, and that the bills were paid by either work comp or group insurance. The Arbitrator finds that the nonpayment of the 1/04/11 date of service to Dr. Psaradellis was likely mere inadvertence.

N. Is Respondent due any credit?

The parties agreed prior to the start of hearing that Petitioner received a PPD advance of $4,000.00 from Respondent. Respondent is therefore entitled to a $4,000.00 credit against the permanent partial disability awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES D. STANLEY,

Petitioner,

vs. NO: 12 WC 34588

15IWCC0401

FRESH EXPRESS, INC.; CHIQUITA BRANDS CO., NORTH AMERICA; CHIQUITA FRESH NORTH AMERICA, LLC & SPECIALTY RISK SERVICES (SRS),

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, notice, causation, medical expenses, temporary total disability, permanency, credit, penalties and attorney fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on October 12, 2011.

The Arbitrator found that while there was a slight variation in the histories given by Petitioner to medical providers, the medical records (Px4, Px8 and Px9) support that Petitioner sustained a work related injury to the left knee. He noted that Petitioner's testimony that he reported the injury to Kevin Lowe was unrebutted, as Lowe did not testify.

Petitioner initially testified he was on his forklift when he felt a pop in his *right* knee. (Tr. 44). He also testified to having to get on and off the lift, from an approximate 10 inch step-up, thirty to forty times per day. (Tr. 43). He then testified that he told supervisor Kevin Lowe that he heard and felt a pop in his right knee while stepping off of the forklift. (Tr. 48). On cross

examination, he then testified again that he was just standing on the lift when he felt the pop. (Tr. 69-70).

Based on Petitioner simply standing on the lift, Respondent argues no accidental injury occurred, as this circumstance would be considered a neutral risk. Respondent further argues that even if we were to find the injury occurred while stepping off the lift, that this still did not constitute an increased risk, as it involved use of a 9" step, and the general public would generally traverse more than 30 to 40 stairs per day. Respondent also stresses the differing histories noted in the medical records.

The October 13, 2011 report of Mercy Hospital states Petitioner had left knee pain starting a year prior, that "there are risk factors including repetitive stress and trauma", and that he had worsening pain after climbing in and out of the forklift at work, with no new trauma, twisting or injury. (Px4). On October 18, 2011, Petitioner then reported to Dr. Psaradellis that he developed left knee pain the week prior due to lifting at work. (Px8). We also note that or about January 13, 2011, Petitioner was complaining to Dr. Savcic about swelling throughout his body. (Px3). Petitioner's testimony seemed to try to minimize his stair usage at home, stating that he never goes upstairs in his three-level home, but did agree he uses a six-step stairway to go in and out of his home. (Tr. 71-73).

The October 13, 2011 Mercy Hospital report, as noted above, reports a repetitive trauma claim to the left knee and references the original September 12, 2010 accident. The October 13, 2011 report from Clearing Clinic notes Petitioner stated he was hurt at work and went to the emergency room, but that he had not made a workers' compensation claim with his employer, and wanted to use his group benefits to pay for his treatment. (Px9). The medical report indicated left knee pain that began a day prior, with Petitioner noting it seemed to be intermittent. The report of Dr. Psaradellis on October 18, 2011, in addition to noting diffuse left knee pain after lifting something at work the week prior, states he had improved since, had a normal examination, and that Dr. Psaradellis believed this was just a flare up of the prior left knee problem. Petitioner testified he returned to work on October 20, 2011.

Petitioner's statement to Clearing Clinic on October 13, 2011 that he hadn't make a workers' compensation claim with Respondent clearly supports the fact that he did not report an accident on October 12, 2011 to Kevin Lowe, and goes against the Arbitrator's finding that Petitioner's testimony that he reported it to Lowe that same day was unrebutted. Respondent's witness Milton Vicentino's testimony further supports a lack of notice to Respondent of an October 12, 2011 accident.

Given the variety of histories of accident noted by Petitioner, including the contradictions in his own testimony, the Commission finds that Petitioner is lacking credibility on this issue, and has failed to prove an October 12, 2011 accident. Based on the finding that Petitioner failed to prove he sustained a compensable accident on October 12, 2011, all remaining issues are moot.

15IWCC0401

Because no benefits have been awarded to Petitioner, no bond is required pursuant to Section 19(f)(2) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed as indicated 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.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 9 2015
TJT: pvc
o 4/7/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES D. STANLEY,

Petitioner,

vs. NO: 13 WC 07262

15IWCC0402

FRESH EXPRESS, INC.; CHIQUITA BRANDS CO., NORTH AMERICA; CHIQUITA FRESH NORTH AMERICA, LLC & SPECIALTY RISK SERVICES (SRS),

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, notice, causation, medical expenses, temporary total disability, permanency, penalties and attorney fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on February 25, 2012.

The Commission initially wishes to note that a clerical error exists in the Arbitrator's decision. The decision has an analysis section titled: "Conclusions of Law for Case # 12 WC 34588." 12 WC 34588 is a companion case that was consolidated with 13 WC 07262. It is clear from a review of the Arbitrator's analysis of the case that he was reviewing the 13 WC 07262 case, not 12 WC 34588, and thus there was simply a clerical error in naming the correct case in the title.

The Commission finds that the Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on February 25, 2012.

Petitioner did not initially testify on direct examination to any specific mechanism of injury on February 25, 2012. (Tr. 52-56). On cross examination, he testified: "I think I was picking my cases and I twisted, and my right knee didn't twist with me." (Tr. 78-80). However, when asked if he disagreed with a medical record stating he was transferring his weight wrong while standing on the forklift, the Petitioner responded, "No, I don't disagree."

Petitioner testified he told supervisor Kevin Lowe on February 25, 2012 that he needed to go to the emergency room due to left knee pain. Asked if he told Lowe why it hurt, Petitioner responds "yes", but didn't testify to what he reported to Lowe at that time. While Petitioner stated he went to the emergency room for left knee pain, the Mercy Hospital medical report from February 25, 2012 states he underwent a right knee x-ray and was sent for a right knee MRI, after which he said he received a right knee injection from Dr. Psaradellis on March 20, 2012. When asked on cross examination how he developed left knee pain at that time, Petitioner testified "I think I was picking my cases and I twisted, and my right knee didn't twist with me". He indicated he wouldn't disagree if the medical records indicate he said he transferred his weight while standing on the forklift.

A February 25, 2012 Mercy Hospital report notes Petitioner complained of aggravating his right knee at work – "turned to the side with knee giving way." A separate history from those records (Px4) notes he was working on the forklift and transferred his weight wrong with sudden sharp pain. He underwent a right knee x-ray, and on March 5, 2012 a right knee MRI. X-ray showed bipartite patella, which was indicated in both knees on bilateral films, and the MRI indicated a possible undersurface meniscal tear, thinning of cartilage, a possible old fracture on top of the bipartite patella, and edema at the MCL likely reactive to the medial compartment/meniscal disease.

Dr. Psaradellis' first report after this accident, on March 6, 2012, notes a history of a new right knee injury. (Px8). It stated that a week ago at work Petitioner felt a pop in the knee and it buckled, and that he had pain since that time. The doctor noted the meniscal tear on MRI was "not overly impressive", and that there was significant medial and patellofemoral arthritis. He believed Petitioner likely exacerbated his preexisting right knee arthritis, and that: "this is occurring from time to time given the strenuous nature of his work. There is not much we can do to prevent these episodes." The right knee was injected, and by March 20, 2012 Petitioner felt ready to return to work, and was released to do so by Dr. Psaradellis.

As was the case in the 12 WC 42768 consolidated case, the evidence indicates a variety of mechanism of injury histories, which impacts the Petitioner's credibility. Ultimately, all he really testifies to is that he somehow shifted his weight, resulting in a twist to the knee. While there is evidence he was on the forklift at the time, he does not testify at all about whether it was something about the lift itself or its motion which caused his weight to shift. Without such evidence, we cannot say that the Petitioner sustained a compensable accident. Based on the preponderance of the evidence, the Petitioner has not proven an accident occurred on February 25, 2012 which arose out of his employment.

15IWCC0402

Based on our finding that Petitioner failed to prove he sustained a compensable accident on February 25, 2012, all remaining issues are moot.

Because no benefits have been awarded to Petitioner, no bond is required pursuant to Section 19(f)(2) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed as indicated 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.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 9 2015
TJT: pvc
o 4/7/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Other (explain) Reinstatement	☐ Second Injury Fund (§8(e)18)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NOEL CANCHOLA,

Petitioner,

vs.

NO: 10 WC 23360

FORD MOTOR COMPANY,

15IWCC0403

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of Petitioner's Petition to Reinstate and being advised of the facts and law, reverses the Arbitrator's Order denying Petitioner's Petition to Reinstate. 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

In September 2009 Petitioner alleged he suffered a repetitive trauma injury to his low back while working for Respondent. The case was filed on June 18, 2010. Petitioner initially obtained medical treatment at Respondent's plant for approximately a year until that treatment ceased. Subsequently, Petitioner obtained medical treatment through his group health insurance.

In December 2013 Petitioner contacted his counsel to provide an update on his injury and medical treatment. When Petitioner's counsel checked the status of the case online, he discovered the case had been dismissed on June 12, 2013. Notice of the dismissal was mailed to

15IWCC0403

Petitioner's counsel's office on June 13, 2013. However, Petitioner's counsel never received a copy of the dismissal order.

On December 30, 2013, Petitioner's counsel filed a Petition to Reinstate. On March 31, 2014, Arbitrator Williams held a hearing on Petitioner's Petition to Reinstate. He denied the Petition during the hearing.

CONCLUSIONS OF LAW

The Commission reverses the Arbitrator, grants Petitioner's Petition to Reinstate, and remands the case to the Arbitrator to hold a hearing on the merits.

Petitioner's counsel never received a notice of the dismissal. As soon as counsel discovered the case had been dismissed, he filed a Petition to Reinstate. The Commission notes that Petitioner continues to obtain medical treatment for his low back injury with orthopedic surgeon Dr. Tyndall, who is considering surgical intervention. We find that reinstatement of the case will not prejudice Respondent and Respondent will have the opportunity to defend the case on the merits during trial.

The Workers' Compensation Rules provide "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 decision." 50 Ill. Adm. Code § 7020.90(c) (2002). Fairness dictates that this case should be reinstated so that Petitioner can proceed with his case on the merits. Therefore, the Commission reverses the Arbitrator and grants Petitioner's Petition to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition to Reinstate is granted.

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.

15IWCC0403

The party commencing the 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: 4/7/15
51

MAY 29 2015

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☒ PTD/Fatal denied
☒ Modify UP	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PHILLIP LEVATO,

Petitioner,

15IWCC0404

vs.

NO: 06 WC 40581

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court Workers' Compensation Division. The case was arbitrated on August 4, 2010. The Arbitrator found that Petitioner proved a compensable accident on September 6, 2006 and awarded him 15% loss of the use of the person as a whole. At the same time, the Arbitrator questioned Petitioner's credibility. He noted variable effort noted by the therapist performing what was deemed an "inconclusive" Functional Capacity Evaluation which the Arbitrator found in actuality to be invalid and its reference to being "inconclusive" to be "a polite fiction", his persistent symptoms magnification noted by his treating physicians, his unimpressive job search, his exaggerated testimony about his previous and current symptomology, and observing his outward appearance of health and comfort at the time of arbitration.

The Arbitrator also found incredible the opinion that Petitioner was permanently and totally disabled from gainful employment proffered by Petitioner's Section 12 medical examiner, Dr. Chmell, as well as the assessment that he was unemployable provided by Petitioner's vocational rehabilitation counselor, Mr. Blumenthal. The Arbitrator found their opinions were contrary to the findings of the Functional Capacity Evaluation, which actually showed exaggeratedly limited physical abilities. In addition, Respondent submitted into evidence a labor market survey citing 15 jobs which were deemed to be appropriate for Petitioner, with salaries ranging between $8 and $20 an hour. The Arbitrator also found that Petitioner was not entitled to wage differential without further explanation.

15IWCC0404

Petitioner sought review before the Commission arguing the Arbitrator erred in not finding him permanently and totally disabled. On November 2, 2010, Petitioner "filed a petition to supplement his prayer for relief to include a request for wage differential." According to the Appellate Court, "that petition was denied, and the Commission never addressed the wage-differential issue on the merits." The official records of the Commission do not show that any petition was formally denied. However, it is absolutely correct that the Commission did not address the issue of wage differential in its decision.

On review, the Commission affirmed the Decision of the Arbitrator that Petitioner failed to prove he was permanently and totally disabled. However, the Commission found that "Petitioner sustained a substantial physical disability as a result of his work injuries," and noted a diagnosis of "persistent low back derangement," his use of a cane recommended by his doctor, and permanent restrictions. The Commission modified the Decision of the Arbitrator to award Petitioner 35% loss of the use of the person as a whole.

Petitioner sought judicial review in the Circuit Court of Cook County again alleging the Commission erred in not awarding him permanent and total disability benefits. The Circuit Court confirmed the Decision of the Commission regarding the denial of permanent and total disability benefits and for awarding permanent partial disability benefits rather than wage differential.

Petitioner then appealed that decision to the Appellate Court Works' Compensation Division. The Appellate Court affirmed the Decision of the Commission denying Petitioner a permanent total disability award. However, it vacated the permanent partial disability award and remanded the case back to the Commission to address the merits of the appropriateness of a wage differential award in lieu of a permanent partial disability award.

In its decision, the Appellate Court rejected Respondent's argument that Petitioner waived the issue of whether he was entitlement to a wage differential award because he did not submit any evidence supporting such an award. The Appellate Court found that there was evidence submitted supporting Petitioner's incapacity to pursue his usual and customary line of employment and an impairment of his earnings. It noted the opinions of Dr. Chmell and Mr. Blumenthal as evidence of Petitioner's inability to pursue his usual and customary employment and the labor market survey submitted by Respondent's vocational rehabilitation counselor to support impairment of earning capacity. Nevertheless, the Appellate wished "to make clear" that it was "not instructing the Commission on the conclusion it should reach on remand, only that it should decide the issue." The Appellate also instructed the Commission that if it finds against a wage differential award, it must reinstate the 35% person as a whole award.

In this case there was no comprehensive vocational rehabilitation assessment or implementation of any vocational rehabilitation program; Petitioner did not exert consistent effort in his Functional Capacity Evaluation; and Petitioner did not perform a diligent job search. Therefore, the Commission does not know Petitioner's actual physical capabilities or his actual earning potential. Even if the Commission were to accept the cursory labor market survey provided by Respondent, the range of earning potential posited in that survey, minimum wage to $20 an hour, is too great to assess a precise and appropriate wage differential.

15IWCC0404

Therefore, the Commission declines to award the wage differential award under Section 8(d)1 of the Illinois Workers' Compensation Act and reinstates the 35% loss of the person as a whole partial permanent disability award pursuant to Section 8(d)2 of the Act in accordance with the mandate of the Appellate Court.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner $619.97 a week for 175 weeks because the injuries sustained caused loss of the use of 35% of the person as a whole.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 29 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
D-5/19/15
46

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

Barry Carter,

Petitioner,

15IWCC0405

vs.

NO: 12 WC 14448

NTN,

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 nature and extent and credit for temporary total disability benefits and being advised of the facts and law, clarifies the Decision of the Arbitrator on the issue of credit and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found that Petitioner sustained a loss of 20% of the left leg as a result of the March 26, 2012 work-related injury to the left knee. The parties stipulated that medical bills were paid and that Petitioner was temporarily totally disabled from April 23, 2012 through July 2, 2012. The Arbitrator found that Respondent should be given a credit of $4,493.30 for temporary total disability benefits paid. Petitioner argued on review that the Arbitrator erred in making an award of $4,493.30 in credit for temporary total disability benefits paid by Respondent when the parties stipulated that "§8(j) credit" was not at issue. Section 8(j) provides: *"In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act."* 820 ILCS 305/8(j)1

15IWCC0405

We note that the language of the Arbitrator's Decision does not designate the "credit" as one pertaining to any claim by Respondent under §8(j), and nowhere was such an issue raised by Respondent. We find that the Arbitrator's award of a general credit for temporary total disability benefits paid by Respondent has no practical significance; it is nothing more than an acknowledgment of an agreed payment of benefits. In conclusion, we find that Petitioner's claim of error in the Arbitrator's Decision with respect to credit is immaterial. All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $365.43 per week for a period of 43 weeks, because the injuries sustained caused the loss of use of 20% of the left leg, as provided in §8(e)12 of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,800.00. 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: MAY 2 9 2015
RWW/plv
o-4/1/15
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0405

CARTER, BARRY
Employee/Petitioner

Case# **12WC014448**

NTN
Employer/Respondent

On 3/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2512 THE ROMAKER LAW FIRM
TOD ALLSWANG
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

0560 WIEDNER & MCAULIFFE LTD
MICHAEL DOERRIES
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0405

Barry Carter,
Employee/Petitioner

v.

NTN,
Employer/Respondent

Case # 12 WC 14448

Consolidated cases: **none**

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **1/21/14 and 1/22/14**. By stipulation, the parties agree:

On the date of accident, **3/26/12**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $**31,694.00**, and the average weekly wage was $**609.05**.

At the time of injury, Petitioner was **51** years of age, ***single*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**4,493.30** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**4,493.30**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $365.43 per week for 43 weeks, because the injuries sustained caused the loss of use of 20% loss of the left leg, as provided in Section 8(e)12 of the Act.

Respondent shall pay Petitioner compensation that has accrued from 3/27/12 through 1/22/14, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

3/17/14
Date

ICArbDecN&E p.2

MAR 25 2014

STATEMENT OF FACTS:

Petitioner began working for respondent as a machine operator assigned to its pre-processing department on October 18, 2010. He operates and monitors machines that produce bearings and component parts that weigh from three to five pounds. He indicated that he takes measurements of products as part of the inspection process and records the results. In addition, he controls switches to check and reset machines, starts up and shuts down the machines, and loads components into a hopper. He estimates that it takes 10 minutes to load a machine and 10 minutes to unload a machine with bending 10 to 20 times per shift and standing the entire time. He performed these tasks as an operator in pre-processing from the date of hire up until the date of injury.

On March 26, 2012, Petitioner slipped while walking into work on a floor that was being mopped and twisted his left knee and felt a pop. He commenced medical care the same day. X-rays were negative and he was diagnosed with a left knee sprain. (PX1). He was given an Ace bandage and anti-inflammatories, and was limited to sedentary work.

Petitioner worked modified duty and underwent an MRI scan of the left knee on April 13, 2012. This study showed a medial meniscal tear and defect of the cartilage at the femoral condyle. (PX2). Petitioner was referred to Dr. Suchy, an orthopedic surgeon, for follow-up care.

On April 23, 2012, Dr. Suchy examined Petitioner and diagnosed a medial meniscal tear with a defect of the lateral femoral condyle. (PX3). He took Petitioner off of work this day, and performed a partial medial meniscectomy and synovectomy arthroscopically on May 8, 2012.

Petitioner remained off of work and attended physical therapy on seven occasions from May 31 through July 5, 2012. (PX3). Although he developed some left groin pain during physical therapy in mid June, 2012, Dr. Suchy encouraged him to continue with therapy to improve his range of motion and strengthen the knee. (PX3).

As of June 25, 2012 Petitioner advised Dr. Suchy he was doing well and was "very happy." He was full weight bearing, exhibited excellent range of motion and good stability. In fact, he wanted to return to work on July 2, 2012. Dr. Suchy released petitioner to return to full duty on that date. (PX3).

Petitioner returned to his regular position as a machine operator pre-processing, performing the demands of his regular job. He returned to Dr. Suchy on July 19, 2012. (PX3). On cross examination, Petitioner denied telling Dr. Suchy at that time that he was feeling very well and was "very happy", noting that he was still having pain and numbness in the knee and that Dr. Suchy told him that it was going to be that way. Dr. Suchy indicated that Petitioner could discontinue formal therapy and could return to regular work. (PX3).

Petitioner returned to Dr. Suchy on September 13, 2012. (PX3). Once again, Petitioner denied telling Dr. Suchy at that time that he had no complaints of pain. Dr. Suchy found that Petitioner was at MMI at that time and could perform his regular activities without restrictions. (PX3).

Petitioner continued performing the demands of his regular job as a machine operator for the remaining months of 2012. He returned to Dr. Suchy on December 10, 2012 reporting that he hyper-extended his left knee at work on December 7, 2012. Dr. Suchy diagnosed a strain and administered an injection. (PX3).

Petitioner returned to Dr. Suchy on January 10, 2013. On that date Dr. Suchy noted that Petitioner was doing much better and that the cortisone injection "did the trick." (PX3). He had no significant pain or discomfort and was performing his regular employment tasks without restrictions. On exam, there was excellent range of

motion, the knee was stable and there was no joint swelling. Petitioner was discharged from care with instructions to follow up on an as-needed basis. (PX3). Petitioner has not returned to Dr. Suchy since that date. Petitioner has worked his regular shift since returning to full duty on July 2, 2012.

At the request of Respondent, Petitioner was examined by Dr. G. Klaud Miller on January 9, 2013 for purposes of a Section 12 examination. Following his examination and review of the records, Dr. Miller concluded that the work injury caused a medial meniscal tear that necessitated a meniscectomy. (RX1). However, Dr. Miller felt that the lateral femoral condyle lesion was pre-existing and was not aggravated or accelerated by the work injury as there were no loose pieces of cartilage detected during the surgery. (RX1). Furthermore, Dr. Miller opined that pursuant to the 6th edition of the AMA "Guides to the Evaluation of Permanent Impairment", Petitioner's injury consisting of "… a partial medial menisectomy with -1 grade modifiers for each of [sic] function and Dr. Suchy's normal examination on 9/13/12 (i.e. -2 grade modifiers) rates 1% lower extremity impairment rating and 1% of the whole body based on Table 16-10 on page 530." (RX1).

Petitioner testified that he currently notices a lot more pain, and that he does not feel that the surgery was successful. He indicated that he has problems standing at work, and that he feels discomfort in the knee and feels off balance. He also noted that he used to work overtime but has not done so since his return to work. He acknowledged that he has received mid-year raises throughout his employment with Respondent, with the last one occurring in May of 2013. He indicated that he used to work overtime on Saturdays and that sometimes it was voluntary and sometimes they would tell him to show up, although he agreed that the only repercussion for not doing so would be that he would not make the extra money. He stated that he presently takes over-the-counter Aleve everyday, which he noted interferes with his sleep and affects his stomach. He also noted that he hears grinding or cracking in the knee when he walks. In addition, he testified that he used to ride bikes and walk prior to the accident but no longer does so because of his knee.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of "1% lower extremity impairment and 1% whole body impairment" as determined by Dr. G. Klaud Miller pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (RX1). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. In making this determination, Dr. Miller noted that he could not connect the lateral femoral condyle lesion to the accident in question and that said defect "… was certainly a competent cause for any and all of his current complaints." (RX1). In addition, Dr. Miller noted that at the time of his visit to Dr. Suchy on September 13, 2012 Petitioner was doing well without complaints, and that he "clearly had a symptomatic exacerbation after the 12/7/12 incident." (RX1).

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record shows that Petitioner was employed as a machine operator at the time of the accident and that he returned to his full duty work on or about July 2, 2012.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to full duty work in his prior capacity as a machine operator and has since received mid-year raises. Petitioner claims that he can no longer work overtime, as he used to, given the current condition of his left knee. However, Petitioner conceded that there was no punishment for not working overtime, other than not being able to earn the extra overtime wages in question.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes as a result of the undisputed accident Petitioner injured his left knee. Petitioner testified credibly that he had not previously injured his left knee. The MRI performed on April 13, 2012 revealed a medial meniscal tear and defect of the cartilage at the femoral condyle. (PX2). Petitioner was taken off work and eventually underwent a partial medial meniscectomy and synovectomy arthroscopically on May 8, 2012. (PX3). Petitioner subsequently attended physical therapy, during which he developed left groin pain. He was eventually released to full duty work and has worked in that capacity since. Currently, Petitioner testified that he notices a lot more pain, and that he does not feel that the surgery was successful. He indicated that he has problems standing at work, and that he feels discomfort in the knee and feels off balance. He also noted that he used to work overtime but has not done so since his return to work. He stated that he presently takes over-the-counter Aleve everyday, which he noted interferes with his sleep and affects his stomach. He also noted that he hears grinding or cracking in the knee when he walks. In addition, he testified that he used to ride bikes and walk prior to the accident but no longer does so because of his knee.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of left leg pursuant to §8(e)12 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))
	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Pisano,
Petitioner,

vs.

NO: 05 WC 49540
08 WC 47656
11 WC 16653

City of Chicago,
Respondent.

15IWCC0406

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and timely notice given to all parties, the Commission, after considering the issues of medical expenses, temporary disability, permanent disability, and penalties and fees, and being advised of the facts and law, modifies the November 15, 2013 decision of Arbitrator Thompson-Smith as stated below and otherwise affirms and adopts the decision of the Arbitrator, which is attached hereto and made a part hereof.

Case numbers 05 WC 49540, 08 WC 47656 and 11 WC 16653 were consolidated at hearing before Arbitrator Black on January 22, 2013. After testimony of the Petitioner concluded but before close of proofs, Arbitrator Black recused himself from the case due to a conflict and the claims were reassigned to Arbitrator Thompson-Smith who conducted the remainder of the hearing on July 29, 2013 and September 3, 2013. Arbitrator Thompson-Smith issued a single opinion for claims 05 WC 49540, 08 WC 47656 and 11 WC 16653.

Claim 05 WC 49540. Petitioner, a heavy equipment operator, alleged an accident on October 31, 2005 in which he sustained injury to the right arm and hand in a fall after slipping on grease. The Arbitrator found Petitioner did sustain an undisputed accident that arose out of and in the course of employment on October 31, 2005 and his current condition of ill-being was casually related to the accident. Respondent was ordered to pay to Petitioner permanent partial disability of $591.77/week for 50.6 weeks for injuries which caused the 20% loss of use of the right arm and a further 61.5 weeks for injuries which caused the 30% loss of use of the right hand under Section 8(e) of the Act. Respondent was also given credit for temporary total disability and medical benefits paid. The Commission affirms and adopts the Arbitrator's award for claim 05 WC 49540.

Claim 11 WC 16653. Petitioner alleged an accident on December 6, 2010 in which he sustained injury in a fall on ice during vocational rehabilitation connected with an accident of December 12, 2007, being claim 08 WC 47656. The Arbitrator found the alleged injuries were sequelae of and related to the earlier accident; as such, benefits should be awarded under case 08 WC 47656, which will be discussed further below. The Commission affirms and adopts the Arbitrator's Decision on claim 11 WC 16653.

Claim 08 WC 47656. Petitioner alleged an accident on December 12, 2007 in which he sustained injury to his right wrist when a car mirror struck him while he was directing traffic. The Arbitrator found Petitioner did sustain an accident that arose out of and in the course of employment and that his current condition of ill-being is causally related to the accident. The Arbitrator further ordered Respondent to pay benefits under Section 8(d)1 in the amount of $616.45/week from August 30, 2011 through the duration of the disability, because the injuries sustained caused a loss of earnings.

On December 12, 2007, Petitioner was directing traffic around an area where his crew was performing graffiti removal duties when a passing car struck his right wrist with the side mirror. Petitioner sought treatment at Mercy Works later that day and was released to return to work with a wrist brace. Petitioner was provided light duty restrictions by Dr. Anderson at MercyWorks on March 11, 2008 due to continuing wrist pain. On August 12, 2008, Petitioner underwent work hardening at MercyWorks. The work hardening report noted Petitioner was able to return to work with accommodations of light to medium physical tolerance with a lifting ability of 35 pounds occasionally, 20 pounds frequently and his duties for Respondent required heavy physical tolerance. Dr. Anderson discharged Petitioner at maximum medical improvement with lifting restrictions as determined by work hardening on September 15, 2008.Petitioner began vocational rehabilitation counseling on July 29, 2009. While attending vocational counseling on December 6, 2010, Petitioner slipped and fell on ice covering the parking lot and sustained injury to his body as a whole and right arm.

The Commission affirms and adopts the Arbitrator's finding of accident and causation for claim 08 WC 47656. The Commission further affirms the Arbitrator's finding that Petitioner failed to prove by a preponderance of the evidence that he is permanently and totally disabled or that there is no stable labor market for his skills, given his injuries. As such, the Commission finds a wage differential award under Section 8(d)1 of the Act is appropriate.

The Commission notes Mr. Steffen, a licensed vocational rehabilitation counselor, found Petitioner was placeable and employable in positions ranging in pay from $15 to $45.18/hour with the likely range of pay between $15.00 and $25.00/hour. Mr. Boyd, a licensed vocational rehabilitation counselor, opined in 2012 that Petitioner was placeable and employable in a job earning between $8.79 to $19.29/hour. The evidence in the record shows a letter sent to Petitioner by Ms. Pak, an agent of Respondent, dated August 15, 2011. The letter stated "this job offer is contingent upon the successful completion of the willing and able questionnaire." Petitioner testified that he received this letter, went to Respondent's office, and completed the willing and able questionnaire for the job of watchman for Respondent. Petitioner testified that he never presented himself for the final step of fingerprinting before beginning work and, as such, Ms. Pak testified that she offered the job to the next application on her hire list. Respondent presented witnesses who testified that there were approximately fifteen positions of watchman available when Petitioner was offered a position on or about August 15, 2011, and the position was within his restrictions. The position of watchman with Respondent earned $19.24/hour. The parties stipulated at hearing that the Petitioner's average weekly wage in the year preceding the injury was $1,694.28.

With regard to temporary and permanent disability benefits in claim 08 WC 47656, the Commission finds, as stipulated by the parties at hearing, that Petitioner was temporarily totally disabled for the period March 12, 2008 through September 2, 2009, a period of 25 weeks. The parties stipulated Petitioner was entitled to maintenance benefits for the period September 3, 2009 through August 14, 2011, a period of 101 4/7 weeks, and the Commission finds the same. While Respondent claimed specific credit amounts for TTD and maintenance benefits paid, Petitioner disputed the accuracy of Respondent's claimed credit and no evidence was submitted to support Respondent's claims

for credit. As such, the Commission is unable to award Respondent a specific credit for temporary benefits it claimed to have paid to Petitioner.

The Commission further finds Petitioner is entitled to a wage differential under Section 8(d)1 commencing August 15, 2011, the date Petitioner was offered the job of a watchman by Ms. Pak. The bona fide offer of a position as a watchman on August 15, 2011 paid $19.24/hour and was full time work within Petitioner's restrictions for an average weekly wage of $769.60. The Arbitrator calculated the wage differential award based on the difference between the average weekly wage for the new position and that of his average weekly wage in the year preceding the injury. However, the Commission notes the calculation of a wage differential under Section 8(d)1 is equal to 66 2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged that the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. The courts have interpreted this section of the Act to mean the Commission is to calculate the wage differential award based on the amount the claimant would be able to earn in the full performance of his duties in his prior employment at the time of hearing. Pursuant to Petitioner's Exhibit 26, the job of hoisting engineer for Respondent at the time of hearing was $44.30/hour for an average weekly wage calculation of $1,772.00. Therefore, the Commission modifies the Arbitrator's finding of the appropriate wage differential rate and awards Petitioner a wage differential under Section 8(d)1 of $668.27/week.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 15, 2013, is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $967.19 per week commencing November 1, 2005 through May 18, 2006, a period of 28 3/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act for claim 05 WC 49540. Respondent shall be given a credit of $25,662.04 for temporary benefits paid pursuant to stipulation of the parties.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $591.77/week for 50.6 weeks, because the injuries sustained in claim 05 WC 49540 caused the 20% loss of the right arm, as provided in §8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $591.77/week for 61.5 weeks, because the injuries sustained in claim 05 WC 49540 caused the 30% loss of the right hand, as provided in §8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,164.37 per week commencing March 12, 2008 through September 2, 2009, a period of 25 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act for claim 08 WC 47656. Respondent shall be given a credit for temporary benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,164.37 per week commencing September 3, 2009 through August 14, 2011, a period of 101 4/7 weeks, that being the period of maintenance benefit due to incapacity from work under §8(a) of the Act for claim 08 WC 47656. Respondent shall be given a credit for maintenance benefits paid.

15IWCC0406

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits, commencing August 15, 2011, of $668.27/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in §8(d)1 of the Act for claim 08 WC 47656. Respondent shall be given a credit for benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner related medical bills contained in Petitioner's Exhibits 9 and 14 pursuant §8(a) and 8.2 of the Act. Respondent shall be given credit for medical benefits paid and Respondent shall hold Petitioner harmless from any claim by any providers of the services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injuries.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 the Circuit Court.

DATED: MAY 29 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/01/15
jdl/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PISANO, WILLIAM
Employee/Petitioner

Case# **05WC049540**

08WC047656
11WC016653

CITY OF CHICAGO
Employer/Respondent

15IWCC0406

On 11/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0391 THE HEALY LAW FIRM
KEVIN T VEUGLER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JOSEPH ZWICK
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PISANO, WILLIAM
Employee/Petitioner

Case# **08WC047656**

05WC049540

11WC016653

CITY OF CHICAGO
Employer/Respondent

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PISANO, WILLIAM
Employee/Petitioner

Case# **11WC016653**

08WC047656
05WC049540

CITY OF CHICAGO
Employer/Respondent

15IWCC0406

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William Pisano
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **05** WC **49540**

15IWCC0406

Consolidated cases: **08 WC 47656 & 11 WC 16653**

An *Application for Adjustment 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 and the Honorable Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **January 22, 2013, July 29, 2013 and September 3, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **October 31, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$75,441.18**; the average weekly wage was **$1,450.79**.

On the date of accident, Petitioner was **47**years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$25,662.04** 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 **$10,040.97** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$591.77**/week for 50.6 weeks, because the injuries sustained caused the **20%** loss of the **right arm**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$591.77**/week for 61.5 weeks, because the injuries sustained caused the 30% loss of the **right hand**, as provided in Section 8(e) of the Act.

Respondent shall be given a credit of $10,040.97 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claim by any providers of the services for which Respondent is receiving this credit as provided in Section 8(j) of the Act. Respondent is not responsible for any further medical bills.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 PISANO
05WC49540
08WC47656
11WC16653

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

William Pisano
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

15IWCC0406

Case # **08** WC **47656**

Consolidated cases: **05 WC 49540 & 11 WC 16653**

An *Application for Adjustment 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 and the Honorable Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **January 22, 2013, July 29, 2013 and September 3, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

B. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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

15IWCC0406

FINDINGS

On **December 12, 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 **$88,102.52**; the average weekly wage was **$1,694.28**.

On the date of accident, Petitioner was **50** 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 for any and all benefits paid for TTD, TPD, maintenance, and other benefits, paid to Petitioner.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits, commencing August 30, 2011, of $616.45/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act. Respondent shall be provided a credit any for overpayment of maintenance benefits.

Penalties are not awarded pursuant to the Act.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

WILLIAM PISANO
05WC49540
08WC47656
11WC16653

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

William Pisano
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

15IWCC0406

Case # **11** WC **16653**

Consolidated cases: **05 WC 49540 & 08 WC 47656**

An *Application for Adjustment 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 and the Honorable Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **January 22, 2013, July 29, 2013 and September 3, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

C. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **December 6, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**88,102.52**; the average weekly wage was $**1,694.28**.

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 $**N/A** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**N/A**.

Respondent is entitled to a credit of $**N/A** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner's alleged injuries from December 6, 2010, arose out of and in the course of the vocational rehabilitation process in connection with his accident of December 12, 2007. As such, any benefits are awarded under Case Number 08 WC 47656.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Pisano	)		
	)		
Petitioner,	)		
	)		
vs.	)	Nos.	05 WC 49540
	)		08 WC 47656
City of Chicago	)		11 WC 16653
	)		
Respondent.	)		15IWCC0406

STATEMENT OF FACTS

The disputed issues in *05WC49540* are: 1) medical bills; 2) penalties; and 3) attorney's fees; and 4) the nature and extent of Petitioner's injury. *See,* AX1.

The disputed issues in *08WC47656* are: 1) medical bills; 2) payment of wage differential/maintenance benefits: 3) penalties; 4) attorney's fees; and 5) the nature and extent of Petitioner's injury. *See,* AX2.

The disputed issues in *11WC6653* are: 1) causal connection; 2) medical bills; and 3) the nature and extent of petitioner's injuries. *See,* AX3.

William Pisano ("Petitioner") testified that he began working for the city of Chicago ("Respondent") in 1979 as a hoisting engineer. He states that he completed a second year of high school and entered the United States Navy until his general discharge. The job of a hoisting engineer involved operating heavy equipment including graders, backhoes, cranes, end loaders, forklifts, bobcats, and snow blowers. Petitioner testified that he was required to lift up to one hundred (100) pounds as a hoisting engineer. Petitioner further testified that on or about October 31, 2005, he slipped while standing on a platform on a machine. Petitioner stated that he slipped on grease and fell backward; landing on his right side with his right arm extended and that he immediately noted pain and swelling in his right arm. Following the accident, Petitioner was sent to MercyWorks at the request of Respondent. Petitioner testified that he was diagnosed with a right elbow fracture, right wrist contusion and a right shoulder sprain; and referred to Dr. Heller, at Midland Orthopedics, who recommended no use of the

right arm and physical therapy. Petitioner testified that in a follow-up visit with MercyWorks on November 8, 2006, he began to notice pain in the right hip and states that physical therapy was recommended for the hip.

Petitioner further testified that Dr. Heller eventually recommended an MRI dated December 30, 2005, which indicated a TFCC tear in the right wrist. Dr. Heller then recommended a cortisone injection in the wrist and Petitioner followed up with Dr. Nagel, who performed surgery to the right wrist on March 1, 2006, which consisted of a debridement of triangular fibrocartilage. Dr. Nagle noted that the right wrist was severely compromised; and recommended additional treatment including a partial fusion procedure.

On April 13, 2006, Dr. Nagle prescribed a functional capacity evaluation ("FCE"), which was performed on April 21, 2006. Upon completion of the FCE, Petitioner was returned to work in a light duty position.

On May 11, 2006, Petitioner presented to Dr. Nagle who placed him on restrictions pursuant to the FCE and instructed him to return in two (2) months. The petitioner testified that Respondent was unable to accommodate his restrictions, therefore he remained off work. *See,* PX5, pg. 23 & Tr. of 1/22/13 at pg. 41.

On July 11, 2006, Dr. Nagel noted that the petitioner continued to have pain in his right wrist and continued his restrictions recommended no lifting greater than fifty (50) pounds from the waist to the shoulder and no lifting of bags or heavy material repetitively.

On October 10, 2006, Petitioner again presented to Dr. Nagle complaining of pain in the right wrist; popping, and clicking in the right elbow. Dr. Nagle indicated that absent surgery, Petitioner was at maximum medical improvement ("MMI"), with permanent light duty restrictions; and should return, if necessary. *See,* PX5 pgs. 29-32 & Tr. of 1/22/13 at pg. 43.

On May 10, 2007, petitioner returned to Dr. Nagle complaining of pain in his right wrist. Following an FCE, Dr. Nagle returned the petitioner to work with restrictions of no lifting fifty (50) pounds to shoulder level and no repetitive heavy lifting. *See,* PX5 PG. 43.

On July 13, 2007, petitioner apparently contacted Dr. Nagle and MercyWorks, requesting a full duty release and although Dr. Nagle ordered additional testing, which petitioner did not undergo, he was given full duty released by both doctors. Petitioner returned to work as a graffiti blaster, which uses fifty (50) pound bags of soda.

Petitioner testified that on December 12, 2007, he was directing traffic around an area where he and a crew were performing their graffiti removal duties. He states that a car drove too close and stuck his right wrist with the car mirror. Petitioner testified that he continued working and later sought treatment at MercyWorks. He testified that MercyWorks released him to return to regular duties but he was returned to a light duty position, wearing a wrist brace.

On March 11, 2008, Petitioner was given light duty restrictions, due to wrist pain, and prescribed physical therapy on April 22, 2008. On June 17, 2008, both Dr. Nagle and the doctor at MercyWorks recommended light-duty restrictions.

On June 20, 2008, Petitioner apparently again requested a full-duty release so that he could return to his job as hoisting engineer. The doctors at MercyWorks prescribed an FCE. He further testified that Mercy Works subsequently provided light duty restrictions and recommended a home exercise program. Petitioner returned to Dr. Nagel who eventually recommended an FCE and based upon that FCE, Petitioner was returned to work in a medium-duty capacity. Petitioner states that on September 15, 2008, MercyWorks discharged him from care and declared him to be at MMI; with restrictions of no lifting greater than thirty (30) pounds occasionally. Petitioner stated that he was offered vocational counseling services with Ed Steffen on July 29, 2009; and testified that he continued to follow-up with a Mr. Bigelow, from Mr. Steffen's office, with regards to continued vocational counseling efforts. *See,* PX3, pg. 7 & Tr. of 1/22/13, pgs. 50-66.

Petitioner further testified that on December 6, 2011, he met with Mr. Bigelow, at a previously determined location, to discuss ongoing vocational rehabilitation issues. Petitioner testified that on that date he slipped and fell on ice, catching himself with both arms. Following this accident, he came under the care of Dr. Paul Prinz. He underwent an MRI on December 23, 2010 that revealed a labral tear of the left and right shoulder. Petitioner states that Dr. Prinz referred him to Dr. Maday concerning his shoulders and Dr. Espinosa, in connection with the reported complaints of pain to the neck. Petitioner testified, on cross-examination, that he requested a note from Dr. Maday indicating that he was unable to complete a job search at that time. Dr. Maday treated Petitioner with injections and therapy and ultimately provided restrictions of no heavy lifting and no extensive driving.

Petitioner testified that on August 15, 2011, he received a letter from the respondent indicating that there was a watchman's position available for him. Petitioner stated that he had contact with Ashley Pak, who instructed him to go to the city's personnel department. Petitioner testified that he completed a questionnaire concerning his ability to perform the job and then appeared on August 19, 2011 and advised Ms. Pak that he wished to discuss the position with Drs. Maday and Nagel. Petitioner testified that he discussed the job with Dr. Maday who allegedly told him not to accept the position.

Petitioner again testified regarding the discussions with Dr. Maday, when he was called to testify as a rebuttal witness on September 3, 2013. At that time, Petitioner was asked what he told Dr. Maday, concerning the job duties of a watchman. Petitioner answered, "It was the ability to have to confront somebody if I was in a situation where I had to confront somebody. There are circumstances where things happen you can't avoid, and I have seen this over the years being on the job for 28 years as an engineer".

Petitioner alleges that the watchman's position was never offered to him. The respondent however, presented testimony from Ashley Pak; whose job involves overseeing the hiring process for the Water Department and the hiring of watchmen. Ms. Pak testified that she called Petitioner on August 30 or 31, 2011 and advised that he was to come in for fingerprinting for purposes securing the watchman's position. Ms. Pak testified that Petitioner responded by stating that he would not attend fingerprinting until he spoke with his lawyer and doctor. Ms. Pak further testified that she heard nothing further from Petitioner after that date. *See,* Tr. 7/29/2013, pgs. 95-125.

Respondent also called Daniel Misch as a witness. Mr. Misch testified that his duties included supervision of watchmen for the city of Chicago's Water Department. Mr. Misch was asked to describe the job duties of a watchman and stated, "A watchman basically sits in the facility which is a different department of water management facilities. They will answer the phone and have to call in every hour to the command center. They may monitor cameras or monitors if they are on location. They will observe any trucks coming and going and log them in and out. If they note any strange activity, they are informed to call 911 first and then call command center". Mr. Misch stated that no aspect of the job required lifting over thirty (30) pounds and that the position absolutely, does not require any physical apprehension of anyone who does not belong on property. In such a circumstance, the watchmen are instructed to call 911 first, and then call the command center. Mr. Misch stated that the watchman's position never requires overhead lifting and stated that some of the positions require limited driving. *See,* Tr. 9/3/13, pg. 9.

Petitioner presented testimony from Mr. James Boyd, a licensed, certified, vocational rehabilitation counselor. Mr. Boyd noted that Petitioner had two years of high school and later secured a GED certificate. He also noted Petitioner's experience in the U.S. Navy; and four year training and apprenticeship with operators Local 150; in conjunction with his job with the city of Chicago. Mr. Boyd stated that, absent any retraining, there was not a stable labor market for the petitioner. With some retraining, Mr. Boyd felt that Petitioner would be able to earn approximately $12.00 per hour. Upon cross-examination, Mr. Boyd acknowledged that the main factor in whether an individual is successful in job placement is whether that individual is motivated to get a job. Mr. Boyd also acknowledged that Petitioner scored only in the fifth percentile in the job category of a hoisting engineer, the job Petitioner had previously held for several years. Mr. Boyd also acknowledged that Petitioner advised him that he had been offered a watchman's position. Mr. Boyd testified that there

was a wide variance in the requirements of certain watchmen's positions and opined that this watchman position would not have reflected a high interest area for Petitioner, according to his COPS testing. *See*, Tr. 7/29/13, pgs. 5-90.

Respondent presented testimony from Edward Steffen, who is also a licensed, certified, vocational rehabilitation counselor. Mr. Steffen notes that he also works with an individual named Duane Bigelow, who is a certified, vocational rehabilitation counselor. Mr. Steffen explained that he supervised the rehabilitation process for Petitioner and notes that Mr. Bigelow conducted a majority of the meetings. Mr. Steffen testified that Petitioner would benefit from computer training, but stated that the same was not mandatory or a prerequisite for employment. Mr. Steffen further testified that Petitioner was employable and identified an anticipated salary range between $10.00 and $41.00 per hour. Upon further explanation, Mr. Steffen acknowledged that the $41.00 per hour range was based upon jobs in which Petitioner expressed interest; otherwise, Mr. Steffen indicated an anticipated salary range of $10.00 to $20.00 per hour. Ultimately, Mr. Steffen stated that if there was a watchman's position available that 1) did not require physical confrontation with other individuals; 2) called for walking to monitor the premises and monitoring security cameras; and 3) required calling emergency police or other assistance, if necessary, in the case of an intruder; then such a position would be appropriate for Petitioner. *See*, Tr. 7/29/13, pgs. 127-191.

Petitioner submitted, as Exhibit Number 4, the records from Dr. William Heller that state that Petitioner began seeing him on November 1, 2005. At that time, the doctor diagnosed Petitioner as having a radial neck fracture of the right elbow that would be treated with immobilization, i.e. two weeks of sling, followed by physical therapy. The records also indicate that Petitioner was complaining of right wrist pain and on December 30, 2005, Dr. Heller noted that an MRI revealed a TFCC tear. The last note from Dr. Heller is dated January 16, 2006; at which time it was noted that Dr. Heller was recommending surgery to the wrist.

Petitioner submitted as Exhibit Number 5, records from Dr. Daniel Nagel, reflecting treatment from Dr. Nagel beginning on January 19, 2006. The records indicate that Petitioner had previously undergone a left rotator cuff repair by Dr. Wolin. Dr. Nagel completed wrist surgery on March 1, 2006 and on March 2, 2006; Dr. Nagel stated that the options included living with the wrist as is, undergoing a partial fusion of the wrist or undergoing panarthrodesis of the wrist.

As of May 12, 2006, Dr. Nagel noted Petitioner was requesting a return to work without restrictions. Dr. Nagel notes, "I explained to the patient that I cannot change the restrictions." On October 10, 2006, Dr. Nagel stated that Petitioner was able to return to work, per restrictions from the latest FCE, which indicated that Petitioner was able to lift one hundred (100) pounds occasionally, fifty (50) pounds frequently and twenty (20) pounds constantly. It also indicated that Petitioner was able to lift fifty (50) pounds above the wrist and overhead.

On July 27, 2007, Dr. Nagel issued a note stating, "I reviewed the job description of a hoisting engineer. This job description makes no mention of lifting fifty (50) pounds above shoulder level. I have no problem with Mr. Pisano returning to the regular duties of a hoisting engineer as outlined in the fax I received on July 26, 2007." Dr. Nagel issued a similar opinion on June 17, 2008.

Petitioner submitted as Exhibit Number 6, the medical records of Dr. Maday, which contain treatment notes from January 14, 2011 through a report of August 26, 2011. The initial note from Dr. Maday indicates that Petitioner was being seen, at the request of Dr. Prinz, for bilateral shoulder pain. Dr. Maday initially treated Petitioner with physical therapy and subsequently diagnosed Petitioner as having bilateral partial thickness rotator cuff tears. Dr. Maday noted that Petitioner advised he did not wish to consider surgical options and on August 26, 2011, Dr. Maday noted, "William Pisano returns today and apparently was offered a job as a watchman." Dr. Maday stated that his understanding of the job was that it "required possibility of contact with suspects" and further indicated that same required "possibility of heavy lifting." Based upon these understandings, Dr. Maday indicated that Petitioner would not be able to return to that job.

Petitioner submitted as Exhibit Number 8, a copy of a job description of a watchman position for the city of Chicago. Petitioner testified that this particular job description was obtained by logging onto the city of Chicago website. Dan Misch testified that this particular job description did not reflect all of the watchman positions, in the city of Chicago.

Petitioner submitted as Exhibit Number 18, a letter from the city of Chicago water department dated August 15, 2011, indicating that Respondent was offering a position of watchman earning $19.24 per hour. The letter is signed by Ashley Pak, who testified in accordance with its contents. *See,* Tr. 7/29/13, pgs. 95-123.

Petitioner submitted as Exhibit Number 19, letters dated September 22, 2011 and November 28, 2011. The records indicate that Arbitrator Black recommended authorization by Dr. Nagel, on September 22, 2011, for purposes of reviewing the duties of the watchman's position. The letter of November 28 indicates that the watchman's position had been filled and confirming that the visit to Dr. Nagel was no longer relevant.

Respondent submitted as Exhibit Number 6, the January 31, 2011 report and April 4, 2011 addendum by Dr. Michael Kornblatt. Dr. Kornblatt stated that Petitioner's right shoulder condition involved a pre-existing arthritis and tendonitis that was unrelated to the alleged accident but stated that Petitioner did have a strain that was related to the alleged accident of December 6, 2010. Dr. Kornblatt provided similar opinions concerning the left shoulder. Dr. Kornblatt also stated that Petitioner had a cervical strain and a pre-existing degenerative disc disease in the cervical spine.

CONCLUSIONS OF LAW 15IWCC0406

05WC49540

J. Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner submitted medical bills from Dr. Maday and ATI Physical Therapy. However, it was noted that the underlying balances from the providers were paid through Petitioner's group insurance carrier and it was agreed by the parties, that Respondent is entitled to a credit under Section 8(j) for those balances. Therefore, the Arbitrator finds that the respondent has paid all reasonable and necessary medical services for this injury.

L. What is the nature and extent of the injury?

Petitioner testified that he fell and landed on his right arm. Petitioner was initially seen at MercyWorks on November 1, 2005, complaining of pain in the right elbow and wrist and diagnosed with a right elbow fracture. Petitioner was prescribed a sling to immobilize the arm and it was noted that physical therapy would begin in two weeks. Petitioner also reported pain in the right shoulder. As Petitioner's elbow improved, he continued to report right wrist pain. Petitioner then underwent an MRI of the right wrist and it was determined that Petitioner had degenerative changes in the wrist that were aggravated by the alleged accident. As such, surgery was recommended and Petitioner was referred Dr. Daniel Nagel, who diagnosed a TFCC tear and performed surgery in the form of arthroscopic debridement of the TFCC and ulnar carpal and radial carpal joints.

The diagnosis was ulnar carpal and radial carpal joint internal derangement and triangular fibrocartilage tear. Petitioner saw Dr. Nagel on March 2, 2006, at which time Dr. Nagel indicated that a possible fusion could be considered in the future. On May 11, 2006, Dr. Nagel reviewed an FCE and opined that Petitioner was not able to return to his regular job duties.

On July 27, 2007, Dr. Nagel issued a note indicating that, since Petitioner's job description made no mention of lifting 50 pounds above the shoulder level, he had "no problem" with Petitioner returning to regular duties a hoisting engineer. Petitioner did return to employment and began working operating a graffiti blaster. From reviewing the medical records, Petitioner's right elbow fracture healed without complication. As such, the Arbitrator finds that based upon the elbow fracture, Petitioner sustained a 20% disability of the right arm.

With regard to the right wrist TFCC tear, Petitioner did require surgery. However, Petitioner was, ultimately, released to return to employment. As such, the Arbitrator finds that Petitioner was disabled to the extent of 30% of the right hand.

M. Should penalties and fees be imposed upon the Respondent?

Petitioner requested penalties and fees pursuant to Section 19(k) of the Illinois Workers' Compensation Act, which states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

The Arbitrator notes that "[s]pecific procedures or treatments that have been prescribed by a medical service provider are 'incurred' within the meaning of section 8(a) even if they have not been performed or paid for." *Bennett Auto Rebuilders, Inc. v. Industrial Comm'n,* 306 Ill. App. 3d 650, 655-56 (1999). The claimant bears the burden of proving, by a preponderance of the evidence, his or her entitlement to an award of medical care under section 8(a). *Westin Hotel v. Industrial Comm'n,* 372 Ill. App. 3d 527, 546 (2007).

A conflicting medical opinion does not present an absolute defense to imposition of 19(l) penalties. The test is not whether there is some conflict in medical opinion. Rather, it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all circumstances presented. *Continental Distributing v. Industrial Comm'n,* 98 Ill.2d 407 (1983).

The Arbitrator does not find that the respondent's actions rise to the level of unreasonable or vexation and attorney's fees are not awarded, pursuant to the Act.

08WC47656

J. Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner submitted medical bills from Dr. Maday and ATI Physical Therapy. However, it was noted that the underlying balances from the providers were paid through Petitioner's group insurance carrier and it was agreed by the parties, that Respondent is entitled to a credit under Section 8(j) for those balances. Therefore, the Arbitrator finds that the respondent has paid all reasonable and necessary medical services for this injury.

K. What temporary benefits are in dispute?

Petitioner denies being offered the position of watchman by Respondent however, his medical records and those records of his vocational rehabilitation counselor state otherwise. In addition, Respondent presented witnesses who testified that 1) there were approximately fifteen (15) positions of watchman available of which Petitioner was offered a position, on or about August 15, 2011 and that 2) the position was within petitioner's restrictions. The Arbitrator finds that the petitioner was made a bona fide offer of position of watchman, on August 15, 2011, which would have paid him $19.24 per hour. As petitioner did not act to complete the application process, the jobs were subsequently filled. The Arbitrator notes that the petitioner did submit the earnings of a hoisting engineer position, as of June of 2012 however, according to his treating doctors; he is restricted from this work and he had a bone fide offer of employment by Respondent in August of 2011. As such, the wage differential will be calculated according to the amount the petitioner could have earned on or about August 30, 2011, i.e., $19.24, and his pre-injury earnings. There is evidence as to the amount Petitioner was earning, i.e., the stipulated average weekly wage of $1,694 28. With a wage of $19.24 per hour as a watchman, Petitioner would be earning $769.90. $1,694.28 minus $769.60 would give $924.68 and a wage differential of $616.45. The Arbitrator finds that Petitioner is entitled to a wage differential benefit of $616.45 per week from August 30, 2011, for the duration of the disability.

Petitioner is seeking either a wage differential award or maintenance benefits for life. The Arbitrator does not find that the Petitioner has proven, by a preponderance of the evidence, that he is permanently, totally disabled or that there is no stable, labor market for his skills, given his injuries. Therefore, the Arbitrator finds that the Respondent shall pay Petitioner permanent, partial disability benefits of $616.45 per week, commencing August 30, 2011, for the duration of his disability, as the injuries sustained caused a loss of earnings, pursuant to Section 8(d)1 of the Act.

Lastly, Respondent claims that it has paid $64,555.31 in TTD payments, $20,823.16 in wage differential payments; 179,896.91 in maintenance payments; and $6,361.50 for an advance in other benefits. Petitioner disputes this but does not state why. Neither party has presented evidence as to what sums were paid for what benefits and as a result the Arbitrator has no evidence to determine what credits are owed to Respondent or what sums have been paid to Petitioner. Nor is there any explanation of payments made in the proposed findings. *See*, AX2.

11WC6653

F. Is the petitioner's present condition of ill-being causally related to the injury?

The Arbitrator finds that the petitioner's present condition is causally related to his injuries.

J. Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner submitted medical bills from Dr. Maday and ATI Physical Therapy. However, it was noted that the underlying balances from the providers were paid through Petitioner's group insurance carrier and it was agreed by the parties, that Respondent is entitled to a credit under Section 8(j) for those balances. Therefore, the Arbitrator finds that the respondent has paid all reasonable and necessary medical services for this injury.

L. What is the nature and extent of the injury?

The Arbitrator relies on the opinions of Dr. Michael Kornblatt regarding Petitioner's shoulder injuries and the nature and extent of Petitioner's injuries are cited in case number 08 WC 47656.

M. Should penalties and fees be imposed upon the Respondent?

The Arbitrator does not award penalties or attorney's fees and the respondent actions did not rise to the level of unreasonable or vexation.

15IWCC0406

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
05 WC 49540; 08WC47656; 11WC16653
SIGNATURE PAGE

Signature of Arbitrator

November 15, 2013
Date of Decision

NOV 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))
	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Chamness,
Petitioner,

vs.

No: 10 WC 46191

David Johnson, Individually & d/b/a David Johnson, and the Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,
Respondents.

15IWCC0407

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein, the Illinois State Treasurer, and notice given to all parties, the Commission, after considering the issues of employment relationship, accident, notice, causal connection, medical expenses, 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 June 9, 2014 Decision of the Arbitrator, which is attached hereto and made a part hereof.

Arbitrator Brandon Zanotti found that Petitioner proved that an employer-employee relationship existed between himself and Respondent David Johnson, that he sustained an accident that arose out of and in the course of employment on October 24, 2010 and that his current condition of ill-being is causally related to that accident. The Arbitrator ordered Respondents to hold Petitioner harmless for payment of medical expenses made by Illinois Public Aid/Medicaid and to pay temporary total disability benefits for 53-4/7 weeks. Respondents were also ordered to pay permanent partial disability benefits of 60% loss of use to the person as a whole, pursuant to Section 8(d)2 of the Act, and 100% loss of use of the right arm for an amputation at the shoulder joint, as provided in Section 8(e) of the Act.

After considering the entire record, and for the reasons set forth below, the Commission modifies the June 9, 2014 decision of the Arbitrator and vacates the portion of permanent partial disability awarded pursuant to Section 8(d)2. All else is affirmed and adopted.

15IWCC0407

On October 24, 2010, Petitioner was welding legs onto a motor that weighed approximately 2,000 pounds. When the legs collapsed, the motor landed on Petitioner's chest, pinning him upright against the sawmill and causing him to lose consciousness. Petitioner was taken by ambulance to Herrin Hospital, diagnosed with a severed right arm, then transferred by helicopter to Barnes-Jewish Hospital in St. Louis. Three surgeries were performed on October 24, 2010 to remove the right arm, and a fourth surgery on October 28, 2010 was performed for purposes of skin grafting. Although Petitioner was fitted for and provided with a prosthesis, he testified that it was a "hassle" and elected not to wear it at the time of the hearing. Petitioner testified that he continued to experience phantom pains in his missing right arm and could no longer participate in many recreational activities or drive manual shift vehicles, which resulted in the loss of his CDL. Petitioner also testified that he required assistance with some activities of daily living.

The threshold issue at hearing and on appeal is whether Petitioner proved that an employer-employee relationship existed between Petitioner and Respondent David Johnson. Respondent argued that Petitioner was an independent contractor. Arbitrator Zanotti found, after considering all of the factors, that Petitioner was an employee, rather than an independent contractor, noting that Respondent exercised significant control over Petitioner's job activities, including directing him where to cut the timber. The Commission notes that Respondent supplied most of the equipment used by Petitioner in the performance of his job and retained the right to terminate Petitioner if he failed to call in to report he was ill. Respondent paid Petitioner weekly in cash and withheld no taxes, indicating that Respondent considered Petitioner to be an independent contractor, rather than an employee; however, Respondent did not furnish Petitioner with either a Form 1099 or W-2 at the end of the year. The majority of relevant factors indicated an employer-employee relationship existed. The Commission affirms and adopts the Arbitrator's finding that an employer-employee relationship existed.

At hearing, Petitioner argued that he was permanently and totally disabled. He had suffered the loss of an entire limb, and his ability to perform his job in the logging business, as well as in his prior occupations of welder and mechanic, was severely and negatively affected. However, Petitioner failed to prove that he was disabled by his condition from performing any job for which a viable labor market existed. Although Arbitrator Zanotti found that Petitioner had failed to prove that he was permanently totally disabled, he awarded Petitioner both 100% loss of use of the right arm under Section 8(e) and 60% loss of use of the person as a whole under Section 8(d)2 of the Act.

Section 8(e) of the Act provides as follows:

> For accidental injuries in the following schedule, the employee shall receive compensation for the period of temporary total incapacity for work resulting from such accidental injury, under subparagraph 1 of paragraph (b) of this Section, and shall receive in addition thereto compensation for a further period for the specific loss herein mentioned, **but shall not receive any compensation under any other provisions of this Act.**

820 ILCS 305 §8(e) (emphasis added).

Pursuant to Section 8(e), and to the Appellate Court's ruling in *Payetta v. Industrial Comm'n*, 339 Ill. App. 3d 718, 791 N.E.2d 682, 274 Ill. Dec. 590 (2d Dist. 2003), a claimant may not claim benefits under both Section 8(e) and Section 8(d) for loss of use of the same body part, as it would otherwise represent a duplicative award. In *Payetta*, the claimant's right arm below the elbow was amputated as a result of his work-related injury. His employer paid immediate benefits for the amputation under Section 8(e). At hearing, the claimant sought wage differential benefits under Section 8(d)1 in addition to the Section 8(e) benefits that had already been paid. The Appellate Court noted the prohibition in Section 8(e) against a claimant receiving benefits under both Section 8(e) and any other section of the Act for the same injury. The Court found that the claimant in *Payetta* could elect to receive a wage differential under Section 8(d)1 *rather than* the scheduled injury in Section 8(e), but that he could not receive that Section 8(d)1 award *in addition to* the Section 8(e) award for amputation of part of his right arm. Since the claimant elected to claim the Section 8(d)1 wage differential, the employer would be credited with the amount it had already paid under Section 8(e).

In this case, Petitioner sought permanent total disability benefits, but failed to prove that he was permanently and totally disabled. He did prove that he was unable to return to work at his current employment, and the amputation of his right arm was not disputed. Therefore, Arbitrator Zanotti awarded Petitioner 100% loss of use of the right arm and an additional 60% loss of use of the person as a whole, presumably for loss of occupation. However, this award of dual benefits for the single injured body part violates the prohibition found in Section 8(e) and the ruling of the Appellate Court in *Payetta*. Petitioner suffered injury or loss of use of only one body part. Pursuant to *Payetta* and Section 8(e), he could have sought benefits under *either* Section 8(e) or Section 8(d)2, but not both. Under Section 8(d)2, the Arbitrator awarded Petitioner the sum of $103,386.00. Under Section 8(e), he received an award of $150,559.00. The Commission finds that Petitioner is entitled to only one of these awards and, based upon the severity of Petitioner's injury, the Commission awards him the greater amount, for 100% loss of use of the right arm.

After considering the entire record, the Commission modifies the Arbitrator's June 9, 2014 Decision by vacating the Arbitrator's award of 60% loss of use of the person as a whole, pursuant to Section 8(d)2 of the Act. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the June 9, 2014 Decision of the Arbitrator is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall hold Petitioner harmless for payment of reasonable and necessary medical expenses paid by Illinois Public Aid/Medicaid, pursuant to Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $382.91/week for a period of 53-4/7 weeks, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $466.13/week for 323 weeks, because the injuries sustained caused the loss of use of 100% of the right arm with an amputation at the shoulder joint, as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of the sum of $344.62/week for 300 weeks, representing loss of use of 60% of the person as a whole pursuant to Section 8(d)2, is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's request for penalties and attorneys' fees, under Sections 19(l), 19(k) and 16, is 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 injuries.

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: MAY 29 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-04/07/15
jdl/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHAMNESS, WILLIAM
Employee/Petitioner

Case# **10WC046191**

DAVID JOHNSON INDIVIDUALLY AND D/B/A DAVID JOHNSON AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0407

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:

2333 WOODRUFF JOHNSON & PALERMO
LEANDRO ALHAMBRA
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2269 NEWCOMB LAW OFFICE
PAULA NEWCOMB
PO BOX 753
BENTON, IL 62812

0558 ILLINOIS ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

☒ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM CHAMNESS
Employee/Petitioner
v.
DAVID JOHNSON, INDIVIDUALLY and D/B/A DAVID JOHNSON, and THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

Case # 10 WC 46191

15IWCC0407

An *Application for Adjustment 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other: Is Petitioner permanently and totally disabled?

FINDINGS

On **October 24, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$29,867.24**; the average weekly wage was **$574.37**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **4** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $382.91/week for 53 4/7 weeks, commencing 10/25/2010 through 11/03/2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $344.62/week for 300 weeks, because the injuries sustained caused the 60% 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 $466.13/week for 323 weeks, because the injuries sustained caused the 100% loss of the right arm with an amputation at the shoulder joint, as provided in Section 8(e) of the Act.

Penalties and attorney's fees are not awarded against Respondent.

Respondent shall hold Petitioner harmless for payment of reasonable and necessary medical expenses made by Illinois Public Aid/Medicaid.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund (hereafter the "Fund") was named as co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General's Office. Award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of the Act, in the event of the failure of Respondent-Employer, David Johnson, individually and d/b/a David Johnson (hereafter the "Employer"), to pay the benefits due and owing Petitioner. The Employer shall reimburse the Fund for any compensation obligations of the Employer that are paid to Petitioner from the 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

05/30/2014
Date

JUN 9 - 2014

STATE OF ILLINOIS)
)SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM CHAMNESS
Employee/Petitioner

v.

Case # 10 WC 46191

DAVID JOHNSON, INDIVIDUALLY and
D/B/A DAVID JOHNSON, and
THE ILLINOIS STATE TREASURER AS EX-OFFICIO
CUSTODIAN OF THE ILLINOIS INJURED WORKERS'
BENEFIT FUND
Employer/Respondent

15IWCC0407

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Respondent, David Johnson, stipulated on the record that workers' compensation insurance coverage was not provided for the date of accident of October 24, 2010. Respondent was present at trial and represented by counsel. Counsel from the Office of the Illinois Attorney General was also present at trial on behalf of the Illinois Injured Workers' Benefit Fund.

Petitioner testified that he began working for Respondent in March 2010. Petitioner was referred to David Johnson for work by his former employer, Wayne Bozarth. Petitioner met Mr. Johnson at a worksite and was asked to cut down some trees. He testified he was hired by Respondent that day.

Respondent is in the business of logging. Petitioner testified that he was hired by Respondent to cut trees, drive a tractor-trailer, operate Respondent's log skidder, and do anything Mr. Johnson needed performed in the woods as it related to his logging enterprise. Petitioner testified that he was initially paid $100.00 per day for his labor. After two months, Respondent agreed to increase his pay to $120.00 per day.

Petitioner testified that he reported to Mr. Johnson during the course of his employment. Petitioner testified that he typically worked Monday through Friday. Petitioner testified that his schedule was set by Respondent. His typical work day began at 7:00 a.m., and lasted anywhere between 8-10 hours per day.

Petitioner testified that he used his own chainsaw; however, the log skidder, semi-truck, and loader was owned and provided by Respondent. Petitioner testified that Respondent also provided the chains, fuel, and bars for his chainsaw. Petitioner testified that the signage on the truck indicated "David Johnson Logging." Petitioner was paid cash on a weekly basis. Respondent did not issue a 1099 or W-2 form to Petitioner.

Petitioner testified that he was asked by Respondent to come into work on Sunday, October 24, 2010, to set-up a sawmill. Petitioner was paid his normal wage of $120.00 per day. The location of the sawmill was in West Frankfort, Illinois, just off of Illinois State Highway 37.

Petitioner testified that he was welding legs on a motor which weighed approximately 2,000 pounds. As he was welding the motor, the legs collapsed and the motor landed on his chest, pinning him upright against the sawmill. Petitioner testified that he lost consciousness. Petitioner was taken by ambulance to Herrin Hospital. The initial assessment for Petitioner for a right severed arm at the shoulder with attached ligaments. (Petitioner's Exhibit (PX) 1). Petitioner was transferred to Barnes-Jewish Hospital via helicopter. (PX 4). He arrived at Barnes-Jewish intubated and stable for pain controlled. Exam revealed grossly dislocated shoulder with open fracture, exposure of pulsating vessels and laceration through the anterior musculature. He was initially diagnosed with near amputation of the right arm attached by posterior soft tissue. X-ray and CT-scans confirmed an open severely comminuted fracture of the right proximal humerus with a shortening by at least 10 centimeters. The CT-scan also revealed a non-displaced right posterior first rib fracture. (PX 2).

Three surgical procedures were performed on October 24, 2010: (1) a right axillary artery and vein cutdown, right brachial artery and basilica vein cutdown and anteriovenous shunting; (2) local wound exploration and ligation of axillary artery and vein; and (3) amputation of the right upper extremity at the glenohumeral joint. Petitioner remained in-patient at Barnes-Jewish Hospital. On October 28, 2010, Petitioner underwent a fourth surgical procedure of irrigation and debridement of the right shoulder and a full-thickness skin grafting from the right thigh to the right shoulder. Petitioner was in-patient at Barnes-Jewish Hospital from October 24, 2010 through November 2, 2010. (PX 2).

Petitioner followed up with his primary care physician, Dr. Michael Workman, on November 24, 2010, and continued to do so through 2011. Dr. Workman continually prescribed Norco, and did so as of his last visit with Petitioner in November 2011. (PX 3).

Petitioner was referred for prosthesis, where he was fitted and adjusted for a right arm prosthetic. He was seen for one final adjustment of the prosthesis on March 17, 2011. (PX 7). Petitioner was not wearing the prosthetic at trial, and testified that his reason for not doing so was because it was a "hassle."

Prior to the accident, Petitioner was right-hand dominant. Petitioner testified that since the accident, he can no longer perform a number of activities, such as buttoning his own shirt, hunting, fishing, hugging his girlfriend, tying his shoes, working on his vehicles, and riding his ATV. Petitioner had to re-learn doing things with one hand. Prior to the accident, Petitioner was an avid bow hunter and would bow hunt every year. He is still able to drive a vehicle, but can no longer drive vehicles that are manual shift. Petitioner is no longer able to drive a semi-truck because most of them are stick shift. Since the accident, he has allowed his CDL license to expire because of the fact that almost all semi-trucks are stick shift.

Petitioner also testified that he continues to have complaints of phantom right upper extremity pain. Petitioner described this pain as burning and tingling all the way up to his elbow. He experiences phantom pain on a daily basis and the pain is constant. Petitioner testified that he has not received any temporary total disability (TTD) benefits or medical bill payments from Respondent. Petitioner testified that all medical bills were placed in line for payment through Public Aid. (See also PX 8). Petitioner has not worked since the date of accident. Petitioner is currently receiving Social Security Disability benefits. Social Security found Petitioner was disabled since the date of accident, October 24, 2010.

On cross-examination, Petitioner testified that between logging jobs he continued to work for Respondent moving equipment between jobsites. Petitioner also testified that at the time of the accident, he was using Mr. Johnson's arc welder. Petitioner testified that prior to the date of accident, he had performed welding jobs on the skidder at the direction of Mr. Johnson. Petitioner also testified that Mr. Johnson directed him on the area of the woods to cut.

David Johnson testified on behalf of Respondent. Mr. Johnson testified that Petitioner was using his own welder at the time of the accident. Mr. Johnson did admit that Petitioner was using an arc welder as a generator. The arc welder was owned by Mr. Johnson. Mr. Johnson also admitted that he initially agreed to pay Petitioner $100.00 per day and two months later he increased his pay to $120.00 per day. Mr. Johnson denied that Petitioner ever drove the semi-truck. Mr. Johnson denied that he set the work hours for Petitioner. Mr. Johnson admitted that he directed Petitioner where to cut timber. Mr. Johnson denied that he provided gas, chains, and bars for Petitioner. On cross-examination, Mr. Johnson testified that he did not remember whether Petitioner drove the truck. He also did not recall if Petitioner drove a load of logs to Twin Mills Sawmill in West Frankfort, Illinois. Mr. Johnson did not recall whether Petitioner helped move equipment between jobsites.

Petitioner was recalled for rebuttal testimony. He testified that he was directed by Mr. Johnson to drive the truck to Twin Mills Sawmill. Petitioner testified that he drove the truck a minimum of 2-3 times per week. Petitioner denied that he could report to the jobsite anytime during the day. Petitioner testified that he was directed to report to the jobsite at 7:00 a.m.

CONCLUSIONS OF LAW

Issue (A): Was Respondent operating under and subject to the Illinois Workers' Compensation Act?

On October 24, 2010, Petitioner and Respondent, David Johnson, were operating under the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). Respondent is in the logging business within the meaning of Section 3 of the Act, and Petitioner was engaged in work for Respondent that day.

Issue (B): Was there an employee-employer relationship?

On October 24, 2010, the relationship between Petitioner and Respondent was one of employee/employer. The courts have articulated a number of factors to consider in determining whether an individual is an employee or independent contractor. The single most important factor is whether the purported employer has a right to control the actions of the employee. Also of great significance is the nature of the work performed by the alleged employee in relation to the general business of the employer. *Ware v. Industrial Comm'n*, 318 Ill. App. 3d 1117, 1122, 743 N.E.2d 579 (1st Dist. 2000). Additional factors the courts consider are method of payment, the right to discharge, the skill the work requires, which party provides the needed instrumentalities, and whether income tax is withheld. *Id*. The Arbitrator now turns to the factors in question.

Control

With respect to the factor of right to control, Petitioner credibly testified that he directly reported to Mr. Johnson. Petitioner also credibly testified that the work schedule was set by Mr. Johnson. Petitioner stated that the start time was dictated by Mr. Johnson. Mr. Johnson directed Petitioner to arrive at the work site at 7:00

a.m. Mr. Johnson admitted that he told Petitioner where to cut timber. Petitioner testified that his job duties of driving the truck, operating the skidder, maintenance of the equipment and welding were done at the direction of Mr. Johnson. Moreover, the signage on the truck Petitioner drove read "David Johnson Logging." These facts strongly indicate that Respondent had and exercised its right to control Petitioner's activities.

While Mr. Johnson testified that Petitioner did not work any set hours, he also testified that the job would take as many hours as needed in order for it to be accomplished. Mr. Johnson confirmed that Petitioner always came in to work at 7:00 a.m. Petitioner testified that he worked until the daily work load was done, which usually took around 8-10 hours per day. Therefore, Petitioner's testimony that he needed to arrive at work at 7:00 a.m. is given more weight than Respondent's testimony that Petitioner could come into work at any time he wished. The Arbitrator also notes the questionable testimony on behalf of Mr. Johnson during an exchange at trial regarding Petitioner driving Respondent's truck. The Arbitrator gives greater weight to the testimony of Petitioner.

Nature of Work/Business

Turning to the nature of Petitioner's work in relation to the general nature of Respondent's business, it is noted that Respondent is in the logging business. Petitioner was hired to cut trees and assist in the daily operations of Respondent's logging business. Petitioner credibly testified that he cut trees, drove the truck to the sawmill, operated the skidder, and performed welding and maintenance on the equipment. At the time of the accident, Petitioner was assisting Mr. Johnson set up his sawmill. Accordingly, Petitioner's work was intimately related to Respondent's logging business.

Payment Method and Taxes

Respondent paid Petitioner cash on a weekly basis and no income tax was withheld. These factors suggest an independent contractor relationship.

Right to Discharge

With respect to the right to discharge, according to Petitioner's testimony, if he failed to notify Mr. Johnson that he was not able to report to work due to an illness he would be terminated. This infers that Respondent had a right to discharge.

Instrumentalities

Turning to the issue of which party provided the instrumentalities needed to conduct business, Respondent provided the skidder, the loader, the semi-truck used to haul the logs, as well as the fuel to run this equipment. Petitioner used his own chainsaw but testified that the chains, bar and gas were provided by Respondent. Mr. Johnson denies that he provided the chains, bar and gas for the chainsaw. Petitioner also stated that he provided his own mig welder. However, there was also conflicting testimony regarding who provided the welder that was being used at the time of the accident. Petitioner testified he was using Respondent's arc welder at the time of the accident. Mr. Johnson testified Petitioner was using his own mig welder, but admitted Petitioner was using Respondent's welder as a generator. It is undisputed that both the motor and sawmill were owned by Respondent. The Arbitrator once again finds the testimony of Petitioner to be more credible than that of Respondent. Because Respondent provided the bulk of the equipment used to conduct his logging business, this factor weighs heavily in favor of Petitioner being considered an employee.

A majority of the factors, including the two most important factors assessed, indicate that Petitioner was an employee of Respondent. Thus, the Arbitrator finds that on October 24, 2010, the relationship between Petitioner and Respondent was one of employee/employer.

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; and

Issue (D): What was the date of accident?

Petitioner sustained an injury arising out of and in the course of Petitioner's employment by Respondent on October 24, 2010. This conclusion is supported by the testimony and the medical records. The records are clear that Petitioner suffered a catastrophic injury on that date that resulted in the amputation of his right arm. Petitioner was working for Respondent on that date, performing employment tasks he was asked to do. Petitioner therefore has met his burden of proving an accident that occurred on October 24, 2010.

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's current condition of ill-being is casually related to the injury. This is based on Petitioner's testimony and the medical records. The medical records show an accident history consistent with Petitioner's testimony at trial. All doctors relate by history Petitioner's complaints to this trauma. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the October 24, 2010 work injury.

Issue (G): What were Petitioner's earnings?

Petitioner testified that he began working for Respondent in March 2010. Petitioner testified that for the first two months of employment he received $100 per day, or $500 per week. After two months, Respondent increased Petitioner's wages to $120 per day, or $600 per week. Petitioner testified that he worked Monday through Friday, five days per week. Respondent agreed that he initially paid Petitioner $100 per day and increased Petitioner's wages to $120 per day shortly thereafter. Petitioner's worked for Respondent from March 2010 through October 24, 2010 (34 weeks). Based on the corroborating testimony of the parties, the Arbitrator finds that Petitioner's average weekly wage (AWW) is $574.37. The following calculation was used to arrive at the AWW: [$500(8-5/7 weeks) + $600(25-2/7 weeks)] ÷ (34 weeks).

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner sustained a severe trauma to his right shoulder, which required emergency medical services, inpatient hospitalization, amputation of the right arm, follow-up treatment and the need for right arm prosthesis. Based on the medical records, Petitioner's treatment was reasonable and necessary. According to Petitioner's Exhibit 8, the medical bills were paid by Medicaid/IHFS. Respondent shall therefore hold Petitioner harmless for any and all payments put through Illinois Medicaid.

Issue (K): What temporary benefits are in dispute? (TTD)

The medical records indicate Petitioner was hospitalized from October 24, 2010 through November 2, 2010. The Arbitrator finds that Petitioner reached maximum medical improvement for his condition when he

was last seen by Dr. Workman on November 3, 2011. Following discharge from the hospital on November 2, 2010, according to Petitioner's unrebutted testimony, Respondent never offered him any one-armed work. Accordingly, the Arbitrator finds that Petitioner is entitled to TTD benefits from October 25, 2010 through November 3, 2011.

Issue (L): What is the nature and extent of the injury?; and

Issue (O): Is Petitioner permanently and totally disabled?

Prior to the accident, Petitioner was right hand dominant. Petitioner testified that he continues to experience phantom pain of the right upper extremity. Petitioner described the pain as burning, tingling and numbness. Petitioner experiences the phantom pain on a daily basis.

Prior to the accident Petitioner was an avid bow hunter and ATV rider. He can no longer do these recreational activities. He is still able to drive a vehicle, but can no longer drive vehicles that are manual shift. Petitioner is no longer able to drive a semi-truck because most of them are stick shift. Since the accident, he has allowed his CDL license to expire because of this. Petitioner testified that since the accident, he can no longer perform a number of activities, such as buttoning his own shirt, hunting, fishing, hugging his girlfriend, tying his shoes and working on his vehicles. Petitioner has had to re-learn to do everything with one arm.

In light of Petitioner's testimony and the medical evidence, the Arbitrator finds that Petitioner sustained the 60% loss of use to the person as a whole pursuant to Section 8(d)2 of the Act. Furthermore, Petitioner sustained a severe comminuted fracture of the humerus which required an amputation of the right upper extremity at the glenohumeral joint. Respondent shall therefore pay Petitioner permanent partial disability benefits for an additional 323 weeks, because the injuries resulted in the amputation of the right arm at the shoulder joint, as provided in Section 8(e)(10) of the Act.

In light of the evidence presented, the Arbitrator finds that Petitioner failed to meet his burden of proving he is permanently and totally disabled.

Issue (M): Should penalties and fees be imposed on Respondent?

Petitioner filed a petition for penalties and attorney's fees pursuant to Sections 19(k), 19(l), and 16 of the Act. (Arbitrator's Exhibit 7). Respondent filed an answer to said petition. (Arbitrator's Exhibit 6). Respondent argues that Petitioner was an independent contractor, and therefore had no responsibility under the Act for payments relating to Petitioner's injury. While an opposite conclusion was made by the Arbitrator in this case, the Arbitrator does not find Respondent's position in this regard unreasonable. The Arbitrator does not find Respondent's actions in this matter to be unreasonable, vexatious or frivolous, and therefore denies an award of penalties or fees.

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

Robert Winters,
Petitioner,

vs. No: 11 WC 48994

David Stanley Consultants,
Respondent.

15IWCC0408

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, temporary total disability, and the nature and extent of the permanent disability, and being advised of the facts and law, modifies the permanent partial disability awarded, and otherwise affirms and adopts the April 4, 2014 Decision of Arbitrator Edward Lee, which is attached hereto and made a part hereof.

Petitioner, a 39 year old roof bolter, was employed by Respondent as a temporary worker in a coal mine operated by American Coal. On December 12, 2011, Petitioner was injured as he was drilling a hole in the ceiling of a mine in Galatia, Illinois and was taken to the Emergency Room at Ferrell Hospital in Herrin, Illinois, where his right ring finger was wrapped and splinted. Petitioner was immediately transferred to Deaconess Hospital in Evansville, Indiana, where he was diagnosed with an open middle phalanx fracture and underwent surgery by Dr. Emerson to irrigate and debride the fracture, to partly repair the dorsal lateral band, to repair the A-4 pulley, and to provide internal fixation of the fracture. Petitioner then underwent physical therapy at Harrisburg Medical Center.

Petitioner testified that he continued to experience pain and limited range of motion after therapy, and he remained off work per Dr. Emerson's order. The doctor referred Petitioner to Dr. King for a second opinion, and Dr. King recommended revision surgery. On February 9, 2012, Petitioner underwent tenolysis of the extensor mechanism, tenolysis of the flexor tendon FDS and FDP, and reconstruction of the A-4 pulley. Dr. King prescribed pain medication, kept Petitioner off work, and referred him for physical therapy. On July 11, 2011, Dr. King found Petitioner at maximum medical improvement, despite ongoing complaints of limited motion, tenderness and swelling.

15IWCC0408

At hearing Petitioner testified he continued to have pain in both his ring finger and right hand. He cannot ride a motorcycle or use certain tools, as vibrations cause pain, and his ring finger remains permanently bent lower than his other fingers.

Respondent accepted liability for this injury and paid Petitioner temporary total disability through July 11, 2011, when Dr. King placed Petitioner at maximum medical improvement. Outstanding medical bills totaled $399.86. Respondent noted that Petitioner had not returned to his orthopedic surgeon for 17 months prior to the arbitration hearing and that at therapy in June 2012, Petitioner reported either no pain or minor pain that rapidly subsided. Arbitrator Lee ordered Respondent to pay the outstanding bills and awarded permanent partial disability of 100% loss of use of the right ring finger and 3% loss of use of the right hand.

On appeal to the Commission, Respondent argues that Petitioner's finger disability was not so severe as to merit an award of 100% loss of use of the ring finger and should not merit any award based on the hand.

The Commission acknowledges that Petitioner did suffer significant damage to his ring finger as a result of his work accident on December 12, 2011. He underwent two surgeries and has reduced strength and range of motion. However, the Commission agrees with Respondent that the Arbitrator's award of 100% loss of use of the ring finger and 3% loss of use of the right hand is excessive.

Section 8(e)9 of the Act provides as follows:

> **The loss of 2 or more digits, or one or more phalanges of 2 or more digits, of a hand may be compensated on the basis of partial loss of use of a hand, provided, further, that the loss of 4 digits, or the loss of use of 4 digits, in the same hand shall constitute the complete loss of a hand.**

820 ILCS 305 §8(e)9. Petitioner here suffered an injury to only one phalanx of one finger. Such a loss of use does not, per se, qualify Petitioner for a permanency award related to the hand under Section 8(e)9 of the Act.

However, the Commission acknowledges that cases involving loss of a finger significant enough to cause the claimant to suffer a loss of use of the hand in gripping, a permanent partial disability finding to the hand may also be awarded. In *McGinnis v. Alcoa Extrusions*, No. 11 IWCC 003780, the Commission reduced the Arbitrator's permanency award, but confirmed that both finger and hand awards under Section 8(e) were appropriate, where the claimant was unable to bend the DIP joint of his middle finger and that disability affected his ability to grip.

However, the evidence in this case indicates a less severe permanent injury than was found in *McGinnis*, and the Commission adopts the rationale of the Illinois Supreme Court in *Meade v. Industrial Comm'n*, 48 Ill.2d 215, 269 N.E.2d 288 (1971), in finding that a permanency award for the hand is not merited. In *Meade*, the claimant suffered injuries to his right hand when it was caught in the cogs of a conveyer belt. The Arbitrator awarded the claimant 80% loss of

use of the right hand. The Commission modified the Arbitrator's award, reducing it to 100% loss of use of the index finger, 40% loss of use of the middle finger, 20% loss of use of the ring finger, and 10% loss of use of the little finger. The Supreme Court affirmed the Commission's modification of the Arbitrator's award, finding that the evidence failed to show any loss of use of the claimant's right hand "other than the disability due to the injured fingers." The Court's rationale follows:

> In the case at bar, the injury to the petitioner was not so serious as to require amputation of his hand. Moreover, there was no injury to either the palm, back of his hand, or the thumb, and he retained the use of the hand except for such impairment as necessarily resulted from the loss of use of his fingers. The evidence failed to show any loss of use of the hand other than the disability due to the injured fingers.

48 Ill.2d at 218.

Similarly, in the instant case, Petitioner failed to show any permanent partial disability to his right hand beyond that due to the injured ring finger. There was no amputation, and, although his range of motion in his ring finger remained somewhat limited, the Commission finds that the injury did not extend to the hand. The Commission notes other cases as additional guidance.

In *Espinosa v. MGD Cement Constr. and IWBF*, No. 13 IWCC 1005, the Commission reversed the Arbitrator's finding that no compensable accident occurred. The claimant testified it was difficult for him to grasp things and he had weakness in his hand, because his middle and second fingers did not bend or extend fully. The Commission based its permanency awards on the claimant's fingers and thumb, rather than his hand. And in *Decesare v. Illinois Dept. of Transp.*, No. 13 IWCC 229, the Commission modified the Arbitrator's award of 7.5% loss of use of the left hand and entered instead an award of 45% loss of use of the left fifth finger. The Commission relied upon Section 8(e)9 and upon the Appellate Court's holding in *Outboard Marine Corp. v. Industrial Comm'n*, 309 Ill.App.3d 1026, 723 N.E.2d 835, 243 Ill. Dec. 532 (2d Dist. 2000), wherein the Court approved the Commission's award of 25% loss of use of each of the claimant's four fingers rather than an award based upon the hand.

After considering the entire record, and for the reasons set forth above, the Commission finds that Petitioner's injuries were properly attributed to his right ring finger and were not severe enough to merit an award under Section 8(e)9. The Commission vacates the award of permanent disability as it relates to the hand and further finds the Arbitrator's award of 100% loss of use of the right ring finger should be reduced to 75% loss of use of the right ring finger. This finding is consistent with the Commission's previous rulings in *Espinosa* and *Decesare*.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the April 4, 2014 Decision of the Arbitrator is modified with regard to the award of permanent partial disability.

15IWCC0408

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $432.68/week for a period of 20.25 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to Petitioner to the extent of 75% loss of use of the right ring finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay $399.86 for reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injuries.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,300.00. 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: MAY 29 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-03/04/15
jdl/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINTERS, ROBERT
Employee/Petitioner

Case# **11WC048994**

DAVID STANLEY CONSULTANTS
Employer/Respondent

15IWCC0408

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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
617 E CHURCH ST SUITE 1
HARRISBURG, IL 62946

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60606

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

ROBERT WINTERS
Employee/Petitioner

v.

DAVID STANLEY CONSULTANTS
Employer/Respondent

Case # **11** WC **48994**

Consolidated cases: _____

15IWCC0408

An *Application for Adjustment 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 **2/6/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **12/12/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$37,499.28**; the average weekly wage was **$721.14**.

On the date of accident, Petitioner was **39** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $ under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of **$432.68**/week for a further period of **27** weeks, as provided in Section **8e** of the Act, because the injuries sustained caused **100% loss of use of the right ring finger** and for a further period of **6.15** weeks because the injuries sustained caused **3% loss of use of the right hand**.

Respondent shall pay the petitioner compensation that has accrued from **12/12/11** through **02/06/14** and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay the further sum of **$399.86** for necessary medical services, 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.

Signature of Arbitrator

3/21/14
Date

APR 4 - 2014

Robert Winters v. David Stanley Consultants
No. 11 WC 48994
Arbitrator Edward Lee

FINDINGS OF FACT

On December 12, 2011, Petitioner was injured while working for Respondent David Stanley Consultants as a roof bolter at the American Coal Company site in Galatia, Illinois. On that date Petitioner was drilling a hole into the ceiling and had used two steel bits back to back and as he let go and sat his right hand down, the steel bits came down and landed onto his right ring finger which caused the right ring finger to dangle. Petitioner testified that on that date he not only experienced pain in his finger but also in his entire hand because of the injury.

Petitioner was thereafter taken to the Emergency Room at Ferrell Hospital in Eldorado, Illinois where his right ring finger was wrapped and provided with a splint. Petitioner was immediately transferred to Deaconess Hospital in Evansville, Indiana at which time he was diagnosed as having an open right ring finger, middle phalanx fracture.

The next day, on December 13, 2011, Dr. Daniel Emerson diagnosed Petitioner has having a comminuted open right ring finger middle phalanx fracture, dorsal lateral band laceration of extensor mechanism, ring finger, right hand, and volar A-4 pulley laceration on ring finger, right hand. On that date Dr. Emerson performed the following procedures: 1) irrigation and debridement of comminuted open right ring finger middle phalanx fracture, 2) open reduction internal fixation of comminuted open right ring finger middle phalanx fracture, 3) partial repair of dorsal lateral band, right ring finger, 4) repair of A-4 pulley, right ring finger. Dr. Emerson referred Petitioner to physical therapy which Petitioner attended at Harrisburg Medical Center.

Petitioner continued to treat with Dr. Emerson post operatively and continued to experience pain and was kept off of work. After continuing to have pain and limited range of motion even through attending physical therapy, Dr. Emerson referred Petitioner to Dr. David King for a second opinion. Petitioner first met with Dr. King on March 23, 2012, which was a little over three months after surgery. Dr. King ordered a diagnostic study of the injured finger and indicated that the finger had scarred down therefore a second surgery would be recommended.

On April 9, 2012 Dr. King performed a second surgery on Petitioner's right ring finger. The procedure performed was: 1) tenolysis extensor mechanism, 2) tenolysis flexor tendon FDS and FDP and 3) reconstruction of A4 pulley. Petitioner was prescribed pain medications, was kept off of work and was again referred to therapy.

Petitioner continued to treat with Dr. King post operatively and was noted on July 11, 2012 to have continued limited motion as well as tenderness and swelling. On that date Dr. King released Petitioner at MMI.

Petitioner is right hand dominant. Petitioner testified that he continues to experience pain in his right ring finger and right hand. He testified that he is unable to do many of the activities that he once could before the injury such as riding a motorcycle or using certain tools. Any type of vibration causes increased pain in his right ring finger and travels throughout his right hand. Because of the injury and subsequent surgeries, Petitioner's right ring finger is permanently bent down lower than his other four fingers. Petitioner continues to regularly treat with his primary care physicians at Ferrell Hospital for pain and discomfort associated with this injury.

Petitioner was paid TTD benefits from the date after his injury until he was released at MMI on 7/11/12. Petitioner still has outstanding medical bills related to this injury in the amount of $399.86.

CONCLUSIONS OF LAW

Based on the above, I find that the Petitioner is disabled to the extent of 100% loss of use of the right ring finger and 3% loss of use of the right hand. I also direct Respondent to pay for all related outstanding medical expenses in the amount of $399.86. Petitioner has been paid all necessary temporary total disability benefits from 12/13/11-7/11/12 and as no evidence was presented at trial as to any benefits paid beyond those dates, Respondent is not entitled to any alleged overpayment or credit.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

☐ 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

Vernon Arnold,

Petitioner,

15IWCC0409

vs.

NO: 01 WC 13489

State of Illinois/Fox Developmental Center,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Sections 19(h) and 8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of whether Petitioner's disability has materially increased since the time of arbitration and being advised of the facts and law, finds that Petitioner is entitled to an additional 5% loss of use of his right leg.

The Petitioner testified at the hearing of his 19(h) petition that he continues to see Dr. Rezin. In 2004, he prescribed him a special type shoe and in January of 2006, Dr. Rezin performed surgery on his right knee. Petitioner returned to his regular job following the surgery and physical therapy. (Transcript Pgs. 5-8)

Petitioner testified that since 2006 his right knee pain is worse and that when it rains and the weather changes it is very painful. His limp has gotten worse and that he has gotten injections to his right knee. He still has problems walking and the pain goes up his back and hips. (Transcript Pgs. 9-14)

Petitioner has returned to work as a carpenter and his job duties still include building, repairing and modifying wheel chairs. He admitted that he must stand all day long at work and that he does not use an assistive device to help him walk. (Transcript Pgs. 19-22)

At the original arbitration hearing the Petitioner testified that his right leg still goes out to the right and that he walks with a limp. He has pain that "comes up my right leg and my back"

15IWCC0409

and he has it "all the time. Everyday." He testified that he has to hang on a rail and is sore by the time he gets to where he is going. He is on his feet all day at work and at the end of the day he is very sore. When he drives a long distance his leg starts to cramp up. He can feel the metal rod in his leg when the weather gets cold or he has been on it for too long. (Arbitration Transcript Pgs. 17-20)

The surgery performed by Dr. Rezin on August 10, 2006 was a right knee arthroscopy with partial medial meniscectomy and minimal debridement of the meniscal fraying. (Petitioner Exhibit 8)

Dr. Rezin testified, by way of deposition on July 30, 2013, that based on a reasonable degree of medical certainty Petitioner has suffered a material increase in his disability since November 23, 2004. Petitioner is having more subjective pain and that he cannot feel his feet as much. The Doctor believes that Petitioner's x-rays show a slow worsening. (Petitioner Exhibit 17 Pgs. (24-26) However, the Doctor admitted that he has not provided any work restrictions on the Petitioner. (Petitioner Exhibit 17 Pgs. 32-36)

As a result of the altered force of Petitioner's leg as it rubbed against his knee, the surgery performed on August 10, 2006, was the result of the Petitioner's original accident. (Petitioner Exhibit 1)

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's request for Section 19(h) benefits be granted for an additional amount of 10 weeks or 5% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that all medical bills contained in Petitioner's exhibits 13 and 15 that are causally related to Petitioner's treatment of his injuries is the responsibility of the Respondent pursuant to Section 8(a) and 8-2.

IT IS FURTHER ORDERED BY THE COMMISSION that since November 14, 2003, Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAY 29 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 4/1/15
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